in their pulmonary arteries, suggesting that for some time before death they have suffered from a lack of oxygen. A third discovery, also by Naeye, is that crib death infants have more brown fat around the adrenal glands than normal babies.)

Another indication that the field is still in a somewhat rudimentary state is the profusion of different theories about the cause of crib death. The scarcity of basic facts about crib death makes it a free-fire zone for armchair theorists. Much press coverage of crib death reflects their activity, not solid research.

Even good theories about crib death are hard to test. An ingenious hypothesis put forward by R. C. Reisinger, a vet at the National Cancer Institute, holds that crib death is caused by the absorption of *Escherichia coli* endotoxin from the gut, particularly of bottle-fed infants, since cow's milk is more conducive to *E. coli* growth than human milk. Reisinger's is an excellent hypothesis in the Popperian sense of being easily refutable but, says its author, it has not been refuted so far.

That there has been a turnabout on priorities for crib death research is due in large measure, it seems, not so much to the awakened interest or conscience of medical researchers, but to vigorous efforts by parents of crib death children. Outraged at medical ignorance of the disease and at being treated like criminals, parents have formed counseling organizations such as the National Foundation for Sudden Infant Death and the International Guild for Infant Survival. Richard H. Raring, a crib death father and cogent letter writer, was one of several parents whose letters to the Senate subcommittee on children and youth prompted the hearings held by Senator Mondale in January 1972 and September 1973. The subcommittee subsequently introduced legislation to provide regional centers for conducting autopsies and counseling parents. The bill passed Congress last month and awaits the President's signature or veto.

NICHD officials say their crib death research program was stepped up in 1971 because of advances in the state of the art. Crib death researchers attribute the government's new-found interest primarily to parent pressure. "There is no doubt that the lay groups have had an influence," says Valdes-Dapena. "They put pressure on Congress, Congress pushed the NICHD, and people began to realize the magnitude of the situation." Even the conference sponsored by the NICHD in Seattle in 1963 came about "because parents raised hell, not because we [in Seattle] are smarter doctors," says Bergman.

The present research program in crib death is in several ways a success for the system. The government eventually responded to pressure from parents, and the NICHD now has a vigorous program that supports many of the best researchers in the field. But should it be necessary for the stimulus to have come from parents? If an international conference in 1963 had decided that 10,000 calves a year were being killed by a specific disease, it is hard to imagine that the agricultural research community would not immediately have assigned a dozen laboratories to work on the problem and would have settled the chief anatomical facts shortly thereafter. Priorities seem to be set differently in the medical research world. HEW officials may be right in saying the time was not ripe 10 years ago to actively encourage research in the field. But that, since it was not tried, cannot be certain.—NICHOLAS WADE

Medical Education: Those Sexist Putdowns May Be Illegal

It is a truism among students that medical school can be hell, but for women in particular it offers its own forms of torture. In the past, women enrolled in medical schools have been vastly outnumbered by men; they have been mistaken for nurses and lower-ranking hospital staff and the frequent butt of the off-color jokes with which medical school professors like to season their lectures.

But in the last 2 or 3 years more and more women have been applying to and have been accepted at medical school (in 1964, 7.72 percent of all medical school students were women; in 1971, 10.9 percent were women; and during the current academic year the number is estimated at 15.4 percent, according to American Medical Association analysts). Moreover, observers and counselors of today's female medical student say that fewer and fewer of them are willing to accept what they perceive as the men's club ambience of medical school.

