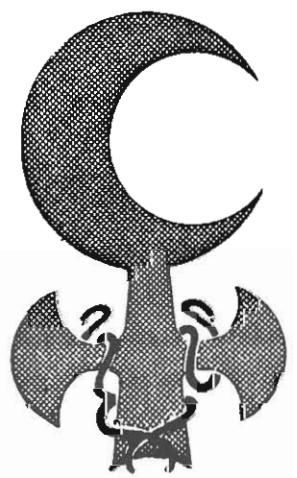
CASSANDRA

radical feminist nurses newsjournal

Vol. 5 No. 2 May 1987



I have learned, as have many other women, that there is powerful truth in what we are learning about how ... institutions jeopardize our health. I have learned to trust feminist sources of information, and to trust myself. I have learned that I cannot take on the system myself, and that I must be selective in the battles that I fight. . . . I have learned the value of women's voices and of having places where we can speak our truths. It is vitally important that we tell our stories to heal ourselves, and to build connections between us so that we can keep working for change.

-- Susan E. Browne
in With the Power of Each Breath

CASSANDRA: RADICAL FEMINIST
NURSES NEWSJOURNAL

A publication of Cassandra: Radical
Feminist Nurses Network
P.O. Box 341
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Published 3 times each year at the time of the full moon in January, May and September. Available to Websters, friends and institutions. Limited numbers of back issues are available for $4.00/issue. Use the above address for:

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BACKGROUND

The name CASSANDRA is a tribute to Florence Nightingale who wrote an essay titled Cassandra two years before her service in the Crimean War. In it she states: "Why have women passion, intellect, moral activity - these three - and a place in society where no one of the three can be exercised?" Like the mythical Cassandra, Nightingale possessed the gift of prophesy and despaired at not being heard. CASSANDRA: RADICAL FEMINIST NURSES NEWSJOURNAL is dedicated to re-creating the Cassandra myth by providing a place where the passion, intellect and moral activity of women who are nurses can be voiced and heard. The Newsjournal is a means for actively preserving and passing on written materials coming from a woman-defined perspective. Our hearing one another is critical to establishing a network among feminist nurses who need to be heard in nursing practice, education, research, administration and health care.

NEWSJOURNAL PHILOSOPHY

The Newsjournal is produced by Websters in Buffalo, NY. We are committed to a feminist approach to media, which includes sharing and nurturing of skills, non-heirarchical relationships, and valuing of diversity. There are no editors or review board members; the material for each issue is reviewed, selected and prepared by local Websters whose names appear in the "Thrums" section of each Newsjournal.

We publish original work developed from a feminist perspective. We encourage exploration of issues that radically effect nurses and women. While opinions expressed are those of the author and not necessarily those of CASSANDRA as a whole, we do accept responsibility for what we print. We will not intentionally print material that is harmful to women because of color, sexuality, religious or cultural background, physical ability or economic situation. We reserve the right to edit with the intent of remaining true to the author's own message. Insofar as possible, edited material will be available to the author prior to publication.

MAILING LIST

CASSANDRA's mailing list is confidential and will not be sold or given to any other group. Names and addresses of women who join CASSANDRA are provided to Contact Women in their geographic area; only the names and addresses of Contact Women and Coordinating Crones (women responsible for specific tasks) are published in the Newsjournal. The Newsjournal is distributed to members and friends of CASSANDRA, and to institutions or groups that subscribe to the Newsjournal.

ADVERTISING

Display ads will be published for businesses offering products that are consistent with CASSANDRA'S philosophy and purposes. Write to CASSANDRA for rates. Judgments about the suitability of ads for the Newsjournal will be made by the Web responsible for producing the Newsjournal.

CONTRIBUTION GUIDELINES

We welcome the contribution of articles, information, and letters that are of interest to women who are feminist nurses. Our regular features include nursing history, feminist research, myths influencing women's lives, reviews of books and journal articles, resource information, and notes that promote networking.

Articles should be original work that has not been previously published; preference is given to articles written by women who are members of CASSANDRA. The suggested length of articles, commentaries and reviews is 2-4 pages, typed double-spaced. Manuscripts of articles and book reviews are reviewed and selected by members of the Web that produces the Newsjournal. Manuscripts are reviewed in relation to consistency with CASSANDRA's purposes and philosophy, conciseness, readability, and strength of presentation.

We welcome letters, notes and resource information from anyone interested in sharing information with members of CASSANDRA. Letters should be no longer than one page in length, typed doubled-spaced. Notes and resource information need to be very brief, approximately 12 double-spaced typed lines.

All material must be accompanied by the author's name and address in order to be published. We prefer to publish names and addresses, but we will withhold your name and/or address if requested.

Please mail your contribution so that it reaches us by the following lifeline dates:

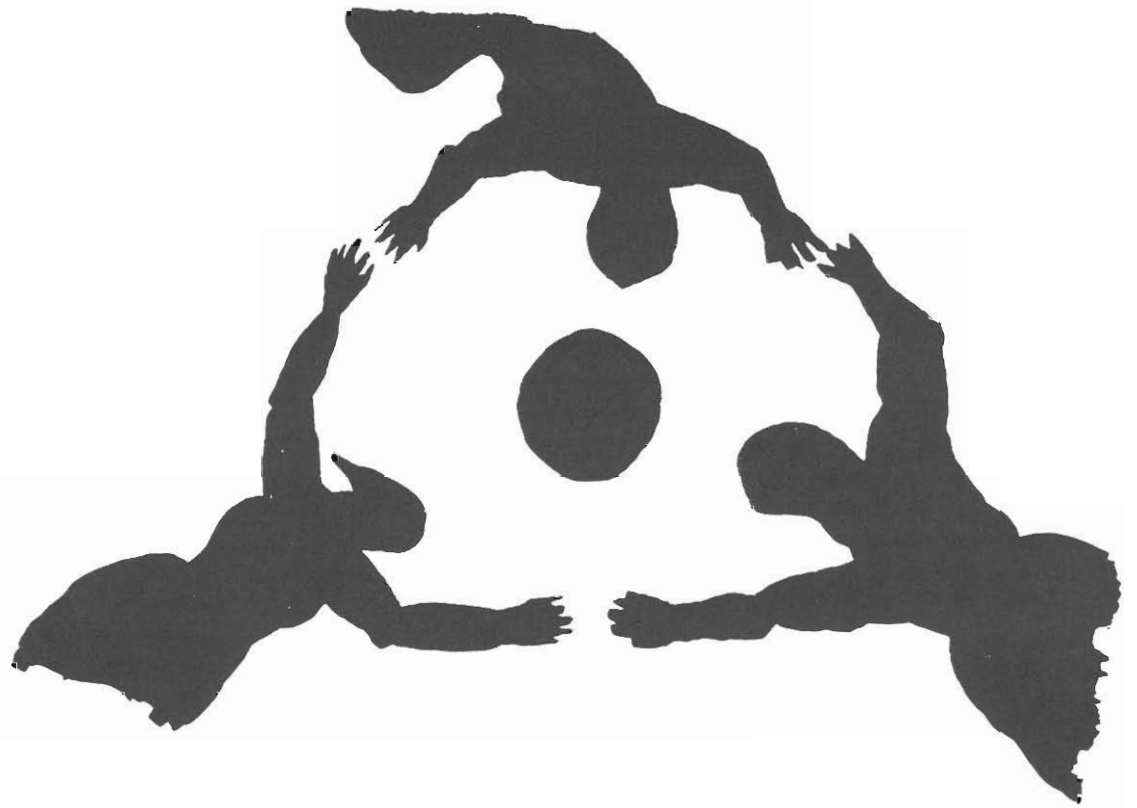
January issue: November 15
May issue: March 15
September issue: July 15

OUR PURPOSES . . .

CASSANDRA: RADICAL FEMINIST NURSES NETWORK is a gathering of women in nursing practice, education, research and administration. Our primary commitment is to end the oppression of women in all aspects of nursing and health care. We believe that oppression of women is fundamental to all oppressions and affects all women.

Our primary purposes are to:

- Develop and communicate radical feminist, woman-centered analyses of issues in nursing and health care.
- Nurture local, regional, and national networks of women in nursing who are committed to a radical-feminist perspective.
- Provide an environment for communication, support and safety among nurses regardless of race, class, creed, ability, or sexual preference.
- Share and pass on skills of leadership, analysis and communication.
- Take strong public actions on nursing and health care issues.
- Preserve and publish past and present significant works of nurses.
- Publish writings on women's health that are rooted in feminist analysis.
- Support nursing research using a feminist approach.
- Develop feminist educational material for nursing programs.
- Establish a feminist nursing journal.



1987 CASSANDRA CONTINENTAL GATHERING

The 1987 CASSANDRA continental gathering will be in Salt Lake City at the Art Barn, 54 Finch Lane, near the University of Utah Campus. The Art Barn is a two story structure with carpet, kitchen and air conditioning with space for about 45 people. The Salt Lake Websters have organized information about housing and transportation. Contact women are available to assist those coming to the Gathering to make arrangements for their arrival and lodging. A welcoming picnic is planned for Wednesday afternoon, June 24th at 4:00 pm in the park adjoining the Art Barn.

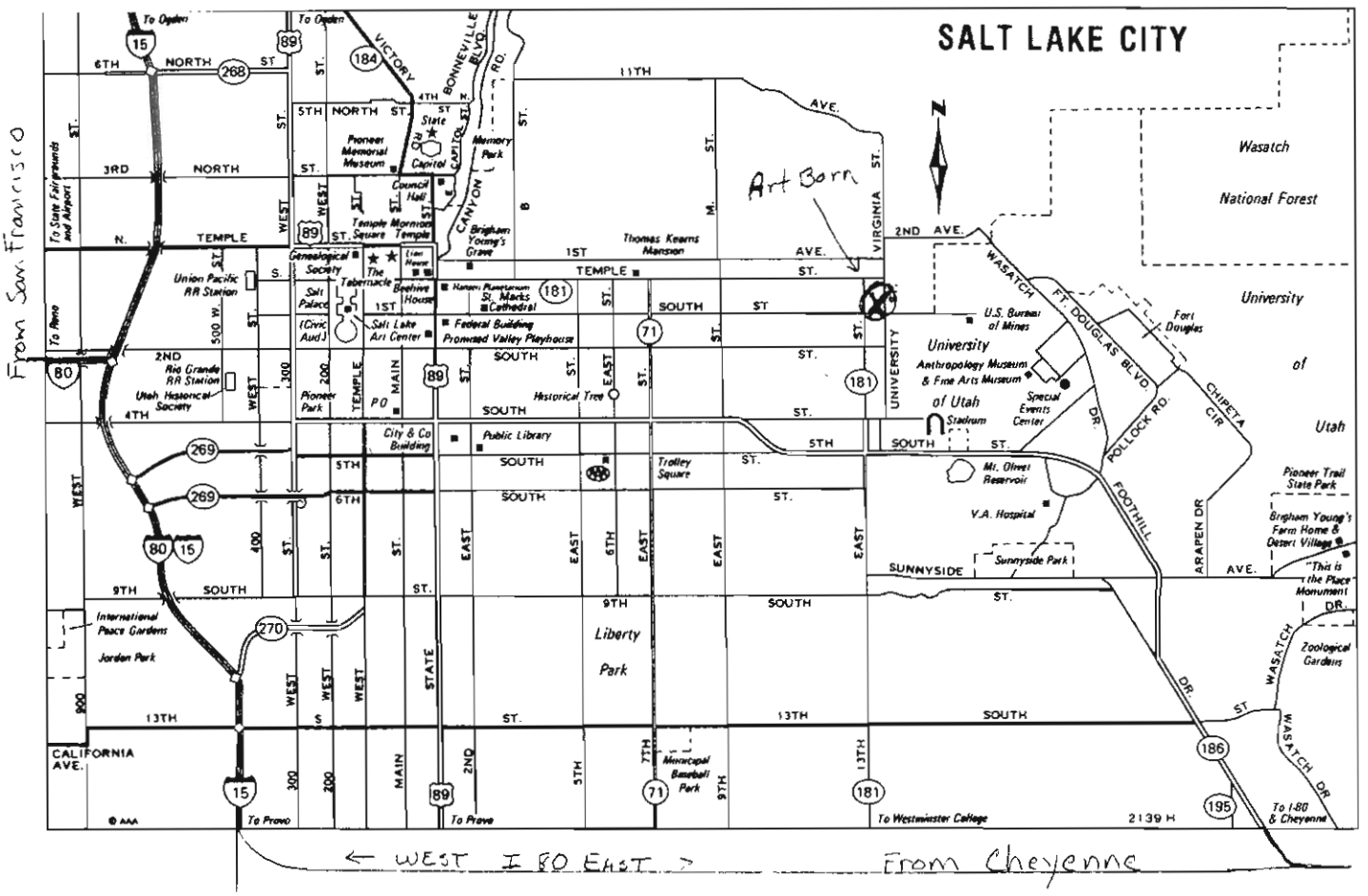
The gathering is open to all Websters -- that is women who are nurses (or students) who have contributed financially to continue to make our network possible. Friends who are traveling with a Webster may participate in selected social events and discussions (to be determined at the time of the gathering by those present) but we have made a commitment to reserve the major portion of the gathering, including Spinning Bees, for Webster participation only.

