Woman's health care movement of Montana 1969-1999: from personal perspectives

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THE WOMAN'S HEALTH CARE MOVEMENT OF MONTANA 1969-1999: FROM PERSONAL PERSPECTIVES

by

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The second wave of feminism in Montana was instrumental in bringing about changes in our social institutions, which early feminist activists viewed as inherently paternalistic. Despite Montanans' fairly conservative stance the state hosted an immense women's movement, which tackled inequalities in the political, economic, and medical domains. Specifically, in the realm of medicine, women fought to equalize health care by educating themselves and other women about their bodies, reproductive rights, domestic violence, rape, abortion, and alternative models of medicine. The efforts of these women impacted their communities by improving the health care quality and availability. Therefore, the historical progression of the women and men of the women's movement in Montana is invaluable, both in the documentation of their battles and the examples of their successes. By collecting and archiving the oral histories of women involved in the second wave of feminism, the MFHP has aided in the preservation their wisdom for future education.
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Montana -- Largest City in each County

Figure 1.1 Map of Montana. (Note: this map was obtained from NRIS)
Chapter I

Introduction

This thesis documents and interprets the women’s health care movement in Montana, between 1969-1999, from the perspective of some of its key participants. During this time there were a number of significant events which occurred that framed the health care movement in Montana, beginning with the formation of formal organizations like the Pregnancy Referral Service (PRS) and Planned Parenthood (PP) and culminating with the end of decade and the institutionalization of organizations such as the Blue Mountain Women’s Clinic (BMWC) which were founded more than twenty years earlier.

The women’s health care movement in Montana has been little documented, yet it has considerably impacted the local communities by introducing new approaches to contemplating and implementing health care for women. The efforts of feminist health care activists radicalized many communities with new models and organizations that advocated for education, access and choice in health care. This claim is substantiated in the narratives of my informants, which describe personal and large-scale achievements of the women’s health care movement, community response (both negative and positive)¹, and the development and perseverance of many organizations created within the movement.
My research does not analyze or critique the major medical institutions in Montana, instead it seeks to analyze a social movement framed around health care. Therefore, I have focused more on questions regarding how and why the health care movement developed in Montana rather than on medical statistics or a comparative analysis of biomedicine and the women's health care movement model. In doing so, I illuminate some of the social factors important to health care.

Throughout this thesis I refer to important themes of the health care movement in Montana which recur within all of the narratives I reviewed. Education, access and choice of health care were viewed by my informants as instrumental to good health care. These elements have been identified both as goals and achievements of the health care movement attained through coordinated public events and organizations. Events including rallies, conferences and political lobbying were organized to educate the community while organizations formed to provide opportunities and choices to women regarding their bodies and health. With these organizations, the health care movement introduced a new interactive approach to thinking about and providing health care in Montana. The women's health care model described by Judy Smith encouraged equality among health care providers and patients (2002) and encouraged women to make their own informed choices about their health care (McCracken 2002).

The radical hands-on tactics of the women's health care movement were controversial because they offered services which the activists were not "certified" to provide as was the case with midwifery, or were illegal as were abortion services prior to 1974 (Sands 2001, Browder 2002). Although these
actions were often radically opposed, they were fundamental in creating health care opportunities for women in Montana and in some cases influenced the medical institutions around the state. For example, midwifery has been a model of natal health care which has sustained over the years. It was strongly opposed by most of the medical community in Montana in the 1970s and did not become a legal practice until the late eighties. After much struggle politically and legally, midwifery eventually came under the protection of the law and has become accepted within major medical institutions. Now it is not only a licensed profession, but nurse midwives practice in many hospitals around the state combining medical and midwifery methods (Browder 2002, Neal 2002, Dannison 2002).

To merely read about these events in government documents or old records is to only have a partial understanding of the story. The personal narratives of these women reveal the details that are left out in impersonal documents and the emotional struggles they endured. Looking at Dolly Browder's oral history, for example, provides a different account of the midwifery legislation then legal documents. Where as court records account for the actual legislative process, Dolly has explained the reasons for the injunction, the struggle of raising money, the process of lobbying for midwifery, and the aftermath of having to create the licensing protocol and supervisory board.

Therefore, in order to gain emic, or local, view of the women's health care movement in Montana I used an ethnohistoric approach which combines ethnographic and historical research. The specific methodology I have followed
is described in chapter two. It consisted of gathering and analyzing information from oral histories to gain a better understanding of how and why the health care movement emerged in Montana. Because I use an ethnohistoric approach, my data provides a more holistic account of the health care movement.

I consider ethnohistory to be a holistic means of researching significant events because it combines documented history with personal narratives of that history, which paints a more complete picture. It supplements historical fact (archived documents) with emotions and opinions of individuals (field data) who experienced the event first hand. Ethnohistory combines the skills of the historian and the anthropologist to piece together the historiography of a specific cultural group, which consists of not only gathering the facts of certain events, but analyzing the cultural implications of such events (Barfield 1997:160-161).

In this case, I am not merely reconstructing the history of the women's health care movement; I am analyzing the social implications of such a movement. For example, why did a radical movement develop in such a rural state? How did the movement's key participants view the effects of the health care movement in Montana? And, how did this movement differ from other movements across the nation? These are some of the questions that came to mind as I was reviewing the archival and ethnographic data that I collected.

The bulk of my data comes from oral histories and rests on the notion that oral histories themselves are a legitimate way of knowing. Oral history has been an important feminist tool in recording a history which has been ignored, that is women's words. Sherna Berger Gluck in her introduction to *Women's Words*
(1991) makes this claim, arguing that there was, and still is, a need to recover women’s words which have been neglected in U.S. history. She states that: “This conviction generated an enormous volume of women’s oral history, making available in accessible forms the words of women who had previously been silenced or ignored. On radio, in community auditoriums, in classrooms, and in bookstores, women from all walks of life were being introduced as agents whose very presence transformed our understanding of the social world.” (1991:1-2)

Gluck’s claim reiterates the feminist assertion that women have been neglected from historical research. It also alludes to the notion that oral histories gather important information that is lacking in other areas of research, either because they have provided information that was never recorded or because they add different interpretations of a given event. In the case of recording women’s oral histories in Montana, I would argue that they provide both. Montana history has long been recorded by historians and anthropologist yet women’s stories have been predominantly presented in a supporting role (Finn 1998:231). Feminists have used oral history as a means to give women a powerful voice in the historical record that has not otherwise been recorded. The oral histories I have used in this thesis not only provide a women’s perspective to health care, they allow women to represent themselves in that history.

Oral histories have not only aided in recording important social phenomena, the have documented the opinions and emotions of these events. Such was the case with the women’s health care movement in Montana, which has been viewed by many of my informants as fundamentally improving health
care for women. Many of its battles influenced legislation and local policy, and extended into the national arena, yet this history has been unrecorded. Using oral histories to document the health care movement has allowed for a more complete recordation of this event. It has also provided personal insight into the development of the health care movement. Simply following a paper trail of “historical facts” only allows a limited understanding of an event. Using oral histories I could begin to understand the how’s and why’s of the movement. Sure I knew that Diane Sands helped found the Pregnancy Referral Service (PRS), but I did not know what motivated her to do so.

The oral histories I used were selected from a larger oral history project, the Montana Feminist History Project (MFHP). My primary data was based on oral histories from five women who were recognized as key figures in the women’s health care movement. Each of these women came from different backgrounds and contributed something different to the health care movement. Here I offer a brief biography of my key informants to familiarize the reader with their backgrounds and involvement in the health care movement. I begin with Diane Sands and Judy Smith, two ardent feminist activists that were key to the foundation of the health care movement.

Hayzel Diane Sands grew up in Montana on an Indian reservations where her family taught. She spent a larger part of her youth in Frazier on the McKinley reservation where she graduated from high school. She came to Missoula to go to college because her family didn’t have money to send her out of state and The University of Montana was far more radical than Montana State (Bozeman).
Diane came from a long line of educated women and therefore a college education was considered important in her family. Diane immediately got involved with all kinds of activism. Diane was instrumental in starting a number of organizations on campus including the Pregnancy Referral Service (PRS) and the Women’s Resource Center (WRC). She left to go to grad school in Washington D.C., but returned and continue with feminist organizations on campus. Diane taught some of the first women’s studies classes unofficially, and created the Montana Women’s History Project (MWHP) which focused on recording oral histories of women who had illegal abortions. She later founded the MFHP in 2000 in order to preserve the history of the women’s movement in the 1960s and 1970s. Diane Still lives in Montana working for the office of public instruction.

Judy Smith moved to Montana from Texas in 1973. She too came from a family that considered education important and went to graduate school in Texas for biology. Judy used her training in biology to help women to learn about their bodies, teach women about reproductive rights and birth control, help women obtain safe abortions, and encourage women to get involved in the hard sciences and technological fields. Judy’s activity in the health care movement in Texas included being part of the group who brought the Roe vs. Wade case to the Supreme Court. She in turn brought her experience and drive with her when she came to Missoula. Judy had been quite active in the second phase of the women’s movement in Missoula helping to start PP, BMWC, the WRC and a number of other organizations around town. Judy started a new organization, Women’s
Opportunity Resource Development (WORD), in the 80s when the WRC finally left campus and has been involved in a number of other community based organizations.

Judy and Diane were both instrumental in the health care movement yet they represented different perspectives. Diane was a radical home-grown activist motivated from the inequalities she grew up with living on the reservation, while Judy was an implant activist from a larger city with higher education in biology and good deal of knowledge about fighting for reproductive rights. Diane represented an intimate knowledge of Montana and Montanans while Judy contributed an outside and technical perspective of the health care movement.

The other key informants, Sally Mullan, Joan McCracken, and Dolly Browder, offered three more perspectives to the movement. I start with Joan McCracken, who began her involvement in the health care movement from a medical and not a feminist perspective. Joan received her nursing degree in 1958 in Washington. She moved to Billings with her husband who was a physician. Joan pursued a position with the Office of Economic Opportunity running a family planning program. She recognized a need for more than just educating women and extended the family planning program into the first women’s clinic in Montana which became Planned Parenthood shortly after. Although she is retired she is still involved with PP, Billings. Joan differs from most of the women involved in the health care move because she was not initially a feminist. Even more she was trained with in the medical field which so many feminist health care
activists were fighting against. Nonetheless, her contribution to the health care movement has been exceptional.

Sally Mullan was also a local Montanan who moved to Missoula from eastern Montana. She was quite active in a number of organizations including Women’s Place (WP) and BMWC. Sally eventually became one of the first executive directors of the BMWC. She served as the director on three different occasions for a total of over seven years. Sally’s narrative provides an historical account of BMWC over three decades. She documents the institutional changes that occurred within the organization. Sally also addresses personal issues that did not always come up in interviews. She identifies internal conflicts that occurred between some of the founding members. This perspective is an important one because Sally not only describes a history of activism and the growth of an institution, she brings to light the problems that were part of that process.

Lastly, is Dolly Browder, a radical activist responsible for bringing midwifery to Missoula in the 1970s. Dolly moved to Montana in 1970 from Seattle after graduating from The University of Washington in Speech and hearing Pathology. She started taking classes at The University of Montana and immediately got involved in the women’s movement. Dolly started the first women’s fire crew in Montana and was active in WP and BMWC. However, Dolly is most known in this state for her accomplishments in midwifery. It started in 1976 when she became pregnant for the first time and home birthed. She became a role model for other families who wanted to home birth but did not
officially practice midwifery until she was formal trained. She was mentored by a midwife from California who moved to Montana. Eventually Dolly and her mentor organized training sessions and work shops in midwifery to teach other women in the community. Dolly was also responsible for the legalization of midwifery in Montana. She helped to create the licensing protocol and create the board of standards, which she has sat on since its foundation. She has delivery over 700 babies and currently mentors seven women training to be midwives.

These women represent both local and implant activists. They are radical, liberal and even non-identifying feminists. Some of them came from educated families and obtained higher education while others did not. Some women, like Judy were active in starting a number of organization and quickly moved on, while others, like Sally were part of an organization for a long time and witnessed it grow and institutionalize. Some women of these women, like Dolly, were instrumental in legislation and others like Diane ran organizations despite the legal implications. Lastly there is the position of Joan McCracken who represents those who were apart of the movement out of mere need and not for political or moral agendas. This was in some ways represented by Dolly whom first began practicing midwifery out of community need. However, Dolly demonstrates how individuals and organizations changed and developed through out the movement as she was forced into the politics of birthing.

These various perspectives I believe create a good representation of the women's health care movement and offer a good deal to research in general.
Because this research is both historic and personal, it contributes to many areas of research.

First, my research is a contribution to anthropology, because it adds to our knowledge of changing health care patterns as viewed by its participants. This analysis offers a more extensive account of a significant social movement because it uses historical documents and records various personal perspectives. It is focused on the social factors of health care instead of biological statistics, which is a contribution I make as an anthropologist to other fields of research.

My thesis also lays a foundation for further research. I identify the women's health care movement as a catalyst for increasing health care options to women. Further research on the effects of the health care movement on overall health care of Montana residents would be a topic of importance. A comparative statistical analysis of biomedicine and the health care movement institutions should at some point be addressed. I also address the impact of social influences on biological health. A more in depth analysis of this issue would be of great interest to anthropology and biology.

This research makes a significant contribution to local Montana historiography. I have documented the stories of local people, because I base my thesis on oral histories of women living in Montana. The oral histories I collected represent different regional perspectives. The field sites extend from western Montana in Missoula and the Bitterroot Valley (See Fig.1-1 Montana Map) through south eastern Montana to Billings. While in general my research was conducted in a rural state, it predominantly focused on the “urban” areas of
Montana. Montana only had two such areas during the 1970s and has often been recognized for its “backwoods” characteristic (Smith 2002). Here Montana is represented as a progressive state struggling with a low overall population and economic status. Lastly, while this research has been focused primarily on health care, the individual narratives provide information regarding various aspects of life in Montana.

My research also makes contributions to feminist literature by providing narratives on the accomplishments of feminists in Montana. An oral history provides a personal understanding of significant history and a model of recording important events which is both accessible and useful to the public. While the women’s health movement in Montana was not as large as some of the movements in denser metropolises around the country it still created models and systems that were utilized across the state and provided services to women in the surrounding states as well as across the Canadian border (Mullan 2002, Smith 2002, Craig 2002).

Equally important is the documentation of a movement in rural region. Feminist literature too has been predominantly focused on urban women and national movements. Examining a rural region supplements research already conducted on larger movements because it offers a small-scale and personal look at the development of a less complex health care movement. The activists I interviewed identified Montana to have been a rural and conservative region. When analyzing the health care movement as they described it, radical feminist efforts and accomplishments are highlighted against this traditional backdrop.
Lastly, I contribute to feminist literature not only with a documentation of important feminist history, but with an anthropological perspective to such a history. This thesis takes on the active role of recording the historical progression of the health care movement in Montana and preserving it so the hard work of these feminists is not lost. I provide a critical analysis of such a movement extracting the key themes identified by feminist activists. Therefore, I do not just provide a documentation of the women's health care movement. I provide an analysis and discussion of what I have identified as motivation to and outcome of such a movement. In the next chapter I will discuss the theory and methodology which frame my research and analysis.

1 When stating "the movement" I am referring to the women's health care movement in Montana, which I also refer to as the health care movement throughout this paper.
2 Urban refers to metropolises defined as over 50,000 (Census)
My research is comprised predominantly of oral histories gathered for the Montana Feminist History Project (MFHP). Specifically, it focuses on five women who actively participated in the women’s health care movement in Montana. These oral histories were supplemented by historical records, and a review of the relevant literature. This chapter explains the theoretical and methodological preparation necessary for collecting, selecting, and analyzing oral histories. First, I briefly explain the theories which support my research and analysis. I discuss the feminist influence from the MFHP that motivated this research, and the positions of practice and applied anthropology which support my analysis of the health care movement. Once I review the theoretical perspectives, I explain in detail the techniques for gathering and interpreting oral histories as primary data.

**THEORY**

I began collecting research for a larger project, the Montana Feminist History Project (MFHP), without the intention of using the information in a thesis. At best, I could say that my original research was informed by feminist anthropology because the MFHP was a feminist endeavor to which I added an anthropological perspective. It was founded by Diane Sands, a homegrown radical Montana feminist, and a key informant in my research. Her desire was to
record and archive the narratives and voices of second-wave feminist activists in Montana before they were lost.¹ G.G. Weix, associate professor in anthropology and co-director of Women's studies at The University of Montana in 2002-2003, supervised the project and mentored student interns in gathering oral histories. The project embodied the very tenets of feminist anthropology: to provide women's stories and perspectives on radical social change.