The result has been something of a feminist-inspired counteroffensive in medical schools across the country, as is illustrated by a recent report: *Why Would a Girl Go into Medicine? Medical Education in the United States: A Guide for Women.* The report, after being privately published last November, has been circulating in something of an underground manner among medical school counselors, deans, and interested feminists. *Why Would A Girl* tries to give the prospective woman applicant some notion of what she is in for in medical school, and how today's feminist-oriented students are coping, by reporting on the results of a survey of 146 female medical students at 41 medical schools across the country from Harvard to Loma Linda. The respondents' comments are interspersed with those of the author, Margaret A. Campbell, a pseudonym for a prominent woman in academic medicine who, according to the feminist author Barbara Seaman, has chosen to conceal her identity because of concern about the kind of male backlash which her report describes.*

* M. A. Campbell, *Why Would a Girl Go Into Medicine? Medical Education in the United States: A Guide for Women* (privately published, 1973). Available through Ann O'Shea, 320 West End Avenue, Apt. 6B, New York 10023, $2.00. O'Shea is Betty Friedan's administrative assistant and Seaman is the author of *Free and Female* (Coward, McCann & Geoghegan, New York, 1972)

Why Would A Girl is timely because some of the discriminatory behavior it describes is illegal. The report does not go into this, but Title IX of the 1972 Amendments of the Higher Education Act states that no one in the United States

> shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal Financial assistance.

That pretty much sews it up. If a student can prove that the sleeping rooms, shower and changing facilities in her teaching hospital are inequitable, or that her school's recruiting policies discriminate against women, under Title IX the school could be liable to loss of federal funds. It is less clear, but possible, that even the psychological environment of the school could be shown to constitute illegal discrimination. Title IX is the most obvious legal recourse, but there are others; among them are Titles VII and VIII of the 1971 Public Health Service Act† which prohibits sex discrimination in admission and employment in health personnel training programs.

The report does mention another mode of redress, the affirmative action plan which some universities have drawn up under Executive Order 11246, which implements the 1964 Civil Rights Act. However, as some of the respondents note in the report, these have only limited relevance for the woman medical student, since they pertain only to employment, such as the hiring of women faculty or of women employed in hospitals.

But Title IX—which is the obvious linchpin for prosecution of discrimination cases in graduate schools—has not proved to be a big stick. It went into effect in June 1972—but the Office of Civil Rights (OCR) in the Department of Health, Education, and Welfare has yet to issue the necessary clarifying regulations on how it will be enforced. A spokesman for OCR states that in the interim federal officials have prosecuted only those Title IX complaints which appeared completely clear-cut.

A preliminary check by OCR revealed that they have received a complaint under Title IX even though the regulations are not out. This involved an incident in March 1973 when a pathology professor at the University of Wisconsin Medical School delivered an impromptu diatribe (it was taped by the students) in which he told a woman student she couldn't make an announcement because "she's got too many clothes on" and added, "We have to give you equal rights and the first thing you know . . . women will dominate society. Thank God I'll be dead before you do though." OCR took no formal action on the complaint, although after it was filed, the professor, J. W. Bloodworth, apologized to the class.

Why Would A Girl reads like a consciousness-raising Baedeker of the men's club style of behavior which, under Title IX, OCR is committed to change. Not surprisingly, asked if they experienced "institutional discrimination" in the questionnaire, the respondents mentioned differences between theirs and the men's athletic facilities, teaching hospital sleeping and locker arrangements, recruiting, and other things. There were reports of inequitable financial aid; in one school, a student said, married women were given fewer scholarship benefits than married men. Physical and psychiatric health services to students were reported by many of the respondents to discriminate against women; for example, the men students got complete general health care, while women often had to pay, or go outside the university system, for routine gynecological care. Recruitment of women was also questioned. "A group of Chicano students were flown to various campuses in the state to recruit and were invited to special meetings. . . . Women are not recruited," said one respondent. Said another: "Our school recruits for minority students and talented white males, but not for women."

Undressed Males

The women noted how teaching hospitals can discriminate. "Surgeon's Lounge—with a sign on the door saying 'Surgeons and Medical Students Only'—is off limits to women students, in spite of the fact that a certain amount of relaxed, informal teaching is done there," said one. More pathetically, another recounted: "As the only woman in a surgical clerkship group, I had to change clothes, by myself, in the nurses' room. Often when I came out . . . the rest of the group had disappeared wholly forgetting my presence." Or, "We can't go into the surgeon's lounge (they dress there), and it is not always comfortable to spend on-call nights sleeping in a long row of beds fully dressed between several undressed males. . . ."