To anticipate the amount of food and beverages, we would appreciate knowing if you plan to come to the gathering, and if you will be able to participate in the picnic. A form was included in the Golden colored CASSANDRA ACTION NETWORK we sent during April; if you have lost yours or did not receive one, please write to let us know when you are arriving, where you plan to stay, and if you need any further assistance. Please write to Carol Ashton,3685 Palisades Dr., Salt Lake City, UT 84109.

As we have in the past, everyone who attends the gathering is responsible for her own travel, meals and lodging. The group expenses for meeting space and other group costs are usually covered by Cassandra.

Housing contact woman: Carol Ashton (801/485-3727), 3685 Palisades Dr., Salt Lake City, UT 84109.

- A limited number of dorm rooms are available at $13/day single, $19/day double; about 15 minute walk from the Art Barn. For information and reservations, call Angelina at 801/581-6292.



- Motels, hotels and camping:
Motel 6: 1990 West Temple (801/322-3061) about 4 miles from University; $20/single; $25/double.
Skyline Motel: 2475 East 1700 South (801/582-5350) about 1 mile from University; $33/ingle; $39 and up/double.
KOA Kampground: 1400 West Temple (801/355-1192) About 3.5 miles from University; $20 full hook-up; $15 tent site.
Temple Square Hotel: 75 W. South Temple (801/355-2961) About 1 mile from University; $32-36/single; $38-42/double.
YWCA: 322 East 300 South. A battered women's shelter with some rooms available $8/night.

Airport transportation contact woman: Judy Colletti (801/487-9297), 1426 Parkway Ave., Salt Lake City, UT 84106.

Judy will arrange for someone to meet you at the airport if you let her know the time of your arrival. Limosine service is also available to all major hotels in the downtown area.

Spinning Bee contact woman: Maeona Jacobs (801/943-9840) 9855 South 3100 East, Sandy, UT 84092. To facilitate planning the agenda, we welcome any advance information from individuals who are interested in presentations or spinning bee discussions. The Spinning Bee is a discussion of a topic of mutual interest to Cassandrans, usually guided by a Webster with special interest or knowledge about the topic.

"We're all preoccupied with the ends, but the means are everything. It is the doing-of-it that transforms the world."
-- Patricia Sun

LAVENDER AND SILVER
by Kore Hayes Archer

Everyday Magic

I do in-home health care, so I have a lot of contact with elderly women. There's this one old lady, she's 94 years old, that I've been taking care of for the last six months, three shifts a week. She's had a stroke, and the left side of her body is paralyzed. She needs assistance with meals, meds, dressing and ambulation. I walk with her when she needs to use the toilet, or, on days when there's no sign of breeze, to the back porch to sit in the sun.

Here's how we walk together: I plant my feet wide apart, my left foot set so as to brace her rubbery left leg, and my right leg planted alongside the edge of the chair, so I can come in close for the lift. I take a deep breath and hold it as I tuck my two hands into the crotches of her arms and heave her weight up and forward to rest on the tripod of her cane, her sturdy right leg, and our two left legs. She is not a small woman; every now and then, in mid-lift, her body will suddenly feel like dead-weight, too much for me. Then I feel the force of my determination, my mental exertion, as I close my eyes, push through the moment of doubt, push the soles of my feet into the floor, and will the stand-up to happen. And it does. Then I let out my breath, as she balances forward on her cane, and I pivot to stand behind her, still holding her up by her underarms.

Then we walk. Heavy on our right legs and the cane, as I kick her rag-doll left leg forward. Then we lurch to the left, just long enough to lift the two right legs forward. We pitch and roll from side to side, following an irregular rhythm, like an old fishing boat in the harbor. In this odd duet, our bodies come together in careful synchronization, pressed warmly against each other for safety, her shapeless butt against my belly, my right breast squashed into her spine, our two breaths audible.

It's a demanding, precarious workout for both of us. My first weeks with her I'd

break out in a sweat halfway to the bathroom; now that I'm lifting weights at the gym, it's gotten a whole lot easier. It gets easier and harder on different days, depending on how alert she is, whether or not she's in pain, and how cooperative she's feeling that day.

Of course, this improvised walk flies in the face of standard medical procedure; it's hard on my back, especially the raising and lowering, and risky for her as well. A walker or wheelchair would've been much wiser solutions. But she has adamantly refused those options, and so this questionable dance is what gets us from here to there. At first, I was uneasy about what could happen if one of us tripped on the edge of a rug, or skidded on the tiled floor. But after a certain number of frightening staggers and near-spills, I began to see that whatever the amount of strength needed to pull her back into safe balance, it would always be there for me. Always. I can feel it now, a given fact: I will not let her fall, no matter what. And this still amazes me.

So our time with each other is very physical, very intimate. Our sense of co-balancing is fine-tuned. To balance that much weight between two moving people demands and develops certain abilities. Trust. Timing. Inner listening. These are some of the qualities I'm acquiring in this role with her, gifts from the Crone.

* * *

Perhaps because English is not her native language, we have a lot of silence between us. The TV is on all day, and that gives us something visual to comment on, but most of the time our thoughts influence without spoken contact.

Again and again I rise to move her through the same exact routines, and we say the same exact things, with minute variations, each time:

"You gotcha me?"

"I gotcha, Grandma!"

"I no zlitt-a?"

"Nope, I won't let you slip, I gotcha."

And:

"OK, all aready!"

"OK, Grandma, here I come!"

"You take me and check me."

"OK, I'm gonna lift you now, and check you ... OK, nice and clean now, Grandma, you can take the stick and go."

"OK, I take-a the stick and go now. You gotcha me?"

The repetition becomes hypnotic as the shift wears on; our words to each other take on a chantlike quality, like the call and response of a gospel choir. Two birds in their separate treetops. Tapping something deep, in the saying of these simple words, deeper than the words themselves. But of course --anything you do over and over again with the same person like that becomes a ceremony. It has that ritual quality, alters awareness.

And so the unconscious comes alive in our speaking and touching again and again in the same way during these humble routines. The walk becomes a sacred walk; our spoken reassurances to each other become the lyrics of a sacred song.

Injustice

Of course, don't get me wrong. This work that I do also includes nightmarish stretches that drag on forever! Sometimes I arrive unprepared to be there fully -- overworked, or weary in spirit; then the little mobile home or apartment becomes an airless dungeon. Stifled by the force of habit here, the old ladies' insatiable pickiness, their meaningless, repetitive ramblings, I become frantic with the need for change. I feel at times as if I'm worthless, becoming a nobody. This place is some kind of a vacuum, sucking the life out of me! Then all I can care about is the hour of my release, the moment when at last I'm restored to my own rhythms, nurturing spontaneity, curiosity, and self-esteem, seeking challenge! Then I despise this confinement, this unending, regimented monotony, wanting only to be on the other side of that picture window, in the fresh, clear air, having an adventure! Breathing, moving, free!

At times like this I look at these old ladies, hunched over in front of their color TV's surrounded by crocheted bric-a-brac and vials of pills and portraits of the

husbands they've outlived, and I rage and despair that this could have happened to them -- this terrible isolation, this neglectedness, the atrophy of joy, their dependencies, their ongoing dread of almost everything out there, the obsession with details that obscures the wisdom of their years and barricades them from heart-to-heart communication. I know this cannot be the end they had in mind! How could this have happened? I feel anxious for my own future, then: this is a vision of the old age I DON'T want for myself! How can I protect myself from this scenario?

Periodically, these questions run through my mind, and over time, my contact with these elders begins to give me an opposite way to claim the ripening of my womanhood. My distress at the tonelessness of their last years fuels my determination not to end up this way. To maintain my community, my interdependence, so that I can yield up my beloved privacy to the caring hands of my dearest friends when my turn comes. To cultivate my fearlessness and open-mindedness and listening skills; my physical and emotional resilience, my passion. To allow change, to stretch and grow, to engage with the world, while I'm here!

Little by little, I'm coming to accept that it's not appropriate to judge these lives, or possible to rescue them. The power that is mine is to design and alter my own seniority. And so I continue to develop the negative of this snapshot: the old lady slumped over in front of the TV set.

That Lifegiving Current

What I can do for the ladies I work for is to love them as they are. To stop projecting some idealized Wise Woman on them and honor them simply for their longevity, for having survived whatever they have survived, and for the courage that it must take to be female and old. I can see them and honor them and be there for them just as they are.

Here is a memory from one of my first caregiving experiences: I was working for an old woman who was dying of emphysema. This is a slow and terrible way to die, and near the end there was a time when she was in great discomfort --feeling her body really beginning to give way, and still fighting it. Parts of her were dead already -- the feet swollen and discolored, the hands too cold -- and still her mind, clinging to the lie, refused to follow.

A young woman from Hospice came to counsel her, and did something that shook me. As I watched, dumbfounded, this young woman climbed into the bed, put her arms around the old lady, and just held her. Immediately the older woman quieted and took the comfort offered. Watching, I realized how truly professional that gesture was.

* * *

What stopped me from being unselfconsciously present for that dying woman in the way that I could have been? For one thing, homophobia -- our learned hesitation about touching other women. Homophobia impaired my capacity to address in my work the needs of the spirit, as well as the obvious physical needs; it was a factor in my holding back my warmth from the old lady who lay gazing at Death, afraid and wanting help. It has been part of my coming out as a Lesbian to become sensitized to this specific habit of closedness in myself and others; likewise, it is part of my coming out as a thinking, feeling adult human to outgrow zombie-like interactions and claim my full presence. To disregard the artificial taboo against openness and return to the compassionate instinct I knew in my mother's arms. To reactivate that lifegiving current that flows from the heart and through the hands.

Because the homes of the elderly ladies I work for are closed worlds, womblike, insulated from any hint of competition for profit or prestige, they are mini-matriarchies, and fertile ground for this way of being. Though my observations of other healing professionals, my connection with the Lesbian community, with country folk and deaf folk, and with people from close-knit families have helped restore the simple human kindness in me, it has been here with the Crone that it has flowered and taken root.

Something else which had hindered my effectiveness as a spirit-toucher with elder women: my mother-awe, my fear of being authoritative with a client old enough to be my mother. I have a tendency, in these jobs, to assume a child-like demeanor, as if something in our relating triggers a deja-vu of my girlhood. Appropriate, yes, to defer to the Old One's wishes; and yet, it is part of caring for her in her wholeness to take charge at those times when her mind is feeble and she is at a loss. So I must become skillful at taking and relinquishing command in fluid response to the actual needs of the moment.

Another barrier to knowing the Crone as she is? Weak guts. Squeamishness about close-up contact with illness and old age. I am intent on banishing any phobias about touching oldness; my commitment is to move beyond any fascination or disgust at the very real sights and smells and textures of her. To go about the inevitable clean-up chores, the necessary unveiling of her secrets, matter-of-factly. To focus on caring for, caring about what's there in front of me. In this way I affirm the old ladies' lady's dignity, and enlarge my own perception.