Feminist anthropology was initially concerned with focusing research on women, who have been systematically neglected, or omitted from anthropological research and analysis (Rapp 1975). Originally, feminist research was directed toward culturally unique groups abroad, such as the adolescent girls in Margaret Mead's *Coming of Age in Samoa* (1971). In other cases, women anthropologists re-evaluated past field research, taking into account women's roles and perspectives. For instance, Annette Weiner reassessed Malinowski's description of exchange among the Trobriand Islanders (1976). Both Mead and Weiner were on the forefront of feminist anthropology; however, their research was directed towards simple societies, specifically among cultural groups in danger of rapid social change.

In the 1970s, a new perspective in feminist anthropology shifted to a focus on the gender imbalance locally in the U.S., instead of abroad. At this time, oral history began to develop as a feminist tool to record women's histories. While oral history has been around since time immemorial it has not been used as a traditional method in academic research (Gluck 2002). It began on a local and
small-scale level with feminists trying to record the knowledge of women around them, and expanded into a national topic of feminist methodology.

At this time, important feminist research was being conducted right here in Montana. Local feminists, like Diane Sands, were conducting oral histories of local women, and scholars like Sally Slocum, a renowned feminist anthropologist, were tackling issues of gender inequality theoretically. Slocum, for example, brought forth an important claim that male bias in anthropology was not just in interpretation, but in the very questions asked. She made important theoretical contributions to feminist anthropology regarding women’s roles in prehistory by pointing to gender bias of anthropological questions. She also taught the first human sexuality class on The University of Montana campus in the 1970s.

Having a strong feminist influence on campus was important to the women’s movement, both practically and academically. While Slocum and others were conducting research in the States, and specifically in Montana, anthropology moved towards emic analysis of culture, replacing research on “the other”, the exotic or the “primitive”, with analysis of the local and familiar. I experienced this shift myself when choosing a thesis topic.

Originally, my thesis involved a health care analysis of an Indian tribe in Idaho during the reservation period from 1830-1930. I was interested in how health care was influenced by social stimuli such as change in diet, religion, and settlement patterns (Spinden 1908; Drury 1958; Walker 1968, 2002; Moulton 1983 v.7, v.5). While researching this topic in the archives, I was conducting oral histories for the MFHP. As I began to get more involved with the MFHP, I
realized that I was more connected with the feminist research. Ultimately, I
switched to an analysis of the women's health care movement in Montana
because I could conduct a more emic investigation of local issues. An emic
perspective is one of understanding a culture from a native perspective (Pike
1954). In this case, because I am a woman and a feminist living in Montana, I
had a personal connection of women's health issues here.

The oral histories I gathered for the project concerned a number of topics
including politics and the constitutional convention of 1972 (Roger Barber and
and Browder 2002), reproductive rights (Sands 2001, Smith 2002, McCracken
2002), education (Sands 2001 and Smith 2002), environmentalism (G.A.S.P.
2002) and religion (Sands 2001). It wasn't until after I had collected a number of
interviews from across the state that I had decided to write my thesis on the
women's health care movement. As I began to develop my thesis, there were a
few anthropological approaches which I found helped clarify my research and
coincided with the feminist framework of that research. Practice and applied
anthropology approaches correlated with my analysis of the health care movement
and the basic objective of my thesis.

One of first things I noticed about the health care movement in Montana
was how women independently brought about the changes they desired in health
care. While many feminist activists were motivated by earlier movements, such
as the civil rights movement and the anti-war movement, they did not have a pre-
established criterion to support their own health care movement. Women were
forced to come up with their own methods for attaining health care goals. These goals were motivated, as my informants viewed it, out of a need for better health care.

For example, women's health care activists identified a lack of access and choice in health care, so they began forming health organizations which provided education and access that they felt were not otherwise available. Most of these women had little or no training in science or health care, but they wanted to be an active part in creating better health care services. They did not want to give control away to doctors, so they learned procedures themselves and only relied on specialists only when they were absolutely needed (Smith 2002). The organizations they ran were operated with their own methods, models, guidelines, and policies, which made these women independent and indifferent to outside critiques.

Here, I began to recognize women as active agents in changing their relationship to the predominant health care system, which was basically hospital or private care (McCracken 2002). This theme parallels one of the key arguments of practice anthropology, which identifies history as a product of individual choice, not as random occurrence. The changes in women's health care were not simple evolution of a system, they were deliberate changes brought about by conventional and unconventional methods.

While the argument of practice anthropology is far more complex then I go into here, I wish to identify some of its salient arguments addressed by Sherri Ortner in her article *Theory in Anthropology Since the Sixties* (Dirks et al eds.)
First and foremost, practice theory is concerned with anything people do, specifically with intentional or unintentional political implication (Ortner 1994:393). It views history as a product of human agency and not a process without subject. Practice theory seeks to explain the relationship between action and system, and assumes that... “history and society are not simply sums of ad hoc responses and adaptations to particular stimuli, but are governed by organizational and evaluative schemes... that constitute a system.” (Ortner 1994:392).

These claims resonate with my analysis of the health care movement which I view as an active and conscious response to problems within the health care system and even the larger societal system. The women I researched were cognizant agents of social change, identifying problems and proactively tackling them. They confronted the dominant system of health care, which I refer to as the medical system, or dominant medical model. The dominant model of medicine in the urban areas of Montana at the time of the health care movement was biomedicine.

Practice anthropology recognizes systems as complex and holistic, encompassing many components of social order. Ortner explains this with the example of marriage systems:

"The system...is rather a relatively seamless whole. An institution-say, a marriage system-is at once a system of social relations, economic arrangements, political process, cultural categories, norms, values, ideals, emotional patterns, and so on and on. No attempt is made to sort these components into levels and to assign primacy tone or the other level. Nor, for example, is marriage as a whole assigned to "society," while religion is assigned to "culture." A practice approach has no need to break the system into artificial chunks like base and superstructure (and argue which determines which), since the analytic effort is not to explain one chunk of the system by referring it to
Because the health care movement was challenging a system of health care within the realm of medicine, it had to be understood in terms of a complex system. The system of medicine itself was comprised of economic, political, social, religious, and biological components and needs to be understood in a holistic manner. Although the movement was specifically directed towards health care, it was also quite political. Many changes in health care had to be battled in legislature before they could be dealt with in the medical realm. It became apparent to me that the medical system, itself, could not be seen solely as a system intended to treat sick individuals; that would ignore the larger social problems of medicine. Therefore, I did not separate the medical and health care systems into social, cultural, or biological categories, but rather I considered these systems to function together holistically.

This is an issue with which feminist activists were constantly dealing, both in the influence of social relationships within the medical system, and in the influence of politics, education and economics on application of health care. While these claims have been stated by many of my informants, they have also been discussed in the larger body of literature critiquing biomedicine. Social issues such as patient doctor relationships, employee relationships and workplace hierarchy, and cultural beliefs within the medical system all have a profound effect on health care. Physicians have a professional influence over patients, and maintain an authoritative role in the healing process. Treatment they suggest, or
insist upon, often appears to be the only option for patients. A patient, then, is subject to the moral and cultural beliefs of their physicians. Professional relationships between physicians, administrators, and staff have also affected the allocation of health care through with an increase in policies and rules, and unequal distribution of professional jobs to white males (Ratcliff 2002, Illich 1976, Sands 2001, Smith 2002, McCracken 2002). Health activists also recognized economic standing of an individual as limiting their choices and access to medicine. Without adequate insurance, many individuals could not receive the treatment, or drugs they required. When taking into account all the components of the medical system, it becomes clear that actual physical treatment is inhibited, or at least influenced, by social factors and its analysis must therefore be understood from a holistic perspective (Martin 1992:149, Nechas 1994:171-175).

Practice anthropology advocates for recognizing the holistic nature of systems. Although, in this thesis, I have not analyzed the medical system itself, I have tried to understand its interrelation with other social domains in order to understand exactly what health care activists were tackling. By interpreting the holism of the medical system, it is possible to understand the critiques and the extent of the battles of the women’s health care movement. Consideration of the political role in health care, for instance, is a necessary prerequisite for reviewing health issues such as reproductive rights, or the early, illegal stages of midwifery in Montana.
Another question addressed by practice theory is how much freedom have women themselves had to secede from the larger social system? The practice theory argues that a system itself has a direct relation in influencing, or controlling social action. It is argued by transactionalists that the organizational features of social structure, social roles, culture, etc. set conditions for action, but do not determine it. Newer practice theories, however, argue that "the system" has a powerful, and even determining, effect on human action.

Simply put, were the actions of feminist health care activists determined by the medical system, or even the larger societal system? I argue here that the medical system, and even society at large, had set conditions for the movement; though, I would not go so far to say that it determined, or controlled it.

In claiming that "the system" set conditions for the health care movement in Montana, I would argue, first, that deficiencies, identified by women in health care, created conditions from which organizations and activism grew. Secondly, I would claim that although feminist activists worked independently to create their own models and methods for providing health care, they nonetheless had to appease a larger system. That is, they had to work within the requirements of the law and they had to comply with many established medical regulations. Feminist organizations also needed to sustain within the economic scheme which governed the very system they were opposing. However, because feminist health care activists were creating new models and avenues for health care, they were not entirely bound to the medical system.
This is evident when one juxtaposes direct entry midwifery with certified nurse midwifery. While direct entry midwives had to work with advocates of the medical system to create the certification procedures for licensing direct entry midwives, they are not part of the medical system. They follow their own philosophies towards, training methods and procedures of birth which differ from the medical model of birth- doctors depend on technological tools to control birth while midwives rely on non-technical practices to aid in delivery. They work with the medical system when needed, but are not bound to it. On the other hand certified nurse midwives are trained under the medical model of birth and work with in medical institutions. Though they bring in a more personalize and "natural" perspective of birth they are bound by the medical system (Dannison 2002, Browder 2002, Ratcliff 2000:213, Martin 1987:143). If direct entry midwifery was determined or controlled by the medical system, as newer practice theorist would argue, it would look more like certified nurse midwifery. Instead, it maintains its autonomy and is only influenced by the medical system.

The last point addressed by the practice approach is the issue of motivation, or what motivates action. There are two theories of motivation that Ortner discusses that follow under practice theory. Those are the interest theory, or action motivated from desire, and the strain theory, or action motivated from necessity. This brings to light an important question which needs to be addressed when analyzing a social movement, why did this movement transpire? I argue that the health care movement in Montana was motivated by both desire and necessity. For some, like Judy Smith who was educated in biology, there was
adhere to educate women about their bodies and choices. For others, like Diane Sands, who did not have the option of birth control, or abortion, and was forced to carry an unwanted pregnancy to term, there was a need to gain access to services that were not available. A second point that needs to be addressed here is public motivation. Many women, who were not activists of the women’s health care movement, utilized and supported the health clinics and organizations in Montana. The supporters of the movement are just as important as the activists and there seems to be a correlation of necessity among not only the activist, but also the general public who used the facilities.

I have drawn upon practice anthropology to identify many of the key ideas in my analysis of the health care movement and see it as a good means for analyzing such a movement. First, I have recognized human agents that were consciously creating their own history, a history which continues to be changed by new actors and changing perspectives. Health care activists have worked both against and within a system that has set the conditions from which change could occur. Ultimately these changes, although radical at first, have become more institutionalized and regulated by the system itself.

Another perspective useful to this thesis is that of applied anthropology. Applied anthropology has grown significantly in the last thirty years. Its objective is to take the skill and knowledge of the anthropologist and put it into practice. This type of anthropology includes “those styles of work which are heavily invested in making anthropological knowledge useful.” (Chambers 1985:17) While this thesis may not be considered “applied anthropology” per
say, I would like to acknowledge that it relies heavily on some of the basic tenets of applied theory. Applied anthropology's tenets set it apart from academic anthropology. It is usually conducted within a group who desires the anthropologist's contribution and increases use of knowledge by extending findings to the public. It is based on a collaborative effort between anthropologist and informants. Within this research, I identify women activists as conscious human actors who create their own history and are key parts of the anthropological process. Informants have not only been active in identifying key themes, some have been active in creating the project as a whole. As I stated earlier, I conducted my research with no specific questions, theories or themes in mind. My thesis developed instead from the ideas of my informants. The concepts of access and education, local and implant activism, and of Montana as a rural and conservative location all came from my informants themselves. By conducting my research in this manner, I have used some basic concepts of applied anthropology to analyze a movement from personal perspectives of active participants, and to preserve those narratives in the historical record. In the next section, I will present my methodology including the techniques for primary and secondary data collection and analysis.

METHODS

This thesis is based on five oral histories from feminist activists in Montana. Their narratives were gathered for a larger oral history project known as
the Montana Feminist History Project (MFHP), which consisted of a total of fifty interviews from around the state. Although my thesis is distinct from the MFHP, I selected five out of its fifty interviews as primary data, and chose individuals according to their participation in the women’s health care movement. All five informants initiated new avenues of access for women and health care, and some of my informants were involved in several local organizations within the women’s health care movement. Although only five oral histories were selected as “primary data”, I refer to several other interviews which pertained to health care.

All of the oral histories in this thesis are part of the MFHP located in The K. Ross Toole Archives in The Maureen and Mike Mansfield Library at The University of Montana. Three of the interviews I used were recorded by me, and two I selected from forty interviews collected by other researchers. Because I was collecting interviews for a larger project, the university archivist provided me with some structure and training for gathering oral histories.

Completing oral histories requires a great deal of work that extends far beyond recording an interview. Many tasks are involved in the preparation and completion of the interview. Throughout the whole process, interviewing usually only requires an hour and a half of the interviewer’s time, while the research and data interpretation can sometimes take months (Ritchie 1995:25). As a student intern, I collected ten oral histories for the MFHP over a period of seven months. During that time, I prepared for and processed the interviews.
Preparation for an interview included secondary research, or gathering documents and background research, which was important to provide a context for the interviews I was collecting. It also included the administrative responsibilities required to fulfill an interview, such as contacting interviewees, scheduling interviews and organizing paperwork (MOHA 1982:16-24). I then continued on with primary research or in this case the interviewing process. Lastly, I had to process my data. Processing started out with administrative tasks such as coping tapes and turning in paperwork. Once the administrative processing was complete, I began to synthesize primary and secondary research in order to produce an ethnohistoric analysis of the oral histories I had selected.

Secondary Research

Initially the project began with secondary research. This entailed investigating information which had already been documented on the second wave of feminism in Montana. My secondary research consisted of three components: historical, methodological and theoretical. The historical research was conducted to gain a contextual understanding of the emergence of the health care movement, from the overall women’s movement. The methodological research included investigation of the processes required for collecting and processing oral history interviews. And, the theoretical research consisted of examining both the perspective of socio-cultural anthropology which attempts to interpret and understand social phenomenon, and the feminist theories applied to
the health care movement. I began with the historical research to get a general idea of the second wave of feminism.

**Historical Review**

My historical review of the women’s health care movement was based on documents donated to the project by a few of the key informants which provided information on the organizations that were a part of the women’s health care movement in Montana. These documents consisted of ten boxes of memorabilia, including articles and photographs that were given to the MFHP by Diane Sands, the founder and director of the project, an ardent activist in the women’s health care movement, and other project participants. They identified the origins of certain organizations, persons employed, and services and training sessions offered. For example, I read pamphlets (figure 2.1), newspaper clippings and newsletter articles on the Women’s Center at The University of Montana, Blue Mountain Women’s Clinic (BMWC), the Pregnancy Referral Service (PRS), Women’s Place (WP), the crisis hotline, and Planned Parenthood (PP); these documents described these organizations goals and services either as their founders wished to represent them, or as the public viewed them. Seeing pictures of the Women’s Resource Center, and reading the words of these women during the health care movement, positioned their narratives of today in the actions of yesterday.
These documents also aided in organizing my research. The donated memorabilia was being given to the archives The University of Montana archives. As a research assistant for the MFHP in 2002, it was my responsibility to index the documents. Sorting these materials became a means for organizing the information into categories. Many of the feminist organizations were interconnected through employees, goals and services, or developed into new organizations altogether. Using the donated memorabilia to outline the historical progression of the women's health care movement allowed me to identify when many of the health care organizations were founded and which ones emerged from other organizations. I cataloged them by date and group affiliation in a preliminary index, which helped me to create a timeline of events and a list of activists and organizations. Categories identified how the feminist movement was organized under specific social domains including health, education, law, environment, economy and religion.