A lot of medical education involves tightly knit, teamwork situations in which the women can be simply elbowed out. Campbell, in her commentary on the students' questionnaire responses, terms this the "invisible woman syndrome" where "one has the eerie feeling" that both one's "physical presence" and "intellectual contributions are simply not acknowledged." Some samples from the comments: "We have asked to have two women and two men on a cadaver if possible (or four women) because most women who were with three men had difficulty participating in the dissections;" or "In surgery . . . once . . . I found myself standing, never asked even to hold a retractor throughout the operation. At the end . . . it became evident that he [the instructor] had assumed I was a nurse or nursing assistant."

But beyond the physical and social situations which could constitute discrimination, *Why Would A Girl* devotes a lot of space to the psychological atmosphere of medical school and the salacious language of the lecture hall. Some of the respondents explained they believed the dirty jokes were all in good fun. Others were not so sure. "It is common knowledge that the head of the Ob-Gyn department disapproves of women medical students. Our one exposure to this professor this year was a lecture on contraception during which he flipped various sizes of diaphragms Frisbee-like across the lecture room and compared the use of contraceptive foam to a paste pot." "There are occasional jokes at the expense of women in the lecture hall," explained another student. "At those times all of our male compatriots turn and stare at us to see how we react. For the most part the women tend to look blank and unruffled." " 'The only significant difference between a woman and a cow is that a cow has more spigots'—lecturer." This kind of humor is one of medical education's oldest traditions, if not among its most revered. While it can be argued that it has its place in distancing the student from the attractions and repulsions of dealing with human anatomy, the women respondents noted that the continual mockery of women's bodies was not

† The relevant sections of the law mention that they include schools of medicine, optometry, pharmacy, osteopathy, dentistry, veterinary medicine, podiatry, public health, allied health personnel, and nursing.

matched by mockery of those of men. One noted, waspishly: "Dr. [X] head of cardiology is very sensitive to the needs of women and after explaining the situation to him [he] laid down the rule that cardiologists, if [they] felt the need to show a woman nude, had also to show a male nude. NO problem was encountered in their section."

The respondents also noted that professors' attitudes rubbed off on their men students, thus guaranteeing yet another generation of male chauvinist male doctors:

> During gross anatomy a group of students gathered for a review found that the review would be postponed 30 minutes. While waiting, some male students showed a film about pelvic exam . . . . The sound in the room was from the television show *The Dating Game*. The whole thing was made into a big farce and several demeaning things were said about the female body. There were grunts of revulsion at normal female anatomy and remarks like "looks like my girlfriend" . . . . The following week a professor who had sympathized with us and reassured us about the previous incident gave a lecture on the ovary. The slide presentations in the lecture were disrupted by several *Playboy* type slides and by a slide of the external genitalia of what appeared to be a Black prostitute (dark body, green painted fingernails). The professor made no attempt to restore order and even seemed to linger over the slides.

Another problem alluded to by several respondents and also by Campbell is the general absence of senior women on the faculty of medical schools who could serve as role models. Several respondents noted that most of the faculty women were, as one said, "on the lower end of the totem pole." Campbell added that the low number of senior women serves to "instruct students about the breadth of possibilities for their own future careers."

When does habitual, even useful, humor cross the line into hostility to women in general, hence discrimination? Campbell notes in her introduction that not all the statements by respondents count as "evidence, in the legal sense." And lacking some court test of Title IX or the OCR regulations clarifying it, the legal bounds of discrimination in graduate schools remain fuzzy.