What She Whispered

I've traded shifts, and so I'm here overnight for the first time. She's had her Restoril, her teeth are soaking in their plastic cup, the lights have been turned out, all but the seashell night-light in the bathroom. There is no bed for me here -- the CNA who normally works this shift says she usually stays awake reading in the bathroom, but I'm already feeling drowsy, and that idea seems harsh to me, like an overnight in a Greyhound bus terminal.

I find myself curling up on the floor by the old woman's bed, her lavender robe around me for a blanket. I can tell from her breathing that she's still awake, probably from the phantom pains in her left leg. I have placed myself so that she can see me from where she lies, propped up at a slant in the adjustable hospital bed. Lying here in the faint odor of lotion and old skin, I feel devoted, like a dog, and I realize once again that in so many ways this old woman is more to me than the client whose checks pay my rent. She is employer and family at once to me; there's an emotional bond, motherly-daughterly warmth weaving around and through the professional relationship of caregiver and shut-in.

So I lie here on the linty, moonstreaked rug, wrapped in my old lady's scent, relaxed yet ready in case she calls (and she will, I know, from the log we all keep: she'll need the bedpan at least twice and may call for a pain pill or a massage if her muscles spasm up. She may soil the bed, or think it's morning and try to get up.)

I lie here cherishing my chance to rest, and ready to attend her when she calls. This is not like the wakefulness of a mother for her child, for their love is in the blood. It's economic necessity that brings me here, and in the having-to-be-here, something else has taken root. Lying here, I suddenly realize what this position reminds me of: all at once I recognize my membership in the timeless and forgotten sisterhood composed of all the family slaves and serving-maids, all the generations of women who've curled up by their lady's bed, intimate strangers to the one whose wealth feeds them.

As cut-off as I've felt here alone with the old woman, the invisible presence of this sisterhood comforts me now. The aggravations and the emptiness and the strange growing tenderness I've felt here are my password into that ancient, worldwide tradition of women who've waited on the Crone: women locked in familiar pattern day after day, knowledgeable of her stubbornness and secret ways; women bonded to her by this complex, symbiotic blend of loyalty and resentment; struggling with and at times against her; women becoming, perhaps in spite of themselves, her ally, her confidante, her adopted relative, even, and all the while maintaining their unequal status with her. Handmaidens sharing with the mistress in close quarters the endless tedium, the accusations and spats, the mutual dependency, the unspoken cruelties and the unexpected opening of the

heart that're part of the day-to-day intimacies of household life.

As I lie here in stillness I let our names, the old lady's name and mine, the sound of our two voices, this place and time, blur with the others. From the gathering multitude of unseen faces and unknown tongues emerges this whisper:

"I'm wakeful tonight, not restless, but lying here with moonlight for a blanket, the dim light on me like something I could listen to, a lullaby even, and I'm remembering feelings from when I was a girl, and how I saw her then. Mama, only ten years her elder was already bent and slow and veiny, aged, by the work and, of course, her homesickness ... But she!! A woman in her prime then, whose prime kept on unfolding for years. And there's still something about her, it's her stature, I think. Though I've seen her lose much -- her looks, her health, her understanding, I've never in all my life, even now, seen her lose that elegance. It's that elegance I serve. In her. In myself.

"The delicate rasp of her breathing embraces me, as does the moonlight. A sound as familiar as my own body's sounds. What would this room be like without her breath? (And, of course, where would I go, what would become of me then? Since I would have no say in this thing, I prefer not to dwell on it.) I embrace instead what surrounds me: the window-shaped moonlight splayed out on the tiles ... her breathing ... my straw pallet, long-softened by the scent and the shape of me, set here on the floor next to the fine, large bedstead with its embroidered linen and open canopy of heavy lace where she lies snoring.

"Later tonight she'll call me, the voice in my dreams I wake up to, and I'll stagger, fighting back the slumber just long enough to haul the clay jar, lift her down to a squat, wipe her clean again, then hoist her back up and under the bedclothes with the right words, the answers her questions call for, the refrain between us as predictable and as countless as the cries of the birds who come every morning to fight for breadcrumbs on the parapet. These familiar phrases that pass between us as reassuring and inevitable as the swooping shapes the swallows leave in the metallic air when I come to empty the night's slops and stand there breathing in the light, feeling the coming clarity, observing the freedom of flight."

Sorceress and Apprentice

There is a place and a time where all the elders are called Grandmother and the newcomers are called Daughter. And this is the exchange: the young ones care and the older ones teach. Teach what? Steadfastness. How to dwell in the void. How to in-listen. How to nurture a life-giver whose life is peaking. To begin a clairvoyance of their own life's peaking. Teach how? By touch. In the receiving of touch. By silences. By rambling, fussy, intolerable monologues. By inverting and making subtle their potency they manage to transmit it, woman-to-woman.

And the Daughter? She takes the Grandmother's weight against her body, is depended upon. She begins to tap what has been hidden in herself. She comes close to the odors from the Old One's openings and crevices; brushes decay from the dentures, changes once again the stained sheets, caresses dried-up limbs with a steaming cloth. And in her elder's aura, in this sheltered, set-apart place where progress happens in a different way, where upward growth has stopped, she receives her inheritance.

FEMINIST THOUGHTS ON NURSING UNIFORMS

by Mary C. Vrtis and
Barbara J. Metzinger

The nursing uniform has been with us since the mid-1870's. Uniforms were initially adopted to encourage sanitary practices (keeping white clean requires frequent washing), and to distinguish hospital trained nurses from informally trained nurses. Long after these initial reasons for adopting uniforms became outdated -- that is, washing machines came to be commonly used and advances in microbiology have shown that spotless white uniforms are not necessarily sanitary -- and, licensure laws have replaced the need for specific clothing as an indicator of educational preparation -- the nursing uniform has remained. Over time, the uniform has taken on various other meanings.

At one time in our history, when a student or graduate nurse dressed in her uniform, she entered into a specific, subordinated social role. The social behavior that physicians and the public expected from nurses in the 1920's is evident in the following two passages from journals:

"Recipe for making a Good Nurse. Mix together equal parts of pluck, good health and well-balanced sympathy; stiffen with energy and soften with the milk of human kindness...Add the sweetness of a smile, a little ginger and generous amounts of tact, humor, and unselfishness, with plenty of patience. Pour into a mould of womanhood...finish with a cap..." (Alumnae Record, Buffalo General Hospital)

"The world grows better year by year.
Because some nurse in her little sphere
Puts on her aprin and grins and sings
And keeps on doing the same old things...
Wearing the same old professional smile...
Taking the blame for the Doctor's mistakes,
O dear! what a lot of patience it takes..."

-- A Pupil Nurse, 1920

In that both of these excerpts were written by nurses, it would seem that many nurses of the time internalized their oppression and believed (especially after the intensive socialization process of nursing school) that subordination was appropriate. Many nurses, and their patients (who no doubt bore the scars of the "Doctor's" mistakes) could certainly have benefitted from some feminist consciousness-raising in the 1920's! Unfortunately, the majority of practicing nurses did not appear to agree with the feminist perspective of many of nursing's leaders of the early 1900's.

Nursing uniforms were often introduced to cause certain social and psychological effects, as can be seen in the following excerpt from a nursing journal:

> "When entering them (students) as freshmen should we not give them the school uniform -- with the exception, perhaps, of the bib and the cap? These could be held as honors to be earned...In some of the schools of our Department the probationers for some time have been given the same uniform, minus the bib and cap, as the student nurses. The psychological effect on the probationary class was felt at once..." -Agnes Ward,1921

The psychological effects caused by gaining the "privilege" of wearing a uniform had a lot to do with the sense of belonging that the probationers felt once the uniform was given. Anything that would have decreased the neophyte's sense of being a stranger in a hostile environment (for example, a more supportive student-teacher relationship) probably would have been as effective as uniforms were. Although the uniform was introduced in this instance to bring about a sense of cohesiveness between probationers and full-fledged students, the deliberate exclusion of certain parts of the uniform (the bib and cap here and the cap stripes, etc., today) results in maintenance of a hierarchy within the student body and fosters competition between nurses.

The student nurse was/is socialized to see the transition from student uniform to RN uniform as a symbol of success and belonging. The other side of this sense of belonging that a specific uniform type confers are the feelings of those who don't belong. Using a uniform to signify membership in the "in-group" is based on the assumption that an "out-group" of inferiors/others exists. The following excerpt from an article written by a male RN is an example of this in-group/out-group phenomenon, with the male RN (only about 3% of nurses are men) as the "other":

> "There's nothing specifically designed for a man in nursing...When a woman dons a white uniform, she's easily recognized as a nurse. Put a white cap on her head, and there's no doubt about her identity. In fact, some hospitals require female nurses to wear caps for just that reason...Not having an easily recognizable uniform causes all kinds of problems..." -David Kearns,RN,1986

Another example of the way in which uniforms tend to further stratify nurses hierarchically and foster competition between nurses can be seen by looking at who wears scrub clothes in a hospital. Nurses on the medical surgical floors generally wear ordinary uniforms whereas nurses in the OR, Recovery Room, ICU, ER, Labor and Delivery, wear scrubs. Attending physicians in the OR, Recovery Room and Labor and Delivery also wear scrubs. House and resident physicians also wear scrubs frequently. Nurses who do not work in the specialty units are not usually allowed to wear scrubs unless a uniform is soiled. As nurses and physicians tend to look alike to the untrained observer (client and significant others) in the specialty units, and also tend to have somewhat overlapping social roles in these areas, the specialty unit nurse often sees herself and is seen by others as superior to med-surg nurses. Whereas the specialty unit "uniform" tends to suggest that these RNs and physicians are members of the same "in-group" -- RNs who are not entitled (by hospital policy) to wear the scrub must then be identified as members of the "out-group" even though the divisions are artificially created and maintained.

Uniforms actually play a major role in helping to maintain hospital hierarachies in general. In addition to reviewing historical and contemporary literature, we conducted a survey of 24 area hospitals to determine what the majority of individuals in several employee groups were actually wearing. The clothing worn by the nursing staff at all of the hospitals surveyed were comparable to those of housekeepers, nursing assistants, and dietary assistants, in that either white or pastel colored uniforms and white shoes were seen. Head nurses and supervisors wore street clothes with a lab coat in some hospitals, and nursing uniforms in others. RN Assistant Directors wore street clothes with a lab coat at all of the hospitals. Respiratory therapists, dieticians, and physical therapists also wore street clothes with a lab coat at all of the hospitals. House physicians and residents also wore street clothes (or scrubs) with a lab coat, whereas attending physicians wore street clothes without a lab coat at all of the hospitals surveyed.

Our observations suggest that there is a correlation between freedom from strict uniform regulations and status in the hospital hierarchy. Attending physicians, the highest status group, were not even required to wear a lab coat in clinical areas. Staff nurses wore uniforms similar to low status, low paid hospital employees. Staff nurses also wear uniforms which are similar to those worn by low status restaurant and chain store employees. Higher status nurses, the Assistant Directors, wore clothing comparable to resident and house physicians. It is interesting to note that respiratory therapists, dieticians, and physical therapists, all health care professions which emerged after nursing's emergence, have not chosen to adopt uniforms similar to the nursing uniform. It is also interesting to note that until recently, these professionals also received hospital salaries that were much higher than those paid to nurses.

We have found, through our literature review, personal conversations with other nurses, and through a second survey (conducted by Barb) that many nurses want to see (many of us do not) uniform policies continued. There are many reasons nurses give for hanging on to uniforms, the first of which is evident in the following statement -- a statement that has support in the literature:

> "We NEED uniforms so that people will be able to tell who the nurses are."
> -- RN, 1983

We decided to check this out by asking our neighbor lady, who discussed her mother's hospitalization with us. Our neighbor felt that uniforms were very important in helping her identify members of the nursing staff. In attempts to help us understand, she began a long story about her mother and a "nurse." As the story continued, we were able to determine from her descriptions of the types of tasks that the "nurse" was doing while interacting with the mother, that the woman in the uniform was actually from housekeeping. In the early 1900's, housekeeping was a very important part of nursing as the following quote illustrates:

> "The Duties of the Head Nurse
> ... She must be skilled in the knowledge of housekeeping, knowing to a nicety the amount of milk, tea, butter, or sugar to give the individual patient at each meal; the particular polish to be used in the cleaning of silver, copper, or brass; and the way each should be applied...with all the other details of keeping house." -M. Helena McMillan, Principal, AJN, 1900.