**Women’s Resource Center**

The Women’s Resource Center is a place for women to meet, share ideas and work together on issues of importance to both women and men in the light of the changing roles of women in today’s society. The WRC attempts to meet the needs for information about these changes in a variety of ways.

The WRC maintains a growing library of books, journals and periodicals on women's issues, as well as extensive files containing additional information. Everyone interested should feel free to make use of the library, whether for research or for their own enjoyment.

The WRC can provide referrals for women seeking help or information in the areas of health, counseling, legal aid, day care, employment and many others.

The WRC is willing to provide meeting space for women's groups and can also help sponsor educational projects or programs.

Volunteers are always needed at the WRC. If you are interested please come in and talk with us.

**In The University Center**

243-4153

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**Figure 2.1 Women’s Resource Center Pamphlet**

By classifying the feminist organization under these social domains, I was able to identify organizations that were specific to health care, such as Planned Parenthood, and organizations...
that were not specifically health care establishments but which incorporated health care issues in their services. For instance, the Women's Resource Center on campus was responsible for a number of health education programs. This historical research allowed me to cluster and compare various groups of activists, and draw connections between organizations.

The preliminary research was then followed by further investigation of feminist organizations through other resources. I used sources which included the main collection at the archives, internet resources, as well as other oral histories that had been both previously and recently recorded. I read books and articles on women's health care, feminism, the women's movement, Montana, methods and theory. I also informally questioned individuals that had been, or were currently involved with the aforementioned organizations.

Literature on the women's health care movement tended to be focused on larger cities, on national research, general studies or historical research. Although none of this literature directly concerned women's health care in Montana, it provided a great insight into the development of the health care movement in Montana. Many of these articles address the same concerns and problems facing local Montana activists. These articles also helped me to understand the development of the movement here in Montana and supported my analysis. Judy Norsigian's "The Women's Health Movement in the United States" (Moss, ed. 1996:80-97) discussed why women have been the primary motivators of health care movements. Articles addressing the topic of women and health care identified similar reasons for the development of health
care movements, namely that women are the main users of health care services, that they are typically responsible for family health care, they comprise the majority of health care workers (that is lower positions in the medical industry), it has been difficult for women to gain access to information about their health, they have been traditionally been exposed to unnecessary treatments, and women specific ailments and treatments have been absent in medical research (Moss 1997:80-81; Ratcliff ed. 2002; Fee ed. 1983:105-116; Nechas and Foley1994:21-38; Illich 1976).

Literature on feminist activism and the health care movement, which I discuss in the theoretical review section, also aided in my understanding of how Montana’s health care movement fit into the larger picture and what the basic feminist positions were that supported our local health care movement. While Montana is a state considered conservative by many (Smith 2002), the health care movement was radical, comparable to those in larger areas. Many of the women’s health care organizations here in Montana were connected to or supported by national organizations (NARAL and Planned Parenthood). Therefore, linking Montana into the national context required an awareness of the national movement, and events such as federal legislation, which profoundly affected local decisions.

Knowledge about the national health care movement was also important because so many of the health care activists were from all over the country. Judy Smith for example moved to Montana from Texas, and was quite active in the women’s health care movement there. She brought with her that experience she
gained in Texas including participation in the Roe vs. Wade Case, a Supreme Court decision, which changed federal laws on abortion.

Reviewing the documents of the MFHP, supplemented by library research gave an overview of the social context of women's health care. This, in turn, provided a setting for the interviews I was to conduct, and helped me to organize my thesis. After I researched the history of the health care movement I prepared for conducting interviews by investigating methodology of gathering and selecting oral histories.

Methodological Review

Because I had never conducted an oral history, I had to learn the proper methodology for gathering ethnographic information. I used three main sources: *Oral History for Montana: A Manual* (MOHA 1982), *Doing Oral History* (Ritchie 1995), and *Women's Words* (Gluck and Patai 1991). The *Oral History for Montana* by the Montana Oral History Association (MOHA), outlines a formal methodology of interviewing for both the beginner and the experienced oral historian. It was written with a local perspective and the necessity for documenting oral histories in Montana. This book was written by individuals from Montana who had collected oral histories here. It offered a short, straightforward and uncomplicated description of oral history methodology. *Doing Oral History* by Donald Ritchie (1995) gave a well-rounded perspective on collecting and preserving oral histories. It was a more formal and thorough presentation of methodology and has been academically recognized as the best
source by archivists. Lastly, *Women’s Words* edited by Sherna Berger Fluck and Daphne Patai (1991), offers approaches to gathering oral histories specifically of women. These three authors shared different perspectives on a range of topics. My aim was a holistic understanding of the processes and techniques involved in collecting oral histories.

*Oral History for Montana* was important to me because I had never done an oral history before, and the book was written for the layperson. This manual recognized the importance of preserving local oral history in Montana (identifying Montana as a region of story tellers with a rich history) but also linked oral history to the national level. *Women’s Words* was of great value to me as it focused the importance and technique of collecting women’s narratives. This book not only provided guidelines, it gave examples of oral histories. *Doing Oral History* was more technical and less personal, however it covered all the questions I had in great detail. All three of these books were important to me as they provided different perspectives (general, local, feminist, technical and personal), yet, collectively, they covered all the key topics.

One of the most important questions for me was what differentiates an oral history from ethnographic and historical research? I found that oral histories are composed with a specific intention of “recording historically significant personal memories for archival preservation and use.” (MOHA 1983:ii) Their purpose has been to fill in missing information from a history that has already been recorded, to record information that is at risk of being lost and could be historically important in the future, and to document the emotions and provide
personal interpretations of historical events (Ritchie 1995). However, another important function of oral histories should be addressed that is, their ability to rectify information wrongfully recorded in the past. By supplementing or correcting previously recorded history researchers can contribute significantly to the historical record.

Oral histories, although different in intention and use from other types of ethnographic interviews, rely on the same skills and techniques. Basic techniques were universally recommended by the sources I referenced. Oral histories were described as personal experiences in which a story came out of a dialogue between the interviewee and interviewer. It was suggested that the interviewer needed to employ good listening skills and must be able to control the direction of an interview without appearing forceful or demanding.

Directing an interview may not be necessary in every time. Some interviewees will be more comfortable with being interviewed or may be more aware of the goals of the interview while other informants need probing or redirection (Ritchie 1995, MOHA 1983). While directing an interview was not required every time, being a good listener was. One of the key elements to good listening was interest (MOHA 1983:19-20). Personal interest in the narrator’s story will keep the interviewer attentive, while conveying interest to the narrator will make them feel more comfortable in telling their story. The most important guidance I gained from my methodological research was to be prepared for an interview, and to be a good listener.
Theoretical Review

Because my thesis was essentially based on empirical data, I have provided only minimal explanation of feminist and anthropological theories, which have been far more grounded than theoretical in nature. My initial introduction to much of this literature was in a seminar class on theory. There, I was first introduced to feminist arguments such as Sally Slocum's argument about the bias of anthropological questions. I was also introduced to Pierre Bourdieu (1977) Anthony Giddens (1979) in Ortner's (in Dirks et al ed. 1994) discussions of practice anthropology. While Bourdieu and Giddens were the first to address practice anthropology, I cited my discussion from Ortner's work because she addresses multiple perspectives of the practice approach and provided a concise discussion.

Feminist theory has been most important to my thesis because it has been a part of it on every level. The topic, theoretical frame work of the MFHP from which my data was drawn, and my methodology has been influenced by feminism. Theoretically feminism has identified the unequal representation of women in ethnographic research (Reiter 1975). The feminist criticism of academic research in the social sciences reveals the negation of women as both sources and topics of research. Some have even gone as far as to claim that western women's history did not begin until the mid-1970s (Armitage 1996:551).

Feminists, in turn, argued that women's perspectives on historical events were needed. In response to the lack of historical representation of women, feminist rediscovered an old mode of recording history that offered personal
perspective to “historical fact”. While oral history is... “much older than that [history] developed by white male historians in the United States in the 1940s”; it was not embraced by academics until the mid-1970s when feminist identified the need to record their own history” (Armitage ed. 2002:4-5). This feminist method of recording history combined feminist theory with practice and in doing so offered a better means to improve the historical record.

Feminist theory was the foundation of the women’s health care movement, and was embraced by many local health activists in Montana (Sands, Smith Browder interview 2002). Elizabeth Fee in Women in Health Care: A Comparison of Theories (1983) addresses the two of the feminist perspectives I have recognized in the Montana movement, liberal and radical; and she describes their role in establishing health care. I then turned to Judith Evens’ Feminist Theory Today: An Introduction to Second-Wave Feminism (1995) to support Fee’s explication of how feminist theories can be applied to health care. This information allowed me to identify such positions within Montana’s movement and it explained why certain individuals made a specific decision.

Once the majority of my secondary research was completed I was better equipped for gathering my primary data and structuring my thesis. Although I was using oral histories as my primary data there was a great deal of preparation that was required before I actually collected interviews. Once I had collected interviews, I also needed to select the oral histories that were pertinent to my thesis. The next stage of research consisted of organization and preparation.
Primary Research

Primary research for my thesis consisted of the oral histories of five feminist activists whom were instrumental in the Montana women's health care movement. Of these five activists, three were interviewed by me and two were interviewed by another intern for the MFHP. In this section I will address the techniques to select and collect these oral histories.

From my secondary research I had mapped individuals and organizations under specific social categories of law and politics, medicine, education, and religion. Using this schema, I narrowed the list of individuals down to those who I considered ideal primary informants. These were women that established organizations, instigated action, and were involved in a number of different organizations and could hence provide personal accounts to the beginnings of the health care movement, as well as recommend other individuals to contact (Ritchie 1995:30). I then scheduled interviews by priority according to availability, location, time constraints and age (concerning elderly individuals) of potential informants.

Initially the donated materials offered leads to contacting women for interviews. Contact information was also received from other project participants, contacting organizations with whom the individuals were affiliated, and searching the Montana telephone directory were three means of locating informants. A number of women could not be contacted and a few that did not want to be interviewed; however, most of the individuals contacted were interviewed.
The next step of an oral history was setting up the interview. Not all informants were excited about being interviewed. Often they felt that they did not play a significant role in an event or they were nervous about what would be done with their interview. In such cases I arranged a casual meeting with the individual to explain the project and sent a written statement of purpose and a list of interview questions (figure 2.2) to ease informant’s minds (Ritchie 1995, Oral History of Montana 1983). In addition to mailing out basic questions, I also personally contacted those individuals I wished to interview. I discussed with those who were unsure about being interviewed why I wanted to interview them and what would be done with the recorded conversation and transcript.

A pre-interview conversation allowed the informant to become more comfortable with me. During the pre-interview conversation a location for the meeting was chosen. I explained that it needed to be a quiet place and offered a few suggestions that would be easy to find, however things did not always work out perfectly. Often, individuals preferred to be interviewed at their own homes. These interviews were good because they provided a comfortable familiar place for the interviewer. However, on more than one occasion I had an interview interrupted by either family members, or by telephones.

A few of the interviews I conducted were with multiple people. These interviews were both beneficial and problematic. Multiple person interviews were beneficial because they provided different perspectives of an event and created a dialogue between informants stimulating thoughts and memories that may have otherwise been forgotten. However, these interviews were harder to
direct. It was difficult to convey the importance of keeping a clear dialogue. Often informants talked over each other or their stories would wonder to other topics.

Once the interview had been set up and my background research completed, it was then necessary to complete administrative tasks including consent and confidentiality forms. My research came from the MFHP database and that project received IRB approval for collecting women’s oral histories in Montana in 2000. IRB approval is the first step in conducting any research on live people and is done to protect vulnerable populations against unethical research.

The next step in protecting informants as well as the project as a whole was to obtain consent forms. Because the oral histories of the MFHP were to be archived it was imperative to obtain written consent to a taped and transcribed interview. I had my informants sign consent forms for both the MFHP and for the Archives at The University of Montana. Although most of my informants did not provide confidential information, it was better to offer the opportunity to close part of the interview due to confidentiality, than to lose an interview because part of it was of a sensitive nature. Many interviewees signed consent forms at the interview; however some informants wished to wait until after the tape was transcribed to sign their consent form. In such cases, I had to spend a lot of time tracking people down to get their consent forms signed before they could be used in the archives.
Other important tasks included checking equipment and bringing supplies for the interview such as tapes, office supplies and water (Ritchie 1995). Having equipment fail, incomplete forms or an uncomfortable informant whom has been talking for an hour with out a sip of water can present an unprofessional situation. Accomplishing as many of these tedious tasks beforehand greatly improved interviews.

Many of the interviews I did were local, and were conducted places familiar to me, although there were several interviews that I conducted outside of Missoula. It was important in these cases to get directions and leave early to insure a prompt arrival to the interview. For the most part, the interviews I collected were fairly close to Missoula, however the few interviews that were far away required more planning.

For a series of interviews I collected across the state, I was traveling for close to a week and had to arrange travel plans and find lodging and transportation. My interviews were mainly in small towns, like Glendive and Havre, with individuals interested in supporting the project. Therefore, every place I went, I was offered rides and sometimes a place to stay. However, I was not so lucky with my plane travel in between towns. I flew to Glendive, Havre and Billings on Bigsky Airlines, a small and unreliable company. I expected to arrive as scheduled to each location and have time for all the interviews I had planned. The planes were constantly delayed for hours, and sometimes cancelled all together. When I was in Glendive, a few hundred miles from my next meeting in Billings, MT, the plane was cancelled and there were no buses or rental cars so
I had to be flexible. I caught a ride with the mail plane and gained a whole new perspective on flying.

Once the research had been done, supplies and equipment checked, the interview scheduled, the room reserved and both the interviewee and I had arrived, the actual interview could begin. If there was a pre-interview worksheet to fill out I would hand those out while I was setting up my equipment. Whenever possible, I arrived early to an interview to set up and retest equipment so the interviewee did not have to wait for me. Sixty minute tapes were used because the quality and durability of the tape was better. I used an external microphone tape recorder which was backed up by an internal microphone recorder when one was available. The external microphone picks up a better sound quality while the internal microphone machine is usually a smaller simpler machine (Montana Manual 1981.) The microphone was placed half way in between the interviewee and me, or in the case of a group interview, in the middle of all the informants. A sound check including all participants was performed and the interview was started.

The first thing recorded were the names of the interviewer and informants, the date of the interview, and the location and the project name. Once this basic information was recorded I began my questioning. Although I did not follow a rigid set of questions there was a basic theme of inquiry that I followed and a broad set of standard question used (fig 2.2). Questions would change depending context, however all my interviews intended to get the same information. Often these questions would lead into one another; however,
sometimes it was necessary to state a specific question. For example, the first question often included in its answer discussion of family and when it did not, I would have to specifically inquire about the role of the individual’s family.

**Fig. 2.2 Montana Feminist History Project Questions**
(Note: These questions were provided by G.G. Weix 2002)

<table>
<thead>
<tr>
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<th>Question</th>
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<tr>
<td>1.</td>
<td>Describe your initial involvement with feminism, or activism, in general in Montana.</td>
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<tr>
<td>2.</td>
<td>What was a typical day like? Describe your routine and ordinary activities.</td>
</tr>
<tr>
<td>3.</td>
<td>How did you come to participate in organizations (e.g. the Women’s Resource Center) or in collective work (e.g. midwifery) that focused on women?</td>
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<tr>
<td>4.</td>
<td>What events do you remember as most significant to that work? Were they what you would consider ‘historical’ events?</td>
</tr>
<tr>
<td>5.</td>
<td>Who do you remember as your closest allies? Who, if any, do you remember opposing your efforts, and how did you overcome political opposition to your work?</td>
</tr>
<tr>
<td>6.</td>
<td>What were the primary goals of you, personally, and of your collective efforts to further feminism, or activism in general, in Montana?</td>
</tr>
<tr>
<td>7.</td>
<td>What gave you the most satisfaction, in terms of your personal or collective accomplishments?</td>
</tr>
<tr>
<td>8.</td>
<td>What would you (in retrospect) have done differently, and why?</td>
</tr>
<tr>
<td>9.</td>
<td>What lasting legacy to your work has endured in western Montana, or in the region? What remains to be done?</td>
</tr>
<tr>
<td>10.</td>
<td>What would you say to people fifty to one hundred years from now about feminism in Montana between 1971 and 2001?</td>
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During the interview, my goal was to have a dialogue occur while speaking little as possible. A dialogue keeps an interview personal and allows the interviewer to probe for information that the informant may not think is relevant,
or forgot to mention. However, as an interviewer I did not want to dominate the
conversation and hence the interview, it was after all their stories not mine. Thus,
if the informant brought up a point I would like to further discuss I would make a
note of it and come back to the point later, as to not interrupt the train of thought.
On occasion an interview would extend past the hour in which case, if the
interviewee was willing, I would start another tape. At the close of the interview,
I always checked with the informant to see if there was anything else they would
like to add before stopping the tape.