It is also evident, both from the report's account of women's groups and university committees springing up in schools around the country, and from the attention Campbell's report has received from the national women's movement, that the women-in-medicine question has stirred up some movement, if not a movement, of its own. The law aside, there are other ways its partisans are coping and *Why Would A Girl* includes some suggestions. They range from a set of slides of nude males collected by women students to insert in the lecture's carousel "if the need be," to giving skits at school parties so that the women can do take-offs on their professors' obscene remarks. A number of survey respondents indicated that they had tried to formalize women's actions groups at their schools—but several noted that the normal pressures on all medical students to make them isolated from and competitive with each other had mitigated against the group's success. Asked what advice they would give to incoming students about coping, many of the respondents gave highly introverted, personal replies. "Speak softly and carry a big stick and an even bigger sense of self," advised one.

Mary C. Howell, associate dean of student affairs at the Harvard Medical School, who has used *Why Would A Girl* in her counseling of students there, thinks that the increasing numbers of women in medical schools are helping the atmosphere to change. Moreover "Each succeeding classful of women students are able to cope better." Howell says there is more willingness among the women students to stand up in the lecture room and object if a professor says something offensive—a type of incident which virtually never occurred as recently as 3 years ago. "I see a lot less unhappiness and depression and a lot more open anger. It's more difficult to deal with, but it's a lot healthier. This is a healthier place to be than it used to be."—DEBORAH SHAPLEY

APPOINTMENTS

Alistair W. McCrone, academic vice president, University of the Pacific, to president, Humboldt State University. . . . **Michael J. Brennan**, dean, Graduate School, Brown University, to vice president for academic affairs, Wesleyan University. . . . **Prince E. Wilson**, executive secretary, Atlanta University Center, Inc., to vice president for academic affairs, Atlanta University. . . . **Michael Athans**, professor of electrical engineering, Massachusetts Institute of Technology, to director, Electronic Systems Laboratory at MIT. . . . **William B. Bean**, professor of medicine, University of Iowa, to director, new Institute of the Humanities in Medicine, University of Texas Medical Branch. . . . **Robert E. Schuhmann**, senior research physiologist, Southwest Research Institute, to dean, School of Science and Technology, University of Houston, Clear Lake City. . . . **B. A. Nugent**, director, School of Music, University of Oklahoma, to dean, College of Sciences and Arts, Washington State University. . . . **Charles H. Gibson**, acting dean, Graduate School, Eastern Kentucky University, to dean of the school. . . . **James J. Muro**, associate dean, College of Education, University of Maine, Orono, to dean of the college. . . . **Mary S. Fasenmyer**, consultant, National Catholic Education Association, to dean, School of Education, St. John's University. . . . **Frederick R. Cyphert**, dean, School of Education, University of Virginia, to dean, College of Education, Ohio State University. . . . **Chih H. Wang**, acting head, nuclear engineering department, Oregon State University, to head of the department. . . . **Terrence M. Curtin**, chairman, physiology and pharmacology department, School of Veterinary Medicine, University of Missouri, to chairman, veterinary science department, North Carolina State University. . . . **S. M. Miller**, professor of education and sociology, New York University, to chairman, sociology department, Boston University. . . . **Joseph I. Budnick**, program director, National Science Foundation, to chairman, physics department, University of Connecticut. . . . **Harold J. Fallon**, co-chairman, department of medicine, University of North Carolina, Chapel Hill, to chairman, medicine department, Medical College of Virginia. . . . **James J. Nora**, director of pediatric cardiology, University of Colorado School of Medicine, to chairman, pediatrics department, Downstate Medical Center, State University of New York, Brooklyn. . . . **Robert F. Bond**, associate professor of physiology, Wake Forest University, to chairman, physiology department, Kirksville College of Osteopathic Medicine. . . . **Paul A. Dahm**, professor of agriculture, Iowa State University, to chairman, zoology and entomology department at the university. . . . **Peter N. Webb**, senior scientist, New Zealand Geologic Survey, to chairman, geology department, Northern Illinois University.