We have obviously not presented enough evidence here to argue with the empirical research that links uniforms with observer expectations (Kalisch and Kalisch, 1985) -- however we think that perhaps at this point it would be safest to state that the general public assumes that any woman wearing any type of uniform in a hospital setting is a nurse. Other assumptions about the power of nursing uniforms are exemplified by the following statements:

> "...the majority [of nurses] say that white uniforms seem to project professionalism and command respect from doctors, patients, and administrators." Nursing, June, 1985,p.13

"I want to start enforcing the uniform policy more strictly. The staff here is just too lax and it's not professional." -Nurse Manager, 1984

If uniforms do in fact project professionalism and command respect from doctors, patients and administrators, then why don't doctors, administrators, physical therapists, respiratory therapists, dieticians, and nursing directors wear uniforms also? Although the argument is often made that these professionals also wear "uniforms", the options that we observed exercised in our study suggested that the "uniforms" could consist of anything from expensive suits to blue jeans. The clothing restrictions in effect for administrators and physicians are seldom in writing and disciplinary action that could result in dismissal is virtually unheard of. On the other hand, uniform policies which are in effect for the department of nursing are usually written regulations and nurses have been fired for not complying with the restrictions.

In 1888, a letter written by a physician who was upset because a man "riding furiously to town...seeking a doctor" had failed to recognize the physician as a member of the "brethren" advocated uniforms for physicians (Koshee,1888). A debate ensued in the pages of The Medical World in 1888, with some physicians advocating uniforms, some badges, some hat bands, and some even suggested that doctors wear longer hair! The author of another 1888 article noted that finding a uniform of any kind that doctors would agree to wear would be extremely difficult because:

"For doctors, as a class, are self-reliant, having ideas, tastes and opinions of their own; and while there is less fraternity than ought to exist, there is a large amount of great good sense, and if you can get down to it, there is an esprit de corps, or a zeal for mutual honor of the profession which ought to characterize such a collection of educated individuals with a mission for healing and relieving." -I.H. Stearns, MD,1888.

Physicians eventually decided that it was politically more wise to lose a few cases through lack of uniforms than to adopt one. Nurses on the other hand have had and do have little choice in the matter. The nurse's uniform has been and still is mandatory (with rare exceptions) for hospital nurses:

"Our director of nursing just told us, 'Wear a cap or resign'"... "Nursing administration tells us we must now wear white pantsuits with tunic tops or standard uniforms..." "If you were one of the many who thought strict uniform codes were history, remember that history tends to repeat itself..." Nursing, Nov.1985;p.13

RNs assume extremely heavy responsibilities, and often make and/or assist clients in making life and death decisions, literally. The fact that uniform policies exist in the first place assumes that nurses are incapable of making decisions on what to wear to work. In view of the nurses' ever-expanding job description and professional responsibilities, this assumption is absolutely absurd and oppressive! If nurses decide that they WANT to wear uniforms (as most of the nurses in our study did, a finding which is supported by the literature review), that's perfectly appropriate for those nurses. As the following excerpt indicates, the existence of options and choice is the primary concern:

"Many nurses feel some sort of uniform is the best choice for bedside patient care. And that's our point exactly: The CHOICE should be ours. An administratively enforced dress code takes away choice - and insults nurses. Because whatever a dress code says on the surface, its underlying message is: Nurses can't be trusted to dress appropriately." -Martin, Martin and Sangster, 1986

In addition to encouraging subordination and hospital heirarchies, fostering competition between nurses, and being based on absurd, oppressive and erroneous

assumptions - uniform policies are also sexist. Probably the most obvious form of sex discrimination in nursing uniforms is the nursing cap. Where nursing caps are mandatory, female nurses have ground for a class action sex discrimination suit unless male nurses are also required to wear a nurse's cap. Another example of sex discrimination exists in those hospitals where female nursing students must wear an apron or pinafore or a dress, but male nursing students do not need to wear aprons, pinafores or dresses (and will probably be suspended or kicked out should they opt to do so). Frequently, sex discrimination in a uniform policy is more subtle, as shown in the following example:

"Cook County Hospital Department of Nursing Services.
Female Nurses:
1. White hose are to be worn with white uniforms.
2. Neutral hose are to be worn with color uniforms.
3. Hose must be full length and non-textured.
Male Nurses:
1. White or black hose are to be worn.
Female and Male Nurses:
1. Nurses' white-tailored shoes are to be worn, or black tailored shoes for males." CCH Orientation Manual,1982

We have not intended to address every issue related to uniforms, nor have we comprehensively covered every topic we introduced. Instead, we hope to generate more discussion about this topic amongst feminist (and non-feminist) nurses. As the largest group of medical/health care providers in any hospital, we nurses have tremendous potential power - let's use it!

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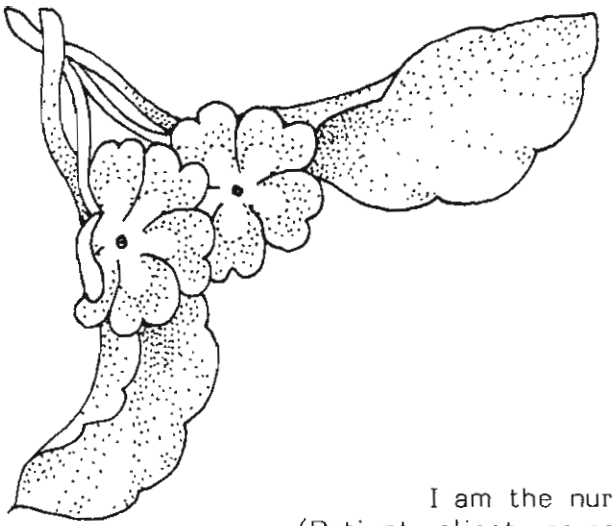
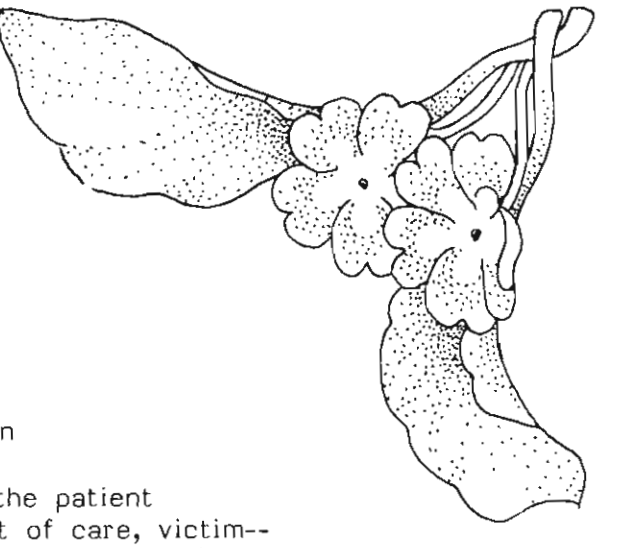
Shortly after we received Mary's and Barb's article on nursing uniforms, the following letter arrived in our mail. The issue is very much alive and well today!

"Thrilled to discover CASSANDRA! I am in a generic masters program (a 9 quarter program for individuals with a degree in a field other than nursing) preparing for primary care as a nurse-practitioner. As a nursing student, policy requires the wearing of a designated uniform complete with cap for female students. Clearly, this is a feminist issue and a nursing image problem, conflicting with what I view as the progression of a nursing image as professional in nature. Any help with literature, statistics, previous resolutions of this problem elsewhere before I challenge school policy? I'd appreciate any help or support around this.

Thank you, Gail M. Nicholson"





Two Women

I am the nurse; she is the patient
(Patient, client, person, recipient of care, victim--
whatever they are calling them these days).

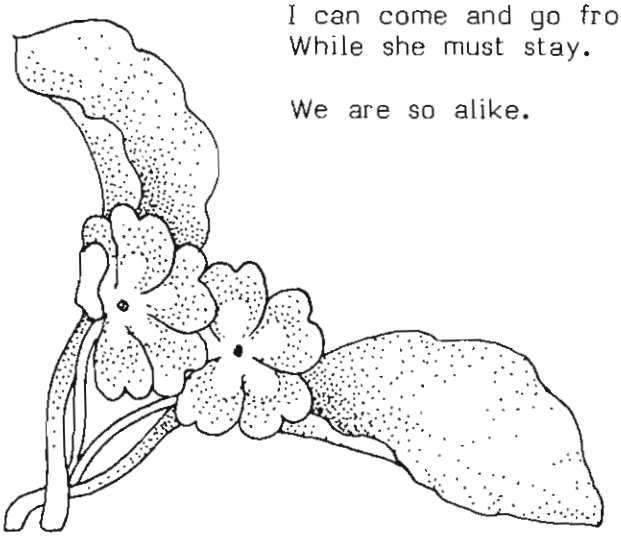
She is 87; I am 38.

She has been a lot of people in her day
(Timid schoolgirl, starry-eyed nymph, protected daughter
firm parent, battered wife, affectionate mother-in-law,
understanding grandmother, suffering invalid)
I see them all come and go across her face:
Sometimes her eyes are luminous.
Sometimes her voice is querulous and demanding.
Sometimes she cries quietly.
Sometimes she has a secret inward smile that
lets me know she has the answer to an
ancient unspoken question.

I decide when she must eat and when she can go to
bed and how far she must try to "ambulate" today.
I am strong and healthy.
I can come and go from this place
While she must stay.

We are so alike.

-- Sheila Bunting



COME, UNITY: CREATING A COMMUNITY IN NURSING

by Adrienne Roy

In the ten years since I decided to become a nurse, I've spent the majority of time proclaiming an intense dislike of nursing and not-too-quietly expressing wonderment at whatever strange force it is that has kept me in it. I knew that I wasn't alone. Nevertheless, knowing that we have company in our ambivalence and even hatred toward our chosen profession is no great comfort -- it only serves to strengthen the fear that we have made an unwise investment of time and money in a career which does little to satisfy us. How many nurses are able to say that they would go into nursing all over again if they knew when they enrolled what they know about nursing after years of experience?

I once maintained that nurses contribute to each other's de-composed attitude toward our profession. Instead of a supportive community among the women who are our co-workers, I found that division, ruthlessness and unpleasantries were the norm. It wasn't the patient care that I objected to, it was the way nurses treated each other!

However, from the knowledge that nurses are an oppressed group I can't any longer lay the blame for this behavior on nurses. I strongly maintain that there are external forces which compel us to behave in these negative ways and that nurses must be aware of the forces before changes can occur in our behavior toward each other. Once understanding of the dynamics of our relationships with each other is gained, it will be possible to initiate steps to promote unity and support networks that can ease and enhance our nursing experience.

The Divisiveness of Oppression

Brazilian Paulo Freire developed a model of oppression based on his experience as an impoverished oppressed person. Some of the basic concepts of the model and their interrelations follow:

Oppressed persons are those who are prevented from being authentically human (or from realizing their fullest potential) by means of exploitation. They, as objects, have no purposes except those prescribed by their oppressors. The oppressors are those who oppress and exploit by virtue of their power. They are those who keep the oppressed in a state of submission and who fail to recognize the others as persons.

Between the oppressor and the oppressed, one group's choice is imposed on the other, changing the consciousness of the oppressed to be congruent with that of the oppressors. Therefore, the behavior of the oppressed group becomes what the dominant group has prescribed.

The behavior of the oppressed serves the needs of the oppressor. At the same time, it is only the oppressed people who can take steps to break out of the submissive pattern and lead themselves to a fuller realization of their potential. The process of breaking away from the strongly entrenched status quo begins with perceiving the state of oppression. With awareness develops a commitment to thoughtful reflection and action aimed toward freedom to work on potentials entirely separate from the needs and desires of the oppressing group. Freire teaches that the struggle to be free is an act of love because its ultimate goal is freedom for all humanity, oppressors as well as the oppressed. With real freedom the oppressed do not turn around and become the oppressor.