Upon completing the interview, I would have the participant sign a
consent form with a confidentiality section. Only one of my informants wished to
indicate that a part of a tape should not be used since she mentioned the names of
individuals in the political realm. She was a past female legislator and did not
want to cause political embarrassment to some of the political figures she
discussed; I was more than willing to accommodate her.

Usually a casual discussion after the interview would bring up points of
interest. When possible I would turn on the tape again, but usually I would just
have to take notes on what was discussed. Such was the case when discussing the
development of Planned Parenthood in Billings, MT with Joan McCracken.
While we were discussing abortion, radical methods and community response,
Joan said very little said on the subject. However, when the interview had ended
she expressed her opinion during casual conversation (Field notes 8/02
Macracken interview). I recorded some of this conversation, but for most of it, I
had to settle for taking notes. This lack of communication could have been due to
three factors: 1. some individuals feel “on the spot” or self-conscious when being recorded 2. certain ideas and opinions were not sparked during the train of thought the individual followed during the interview or 3. the informant did not want to discuss the specific subject on tape and was uncomfortable indicating that. Nonetheless, I tried to be aware of such cases and compensate for these instances in post-interview conversation. Once the interview was complete, I packed up my things and prepare for the next step.

**Anthropological Analysis**

Using anthropological methods to analyze the women’s health care movement in Montana has been equally import to this project as its contribution to the historical record. Historical research records significant happenings in history, but does not address theories as to how such an event impacted local ways of life. Likewise medical analysis considers the biological influences and repercussions. I, instead, offered an explanation of a social movement in terms of social consequences.

In this research I employed an ethnohistoric approach to the analysis of the women’s health care movement by combining historical documentation and ethnography. As the anthropologist I interpreted the narratives of my informants by extracting the themes which recurred through their accounts. In turn I have provided an explanation of a social movement as seen through their eyes. This technique had three benefits: 1) it allowed for multiple perspectives of the same event, 2) it recorded the emotions and opinions of the participants, 3) it
synthesized emotions and opinions with other historic documentation. In this case, using an ethnohistoric perspective I advocated an understanding of why the health care movement emerged in Montana through providing personal perspective of its effects socially.

Within this thesis, I did not attempt to critique biomedicine or the medical institutions in Montana. Nor, did I evaluate the quality of health care the institutions created during the health movement. This analysis has instead evaluated the social impact of the health care movement as its participants experienced it. I have focused on specific questions concerning why the health care movement developed; what it produced in terms of institutions, models and educational programs; and what its participants felt they gained. Therefore, my analysis explains how women activists viewed the dominant medical paradigms, the actions they took to change such paradigms, and evaluates their success through personal opinion and community response.

Summary

This chapter has addressed the theory and methodology used in researching and analyzing the women's health care movement in Montana. I began with an explanation of the basic theories that supported my research and its analysis. These concepts incorporated feminist anthropology which argues for a basic need to include women in ethnographic research, and arguments from practice and applied anthropology which supported my analysis. I then discussed my methodology beginning with an account of extensive secondary research that
prepared me with the information and organization necessary in gathering my primary data. Secondary research included a historical, methodological and theoretical view. The collection of primary data included collecting, selecting, and analyzing five oral histories that I felt best represented the women’s health care movement. My analysis used ethnohistorical approach allowed me to combine historical impersonal documentation with personal and emotional recollection in order to present a more complete analysis of the health care movement.

In the next chapter I will discuss the historical development of the women’s health care movement as it emerged from second-wave feminism in Montana. This review will discuss the formation of early organizations and their development into long-term institutions.

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1 This project is described in more detail in chapter III
2 In Montana, there was Diane Sands research on illegal abortions in Montana” Using Oral History to Chart the Course of Illegal Abortions in Montana (Armitage, Hart and Weathermon 2002:213-226), and Janet Finn’s research on women and copper mining in Montana (Armitage 1998:231-249)
3 For definition and analysis of a of the biomedical model see Illich (1976), Ratcliff (2002), Nechas and Foley (1994).
4 The primary example here is Diane Sands founding the MFHP the source of my data. Other examples include those women who took time to not just tell their stories, but to offer advice and critique of the project (Judy Smith, Lynn Smith, Joan McCracken)
5 Originally I selected between ten and fifteen of the interviews, however, I decided to limit my data to five key interviews.
6 The archivist in 2002 was Jodi Allison-Bunnell
7 These documents included WRC pamphlets which listed all local organization such as Blue Mountain Women’s Clinic and Planned Parenthood.
8 Normally documents donated to the archives would not initially handled by anyone but the archivist. However, Diane gave her documents to the MFHP and initially did not want to gift them to the archives. Therefore I had to index them for the project. Had they been direct gifts to the archives I would not have indexed them
9 I discuss Fee’s explanation of feminist theory applied to health care on pp. 2-4.
10 A number of informants were reached through the help of Diane Sands, e.g. Judy Smith and Pat Regan (Montana Legislator). I reached Joan McCracken through contacting Planned Parenthood in Billings and passing my number along. Sally Mullan and Nancy Munroe were found in the local Missoula directory.
11 This letter was drafted by G.G. Weix, professor at the University of Montana and my MFHP supervisor.
Chapter III

Historical Review:

The social context of the emergence and development

Montana women's health care movement

In this chapter, I trace the development of the health care movement in Montana beginning with its roots in the larger women's movement. Although the women's health care movement was a product of the second wave of feminism and the women's liberation movement, it became an important focus to many women and developed into its own specific movement (Ratcliff ed. 2002:294) that generated several health care institutions around the state. Here I describe the development of the health care movement into its own specific movement and the formation of its key institutions. I have created a concise list of significant events as an overview (figure 3.1) to the chronology I present. This chronology was intended only to present the women's health care movement in the order in which events occurred. This history was based on oral histories from the MFHP and from the archived documents.

Feminists viewed their treatment and participation in health care as unequal to men. The health care movement in Montana began to gain momentum in the 1970s with women informally teaching themselves about their health and their bodies. As the movement progressed, these women began creating organizations and institutions, which not only provided education, but access to services as well. Services were based on feminist philosophies and models that
1968 - Women’s Liberation Movement begins
1968 - Women’s Liberation was formed
1969 – The formation of the Women’s Action Center. It lasted until 1974
1969 - The beginning of the Pregnancy Referral Service (PRS)
  Joan McCracken Works for the OEO doing family planning
1969 – Planned Parenthood Missoula was founded
1970 – Planned Parenthood Billings was founded (a few months after Missoula)
1971 Status of women and Employment at the U of M report
  Katherine Weist teaches the first women related class: Anthropology of sex roles
1972 Suit filed against the university for sexual discrimination and unequal employment practices
1972 – "Red Star Crew” first all women’s fire crew
1973 – Roe vs. Wade
1974 – Reformation of the WC into the WRC which became a foundation for many of the local women’s organizations. Out of the WRC came the first “Women’s Studies” classes which were not acknowledged by the university at first
1974 – Montana withdrew a law outlawing abortion after the Supreme Court had found it illegal for any state to ban abortion during the first trimester
1974 – PRS becomes Women’s Place
1975 – The WRC starts publishing newsletters covering all kinds of health topics including reproductive rights, rape, self breast exams, sexually transmitted disease, etc.
1975 – First midwives were prosecuted in the United State in California; one of them was Jenny Walker, Dolly Browder’s mentor
1976 Women’s Health Conference
  Article on the WRC in University Outreach v.2 issue 1 by Joe Marra
1976 – Dolly Browder has her first homebirth know very little about midwifery
1977 - Dolly Start going to births casually
1977 – The Missoula YWCA Battered Women’s Shelter began
1977 – BMWC formed providing the first legal and accessible abortions and health care to all women despite their economic status
1978 – California midwife Jenny Walker moves to Montana. Together Jenny and Dolly start doing workshops
1978 – MPCC formed to protect the right to abortion
1978 – Dolly starts officially attending births
1978 – Dolly organizes the “Childbirth in Controversy” conference which discussed what was best for birthing women
1988 – R.D. Marks files an injunction against Dolly for practicing medicine without a license
1993 – BMC was firebombed
differed from the dominant biomedical models. Much of the process of creating these institutions was documented and has provided a good historical record with which to retrace the progression of health care movement. Documentation was saved in the form of personal records, institutional records, and memorabilia. It contains information regarding organization’s employees, procedures, philosophies, and statistics (i.e. number of clients, reasons for attendance, etc.).

Figure 3.2 MFHP Collections: Photographs (above women from the WRC, Judy Smith bottom row second from left, Diane Sands top row second from right; bottom picture of meeting against the new right)
The documents gathered for this chapter come from materials saved and donated by participants of the Montana Feminist History Project or by records requested by the MFHP\(^3\). These documents consisted of newspaper clippings, meeting minutes, newsletters, photographs (figure 3.2), legal documents, formal letters, logbooks, petitions, pamphlets (figure 3.3), posters, notes, and personal correspondence (U of M archives: Diane Sands papers boxes 1-9). Multiple oral histories were also referenced to expound the documental data.

This review offers an overview of the first thirty years of the Montana
women's health care movement from 1969-1999. These dates were selected because that was the period I determined to have brought about significant changes in the community. The first formal feminist health care services were established in 1969 (the Pregnancy Referral Service, Planned Parenthood in Missoula, Joan McCracken starts the family planning program in Billings), while 1999 brought about the end of a century and a time for reflection.

Much attention was given to the early part of the movement from 1968-1979 because that is when most of the core health organizations developed, such as Planned Parenthood in Billings, Women’s Place, Blue Mountain Women’s Clinic, YWCA battered women’s shelter, the first official midwives began practicing and abortion was legalized. 1979 was not an adequate place to conclude my analysis for two reasons. 1) Significant events within women’s health care occurred up until 1999 such as the firebombing of BMC (1993) and the injunction filed against a Dolly Browder for practicing midwifery (1988). 2) The movement itself changed in the 1980s and 1990s. Although it was not radically developing new organizations, it had taken on its own momentum and was becoming more institutionalized. This aspect was equally important to the analysis of the health care movement, as it was instrumental in sustaining those organizations formed by the early part of the movement.

Through this historical research, I have provided the context of the health care movement from which the narratives of chapter IV can be better understood. Presenting the history and context of the movement not only supports the narratives of my informants with historical documentation, it supplements their
accounts with a thorough understanding of the movement that may be lacking in individual excerpts or stories. I begin this historical account with a brief discussion on the origins of second-wave feminism in Montana, because that is where the roots of the health care movement lay, and then move into the chronology of the health care movement.

The Origin of the Health Care Movement

The second wave of feminism began in the 1960s and progressed into an influential women’s movement in the 1970s (Evans 1995). This is where the roots of the health care movement lie (Eisenstein 1983). The early women’s movement was very informal and was based mainly on consciousness-raising groups. During the late 1960s and early 1970s, there were really no frameworks or theories defining the women’s movement which tackled an array of problems from education to health care to politics. Early women’s activism was very much intertwined with other major social movements that slightly preceded it, specifically, with issues surrounding the Vietnam War and civil rights (Sands interview 2002, Eisentsein 1983:xvi, Evans 1995:17). These other social movements provided the women’s movement with a basic framework of organization. Diane Sands describes this in her interview with the Montana Feminist History Project, “There was no such word as feminist. I mean if you read Betty Friedan the problem was that it had no name... It [feminism] didn't have a framework around it. The first framework was around racism because of the Civil Rights Movement.” (12/01)
Myra Marx Ferree and Beth Hess, in their book *Controversy and Coalition: The New Feminist Movement*, explain the role of the civil rights movement in the development of the second-wave of feminism:

From their work in the civil rights movement, women acquired a number of valuable resources. First and most important was a sense of personal power, of taking a difficult task and making things happen. Secondly, women became skilled in organizing people and events, and in using effective tactics for implementing change and manipulating the media: civil disobedience, mass demonstrations, passive resistance, community organizing, law suits, and the mimeograph machine and press release. They also learned another crucial lesson: that if they were to pursue feminist goals, it would have to be a movement of their own. This realization came slowly, to many different groups of women as they participated in the other social movement[s] of the 1960s (1985:46).

This was the case in Montana as well. Many of the activists were “fed up” with the patriarchal structure of the anti-war movement and civil rights movements here, and with the university system (Sands and Schwann interviews 2002). However, their experience working in these other movements and institutions provided women with the training and skills to start their own movement. For example, Linn Smith whom was an activist in Texas before moving to Montana, was involved with an underground paper, *The Rag*, in Austin. She became skilled in running a printing press and upon moving to Montana, she started the Mountain Moving Press, which printed most of the local feminist literature around Missoula (Smith, Linn interview 2002).

Diane Sands illuminates the problems of within the anti-war movement, helping draft dodgers get across the Canadian Border:

“when we were in the anti-war movement, god I remember being in the back of truck going to Seattle for draft counseling, training ya know. As kind of a counter culture hippy person what that really meant was sexual freedom for men. Kind of for women but, you were viewed as a sexual object. I cannot tell you how many of these guys [said] ‘you wanna fuck snake, you wanna fuck That is all they
would talk about. That was how they saw women, was to wait on
them, to become earth mothers to them, to have their children, for
random sex or what ever, a good time. They did not take women the
smallest bit serious. It was very difficult to be heard as an
independent person in that environment. The ways you could do it
primarily was to find some guy, I partly did, which kind of insulated
you from that. If you had a partner you could kind of make them
knock it off a little bit. But, to be heard as a separate voice with an
opinion that was respected was very difficult. Many of the young
women at that time probably had opinions but know one ever asked
them and no one ever gave them a place to talk about it. Women
weren’t drafted so they weren’t at risk in the same kind of women.
So, women who were supportive of that ended up being in ... support
roles, but seldom in leadership.

According to Sands, many women in Missoula who were involved
with the anti-war movement and civil rights movement felt mistreated and
regarded as sexual objects. Women felt that they were taken for granted in
these organizations, as they were often expected to fill the role of secretary
and housewife. Women did much of the grunt work and often received
little or no praise for their labors. They were not allowed to voice their
opinions and when they did, those opinions were usually ignored (Sands
2001, Schwann 2001). Byrony Schwan, a local environmental activist
discusses some of these issues,

“And I kept seeing these women come to environmental group
meetings, and I’d see them show up two or three times and then not
again, they’d disappear. And so, as I ran in to these women... I
started asking them, ‘well how come you’re not coming to the
meetings anymore?’ And I’d get pretty much the same story from
women most of the time. Because I would ask them specifically, ‘are
you just not interested in the issue?’ And what most of them said
was, ‘no, we’re interested in the issue, but we find the meetings – we
just don’t like the culture in the meetings. There is not a place for
women’s voices.’ Some women even said to me, you know, ‘we
asked how we can get involved, we’re told, ‘well, you can bring the
coffee and cookies for the next meeting.’ And so there was a
tremendous disregard for what women had to present.” (MFHP
interview 2001)

Although this account is of an activist organization nearly twenty
years later, it describes some of the same problems women like Sands
dealt with in earlier activist organizations that were not specifically feminist. Ironically, these problems remained and demanded a similar recourse. According to Schwann, women were fed up with being ignored and degraded and turned to creating their own organization. This reflects the issues women dealt with in the movements of the 1960s.

In Missoula, as in other places, women began to recognize that they had the skills and intelligence to organize themselves. They began organizing into small casual meetings and gradually, working together, created large organizations aimed at achieving equal opportunity in specific social domains like health care, law and politics, education and economics.

The initial stage of the women's movement consisted of informal meetings of interested women. These meetings were called consciousness-raising (CR) groups and were essentially… “a means of sharing reliable information about female experience (Eisenstein 1983).” Women examined their oppression and validated that experience. The early consciousness-raising groups consisted of a few women gathered together at someone’s house talking about what it meant to be a woman socially, physically, mentally and spiritually. However, as the movement began to grow, so did these groups. They became more formal and provided a structure of organization for women’s liberation.

Early concerns of the women’s liberation movement were equality in health care, education and employment. Within the realm of health
care, women were trying to gain an understanding of their bodies. Many women did not comprehend how their bodies worked or what “normal” reproductive (menstrual and prenatal) cycles were because of a lack of health education. Autonomy was another problem with which many women identified. In the patient doctor relationship, women felt they had no say in how they were treated; ultimately they were forced to accept physician’s decisions (Fee 1983, McCracken interview 2002). Women began to tackle this lack of knowledge and control in their consciousness-raising groups. They discussed and they looked at their bodies and, through sharing information with each other, they began to understand their bodies. Women discussed sexuality, reproductive organs and process, and physical appearance. They looked at their vaginas and cervixes, shared personal experiences with each other, and began to gain an understanding of the women’s body as healthy, normal and naturally varying.

Women health care activists also expanded the dominant definition of health to include mental well-being, safety from abuse and control over one’s own body. Throughout history women’s mental well-being has been manipulated within medicine. Such an example was the mass development of women with hysteria which, “confirm[ed doctor’s] notion of women as irrational, unpredictable and diseased. On the whole, however, doctors did continue to insist that hysteria was a real disease- a disease of the uterus.” (Ehrenreich and English 1973:41). In the latter part
of the twentieth century, hysteria returned in the new and improved form of PMS (premenstrual syndrome) and PMDD (premenstrual dysphoric disorder), both of which reinforced the notion that women were unpredictable, unreliable, and, at least temporarily, mentally ill (Nechas and Foley 1994:132-134). In both of these unfounded cases, women specific disorders imply that women are inherently mentally unstable, hence reinforcing their inferiority.

A second problem women identified was the biomedical definition of mental illness, which negated social influences. It considered mental illness to be “a result of neurochemical imbalances in the brain, which can be treated through biological treatments such as psychotropic medication or electroconvulsive therapy (ECT).” (Moss edt. 1996:195-202) It did not consider that mental trauma could be induced by social factors such as violent crime towards women. Socially induced mental trauma was a problem that feminists believed needed to be acknowledged by the public. The first step was educating the public and professionals that violence against women was a problem; and second, that these problems resulted in mental as well as physical suffering. This ignorance was manifest in the medical treatment of victims, which overlooked mental trauma, and in the treatment of victims by police. Dolly Browder identified this problem and the role of Women’s Place in combating it in her narrative.

These obstacles were tackled at first with informal CR groups and then expanded into more formal organizations. In Missoula, women
formed the Women’s Resource Center and began documenting their experiences to pass along to other women by creating educational booklets, forming libraries of literature about women and holding workshops. As the women’s movement began to grow, so did the desire to improve health care for women. The expansion of women’s efforts to improve their access to health care produced a number of health care services (Smith and Sands interviews 2002). In the following section I have provided a chronology of the health care movement in Montana as described by its key participants.

Chronology of the Health Care Movement

In Montana much of the organizing and activism of the women’s movement took place in the urban areas of Billings and Missoula. At that time Billings was the largest city with a population of 61,581 people in the central city (US Census 1980). The population of Missoula was less than half that of Billings, yet it had the most activity of the health care movement. This was probably because there was a major university there (The University of Montana). The university provided resources, such as a space in the university center, that were helpful to organizing a social movement, as well as attracted a large group of radical individuals who desired social change.
Early Health Care Activism at the University of Montana

Shortly after these women began consciousness groups they formed a more formal organization. In 1968, the same women organizing the CR groups on The University of Montana campus in Missoula formed the women's action center (WAC) which was intended to provide women with resources such as a library, meeting room and phone. A few women set up a table in the University Center where they collected names of women who were interested in starting a women's liberation organization (the Missoula Women's Liberation). The response was strong and over two hundred women initially signed up. One of the initial tasks of the Women's Liberation was setting up the Women's Free School where women taught each other bicycle repair, pottery, women's health, self-defense, and mechanics among other topics. A second task was to teach women about birth control and women's health. Organizations like the Women's Resource Center (WRC) began distributing information around campus concerning birth control. The WRC ordered the McGill University Birth Control Handbook, and women like Judy Smith and Diane Sands attempted to hand them out around campus. The University administration locked up the handbooks and refused to give them back. Eventually the university returned the books with the agreement that they would contain a statement disclaiming university support of the literature (MFHP document: WAC chronology 1984 see appendix 1).
Women's Clinics: Issues of Abortion, Reproductive Rights and Family Planning

Birth control became an exceedingly important issue for these feminists. From 1969-1972 it was extremely difficult to get birth control, especially for single women (Ratcliff 2002, Willie 1962). Abortions were illegal, and there were almost no options for women with unwanted pregnancies. The main option was to leave town, carry to term and give the baby up for adoption. The other option was illegal abortions, which was dangerous and difficult to find out about (Currier 2002). Around this time, Diane Sands became pregnant and was forced into the former option. She was faced with a lack of choices and the disregard of her opinion. She decided that women should not be forced in to these choices; rather, they should have information and autonomy regarding their bodies. With the help of some other women Diane founded the Pregnancy Referral Service (PRS) in 1969. This service provided information on how to obtain birth control, pregnancy tests, and safe legal abortions in other states. The PRS offered counseling to women regarding pregnancy termination. They also handled emergency situations which advised women on how to handle their specific emergency, which doctors to see, which to avoid, and what their laws and rights were. Emergency situations could include anything from a miscarriage to a self-termination.

At the same time, in Billings, Congress had allocated money for family planning through the Office of Economic Opportunity, and was
intended to educate women on how to plan out their children and control the size of their families. Joan McCracken, a trained nurse, was awarded the family planning position. According to her account, she quickly realized that education was not enough; many women in and around Billings needed access to birth control and had no means of health care. At that time there were no clinics or public health services. If women needed health care they had to see a private physician which was not an option for poor women. Furthermore, women who could afford private services were subject to the physician’s moral opinions on issues such as birth control and abortion. In her oral history, Joan recounts the development of the first women’s clinic in Billings (McCracken interview 2002). She decided a women’s clinic was needed, so she used the O.E.O initiative money to set up a small clinic for services as well as education. The clinic provided birth control and basic health care services such as gynecological exams.

In Missoula, women were also demonstrating a need for a clinic and women specific health care that was accessible and affordable. In 1969 in Missoula, the first Planned Parenthood (PP) in Montana was established. Although it was small and local, PP was supported by the national institution with its pre-established protocols, training and guidelines. Shortly after the establishment of the Missoula Planned Parenthood, the women’s clinic Joan McCracken had established in Billings turned to the national organization for support as well. While the
local Planned Parenthood clinics were financially independent private establishments, they depended on the national organization for affordable and dependable insurance, supplies and legal support when need be. Both clinics in Montana offered education, counseling, health care services and access to birth control. They did not, however, offer abortions or abortion referrals because they were illegal without a just cause until after the Roe vs. Wade decision in 1973. Even giving out information in Montana on abortion before Roe vs. Wade was illegal.

While organizations provided local services, both legally, as in the case of Planned Parenthood, and illegally, as with the Pregnancy Referral Service, nationally there was a battle that would affect these small community organizations. The court case of Roe vs. Wade, brought to the Supreme Court in 1973 as an appeal of a Texas court decision. The Supreme Court ruled that women should have the federal right to terminate a pregnancy in the first trimester for whatever reason. Before this decision, abortion was a state decision, and usually required extenuating circumstances such as the threat of health problems for the infant, or mother, or, in cases of rape and incest (Ratcliff 2002).

Prior to Roe vs. Wade, abortion was difficult in the state of Montana. Physicians had the power to provided the procedure if they felt it was necessary, but women themselves did not have the right to choose and abortion. Often times it was not discussed, or if it was, it was referred to as a menses extraction (Pearson 2002:307, McCracken field
notes 2002, Browder 2002 interview). This option was only available to some women who could afford to see a private physician that would provided such procedures. Otherwise, women had to resort to “back-alley” abortions, self-termination, or going out of state to get legal abortions. The latter option was afforded only to the wealthy as it required substantial money, transportation and the freedom to leave town.

Although the Roe vs. Wade decision declared it illegal for any state to outlaw abortion in the first trimester, Montana did not withdraw its law banning abortion until 1974 (MFHP document: MPPC history).

Organizations like the Pregnancy Referral Service risked prosecution to provide such controversial information to women. Billings did not have such a service that was so explicit in its mission. However, Billings did have a group, the Clergy Counseling Service, which would help women get safe abortions (McCracken 2002). After the Roe vs. Wade decision, both Planned Parenthood offices in Montana offered information on abortion, however they did not offer the actual procedure until years later. The Billings office began providing abortion services some time after Blue Mountain Women's Clinic opened up in 1976; whereas the Missoula Planned Parenthood did not offer abortions until 1993, after the BMWC was temporarily shut down.
In 1974, the year after Roe vs. Wade decision, a number of changes had occurred within the women's movement and the health care organizations that had formed both in Montana, and nationally. Many of the women that supported the health care movement were in transition to other places, either because of school, or the need for change. At that time, new women had moved to Montana and were interested in getting involved in the women's movement. In Missoula, the arrival of Judy Smith marked the transition of the Women's Action Center at The University of Montana to the Women's Resource Center, which moved into the main floor of the University Center. It was revamped with the help of Judy Smith and Diane Sands, both of whom wished to improve and expand the center. Shortly after the renovation, Diane left Missoula to begin graduate school at George Washington University in Washington D.C.

The new WRC offered a number of services and resources to students and community members. It was described in one its pamphlets as:

"...a feminist organization providing educational and referral services and support for students, community and state residents. As a drop in center, the WRC provides referrals, services and information in health, day care, employment, legal aid, counseling, education, rape and violence, ecology, support groups, and skill sharing. The WRC also provides a variety of educational programs and resources on women's and men's changing roles in society."
The specific resources it offered consisted of a library of women's literature containing over 500 titles, access to twenty-five feminist journals, "special files" containing information on 150 topics for personal and research use, counseling referral files, referral box, and violence and victimization files. The WRC also provided resources such as meeting space for women's groups, telephone and copy machine. The services it extended included Brown Bag Discussions, skill sharing workshops, assertiveness training workshops, conferences, cultural events (co-sponsoring the presentation of films, speakers and women's art), women's studies classes including the "Issues in Women's Health" class, the Montana Women's History project which documented illegal abortion in Montana in the nineteenth century, employment counseling, employment discrimination counseling, referrals regarding health, legal aid, and daycare, consciousness raising groups, and information on all the women's organizations and events around town.

The WRC also distributed newsletters which covered an array of topics, many of which were regarding women's health. Articles provided information on abortion rights, sexual education, rape, birth control, hormone replacement therapy, STDs, health issues concerning breast exams, the cervix, vaginitis, holistic health, parenting, domestic abuse, pornography, mental health, sexual preference and legal issues around various health topics. These newsletters provided yet another source of
information that was given to women all over the state (MFHP document: WRC newsletters v1 1975- fall 1986).

At this point health care began to receive more specific attention from feminist activists. Many organizations had been formed to deal specifically with women’s health. The WRC formed classes to address health directly towards women while local literature on the topic was increasing. A second transition from women’s liberation to the women’s health care movement that occurred in 1974 was the evolution of the PRS in to Women’s Place (WP). Upon becoming WP the focus of the organization expanded to include other issues of women’s health such as domestic violence and rape. It was described by the WRC as:

“...a health information, counseling and community resource for all. Services included information on gynecological care, birth control, abortion, venereal disease, menopause, and sexuality. Women’s Place also does crisis counseling for women who are victims of rape or battering, and a volunteer is on call at all times. Women’s Place is based on the belief that women have the right and responsibility for making their own decisions concerning their lives.” (WRC pamphlet mid-1970’s)

Another shift towards a specific health care movement was marked with the formation of the Missoula Women’s Health Collective (MWHC). It was formed by group of women of the Women’s Liberation who were focused on women’s health. They offered intensive study groups and workshops; and they educated themselves and other women on measures required both medically and economically, to open a women’s clinic. This included raising money and training one another on the procedures necessary for running a clinic. The MWHC was one of the groups that
help found Blue Mountain Women's Clinic a few years later (MFHP document: WAC chronology 1984).

A Different Approach to Birth

A third major change delineating in the women's health care movement occurred in the field obstetrics. An interest was growing in natural child birth and midwifery. In 1975, the first midwives, Jenny Walker and Kate Boland, in the U.S. were prosecuted and found guilty of practicing medicine without a license. They were from Santa Cruz, California, and although the case had little impact on the Montana health care movement at the time, it would ultimately influence the public emergence of midwives in Montana.

In 1976, a resident of Missoula named Dolly Browder became pregnant and decided not to have a hospital birth. She consulted a physician by the name of Dr. Panell. Dr. Panell was aware that Dolly was going to have a home birth and agree to do all her pre-natal care. Dolly gave birth to her baby on September 9, 1976. According to Dolly, she had minor complications and decided to go to the hospital to get checked out. When the hospital staff found out what the Browders had done, Dolly explained, "the shit hit the fan." Dolly claimed that the medical community was appalled, because in their eyes, this couple had endangered a newborn with a natural child birth. Both mother and baby were ultimately fine, and Dolly eventually left the hospital against their wishes.

A year later, another Missoula woman decided to have a homebirth. She asked Dolly to come, since she had been through it before. Dolly agreed but
specified that she was not a midwife and would be going only for support. More
women began asking Dolly to attend their births. Dolly reiterated to these women
that she was not a midwife. Then in 1978, Jenny Walker moved to Missoula and
brought with her experience and knowledge of midwifery. Jenny began
mentoring Dolly, and shortly they began to educate women about midwifery and
different methods of birthing through a series of workshops. They invited Kate
Boland, Jenny's mentor, to help out with the workshops and share her experience.
Dolly attended a few births as an apprentice to Jenny and began officially
attending births on her own in 1977.

Prior to Dolly attending births, there were a few other events that were
important to the health care movement. In 1976 there was a major conference, the
"Women's Health Conference" that was hosted in Missoula. The purpose of the
conference was "to make public the issues the women's health movement has
raised nationally and to invite a discussion about their application and usefulness
in the Montana health care system. The conference addressed issues regarding
patient informed consent concerning the hazards and benefits of treatment, birth
control access, sexuality, mental illness and the biases of professional, medical
ethics, religious influence on public policy, equal access to health care, alternative
models of health. The featured speaker of the conference was Barbara
Ehrenreich, a well-know author and activist in the women's health care
movement. Other participants included multiple clinics from Washington and
A year after Dolly began officially attending births, in 1978, she organized a conference called “Childbirth in Controversy”. She had written a grant to the Montana Committee for Humanities and received ten thousand dollars to put on a conference on childbirth. It was addressing the question of what is best in childbirth. It considered topics of hospitals vs. home, drugs vs. natural, unnecessary procedures and spousal participation. It was advertised to doctors and nurses around the state. Although only one physician attended, it attracted individuals from all across the country.

Between 1977-1978 two major organizations were founded. In 1977 the YWCA started the Battered Women’s Shelter, which provided refuge, counseling and support to women and children suffering from domestic violence. Also at this time women were organizing to open a women’s clinic that would provide abortions. In 1978 the Blue Mountain Women’s Clinic officially opened and provided health care services to women by women. It was describe by the WRC as: “a non-profit clinic run by women for women. It is dedicated to providing health care services and information to women from all parts of Montana in a positive and supportive atmosphere, and to the involvement of the women who come to the clinic in the process. The clinic… provid[es] abortions and related services as well as educational programs.” (MFHP document: WRC pamphlet 1970s).

Finally, the issues of reproductive health led to the formation of political lobby groups. The Montana Pro-Choice Coalition (MPPC) also formed in 1978. It organized in response to the increase in “Right to Life” activism in Montana.
The main goal of the MPPC was: “to ensure that every woman in Montana has accurate information on the option of safe, legal abortion, and through legislative, electoral and educational activities, to kept abortion safe and legal. The basic premise of the organization is that pro-choice victories, whether on a local or state level, depend on the creation and mobilization of the Montana pro-choice constituency. The coalition has lobbied against the anti-abortion bills that were sent to the legislature and educated communities about abortion and its legal status (MFHP document: MCCP history 1980s see appendix 2).

By the end of the 1970s women’s clinics around the state (in Bozeman, Billings, Great Falls, and Missoula) had been set up to provide health care to women, abortion had been legalized and there was an organization providing the procedure (BMWC), women’s shelters were available, and midwifery was being practiced legally. With the exception of minor internal changes, all of these institutions continued to provide support to hundreds of women. However, by 1988, trouble began to develop.