In a state of oppression, the consciousness of oppressed people is barred from turning away from the consciousness prescribed by the oppressor. Some of the barriers are:

1. the oppressed group's internalization that the oppressor group is right and good by virtue of their power, and that they are to be emulated;
2. the oppressed group's taking on of the oppressor's view of reality, attitudes and characteristics;
3. the oppressed group's fear of freedom (in nursing, read unity) and inability to take risks to achieve freedom;
4. the oppressed group's inclination to conform to the ideals of the oppressor and, in fact, to become the oppressor.

The oppressor group has a great deal to gain by keeping the other dominated. Their privileges depend on continued subjugation

of the oppressed, and the oppressor group ensures this state in a number of ways:

1. keeping the oppressed group divided among themselves;

2. limiting the quality and extent of education by gearing it to encourage conformity with the dictates of the oppressor group;

3. periodic granting of favors or small tokens to the oppressed (as in a small pay raise or giving a high status position to a member of the oppressed group), especially when the dominated group begins to exert effort in the direction of freedom.

It appears to the oppressor that the oppressed people's initial acts of tearing away are acts of violence, but Freire teaches that these acts are necessary to initiate control and to announce the intention of gaining liberation (again, read unity). Freire contends that his themes are universally applicable wherever one group is dominated by another.

Nurses as an Oppressed Group

How do I arrive at the conclusion that nursing is an oppressed profession and that nurses are an oppressed group of people? And who, by the way, is the oppressor?

Oppression is traditional for the medical profession. Lovell documents that nurses are demeaned by medicine to exalt its power. Every time a physician publicly and abusively is demanding of or criticizes a nurse, it makes her look bad in the eyes of other nurses and/or patients and decreases her self-esteem as well as the self-esteem of the nurses she works with. Low self-esteem perpetuates the cycle of domination and subordination. Most nurses don't recognize their situation as abusive because they have internalized the values of physicians not only to maintain the status quo, but also in the belief that pleasing the oppressor will lead to power and control. As a result, nurses have little faith in their own ability and responsibility.

Like other oppressed groups, nurses lack belief in the existence of alternatives to the status quo. How many times have we had legitimate gripes about physicians' behavior but have failed to do more than complain among ourselves and not confront the physician who is responsible? Or worse, to turn around and heap abuse on each other?

Keeping the oppressed group divided among themselves is especially successful in nursing and it hurts individually and collectively in our desire to be happy with ourselves, our co-workers, and our profession. Dislike for other nurses is evident in the divisiveness and lack of unity in nursing groups. Susan Jo Roberts states that a lack of participation in nursing organizations is one indicator of a lack of desire to align oneself with other nurses and a lack of pride in being part of a group for which one has no respect.

Nurses overtly and covertly display our lack of allegiance to each other. When a group is oppressed, its members are resentful (perhaps unconsciously) of the group that oppresses them. However, it is too risky to openly display resentment and discontent to the powerful group for fear of falling out of favor and suffering reprisal. Instead of displaying aggression toward the dominant group, then, the oppressed group displays "horizontal violence" and directs aggression at one another.

Come, Unity: How To Do It

While we as nurses do often treat each other poorly, there are external forces which encourage and even dictate that we do so. How, then, to break out of this self-defeating pattern? Some suggestions follow:

1. Consciousness raising/education:

Nurses need to learn that we are oppressed. We need to learn about the dynamics of our behavior -- to do so we have to deliberately place ourselves in consciousness-raising situations. Discussion groups which focus on readings and the group's exploration of them is one idea. No one needs to be an "expert" in the group -- the important element is the discovery of commonalities and differences within the group and how they are reflected in the readings. Individually, we can read and then informally talk about what we've read

to those we work with. Recognition needs to be sparked within ourselves and others that nurses are oppressed and to be aware of ways that we help to perpetuate the control of physicians. From there, nurses can learn to refuse to be trapped into the submissive conversations and roles that physicians and other dominant groups require.

2. Value nurses and nursing

We need to learn to value ourselves, other nurses and our profession. We can begin by reading about our historical roots and the strides made by nurses to the benefit of humankind -- women we can be proud to be descendents of. Nurses who understand the dynamics of oppression will refuse to derogate our nursing experience. We will generate evidence that refutes negative stereotypes of nurses and publicly advocate the value of nurses and nursing. We can take steps to avoid falling into the trap of horizontal violence. Careful examination of frustrating experiences makes it possible to place the responsibility where it belongs. When the dominant group is responsible, we can avoid placing blame on one another. It is unrealistic to believe that we can love all nurses and everything about nursing. But when difficult situations arise, an honest critique can be done in an atmosphere of caring, with the purpose of everyone learning and growing. Much will be gained in working toward improved individual and collective higher self-esteem and valuing of ourselves and our profession.

3. Networking in nursing

There are some small groups of nurses who have understood the need for support among ourselves and have begun to form networks of caring individuals to help develop individual and group strength. CASSANDRA, which was formed in 1982, developed in part from a need to find support in the endeavor to integrate feminist philosophy into nursing. In many towns and cities, nurses have united in long strikes against unfair wages and practices. Their unity resulted in perceptible improvements and a continuing sense of cohesiveness among the women and men who striked. CASSANDRA and nurses who strike began their work at grassroots levels -- and there are small ways to being networking that any nurse in any workplace can initiate.

You can probably think of an issue that you have a difficult time with in terms of your job. Perhaps you are a single mother who is not happy with childcare provisions which you have or don't have, and you have little idea of how to improve your situation. Or you may be suffering from the effects of burnout and need to know that you aren't alone. There may be a physician on your unit whom you fear is a potential danger to the welfare of your clients, and you aren't sure how to alleviate the problem. Maybe you are a member of a minority group and you feel that you are experiencing discrimination or harrassment.

Chances are excellent that there are others you work with who experience similar concerns or problems. This is the place to begin developing a supportive environment. Start by speaking with your co-workers about starting a group to talk about your shared concern. Or put a notice on a bulletin board that you are interested in meeting with other nurses who have a particular concern and offer a meeting place and a time or your telephone number. You may be surprised that you have company that you never expected to find! Your first meetings may be set aside to air complaints, talk about experiences and to offer each other the knowledge that you understand and can relate to each other's concerns. For some individuals, airing complaints may be all that is needed. Often, real relief will come from movement toward defining goals and planning methods to alleviate the problem. Support may be the element that has been missing all along and you can now find strength for action!

Within small groups of nurses who find support from one another, a sense of the need for greater overall unity will evolve. Support groups (which might have only three or four people) will find common concerns and will motivate action toward including more and more nurses in their newfound feeling of community.

Unity and a caring environment are essential elements for nurses to be able to

say that they'd choose nursing if they had it to do all over again. If we understand the dynamics of the oppressive forces which work to divide us, there are steps we can take to overpower them! By individually and collectively raising our consciousnesses, by learning to value nurses and nursing, and by taking deliberate steps to promote unity, we'll experience a rebirth of allegiance to and satisfaction with ourselves and our profession.

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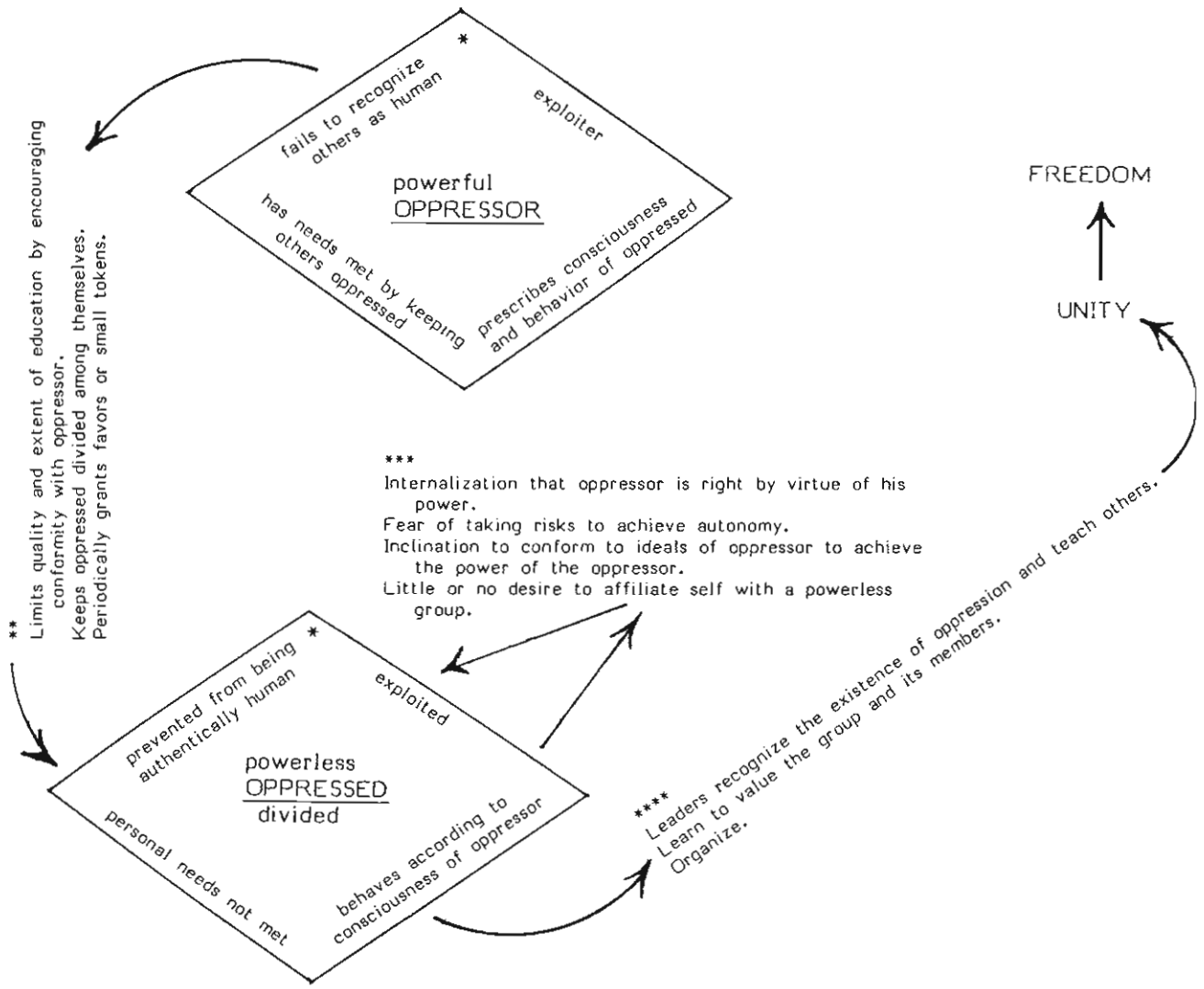
ROY'S DEPICTION OF
FREIRE'S MODEL OF OPPRESSION



* characteristics of the oppressor and the oppressed
** how oppressor ensures continued suppression of the oppressed
*** barriers to oppressed group's ability to achieve freedom
**** how to get around barriers and to work toward unity

RACISM IN NURSING PRACTICE
by Nancy Pfaff McDonald, RN

The impetus to write this article came from several sources. One source was a description in the September, 1985 American Journal of Nursing of the negative effects of homophobic attitudes of health care workers on patients with AIDS. This article led me to reflect on the impact in general of attitudes held by health care workers in relation to their patients. Second, on Martin Luther King's birthday last year, I listened to a tape of one of his speeches. The speech offered a perspective on racism not often heard: that racism is a disease that not only damages its victims (people of color) but is equally devastating to those who possess it (people without color). Dr. King exhorted his followers, the victims of white racism, to show those with the disease the possibility of rising above, of changing for the better.

My final source of inspiration (if a sense of frustration and near despair can be termed "inspiration") has been my observation of a number of racist interactions between nurses and patients and their families, as well as racist interactions between nurses themselves. Unfortunately, the racism and racist attitudes are tolerated by the individuals or institutions involved. I do not exempt myself from this category of interaction, and I am not claiming that all contact between nurses and clients of different races is negative. One of the many positive features of nursing is the ability of nurses and clients to transcend superficial reality and work together harmoniously under adverse conditions.