Community Reactions

In 1979 Jenny Walker, the only other midwife in Missoula who had worked with and trained Dolly over the prior two years, stopped practicing. There were only a few other known midwives in the state at that time, so when Jenny left, Dolly services as a midwife were even more so in demand. Throughout the 1980s, Dolly remained extremely busy doing up to fifty births a year including pre-natal examinations. Community response was mixed. There
was obviously support of midwifery, however midwives claim that the medical community was still wary, even spiteful (Browder 2002, Dannison 2002, Neal 2002). There was a lack of understanding midwifery within the medical community.

While many doctors and nurses were tolerant of the practice, many were certainly not supportive. For example, women home birthing that went to the hospital due to complications were often treated poorly (Browder 2002). They were listed as having no prenatal care, even though midwifery prenatals were often more thorough that medical ones. A few of the medical community did work with the midwives, like Dr. Tom Baumgartner whom was obstetrics physician (OB) in the late 1970s, and helped to influence some change and acceptance with the hospital. In general, midwives felt their relationship with the medical community was tense, but not extremely hostile. There was little evidence to support medical resentment as Dolly had an excellent track record with homebirths. By 1988, she had helped delivered over three hundred healthy babies. That all seemed irrelevant when, following one homebirth, a new physician in town filed an injunction against Dolly.

Dolly Browder was attending a birth that she felt was not progressing properly, so she decided to take the woman into the hospital. The problem was that the baby was too big and the women needed to have a Cesarean-section procedure. The physician in charge, Dr. R.D. Marks, was a family doctor new in town. Dolly claimed that he had no rapport with the local midwives and did not agree with midwifery in general (Browder 2002). According to Dolly, Dr.Marks
felt that the midwives were problematic, and he tried to press charges against Dolly for practicing medicine without a license, but could not, since midwifery was illegal at the time. Dr. Marks instead contacted the Medical Board of Examiners and an injunction was sent to Dolly to stop her from practicing midwifery. This was a civil case, and Dolly had to appear in front of a judge.

There was a lack of information, on midwifery and there were very few legal cases, certainly no positive ones, from which to model Dolly’s case. The midwives, with the support of some individuals from the community, raised money to hire a lobbyist, Mona Jamison, to help them with the case. Although, Dolly was found guilty of practicing medicine without a license and was forced to stop practicing midwifery. The next session, Dolly and Mona went to the legislature, and lobbied for a bill to declare that births were not a medical event, and therefore midwifery was not practicing medicine without a license. Their bill passed on April 5, 1989 by seventy-five percent vote of the legislature. The initial law simply exempted midwives from the medical practice act. The midwives then had to create new legislation that would regulate practicing midwifery, which entailed establishing a standards board and licensing procedures. In 1991, that legislation was accepted, and the law passed.

Also, in the early 1990s Blue Mountain Women’s Clinic faced a number of struggles. As the clinic began to grow, they became more institutionalized, and unofficially extended services to men and children, and expanding their range of services past abortion and gynecology. They finally decided that the clinic would officially extend their services to both men and women and the clinic changed its
name to Blue Mountain Clinic (BMC). Although the clinic had diversified to offer all kinds of health care, they were still labeled by some as an abortion clinic. BMC began receiving major protests from anti-abortion supporters like Operation Rescue. The protests were so severe that volunteer escorts had to be trained to protect the women entering the facilities and the police were required on several occasions. A number of arrests were made at various protests.

Despite the cooperation the BMC received from the police, the clinic was firebombed and destroyed in 1993. The clinic was shut down for two years, during which time much of the local community helped out by donating money, office space and time to keep the services that BMC provided going. Planned Parenthood began providing abortion services at that time, and some of the local physicians began offering procedures out of their practices due to the demand. In 1995, BMC reopened in a brand new building with expanded services.

Summary

In this chapter, I have outlined the health care movement in Montana, a dynamic phenomenon that feminist activists viewed as radicalizing local Montanan communities. I presented a chronology of the development of a specific women's health care movement, which began as a part of the larger women's movement. Community need and responses demonstrated the effect the women's health care movement had on several urban centers and local Montana communities.
This history has illuminated some important themes, which appear to have motivated the movement, and developed with its progression. In the early stages of the women's movement, before the health care movement had branched off into its own specific movement, lack of education seemed to be a driving force. Women started recognizing the fact that they didn’t know anything about their bodies, and had little to no choice in their health care. At that point in time, education was primarily about exploration and sharing. Women educated themselves by looking at their own bodies and sharing their experiences with others creating a sense of normalcy about their bodies.

Self-education expanded into more formal education where women researched topics and offered classes on health related subjects to other women. Formal classes in turn led to a deconstruction of medical paradigms of women’s health. Notions that women were crazy, not normal, or inherently sickly and weak were being deconstructed. Medical paradigms were replaced with new models incorporating equality between patients, experts, and staff; natural and alternative methods to medical treatments; education leading to patient choices, and economic destratification.

These elements were all intended to provide access to health care to all types of women. Access is the second major theme of the women's health care movement. Women strove to solve the problems they identified, which ultimately meant women managing their own health
care. The combination of education and access was seen as the basis for women to provide themselves the opportunity to get good health care and participate in making choices about their own lives and bodies. In the next chapter, I will expound on this history of the health care movement and its important themes using the personal narratives from five of its prominent activists.

1 The WRC newsletter health topics 1975-1986 (Box 1 of the Diane Sands collection comes with a list of the collection and the articles in it.) Key newsletters- v.1 n.1: abortion rights council, changing attitudes towards rape; v.1 n.2: establishment of rape crisis center in Great Falls; v.1 n.3: sex education; v.1 n.4 an extended article on venereal disease and herpes; v.2 n.1: article on rape, birth control and ERT, flagyl. rape as political crime; v.2 n.2: “Women leave State to Get Abortions: and the establishment of the MT Health Agency, curing vaginitis, birth control, Barbara Ehrenreich’s Health Right, patients rights; v.3 n.1: abusing Women is Unlawful”, domestic abuse articles and an article on Women’s Place, list of shelters across the state; v.3 n.2 skip: predominantly on parenting; v.3 n.3 self-breast exam, cervix. (v.4 n.1???)Issue on Women and Psychology; v.4 n.2: A UM rape and violence task force, brown bag on health, issues in women’s health; v.4 n.3: “Violence and Victimization” by Jane Burnham, the socialized penis, battered women...; v.5 n.1: “Holistic Health” articles on stress, body awareness, nutrition, fitness, tss...; v.5 n.2 Illegal abortion in MT, Women’s right to Choose; v.5 n.3, National Abortion fund; v.6 n.1 skip; v.6 n.2 skip; v.6 p.3 skip; v.6 n.4: pro-choice coalitions speaker Meridel LeSueur; v.6 n.5 skip; v.6 n.6: article on local shelters, women’s place; (spring 1984) take back the night; (Summer 1984) Reagan’s assault on abortion worldwide; (Fall 1984) Non- Gender insurance. Pro-choice and Planned Parenthood alert. Domestic violence legislature; (Winter 1984) Pornography: emotional violence against women; (Spring 1985) “Midwifery in Montana”, Teen pregnancy, and articles on health; (Fall 1985) skip; (January 1986) fitness, love with out fear week. Women and Welfare; (Spring 1986) domestic violence articles; (Summer 1986) “Women and Power”; (Fall 1986) skip.

2 The biomedical model has been critiqued as being iatrogenic, paternalist, symptom obsessed and economically stratified (Illich 1976). Critics argue that it is one-dimensional, focused only on the treatment of problems and abnormalities, opposed to holistic and preventative models which take in to account social factors of illness and focus on preventing problems from developing (Ostlin et.al. 2001:6). The feminist models used in the Montana women’s health care movement concerned providing education and choices to women. It was based on egalitarian work ethics, in which everyone took equal part in decision making, labor tasks and procedures (McCackeen. Sands, and Smith interviews 2002).

3 For example, Darla Torrez, intern to the MFHP, approached Wayne Chamberlain, the clinic director, who donated a number of documents The University of Montana K. Ross Toole Archives for preservation.

4 Evan’s begins her account in 1963 with the publication of the Feminine Mystique (1995:2)

5 Abortions were permissible in extreme cases such as incest or rape.

6 According to Dolly, Jenny stopped practicing for two reasons. she was having her fourth child and her husband, whom was a physician, was feeling a lot of pressure from his colleagues.

7 Dolly lists three women that she knew of: Michelle Neal, Morning Star, and Dee Golas. Other Montana midwives Dolly later lists are: Sandanho Danison (Missoula), Kathy Dunham (Great Falls), Ollie Hamilton (Great Falls), Patricia Murphy, Vicki Cane, and Leslie Fellers (Whitefish).
Chapter IV

Their Stories:
Narratives of feminist health activists in Montana

History tells us about events of the past, but often it is a cold and detached recording of activities which were filled with emotion and struggle. To hear the personal descriptions of an event from those who witnessed it adds a new dimension to history. It offers an interpretation of why history developed as it did, why people made certain choices, and how it felt to be part of a specific experience. In essence, it offers an extended knowledge of the past. So far, I have described the health care movement in Montana as a history in a somewhat detached manner, as a researcher who reconstructed a chronology of events. Here I wish to expound on that history with narratives of some of its key participants.

Diane’s Story:

“In 1968 I was 21, a college student, and very much in love for the first time. I was president of the local campus student Christian council and in love with a Catholic Monk, I had met and worked with through a campus ministries social action program. On Good Friday I made love for the first time. Foolishly we were not using birth control; we had not even discussed it.

I became pregnant as a result and what had been a loving act turned into a terrifying experience. I knew absolutely that I did not want to be a mother, that I was emotionally and economically unable to care for a child. The father offered marriage but he was no more able to provide for a child. I also believed that
pregnancy was not a good reason to marry. I wanted to finish college, to be able to provide for myself and my future.

For these reasons I considered and decided to seek an abortion. In 1968 abortion was illegal in Montana but I sought information via the underground grapevine about abortionists. I heard there was a doctor in Shelby but a friend who had gone to him found an alcoholic with instruments and sponges in a bloody basin. I wasn't willing to risk my life with a quack. Another friend told of a way to get a Mexican abortion, complete with being met at the airport by a man with a red carnation who whisked you away to an unknown fate. I was too scared to take the risk. If I couldn't find help, I would abort myself. A friend and student nurse helped me acquire and consume dozens of birth control pills under the theory that when I stopped taking them my period would start, no matter what. It did not work. My desperation led me to try excess exercise, hot baths and once I threw myself down the stairs at the campus building in hopes of causing a spontaneous abortion. I was bruised physically and emotionally but still pregnant. Also, I went for a pregnancy test to two different doctors and begged each of each of them for help ending the pregnancy. One said, ‘If you’re going to play, you have to pay the piper’ and the other one was sorry, but neither would help.

Time had run out. Furious at being unable to end this unplanned pregnancy I accepted my unwanted fate. Through the assistance of the campus minister I was ‘sent away’ to an out of state home of the minister’s friend where I completed the pregnancy, gave birth and placed the child for adoption. My body
was not under my control; I spent 9 months of forced servitude. And although I was told at her birth that she was okay – not a year passes when I don’t worry about the consequences of the large [lots?] of b.c. pills on that child...

When I returned to college after a six month absence, my relationship with the father and my first love had ended as a painful consequence of the pregnancy.

Most important to me, from my anger I promised myself that I would do whatever was in my power to insure that other women would not be left with no choice but to bear an unwanted child, as I had. I joined with several other young women who had had similar unwanted pregnancies – some had risked illegal abortion and some had given birth to unwanted children. Together we began Pregnancy Referral Service which provided peer counseling and referral for safe legal and illegal abortions out of state. We also provided referral for services to place a child for adoption or to support raising a child as a single parent, although few women opted for those choices. At the time – it was a crime under [illegible] law to provide women w/information on abortion. When we started our abortion referral service we were too late to help some women – in the 1" month of operation we heard of [illegible] women who had recently died of a self induced abortion produced by a vacuum cleaner, a near death self induced [illegible] by [illegible] needles and other horror stories.

I was angry then and I am angry today when I face the reality th[a]t still condemns many women to unwanted pregnancies because of lack of sex education, lack of safe and effective birth control, or lack of money and access to
an abortion. Reproductive freedom is our right—including abortion—and I, for
one, am committed to winning, expanding and preserving that freedom.”

I have begun with an account from Diane Sands describing her experience
with carrying an unwanted pregnancy to term. I present Diane’s narrative first
because it describes what it was like when there were no formal women’s health
care organizations in Montana. Diane states, in one short story, what the
women’s health care movement was about for many of its participants. She
indicates the lack of choices, or autonomy over her own body, what some women
were willing to do to gain control over there bodies (even jeopardize their own
lives), and how ultimately many women were still forced into carrying unwanted
pregnancies to term. Diane recalls the ridicule that she received from some
doctors when she tried to get help and how she was “sent away” while dealing
with the problem. Diane, like many other women, was so angry from her
experience that she was motivated to found an organization which illegally helped
women deal with their unwanted pregnancies, namely by providing education and
access.

Education and access are themes which recur throughout all of these
narratives. I have selected excerpts from these oral histories which focus on
health care because the narratives jump around to various topics. I have tried to
present these excerpts in as much of a chronological fashion as possible without
chopping up individual stories. Therefore some of the stories may overlap with
different topics of the health care movement. The first selection of narratives
discusses the beginning of the women’s health care movement in Montana and
some of its key elements such as education and access. I start out with a brief comment from Dolly Browder about the early stage of the women’s movement in Montana.

"... I immediately got involved in the Women’s Resource Center, and it wasn’t really a resource center at the time. This was the, the fall of 1970 and it was just... I think a group of us women were getting together, meeting. And this was, you know, Diane Sands, and Judy, and another woman who’s... I was closer to. [...] But the 1970’s really for me was the start of the women’s movement."

In this brief quote, Dolly illuminates the informality in the beginning of the women’s movement. The next quote from Judy Smith expounds on the women’s movement and discusses the beginning of the health care movement emerging out of the women’s movement.

**Education: The Roots of the Health Care Movement**

"...So, for a group [of] us, we decided we would spend a fair number of hours with each other talking over the whole concept of what it meant to be a woman, and how’d you grow up being a woman, and what did you feel about it, and that was called the consciousness-raising groups. And again, it was a kind of a spontaneous evolution. No one told us how to do that. It was just, okay, let’s all get in someone’s backyard and talk over sexism and socialization and the meaning of the things that we’ve been taught and how- what we want to do about it. So, that was one thread of that was really important to me."
A second thread is that I’m trained in a particular field, and that’s sort of played directly into the whole birth control and abortion movement, because I had some training in that area. I was in graduate school in Biology, and at that time, basically it was hard to get birth control pills, and it was very hard to get an illegal abortion [...] because basically in Texas it was illegal. There were very few places it was legal. So, a group of us decided we’d start making birth control and abortion available. And we didn’t provide the actual abortion, but we did take women places that they could get abortions. And my colleagues and I in the graduate program at the Biology department went down and investigated the clinics and made sure that they were safe, and made sure that they used sterile technique[s], and all those kinds of things. So, we took on a certain responsibility around birth control and abortion at that time. And again, I think when you have your own experience of something being, being illegal that you think you absolutely have a right to, that’s a radicalizing experience. And so, we worked at different levels. We did some legal challenges. We did, as I say, direct access kinds of things. We did quite a bit of education. And it just worked out that I was part of the group that brought a court case that ended up being Roe v. Wade case and so we went to the Supreme Court and won that particular case. But, I think more importantly than that was just the sense of it that we were very, you know, entitled. And I- and I think that’s something that’s always interesting to ask, ‘who gets involved in what part of the women’s movement, when?’

So, it was a lot of women with quite a bit of education, quite a bit of a sense of themselves that they should have what they want. And so the issues that
came from that are issues that are pretty predictable. You know, women wanted sexual freedom, okay. Women wanted equal rights to jobs that pay money, okay. Women [wanted] you know, those kinds of things. So, those were the first issues that kind of rolled out of that part of the women's movement, and it's because it was a student-based movement, those were the kinds of conversations a lot of us had...."

"...[When I came to Montana] what I brought was a focus also on the whole birth control and abortion thing, and so, when I came in, I tried to find the women who were working around those issues and said, 'Look, we- I want to start a clinic. So, I want to talk to you about starting a women's clinic here.' And then I also said to the women on campus, 'Look, I want to teach Women's Studies. So, I want to do that here, so how do we do those things?' And there wasn't a women's center, so I said, 'Well, let's just start a Women's Center.' And again, there's a certain pattern to all of this because, like I say, I think many of us who got involved in this wave of the, you know, women's movement, were very entitled women. Like, we just said, 'You know, there should be this.'"