I also write this article because I have seen very little information in most current nursing journals about the impact of racism on health care. I can only attribute this to a generalized refusal by our profession to acknowledge the existence of the problem. I see it as a responsibility of white nurses to expose and discuss our racism and to take positive action to change things. It should not be the burden of nurses of color to raise this issue and to call us to task for our behaviours. A discussion of race should be integrated into the thought, writing, and practice of nursing on every level. A prime example of a nursing issue suitable for this analysis is the discussion

of entry level requirements for nursing. Nowhere have I seen a breakdown by race of nurses with AD, BSN degrees or diplomas; nowhere has there been an acknowledgement of the obstacles of race or class to obtaining a university degree in nursing.

Racist attitudes are not always displayed overtly. People may feel that because they are not KKK supporters or do not call Black people "niggers" they have conquered the disease of racism. Unfortunately, racism is much more subtle and systemic.

By racism or racist interaction I mean a set of negative attitudes, values and behaviours held by members of one racial or ethnic group about another. This mind set is played out in destructive ways on a one-to-one basis as well as on an institutional level, where it underpins a system of oppression which robs groups or classes of people of their potential to achieve their destiny as individuals and as a group.

In a health care setting, racism profoundly affects how we view and care for members of racial or ethnic groups other than our own. Racism affects how we interact with staff members of differing racial or ethnic groups too. But one thing I have come to realize, to my amazement and horror, is that not all nurses or health care workers believe that racism is wrong. We justify our racist attitudes by pointing to "bad examples" of violent, self-destructive, other-destructive behaviour and generalizing them to an entire group or race.

Not only do many nurses and other health workers not believe racism is wrong, we also are nearly oblivious to the existence of skin privilege for Caucasians (or people without color).

Skin privilege is a concept made operational through a system of preference for all things pertaining to the majority color and culture. Unspoken advantages adhere to those with the preferred skin color: for example advantages in education, employment, advancement, health care, as well as preferential treatment by the world at large.

I would like to identify some negative behaviours and attitudes I have observed in myself and my peers, with the hope that this process of exposure will lead us nurses without color to develop strategies for change on an individual and professional level.

The use of racist or denigrating language in reference to clients who are people of color occurs frequently, e.g. calling elderly Black clients "boy" or "girl." An element of class prejudice enters into our language too, such as calling a patient brought in from the streets or a shelter a "yard dog" a "bum" or a "dirt ball."

I also view parodying Black dialogue or speech patterns as racist. This includes mocking or imitating Black English. White nurses also often say to each other, "you know, you can never understand them when they talk."

Judgmental attitudes about Black family structure are rampant in nursing. For example, statements are made about "gangs" or "hordes" of family members "demanding" to see patients, calling frequently to inquire about a patient's condition, and generally complicating patient care activities by asking questions, looking under the covers, etc. Instead of viewing the existence of a strong, close knit, extended family as a positive, supportive structure, we white nurses "judge" that it is less than desirable because it is different from our reality, and "gets in our way" as we perform nursing tasks. But if our purpose is to nurse a client in the context of his/her family and community, we must respect the existing family dynamics. We also cannot ignore the fact that for many years (and in recent memory) people of color have received less than adequate care from a white dominated health care system. Therefore, many family members see the necessity to act as aggressive advocates to protect their ill relatives. Making negative comments or jokes about the absence of spouses, presence of girlfriends, boyfriends, fiancees, or "illegitimate" children does not serve our clients well. It also damages us, in depriving us of the experience of witnessing an institution (the Black family) which has flourished in spite of our best efforts to destroy it.

We often refuse to acknowledge the impact of forces greater than the individual on that person's destiny. For example, there are real compelling reasons why a sixty year old Black man has spent his working life as an itinerant day laborer, and a sixty year old white man is a government attorney. These reasons have nothing or little to do with the individual's drive, intelligence, motivation, or innate worth. White skin privilege exists in America today, and we white people benefit from it. It operates to the detriment of people of color, who are denied opportunities, and it operates to our detriment because we are deprived of the benefits coming from the skills and talents of people locked out of the process. Spending a lifetime at hard manual labor (or as a domestic servant) often without sick leave or health insurance, does not allow for preventive health care. This means that minor ailments are left unattended and serious disease go undetected until well advanced.

White nurses often view health problems and disease entities of people of color as somehow under their control, and "their fault." This displays an ignorance of the subtleties of the disease process involved in hypertension and obesity, for example. We also need to educate ourselves more fully about disease processes particular to certain ethnic groups, e.g. sickle cell anemia.

We extend racist interactions to other nurses and health care workers when we overtly or covertly hold differing expectations of care-giving activities for nurses of color. For example, assignments for nurses of color may be more strenuous (are they afraid to complain?) or nurses of color will not be encouraged to assume charge responsibilities or other leadership positions (why?).

Finally, we nurses without color tend to generalize hostile interactions between ourselves and people of color to an entire race. We fail to view people as individuals, responsible for their actions, and chalk up undesirable behaviour by saying "they're all like that." This projects characteristics of individual members of a racial or ethnic group to the group as a whole.

The first step toward ending our racism is naming it and owning it. But racism will never end until we actively work to stop it on individual and systemic levels. The prerequisite for this process is the desire for change. We must acknowledge that change is difficult and unpopular, and that an attempt to turn around attitudes held all our lives and which are part of the collective American consciousness will take a long, long time.

It is not easy to be anti-racist. There are no material rewards for giving up and letting go of old attitudes and behaviours. Fighting racism within ourselves, much less on an institutional level, is an exhausting process which can lead us to question the basic assumptions of our world view. We must ask ourselves hard questions every day about the meaning of our interactions with others. Nurses, because of the unique intimacy of our relationships with patients and peers, as well as our stated mission for the promotion of health and prevention of disease, have a special opportunity and challenge to work on destroying the disease of racism among ourselves and in our professional interactions with members of the community we serve.

Following are some ideas I have for starting to work on racism in nursing practice. I hope that these ideas will start a dialogue in nursing at all levels.

We must examine ourselves, our attitudes, our values, and take responsibiltiy for our own racism. This does not mean a self-flagellation for all past activities, but an honest appraisal of ideas and attitudes we have which need to be changed.

We must educate ourselves to the experience of people of color in this country and throughout the world. Their experiences and history will help us understand the present conditions which give rise to negative attitudes and behavior on both sides of the color line. Go to the public library and start reading. Turn to the "black" radio station and start listening to the news. Find out the history of the civil rights movement in this country. Keep track of what is happening in South Africa.

Pick a starting point for self-action, a particular attitude you would like to change, an area of knowledge you would like to acquire. For example, you might learn more about the infant mortality rate for people of color in your community.

Observe your surroundings and the interactions of nurses, clients, and families in light of your new knowledge.

Stop day-to-day racist behaviour, and confront it in your peers. This does not necessarily mean saying to another nurse, "you're being racist and you should stop it." It does mean questioning statements, walking away from group joking or gossip sessions, and stifling negative statements you're about to make yourself.

Turn hostility around by extending yourself to clients and families of other racial and ethnic groups. Listen to their questions and answer respectfully. Find out why people are upset. Take responsibility for problems you can solve. Be willing to admit when you're wrong, or when your institution is at fault. But don't take abuse. Remember, nurses can't "fix" everything. Be aware that we are the "out front" members of the health care team, and as such bear the brunt of people's frustrations with the health care system as a whole. Don't take anger personally.

I know that many white nurses and health care workers will disagree strongly with what I have written here. We see ourselves as providing care to an angry, hostile group of clients who have brought many of their problems on themselves, who are wasting precious tax dollars because they won't take responsibility for themselves, whose lifestyle and culture is different and therefore not as good as ours. Read those words over again, and see what an awful, diseased view of the world it is. Open yourself up to the richness, beauty and diversity of all the people who live around you. Don't let irrational hate and racial sickness deprive you of the joy of friendship and the chance to make the world different and better for all of us. You will gain much more than you'll ever lose.

Ohio group for gay nurses

Dear Colleague,

As a nurse, you are aware of the stresses and challenges that you face every day in your profession. For most of us, being a nurse is more than a job; it's something we are.

We at the Southern Ohio Nurses' Network feel that being a gay nurse is a double challenge and, at times, a double stressor. Very few of us are comfortable enough to "come out" to our fellow nurses with whom we work and many of us have gay friends who simply don't understand or appreciate the nursing profession.

Southern Ohio Nurses' Network (SONN) was started for the purpose of bringing gay nurses together for the support they need. We are not a political organization, nor are we affiliated with any other organization. We are a confidential network of independent working nurses who believe in the personal and professional support of gay nurses. We invite all interested nurses to contact us at P.O. Box 09492, Cincinnati, OH 45209 for more information.

We look forward to hearing from you.

-- Jae Baer, RN
Southern Ohio Nurse's Network

Dalkon Shield Information Network

Dear Cassandra,

We are writing to let you know about our newsletter "Dalkon Shield Information Network". The newsletter is published by a group of Dalkon Shield survivors who hope to reach others interested in staying informed about this health matter. There were two million American women and a total of four million women worldwide who used this birth control device. The survivors of this tragedy currently have nowhere to turn in order to keep abreast of developments in the U.S. Bankruptcy Court litigation which involves the A.H. Robins Company, manufacturer of the Shield. Through this newsletter, we hope to keep the issue alive and vital during the lengthy court proceedings.

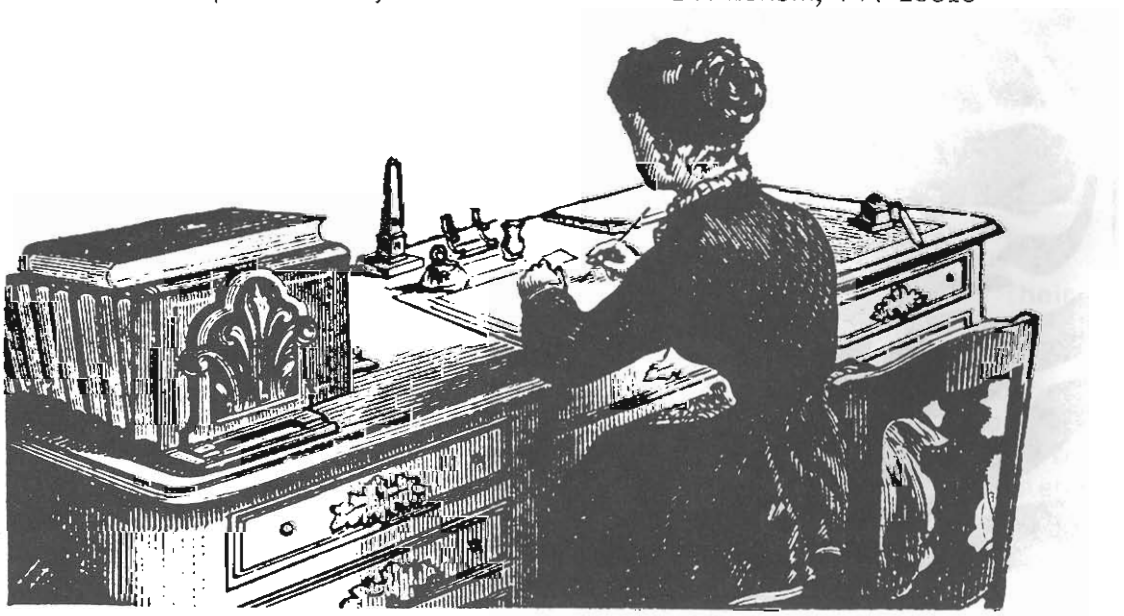
The newsletter will have at least three issues per year. Hopefully, the need for this newsletter will not exceed two or three years. Every newsletter will include a court update, timely news items, interviews, a reader's column, and important information relevant to Dalkon Shield users and their families.

As publisher of this newsletter, I appeal to you to help me locate other Dalkon Shield survivors and potential readers. The minimum subscription fee for the newsletter will be $10 per year. Interested parties should write to me at the address below.

Thank you for any help you can give us to inform others of this project.