In the first paragraph, Judy starts out by discussing how feminism began as groups of women gathering together casually and holding consciousness-raising groups. These groups were simply women discussing their opinions and beliefs with each other. They were in effect giving themselves a voice. This was a key element of the women's movement because not only did these consciousness-raising groups stimulate early activism, they remained a significant
constituent for sharing knowledge (Ferree and Hess 1985). They were not just an ephemeral initiatory stage, they were important in providing education, support and opportunity to women throughout the movement. These consciousness-raising groups provided a forum for discussing an array of issues, including health, which impacted women’s every day lives.

Judy then identifies a “second thread” of the movement that was of importance to her. The need to provide access to birth control and abortion was one of the priorities of the early women’s movement which evolved into its own movement. Being one of few women that was actually trained in the hard sciences and held a graduate degree she had the education to back up her desires as well as a network of other women whom were in similar situations. Judy’s main point here is that these women proving such services and education were doing so because the felt entitled. The ability to control what happens to one’s own body was viewed as an inherent right and not a privilege to be controlled by those whom had little desire to understand the women’s body. Here it seems that autonomy seemed to evolve from education.

Although Judy spent the early part of the women’s movement in Texas she was actively involved with many aspects of it including providing health care options, legal support and education to women. Like many of the implant activists in Montana, when she came to Missoula in the early 1970s she brought with her both experience and a desire to improve the opportunities for women. In this next quote Judy talks about the interconnectedness of many of the women’s organizations and the importance of education in the movement.
“And then as I mentioned earlier to you Erin, The other programs that we had started in the community, like Blue Mountain Clinic and Women's Place-those really fed in and out of the Resource Center, because we would recruit there for students who would want to work in the different organizations. We'd do educational on...There was a lot of flow though because there was a core of women that would be involved in several of those. Since my particular interest was in that [WRC], I was involved in all of them. But some of the people would be involved in one or two or three of them. And so, again, there was that flowing around of, of people that were interested. So we always had something new-a new Brown Bag topic at the Resource Center with...you know... One time it would be history. And the next time it would be reproductive, because we'd want to do that. And then we might want to do health, and we might want to do...oh well, whatever it was, you know, we just would be constantly flowing in those other issues. And we did assertiveness...These are the little things – like I can remember- we were the first people to do assertiveness training, we did it of course from a feminist perspective, and then other people picked up assertiveness, and it became sort of a standard conversation, but, you know, that was a feminist tool quite early on. We did the first divorce survival workshops, and we did a divorce survival handbook. I don’t know if Diane told- talked to you much about this, but... Because of my sister Lin, who was a printer we got into self-publishing a lot. And we, we- 'cause we worked on The Rag, we really believed you have to get information out to people.... So we ... you know, did the birth control
Most feminist activists were involved with education in some way or another. In Judy’s discussion on the WRC, for example, she talked about the Brown Bag topics they covered, the trainings sessions they held, and the literature they published. Judy mentioned the WRC on the university campus as fundamental to the local feminist organizations because it provided access to alternative forms of education to the student community. This access meant both a means to disperse education, and a resource to recruit students for employment. Judy addresses the importance of education from the organizational and student perspectives.

In the next quote from Dolly she identifies the need of education from a technical perspective. In her rejection of the medical model of birth she found there was very little documentation of homebirth methods. Dolly also discusses earlier forms of hands on education that took the form of “self-help” classes and the statewide education regarding rape and violence which activists brought to communities around Montana.

“But then that fall, about a year after [my daughter] was born, a midwife moved here from California, whose name is Jenny Walker.”

“... [Jenny’s] husband was – is a physician. He’s an emergency room doctor. And they had had their third baby at home in California, and she had mentored with another midwife in the Santa Cruz area. And I think probably Jen had been to maybe fifty births or so. And I thought that was a lot at the time.
And, and she was willing to, or she heard about this crazy woman that had her baby at home, and came and met me. And we talked and so she decided to start doing some workshops for people who wanted to learn. And I had told her how I really needed to learn, if I was gonna do this...And so we decided to do some workshops, and Jenny invited her mentor midwife, whose name is Kate Boland. And Kate and Jenny did several week-long workshops on quote beginning midwifery unquote. And we – it was really great. It was a lot like what I remember women’s self-help classes were like in Women’s Place... During that time that I was working, I also was still being part of Women’s Place and we – I, I helped start a group during [then] when we moved downtown to do women’s self-help groups. And, you know, that was the beginning of self-help groups all across the country of, you know, we all brought our speculums, or we had speculums and doing them on each other, and basically teaching each other about cycles, and what happens to your body when you give birth, and what happens for birth control, and... That – and it was a really big issue around abortion then.

And vacuum extraction was a big issue. I mean, I remember seeing a vacuum extractor and you know – a menses extraction kit. You know, just this little pump, a little hand – foot pump that you could use, that you could actually put a thing up into your cervix and actually extract your menses, which was I think the very beginning of self-abortion for women. Instead of having the day-after pill, they would, you know really, try and get all their menses out so that they wouldn’t get pregnant, or pregnancy wouldn’t continue on. And I never did that. We never practiced that on it. I think we just kind of knew about it. It
seemed a little too technological for me, and risky, and so we never practiced that on anybody...

At the timing that Blue Mountain Clinic was beginning, it was Blue Mountain Women’s Clinic at the time. And, I was, you know, helpful in just being a part of supporting them, although I was clearly being involved in Women’s Place, because at the time I was then starting to teach child birth classes, at the same time doing this beginning midwifery stuff...I was not only doing the self-help groups, but doing rape counseling and doing, you know, battered women counseling.”

Dolly identifies the need for vocational education. There was demand for her services as a midwife even before Dolly had training. She learned from other women the skills of midwifery. This was an import approach to education in the health care movement. Dolly compares this method to that of women in self-help groups learning about their bodies. Women did not just want to know what something was, they wanted to know how it worked, as was the case with their bodies and reproductive health. Dolly then addresses a subject that was quite controversial at that time, the menses extraction. Here she demonstrates that although many subjects and procedures at that time were controversial, they were known and discussed among all kinds of women. Dolly then goes on to discuss the importance of community education. Women teaching themselves about their bodies and rights was not enough. Such information had to be extended to the general public and to authorities.
"And part of it was that Women’s Place did a really – We got a grant through Women’s Place to do a statewide rape – What did we call it? – Intervention across the whole state. And I wasn’t part of that. Two other women were actually – took over the grant and participated in it. But I certainly helped out in it. And, they would go around the state of Montana in communities giving lectures about rape, and talking to police departments about how to handle rape victims, because the police were just terrible. And, you know, we had to teach them how to deal with it. And, actually a couple of time had – was called, because I was on call for Women’s Place, or two or three times, more than a couple – several times had to go down to talk with a rape victim because the police were there. And the police were actually getting savvy enough to call one of us to go down because they didn’t know how to talk to this woman. And she didn’t know her rights. She didn’t know how to deal with the situation. And so that was very, very heavy time dealing with rape victims. I mean, rape crisis centers were really big then."

Education was vital part of the women’s movement. Institutional education was viewed as inherently biased and paternal (Evans 1995:34, 74). Therefore women believed it necessary to take control of the information that they were receiving and to extend what they had learned out to other women. Education took the form of informal discussion, brown bags, conferences, self-help classes and training seminars. It was meant to empower women by providing them with information need to make the important choices that affected their lives. Women could not make choices about birth control with out knowing
how it worked and what the side effects were. They could not choose how to give birth if they did not understand the birth process and were not afforded options.

The women in the health care movement felt that education was, therefore, essential in improving health care for women.

It was also used as a tool to deal with the community. Until women started addressing domestic violence and rape publicly, it was not talked about and often not considered a problem. In the case of the police, Dolly indicates that they didn’t know how to deal with victims. In her article *Violence Against Women*, Katherine Strother Radcliff (2002) claims that, “Women who turned to the police and the legal system found attitudes and procedures which often ignored, trivialized or normalized the violence they had experienced.” Women had to make a conscious effort to educate the public and the officials on how to identify and deal with domestic abuse and rape problems.

**Access: Local Women’s Health Clinics Fulfilling Women’s Needs**

Women confronted the problems of education with in health care first. Once they had learned about the processes of their bodies, and that there were other options, they needed access to alternative methods of health care. Formal organization began forming to provide access to services and to continue with specialized education. Joan MacCracken articulates the need extend education into access.

“I probably did not notice that women were not getting a full range of their options in health care until I moved to Billings and had our fifth child here.
There were few obstetricians and I was very naïve and I kind of went around and interviewed. I was in my almost ninth month of pregnancy, and kind of went around and kind of interviewed who I was going to have deliver me. And I think I was surprised that even at that time physicians had very definite opinions about anesthesia, about family planning methods, that they held to regardless of what the patient wished. I think it’s important to know in those days that medicine was very paternalistic. Patients, whether they were men or women, did not ask questions, that was thought to be almost rude, for lack of a better word. That you did not question your physician, if he said take these pills you never said, ‘What is the name of them, what are the side effects, do I have other options?’ That was not done. So in those days many, many physicians chose for their patients what they thought was best without asking a whole lot of questions of the patient about how their regimen would be accomplished in that patient’s life.

After I had my last child, which was our first year in Billings, I taught in a nursing school, which is no longer in existence. And it was a Catholic school and it was told in no uncertain terms that we would not be teaching anything about contraception, anything absolutely. Abortion was illegal so that term was not even mentioned and I did that for a year. And then the school closed and I remember one morning in the newspaper there was an article about Congress thinking of devoting some funds to family planning for poor people and the newspaper here in Billings interviewed several people about what they thought about that. And one minister said, ‘Women should not have to use family planning, they should just use self-control.’ I said to my husband that morning, ‘I
can not believe that someone would say that.’ And my husband said, ‘Why don’t you do something about it.’ And it was like something I never even thought of doing, but I went and talked to, at that time it was a local OEO project (Office of Economic Opportunity) and went and visited them and they did have some local initiative money that it was going to be for family planning. I think because I was a nurse I got the job. I was to go out and just teach women. Well as naive as I was it only took about three of four days to realized it wasn’t just teaching, women had to have access now. There were school health nurses, there was a county health officer, but they did not provide services. If women wanted something they would go to a private physician and many felt they couldn’t because they owed money [or] because they knew the physician had opinions that were not conducive to there lifestyle. And so it was, well we have to set up a clinic. It was, again, I cannot begin to tell you when I look back on it how naive we were.”

Although Joan came from a medical background, she recognized the same needs as the feminist activists of the health care movement, which was the need for access to women’s health care around the Billings area. Access has been typically thought of the ability to obtain health care services; however, there is another element of access identified by Joan. That is the ability to access rational health care. Joan states that prior to this era, physicians were not questioned. Whatever a physician diagnosed or prescribed was considered right regardless of whether it was best for the patient. Consequently, women whom did have physical “access” to health care did not always receive proper health care.
Therefore, creating a clinic for women allowed not only access to basic health care such as pap smears, it offered a choice in one's own health care.

Sally Mullen, one of the founding members of Blue Mountain Women's Clinic (BMWC) addresses the need for local access in Missoula and describes the first women's clinic in Montana to offer abortion services.

"And so anyway, I, you know, I got involved in Women's Place, and then there was the group of people at Women's Place who had – Well, because we were referring women out of state all the time for abortions, it became painfully apparent that there needed to be some local access. So that's kind of what happened, was that a bunch of very strong women put their minds to it, and their shoulders to the wheel, and made that thing happen."

"[It was at] 218 East Front, in that Medical Dental building, upstairs. And I bet the whole thing wasn’t 600 square feet. It was amazing. There was a large closet that was used as counseling space. And the – you know the divider, that people would be sitting on the floor behind it to use it as a counseling space. And there was one - one procedure room, and a recovery room, so people would just be kind of plopped into the recovery room. It was tiny. And a few years later it moved downstairs, and got a couple of procedure rooms.

"The first abortion clinic was... February 19ᵗʰ, 1977, but they'd been working probably for nine months ahead of that to make it happen. It was incorporated in ’76. And what became very apparent very quickly was the- what a huge need there was. I mean, there - you’d do twenty or thirty, well not so often thirty, but probably eighteen to twenty-five procedures every weekend."
"And women were coming from all over the state, and Idaho and Eastern Washington, and sometimes as far away as Wyoming. The – cause there just wasn’t anything. So, it was really, I mean it was a huge boost to people to not have to, for instance go to Seattle… But, so anyway, that stared booming quickly."

The BMWC started out by offering services that specifically concerned reproductive issues. It focused on services which were almost entirely ignored in the biomedical system in Montana. Access in this sense was extended to allow women to receive treatment which was within their legal right to receive but was predominantly ostracized by the local medical community.

The Alternative Models of Women’s Health Care

The need for access gave way to new philosophies and models of medical treatment. For many women the biomedical model did not meet their needs. It did not necessarily consider the same health issues important as many women themselves did. In many cases women even viewed biomedical “treatment” as invasive and harmful. These points are elucidated by Dolly Browder and her perspective of the midwifery model of child birth verses the medical model.

“They had just passed a law that year, and so they established a board called the Alternative Health Care Board, which I think is unfortunate, the name… Cause really, the medical model, in my mind, is the alternative.”
"The problem that I have with it is that you really have to be careful to not be co-opted into the medical model. And that’s where if we were ever to be under the board of medical examiners, we would not even exist. We would be little mini-nurse midwives. Not even nurse midwives, but the little, little underlings of doctors. And that’s all physicians want. They just want that control of all medicine, and even though birth is not medicine, it - birth is one of those non-medical events that can turn into a medical event. And, and then that’s why people look at it more as a medical event than really what it is. And for that reason we could never have been under the board of medical examiners and survived. And so I really felt like this was the only route that we had to go, in order to survive and keep our – at the time I didn’t know this – this is a new term now – it’s call the midwifery model of care. Only in the last year has that term come out. That we really are midwives for women. And to me, I mean. I’ve always been a feminist, and I make no bones about it, but I have to say that I think the problem with birth is that it’s tied too much to a fear of pain. And that, that alone has made women believe more in the medical model than the midwifery model. And when you believe that doctors and hospitals can take care of you, and, and I honestly think that another reason why women don’t choose to birth at home as much is because they’re, they’ve never really had to work that hard. You know? And they’re – I mean not in – not that women don’t work [hard], god forbid! Mothers still are working, and being mothers, and cleaning the house and everything. That hasn’t changed. But, they’re not doing the hard labor work that I think a lot of women used to do. And that they just can’t tolerate what they think
is normal birth. They just don’t even want to think about it. They really – that a lot of women are wanting to be anesthetized to life. And when you’re anesthetized to life, you don’t want to experience anything out of the ordinary, and birth is definitely out of the ordinary for most women. So, it’s - that to me has been the one thing that hasn’t changed very much, and I am very sad about that. I, every birth class I teach I try to think of something new to try and talk to women about. ‘Why are you so afraid?’ Why is it that you’re willing to go to the hospital and just give up all of your power, and do what they tell you to do, and not experience something that is just absolutely incredible in your life?’”

“I mean, that’s what I really, that’s the whole purpose for me to help a woman have a natural birth is for her to understand what her personal power is all about. That you can do so much with that, and I think that translates into your parenting. I mean, you can change the world by having a powerful, positive birth experience for everybody.”

Dolly describes the midwifery model as natural model which represents birthing as a normal process. She claims that biomedicine is controlling and tries to medicalize birth. In fact, some doctors in Missoula have actually gone as far as claiming that birth is not normal and should be treated as problematic until it is over (Danison interview 2002). Dolly expresses that many women accept the medical model because they are afraid of birth. She infers that this fear is of the pain and hard labor that comes with child birth. The medical model exaggerates this fear by inferring birth to be painful, dangerous and abnormal. The midwifery
model in essence was viewed by its supporters as providing another model of birth which views the experience as normal and embraces the body's natural processes. In doing so, it empowers women by giving them control and letting them use their strength.

Yet another alternative to the biomedical medical model is that of the women's health movement model or the cooperative model described by Judy Smith.

"I mean, we all just said, 'We're doing it.' And it was in the women's health movement model, which is you know, everybody can learn how to do these things. You just figure them out and then if you need to have, you know, professionals, you put them where you need them, but they don't have more say than anyone else does."

"And you work by example, like if lots of stuff has to get done, just because you happen to be a person that has, you know, more at school, or a different credential, doesn't mean you don't do it all. So, at the resource center we did it all..."

"One of the parallels that's very clear is that what we've done out in the community, just like what we did here, is we said, okay, we know how to do something. We'll set it up, we'll show you it works. And then, we want you to do it too. That's the – you know, creating a model and, based on your own principles..."