Sincerely,

Karen M. Hicks
626 Center St.
Bethlehem, PA 18018



S I S T E R S

S end
I n
S ome
T houghts
E pistles
R esponses
S oon

Dear Sisters,

I am writing to explain a little about the enclosed photograph that I've been wanting to share.

I decided to get a tattoo about six months ago when a friend suggested we go together -- and "get tainted". Lisa was getting her second tattoo and was reassuring. I began considering the possibilities, keeping in mind permanence, practicality, and pain. I wanted the design to reflect a part of me -- who I am, what I believe in.

Another friend, who knows me very well, wondered if I had considered the Cassandra logo. I re-read the symbolism of the logo and knew -- "this is it"!

I made a couple of modifications in the design:

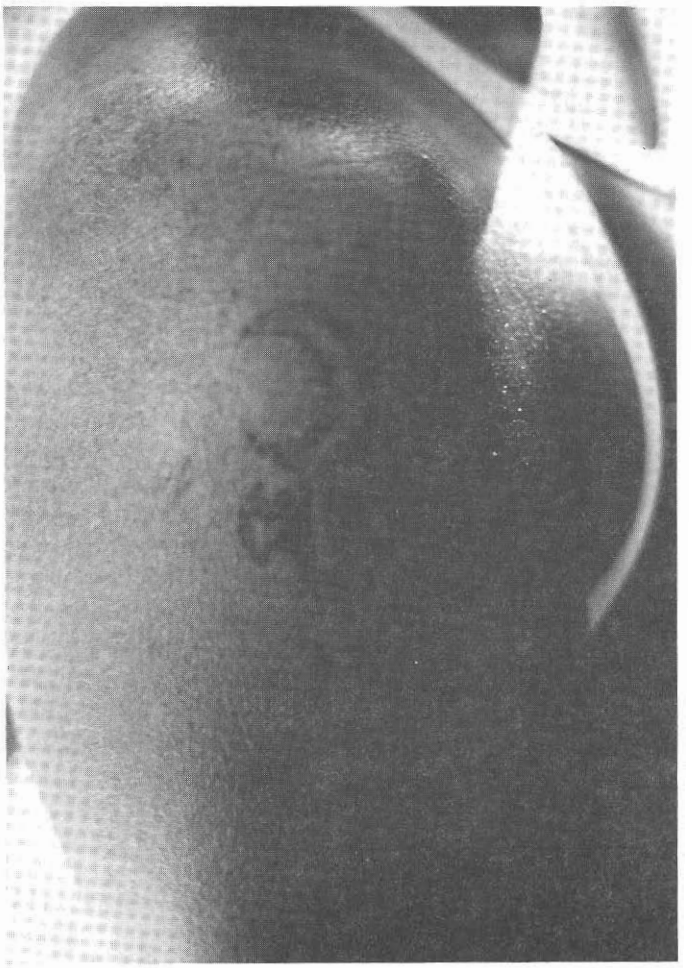
1. First I used the mirror image to signify the "reflection" of my ideas, thoughts, etc.

2. The colors (red, yellow, orange) represent the sun -- a source of energy and special memories.

I didn't realize how often I would be explaining my tattoo (reason for, as well as the meaning). It has given me more opportunities to talk about Cassandra with a variety of people. But, since the time I got it I've wanted to share my tattoo with people who needed no explanation of the logo --people who hold a special place in my heart, who I am a part of ... CASSANDRA.

Thanks for all that you give,

Rebecca Hawkins



Dear Sisters,

I am an Associate degree (1975) nurse; suffered a back injury in 1982; am currently a senior nursing student in a BSN program at the University of Southern Mississippi.

Recently, I was writing a "change paper" for my management Nursing class. The paper is entitled "Empowerment of the Nurse: Change from Within." Some of my re-search sources include: Mary Daly, Pure Lust; and Audre Lorde, Sister Outsider.

In Ch. 8 of Pure Lust, I found Denise Donnell Connors' footnote referring to the formation of "Cassandra: Radical Feminist Nurses Network." I was truly a-mazed. Here is Mississippi, the air of conservatism within the nursing community is stifling. As an out feminist lesbian nurse the struggle is hard to bear at times. I have been searching for a radical nurses network for the past two years. I'm so glad I found ya'll!

In sisterspirit,

Wanda Elliott

DIXIE DYKES: Southern Exposure Craftswimmin
1806 Curcor Dr., Gulfport MS 39507

Wanda (who is also a Cassandra contact woman) and Barb are craftswimmin who make jewelry, festee pants, dyke dolls and crocheted "concert covers" (lap blankets). They describe the Festee pants as "possibly the most comfy britches you'll ever own," with zero restriction of movement, drawstring waist with elastic at the back, big pockets and blousy legs with elastic at the bottom. The pants come in two sizes: Free=up to 36 inch waistline; Free-er=up to 50 inch waistline. The pants can be made to fit any specified measurement, choice of one or two pockets, choice of 100% cotton muslin, sheeting or flannel, either plain, ty-dyed or splash dyed. Write for more information, or visit Wanda and Barb at the Southern Womyn's Music Festival in Georgia or the Michigan Womyn's Music Festival (booth 150).

MEDICINE TALK Newsletter and other resources from Suzette Haden Elgin,
Ozark Center for Language Studies, P.O. Box 1137, Huntsville, AR 72640.

Suzette Haden Elgin, author of the widely acclaimed science fiction Native Tongue and Native Tongue II: The Judas Rose has prepared a wide range of materials and resources of particular interest to nurses and other health care professionals who seek change in health care. The Newsletter Medicine Talk is published 6 times a year ($18.00/year) is devoted exclusively to the subject of language in health-care for the purposes of 1) Making clear that negative impressions of American health care --however distorted -- have serious real world effects that must be dealt with and that can't be fixed by money or machine. 2) to demonstrate that language is the heart of the problem -- with plenty of examples of language that makes the negative perceptions worse. 3) To show how to use language to STOP making matters worse, 4) To show how to use language to make matters BETTER, and 5) to provide information about other resources for accomplishing goals 1-4.

Another item of interest is a cassette tape "Medical Melodies from The Magic Granny Line's Intensive Song Ward" (with song booklet), featuring folksongs for doctors and nurses; 30 minutes, $8.00. The Magic Granny Line also features video tapes on science fiction and music.

A 50-minute videotape (VHS) narrated by Suzette, titled "Introduction to Medical Syntonics: Verbal Self-Defense for Medical Professionals, is available for $59.95. A cassette tape of the same material is $10.00.

LEGAL SPECIALIST ON NURSING
Susan M. Jenkins,JD, 1730 K Street NW, Washington, DC 20006.

Susan specializes in representing nurses and nurse specialists in such areas as independent practice, employment disputes, licensure/regulation, and other practice-related matters. She has joined Cassandra as a Friend, and wrote to share information about her practice which she feels closely matches the philosophy and goals of Cassandra. Her article "Exercising Nurses' Right to Fight for Clinical Privileges" appeared in the November 1986 issue of Nursing and Health Care, along with interview with two of her clients.

VIETNAM WOMEN'S MEMORIAL PROJECT
511 Eleventh Ave. South, Box 45, Minneapolis, MN 55415.

This project was formed to erect a lifelike bronze statue of a woman to represent and honor all women who served during the Vietnam war, from every branch of service as well as from other private and government agencies. 33 inch bronze replicas of the planned statue are currently being displayed throughout the country to help raise funds for the Project. For additional information, and a quarterly report, contact the project at the address above.

THE HOSKEN REPORT, 3rd edition
WIN NEWS/Fran P. Hosken, 187 Grant St., Lexington, MA 02173.

The most comprehensive and detailed report available on genital mutilation around

the world. Includes chapters on the history of genital mutilation, the health facts, report on the W.H.O. seminar in Khartoum, Feb., 1979, the politics of genital mutilation, and more. Includes a map and estimated number of women operated in each area of the world; case histories and an extensive bibliography. $17.00 prepaid.

Also available is Action Guide: Female Sexual Mutilations: The Facts and Proposals for Action ($5.00); The Childbirth Picture Book (Basic or Universal editions) ($7.00); and Women's International Network News, published quarterly, $20 /year.

FILM: RETHINKING RAPE

Film Distribution Center, 1028 Industry Dr., Seattle, Tukwila, WA 98188

One in three women will be raped in her lifetime; in over 2/3 of reported rape cases, the rapist is someone the woman knows. This film provides an in-depth look at acquaintance rape and its societal causes. In order to understand the high frequency of rape in our society, we must examine our cultural attitudes towards women, female/male relationships, and rape itself. This film questions our attitudes and the influences that shape them. Six people of varying backgrounds share their perspectives on the topic, including a survivor of an acquaintance rape, a male college student who nearly raped a good friend, a former model who reevaluates her career, and a social psychologist who recounts recent research on how sexual violence in films affects men and women. 26 min, color. 16mm film- $425; 3/4 or 1/2" videocassette-$275; rental-$45; preview for purchase-$15.

VENUS ADVENTURES: Feminist Worldwide Tours

P.O. Box 55157, Washington, DC 20011 or call 800/422-1074 or 202/723-3945

Venus Adventures is a feminist company seeking a harmonious atmosphere for cross-cultural vacations. Tours are planned to provide opportunities to get to know the people you visit, to provide insight into the customs and lifestyles of other cultures with an emphasis on the cultural roles of women, with ample free time to relax, visit women in the marketplaces, shop, or see attractions. Each tour is accompanied by Delores Darlene; local tour guides provide specially designed sightseeing excursions. Some tours include workshops by women with special expertise or meetings with host nationals. The following tours are planned for the remainder of 1987: Alaska - August; Caribbean Cruise -September; and India - October.

FEMINIST MEDIA DIRECTORY FOR 1987

Women's Institute for Freedom of the Press (WIFP), 3306 Ross Place,NW, Washington, DC 20008 or call 202/966-7783.

Lists 525 women's periodicals, 112 women's presses and publishers, 13 women's news services, 46 regular women's radio programs, 48 women's arts/graphics/theater groups, 86 women's bookstores and mail order, 36 women's organizations, 7 women distributors, 6 editorial and P.R. groups specializing in women, 18 women speakers bureaus, 11 women writers groups, 72 special library collections, and 30 directories and catalogs, and 455 media women and media-concerned women. $12.00 prepaid to WIFP

RETURN OF THE GODDESS audio cassettes of the 1986 CBC Radio series.

Merlin Stone, Box 266, 201 Varick Street, New York, NY 10014

Four one-hour radio programs that include interviews, readings and music with, and by many contemporary feminists concerned with the emergence of women's spirituality and/or the reclamation of the Goddess in their own work. Narration and interviews are by Merlin Stone, hosted by CBC Ideas announcer Lister Sinclair, produced by Linda Perry with the assistance of Gail Brownell, Max Allen and Lorna Tulk. The programs are titled: "I - The Goddess in contemporary women's music and art"; "II - The Goddess in contemporary women's literature, performance and psychology"; "III- The Goddess in contemporary women's history, theology and religion"; and "IV - The Goddess in contemporary women's politics." $25 per set ($30 Canadian)

EXCHANGE

CASSANDRA shares our newsjournal with several other groups who in turn send us their regular publications. This column highlights selected material from exchange and sample publications we have received since our last newsjournal (not all exchange groups are listed here). If you want to know more about these groups or publications, please contact them directly, and let them know you found out about them in our newsjournal.

THE ANIMALS' AGENDA

P.O. Box 5234, Westport, CT 06881. The December issue carries notice of a boycott called by Ark II against Gillette Labs for animal cruelty and fraud. Write letters of protest and send back any Gillette items you may have to: Gillette Company, Prudential Tower, Boston, MA 02199. For more information or to purchase a copy of a 12-minute documentary videotape "Products of Pain" contact Ark II, P.O. Box 11049, Washington, DC 20008. Among the items produced at great pain and suffering (including death) of animals are: Soft and Dry, Right Guard, Dry Idea and Imagine Body Spray deodorants; Gillette Foamy Shaving Cream; Atra, Gillette Swivel, Face Saver, Daisy, Trac II, and Good News razors and blades; Silkience, White Rain, Mink Difference (made of minks killed for their fur), The Dry Look, Tame, and Toni Home perms hair products; Aapri and Jafra skin products; Paper Mate, Flair, S.T. Dupont Write Bros., and Liquid Paper pens and paper products.

BROOMSTICK

3543 18th Street #3, San Francisco, CA 94110 ($15/year)

The Jan/Feb issue includes an informative article about the OWL (Older Women's League) national meeting in Oakland, September, 1986. OWL is doing very important work in relation to women's health and health care. They were successful in getting a bill passed at the federal level called the Continuation of Health care bill which provides that upon the death of a spouse or upon divorce, the insurance company who covered an employee and his wife must continue to cover the woman at group rates for three years. OWL's ultimate goal is a national health system which covers every citizen. Women of all ages are urged to join for $10/year. Write OWL National Office, 1325 G St. NW, Lower Level B, Washington, DC 20005.

AEGIS: MAGAZINE ON ENDING VIOLENCE AGAINST WOMEN

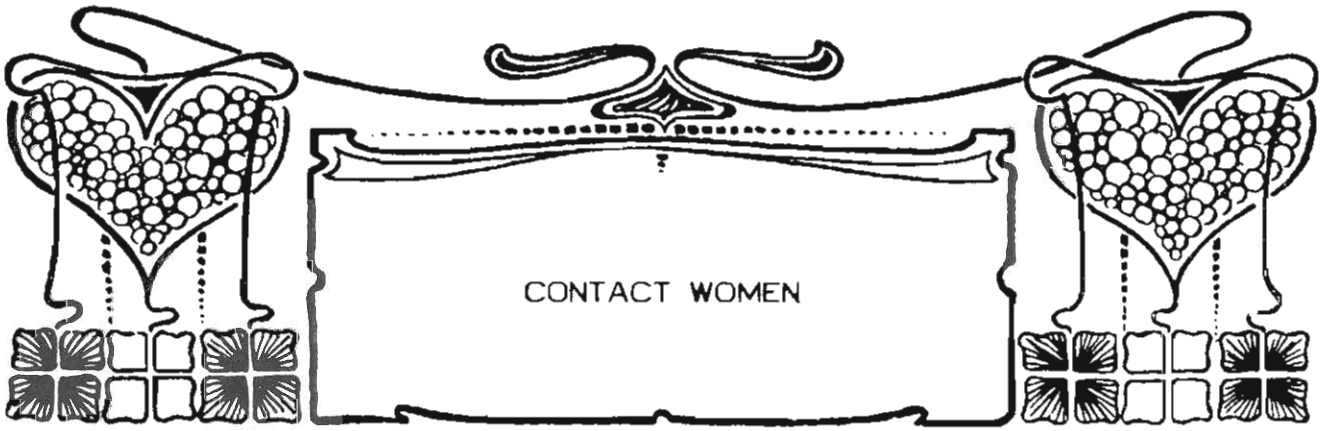
Feminist Alliance Against Rape, P.O. Box 21033, Washington, DC 20009.

We received a sample issue of this important magazine from their 1986 volume. This issue contains articles on battered women's shelter movement, lesbian battering, connections between homophobia and violence against women, military occupation and prostitution tourism, "The Speak Out Against Shrinks" by the Coalition against Misdiagnosis, and much more. The Alliance is seeking to build a network of contributors to Aegis; if you are interested in contributing on a regular basis write for information about becoming an affiliate. Subscription is $10.50/4 issues; $19.50/8 issues; $3.50 sample issue.

WOMAN OF POWER: A MAGAZINE OF FEMINISM, SPIRITUALITY AND POLITICS

P.O. Box 827, Cambridge, MA 02238 or call 617/625-7885.

The Winter 1987 issue (#5) is a comprehensive issue on the theme "Healing". Providing international and cross-cultural perspectives, this issue provides articles, healing profiles, fiction, poetry, art, photography focusing on woman as healer. Single issue price is $6.00; subscription is $22/year.



Names and addresses of all Cassandrans are forwarded to their nearest contact woman; otherwise our mailing list is not distributed. This list is arranged by state alphabetically, so find the location nearest you to connect with the nearest contact woman. There are many cities and states not yet represented by a contact woman, so if you would like to be a contact woman and encourage networking in your area, please let us know. If you are a contact woman and you are not listed, or if the information given here is incorrect, please notify us. Write Cassandra, P.O. Box 341, Williamsville, NY 14221.

Arizona:

CYNTHIA K. RUSSELL
3207 North 53rd Parkway
Phoenix 85031

BARBARA SCIACCA
Box 4432
New River Stage, II
Phoenix 85029

British Columbia

MARGARET NIXON
1645 Broadmead Ave.
Victoria V8P2V5

California:

SUE DIBBLE
141 Leslie Dr.
San Carlos 94070

SUSAN PASTOREK
918 Palm Ave.
S. Pasadena 91030

Colorado:

LINDA BERGSTROM
1086 Corona #17
Denver, 80218

MAGGIE WILLETT
180 S. 42nd St.
Boulder, 80303

Connecticut:

ANNE TEITELMAN
17 Grafton St.
New Haven 06513

Illinois:

HELEN M. RAMIREZ
5615 N. Kimball
Chicago 60659

Iowa:

MARY HETTINGER
2408 Jennings
Sioux City 51104

Kansas:

SYDNEY H. PENDLETON
3112 West 73 St.
Prairie Village 66208

Massachusetts:

DIANE PINGETON
22 Brook St.
Somerville 02145

Michigan:

JACQUELYN CAMPBELL
3777 Greenook
Ann Arbor 48103

Minnesota

SHARON McDONALD
6001 11th Ave. South
Minneapolis 55417

Mississippi

WANDA ELLIOTT
1806 Curcor Dr.
Gulfport, 39507

Missouri

JOAN GARY
16480 Walnut Rail Rd.
Chesterfield 63017

New Jersey

DOROTHY VERNA
70 Wittingham Place
West Orange 07052

Ohio:

JUDITH A. CARR
28560 Blackjack Rd.
Logan, OH 43138

KIRSTE L. CARLSON
3085 East Overlook Rd
Cleveland Hts. 44118

BRIGHID KELLY
9040 Spooky Ridge Lane
Cincinnati 45242

South Carolina:

PAMELA CLARKE
Rt. 1, Box 93
Irmo 29063

SHEILA REIHING TRUBY
11 Ashwicke
Greenville 29615

CALL FOR CONTRIBUTION TO ANTHOLOGY

This is a call for submissions for an Anthology to be titled Our Eyes Have Found You: Angry Words from Honest Women.

Nearly all women suffer from acts of physical, sexual, emotional or mental abuse sometime during our lives. For those who undertake the healing process, few ever get beyond the point of grieving to the wellspring of anger. Too often our anger is patronized, mythologized, or ignored. Few cultures tolerate angry women. We can scarcely feel or focus our anger long enough to know it as a true source of strength and energy. Our anger protects us from continued victimization.

This anthology will provide a creative and constructive expression of our anger as we use it to heal, recover and create. This world needs our angry voices; in patrist cultures anger is expressed through brutality, violence and isolation. We can actively shape other ways to express our anger that foster growth and change. Our Eyes Have Found You will help to create a language that reflects our experiences and provide a way to hold perpetrators of violence responsible. Righteous anger protects our boundaries, fortifies our resistance and heals our wounds.

Previous writing experience is not important. All pieces will be published in the language in which they are written.

Please send poems, short stories, plays, journal entries (all forms of expression are acceptable) along with a SASE by September 1987 to:

Celin-Marie Pascale
P.O. Box 2959
Santa Cruz, CA 95063

BUDGET REPORT
October 1, 1986 - March 1, 1987
by Maeona Jacobs and the Utah Web

Draft Account (available for use)

Balance Forwarded:	$ 4,034.31		
Income:		**Expenses:**	
Membership:		Transfer to WSH Fund:	$ 358.90
Webster: New	$ 955.00	Check Charges:	.00
Webster: Renew	1,680.00	Membership:	242.62
Friends: New	100.00	Newsjournal:	1,665.20
Friends: Renew	25.00	Action Network:	.00
Subscribers: New	.00	Gatherings:	.00
Subscribers: Renew	.00	Public Relations:	.00
Newsjournal Reprints:	12.00	Finance:	8.43
Donations:	.00	Coordination:	116.04
Check Interest:	91.00		
Total Income:	$ 2,863.00	Total Expenses:	$ 2,391.19
Total Useable Assets:	$ 6,897.31		
Total Expenses:	$ 2,391.19		
Closing Balance:	$ 4,506.12		

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Wilma Scott Heide Research Fund (not available for withdrawal)

Balance Forward:		$ 3,609.81
13% Webster Dues:	358.90	
Interest Dividends	58.43	
Total Income	417.33	417.33
	Closing Balance:	$ 4,027.14

T H R U M S

(Any loose end, fringe, or tuft of thread; the fringe of warp threads left on a loom after the cloth has been cut off).

This Newsjournal was produced by:

The Buffalo Web. The Newsjournal Staff Nurses who were responsible for production of this issue were Charlene Eldridge Wheeler and Peggy Chinn. Elizabeth Mathier and Adrienne Roy participated in review, selection and proofreading.

Appreciation to:

- Women who felt our vibes yearning for substantive material to print, and sent wonderful material before we got our S.O.S. message in the mail. The result is a newsjournal with articles like we have not seen in years. Thank you from all of us;
- Women of the Buffalo Web who assist with mailing tasks.
- Frigid, the technological wonder, without which all of this would be infinitely more difficult.

Illustrations:

Unless otherwise specified, the graphic/clip art illustrations are from Jewels Graphics' Feminist Clip Art, P.O. Box 29303, Oakland, CA 94604.

Dover publications: Women: A Pictorial Archive from Nineteenth Century Sources (1978), Treasury of Flower Designs by Susan Gaber (1981), Banners, Ribbons and Scrolls ed. by Carol Belanger Grafton (1983), Treasury of Art Nouveau Design and Ornament by Carol Belanger Grafton (1980), & Art Nouveau by E.V. Gillon (1969).

Quote:

The quote on the front cover of this issue is by Susan E. Browne, Cassandran and co-editor (with Debra Connors and Nanci Sterns) of With the Power of Each Breath: A Disabled Women's Anthology, 1985, Cleis Press. This quote is from the closing paragraph (p.22) of Susan's story "Infusing Blues", pp. 15-22.

Newsjournal Staff Nurses' Notes:

Dear Websters,

We are delighted with this issue of the newsjournal. Every article that you see here arrived before we sent out the Cassandra Action Network addressing how everyone might contribute. The fact that material arrived before we had mailed the C.A.N. was a sign to us of wide-spread concern about how the newsjournal fares.

Please don't assume that this will continue! Right now we don't have a single other item "in the works" for future issues. We would like to have articles to review and work with well in advance of each lifeline date -- we want to participate with you to develop writing skills, analytic skills, and other related publishing skills. Please refer back to the bright blue CASSANDRA ACTION NETWORK for ideas -- if you don't have it write and let us know and we'll send you another one.

- Peggy and Charlene

Invitation to participate: Female Friendship Survey

Cassandrans Peggy Chinn, Charlene Eldridge Wheeler, Adrienne Roy and Elizabeth Mathier, Buffalo, are refining a survey on female friendship in nursing that will appear in the February, 1988 issue of the American Journal of Nursing. We are seeking groups of women nurses (students, retired, staff nurses -- anyone) who would be willing to complete the pilot version of the survey. If you are interested and know of others who are interested, write to us by June 1, and let us know how many surveys you need. Surveys returned to us by July 1 will be included in the pilot analysis. We will send additional details about the project to everyone interested in participating. Please write: AJN Friendship Survey, P.O. Box 743, Buffalo, NY 14215.

Ya know, Sal, I think it's time to re-new my CASSANDRA commitment -- remind me to check to see if my label has the date circled, would you?

I'll bug you 'til I know it's done, Sweets.

If your mailing label has the renewal date circled in red, then your renewal is due before the mailing of the next Newsjournal. Websters contribute $35-75, students, retired, unemployed, and differently abled $15, Friends $25, Institutions $35. Our address is P.O. Box 341, Williamsville, NY 14221.