"Well, here's – here's another one of my theories. If you're gonna be different, you have to be really good. Because people have to overlook all the
weirdness about you and kind of say, ‘Okay. You know what you’re talking about.’ And that’s one of the things that I think has helped us out here is that a subset of us who kind of worked like at the clinic...You know, we could....We knew what we were talking about. We were really pretty good.

“Again, we weren’t asking to be accepted in the middle. We were acknowledging that we were a pretty unique track. We had things that were important to raise, and...We were willing to be on the edge.”

Judy talks about creating models to achieve different kinds of goals. Because many of the women in the health care movement had dissimilar ideas of health from biomedicine, they needed to follow different models to attain their standards of health. Judy explains these models as cooperative and egalitarian.

In many of the organizations around town and in the educational programs women worked together to educate themselves about their health. Working together and sharing knowledge allowed them more opportunity to be in control of their endeavors. In the case of reproductive rights, women sought training in the technology of things like abortions so they did not have to be dependent on physicians. When they did need physicians, they did not allow them more power to make decisions or be in charge. This was especially important since most of the physicians were men. Judy emphasized a belief that if you are going to do to something questionable, do it well. She also discusses a willingness to be “on the edge”. This was an import concept because these women were not asking for acceptance within the medical model, they were not asking for it to be
restructured around their needs and beliefs. They instead created new models and methods to fit their own needs.

By following different models of health care, women achieved many of their goals. In the following quote, Sally Mullen talks about the accomplishments of BMWC.

"But, but what’s interesting, I think, is that...it was the people, people before the profit, and, and just this huge push to have information available and to have – so people can make informed decisions. I mean, the informed consent was amazing [at BMWC] compared to every place else in the world practicing medicine at the time. Some of the stuff you get in the doctor’s office is not, you know, just routinely telling you about any affliction you might have, I think are a real direct result of the women’s health care movement. I remember in the olden days... Geez, you’d have to , you’d have to generate all of that information yourself ‘cause there wasn’t any place you could steal it from."

“So what [the clinic was] doing [was] abortions and birth control. People’d walk out the door with pills. In order to get those, they’d you know, have to have pap smears. And then pretty soon it became apparent that people just needed to come in for family planning purposes. So, that happened probably within the first year. So then the annual exam started happening, and started probably a half day a week being open to do both follow-ups and annual exams for people who wanted birth control. And then things evolved pretty rapidly... So it was in 1977 that, the same year the clinic opened, that Medicaid extending for abortions was cut, and I think the clinic got paid for maybe four or five abortions
that first year. And [we] probably did...a few hundred procedures. You know, the 
[...]
Canada- it was such a hassle to get an abortion, and so one year we had like four
hundred women from Canada come down. And then the nurse practitioners came
probably at the beginning of the 1980's. That would be right 'cause we’d just
moved to Professional Village, and were able to hire nurse practitioners to do
regular care including pediatric care. And then Doc Pannell, as a matter of fact,
started delivering babies. SO we were able to add obstetrics in the early 80s.
That was a real renaissance period. Started doing vasectomies probably in '82,
or '83. And a lot of well child care, and then did some really innovative
workshops on, for instance, women and addiction.

Sally points out first that one of the goals of the clinic was informed
consent. It was important to make information available and easy to get so
women could make their own choices. Then not only offering women choices but
demanding patient consent extended control to women which Sally implies was
lacking in other medical establishments. Giving women information to make
their own choices and contributing to their own health care was part of the
women’s health care model. Sally then goes to discuss the services provided by
BMWC which was considered by many to be just an abortion clinic. These
services quickly surpassed abortion procedures to include family planning,
gynecology, obstetrics, and counseling. BMWC further extended its practice out
to children and men, yet still followed the same model of health care designed for
women.

Midwifery: Education, Practice and Politics

Dolly talks about some the obstacles that were overcome by herself and
midwifery as a whole. By conquering the obstacles thrown in their way,
midwives made significant accomplishments for midwifery in Montana.

"Yeah, well we got ten thousand dollars to put on this conference, and we
called the conference "Controversy In Childbirth"...

"... we were at the forefront of trying to decide what was best for women
was just a ton of issues we were dealing with. One of the people...and so we
brought people from all over the country. I remember one guy we brought from
Kentucky; Ontario, Canada; California... You know, there was nobody here, and
had panels, and group discussions... We, you know, and then the hard part about
doing those conferences for me is organizing the whole thing. You know, doing
advertising, sending out notice to all the doctors and the nurses in town – that this
is gonna happen, hoping that some of them would come, because we really
wanted to change what was going on in the hospitals, too. It was a terrible place
to have a baby. There were no birthing rooms. Fathers were barely allowed. It
was archaic and we knew things had to change. And that's why women were
wanting their babies at home."
So, amazingly enough, a new OB came to it. So, one doctor came to our conference. And this was Tom Baumgartner. Tom was just beginning his practice as an OB. And you know, when you come to start a practice, you look for business. And I know that’s why he came. But, you know, he was also trying to be open-minded and seeing what things need to change. After that conference, a year, Tom convinced the hospital into opening up its first birthing room. And, and I really think that our conference, and the home-birth community here made the hospital do some major changes. Because it wasn’t only us saying, ‘Listen, you don’t need to do episiotomies on women. That’s only changed in the last five years. They finally stopped doing that. You don’t need to do this to women. You don’t need to do this, or this or this. And it was many, many things that they were doing routinely that were actually dangerous and terrible for women. And, and not only were women going in and finally doing what I felt that the women’s movement has started for women – interfacing with their doctor.

Before the women’s movement, if you went to a doctor, you sat there and you listened to what he wanted you to do. And it was ninety-nine percent of the time a he, not a her. And you had no choice, and most women didn’t even know what to ask. So, suddenly now women were going into their OB’s and saying, ‘Okay. I don’t want you to do an episiotomy. Furthermore, I want my husband there. And I want to be upright. And I don’t want to be on my back. And, you know, and I want my baby with me the whole time too.’ And they’re just going, ‘Well, I don’t know about this. I mean, who do you think you are?’ You know, and slowly things have changed, you know, over the years now. So, I really
believe that the homebirth movement and certainly that conference helped to change the, the right of passage for women in going through childbirth."

Aside the accomplishment of attending hundreds of successful births in Montana, Dolly has made a large contribution to women’s health care through educating women and professionals about the midwifery model of birth. Here education seems to have expanded from its initial intensions. Early on in the movement education was a tool to empower women through teaching themselves about their bodies and their rights. In small informal groups women shared their knowledge and experiences with each other and began to identify problems with their health care. As the movement evolved and intensified, education grew and formalized and became a tool to change a larger system through public education. Education was the foundation for achieving major accomplishments such as encouraging women to have a say in their health care and deterring unnecessary procedures.

The midwifery model empowered many women to take control over their births, even in hospitals, by being assertive toward physicians. Women began demanding input in how their babies would be delivered and the types of drugs used if drugs were opted for. These were not necessarily women who promoted midwifery. Rather, many of them had just become aware that there were options to be had. The midwifery model influenced the medical model of birth in Montana not only by educating and empowering women but also by demanding systematic changes. The midwifery community dissuaded physicians from doing certain procedures that midwives viewed as dangerous or unnecessary such as
episiotomies. Dolly identifies that even having one doctor listen to the midwifery perspective inspired change in medical institutions. The influence of midwifery did in fact extend into the hospitals and pursued some change in the practice of obstetrics. While small changes were being made in medical institutions, even bigger accomplishments for midwifery were implemented in the political realm.

In the next quote Dolly addresses the process of legalizing midwifery in Montana.

"And on January nineteenth, the judge came out with this ruling that I was indeed practicing medicine without a license, and I had to stop or I'd be – I'd have to go to jail. And, and so I had twenty women due between that January and May, when the legislature is in. I really didn't know what to tell them. I mean, I just felt terrible about it. And so, Sandanho [Danison] and Michelle [Neal] helped take over a few of the births. A couple women I know decided just to go to the hospital. One woman I know moved away. And everybody got taken care of who [needed to be] – but I had to stop. I mean, I just couldn't practice, and...But everybody else kept doing it, even though, you know, they were watching what was going on.

And we were in the legislature. We had raised the money. Now, now it was up to thirty thousand dollars that we had raised to pay Mona Jamison, our lobbyist, and just spending lots of time driving to Helena, and educating people. I mean, I felt like – I wish that I could have had a classroom, but I was having to go one to one, and tell whole story all over again. 'Do you know that pregnancy is not an illness? And don't you know that women can give birth on their own? And don't you know we don't need episiotomies?' And, I mean just constantly doing
this. I felt — I really remember thinking ‘Oh, this is what it’s like being a kindergarten teacher. You’ve just got to keep telling these five years old over and over and over and over again.’ Oh, God it was exhausting. Anyway, amazingly enough we prevailed. By April fifth, we had passed our law, and it was over. It was resounding. I mean, nothing gets passed by seventy-five percent in the legislature here. It was a seventy-five percent passage! And what we did, we were not able to set up anything complicated at the time. Mona’s vision at the time, because see, we didn’t even really hire her until December. And the legislature was starting in January. So, we had put in a package to say that midwives were not practicing medicine, and so we exempted midwives from the medical practice act. And that’s all we did in that first legislative session. And with the idea that at the end of the session, the legislators told us that they wanted us to come back, and put a licensing package in in two years, and that we would hopefully set up a board and all that stuff.”

From this passage, we learn some of what Dolly and other midwives and supporters of the health care movement had to do to be able to offer the kind of health care they felt was needed. Again she points out the power of education with the public. In this case, Dolly had to create new legislation to be able to practice midwifery and aid women in their decision to home birth. She had to teach the general public, political officials, and the medical community about the midwifery model before birthing was finally accepted in the courts as non-medical phenomenon. This excerpt also demonstrates the complexity of the
medical system. As I discussed earlier in the theory section, systems should be understood as holistic in nature. Although the system considered here is medical, it is evident that it cannot be separated from political, economic, or social institutions. Dolly goes on to discuss the process of creating a licensure procedure for midwives required by legislature.

"There were seven of us. And what — that’s another long one. I can make that story really long, but there was actually a kind of group of us that were attending births across the state. Only seven of us of that were able to say that we had been to at least a hundred fifty births. No, we — they were only qualifying that...See, what happened is, that we had to set up some sort of interim thing between the two years, so that we could get a group of midwives that were legal, that would then be the grandmother midwives. And, and so we had to set some standards. And so Mona Jamison helped us do that and the legislature wanted us to do it. We had to put something down. And so we stated that we would have a temporary license for those two years, those of us that were practicing could continue to work for those two years. But by the time we went to the legislature the next time, when we set up the whole new system of our licensing procedure, then you were gonna have to prove that you had been to at least seventy-five births, and we had to be — you know, it had to be all pre-natal care, birth, and post-partum for seventy-five people. I mean, I think at the time I’d been to over three hundred, so seventy-five didn’t seem like much to me. But, there were a few midwives that didn’t make the cut. And there...Sandanho was one, Kathy
Dunham was another, there was a midwife in Great Falls who didn't make it, because they just only had attended maybe forty or fifty births, and in order to be the grandmother group that we weren't requiring education from, the state really said you have to make it more stringent. And I felt badly about that, because I felt like they certainly knew a lot, but I also knew that, you know, you have to set the standard somewhere. And somebody's gonna fall through the cracks. If we'd set it for fifty, there'd be somebody who at thirty-eight didn't have enough, and so that was kind of hard to see."

"...New Mexico and New Hampshire were the two that we were looking at. And so we based our law a lot on that, on theirs. And, you know, tried to figure, you know trying to vision in the future what could possibly be something we were missing from their laws that we'd want to include in ours. Oh, little did we know, we still missed a lot, but...You know, we did the best we could at the time. Lots, again, lots of testimony, going over in front of committees, and you know, in the middle of February, trying to get over there in storms, and, you know, caravans of cars, because we had to try and pack the courtrooms, and the places over there in Helena when they were having meetings. And, amazing enough, we prevailed again, and passed law. Didn't pass as easily this time. It was a lot harder because the state hates to set up boards, because it – we had – we knew that we had to set up a board that would be self-sufficient monetarily, financially capable of doing that."

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A major accomplishment of midwifery in Montana was its legalization. Although many of the midwives have stated that they preferred illegal practice to legalization and licensing (Sandanho 2002, Browder 2002), formal legislation provided protection against non-supporters. Because Dolly was forced into a lawsuit that challenged the validity of midwifery she had to educate people across Montana about midwifery. In doing so, she helped to create a system of legal protection for its practice. At the same time some midwives, such as Dolly Browder and Sandaho Dannison, viewed falling under the legal system for protection as reducing midwives autonomy. They did not want to be regulated by a system that did not understand, or support their methods of birthing. They were also somewhat bound to the medical system, in that they were required to have at least one physician on their board. Midwifery has been regulated by the medical system with such “safety” requirements. For example, it is required that midwives bring birthing mothers to the hospital under certain conditions such as prolonged labor and breach births. These were conditions that physicians, and not midwives, determine to be dangerous.

This discussion provides an example of action being limited by the system which it is opposing. As I discuss in the theory section, there are two perspectives of practice theory, transactionalist theory and new practice theory, which argue that action is either influenced, or determined by the dominant system. From the latter example, I would argue that once midwifery was forced to interact with the medical system it was influenced, but not controlled by that system.
The BMWC: A Measure of Success

In the next passage Judy Smith describes what it was like forming the Blue Mountain Women's Clinic. Again, the formation and success of such establishments were based on the women's health care model. The desire to create health clinics was based on that feeling of entitlement which encouraged the health care movement.

"Barbara Birk is one of the people I met when I first moved here, and she's one of the ones I'm thinking of now. She started running Planned Parenthood. She went off to the University of Michigan, Ann Arbor, got her Public Health degree and came back and started running Planned Parenthood. And we were friends. And I went and worked with her for awhile when she would need that. And so, when we started Blue Mountain, we brought half of the Planned Parenthood staff into Blue Mountain.

We had a number of conversations with the Health Department people. Because they were the more progressive edge. When we were doing Women's Place around abortion, they knew we were doing abortion referral. They knew we had that interest. And we went around and talked to a lot of them. So, again, we had a certain credibility from our background. And, you know, I'm not a big advocate necessarily of having Ph.D. degrees, but it does help you when you're gonna do this kind of stuff. So, if you're gonna — again, this is my argument — if you're gonna be different, it's very helpful to have a credential, it's very helpful to act like you know what you're talking about and to have people be able to go there with you. So what we did is we just started having a clinic. And, you know,
again, we just believed it was the right thing to do. We just went to all these medical doctors, sat down in their offices, and said, ‘We want to do this clinic. Do you want to do it?’ So, I went and talked to a lot of different medical people and they were all sort of embarrassed to say ‘no,’ because you know, they realized they should do it. And that’s the other thing. When you’re around these people, you know, that are working with their own professional guild and whatever, that’s, you know... we could go talk to and, and all of sudden then we were saying to them, ‘Come over here and work in this clinic, and, you know, just didn’t find any takers.

But, the other idea that I had was ‘Well, if we need money, what we want to do is we’ll, we’ll setup notes and we’ll self-finance the clinic. And I’d been always into that kind of stuff, which is you know, how do you figure out how you put resources together, and ...you know, entrepreneurship and things like that. So, I went to ten people and said, you know, ‘Give us two thousand dollars, and then we’ll write a note and we’ll pay you back by a certain time. And that’s how we started Blue Mountain Clinic, with that money from those people.

And we went and finally we said to this doctor – and, and this is the other very interesting that you learn – is that, when you’re out on the edge, there’s a lot of people out there with you, and some of them are out there for reasons like you are, an some of them are out there for other reasons, and you’ve got to sort of figure out where you can work with them and where you can’t. Well, there was this doctor that was kind of out there on the edge, and he was being denied hospital privileges at one place, but we went and talked to him, and we watched
him, and we thought he really knew what he was doing. So, we took a doctor to open up that probably, everything else being, I wouldn’t have wanted to do. But, that was the only way we got started. His name was Lewis and he had, as I said, lost his privileges from one place. But it was over one of these personality things, not over his ability.

We took an old room in a dental building. We made all the furniture. We cleaned it up. We went to Seattle and learned all the procedures. I wrote the standing orders for the nurses. I mean, we all just said, ‘We’re doing it.’ And it was in the women’s health movement model, which is you know, everybody can learn how to do these things. You just figure them out, and then if you need to have, you know, professionals, you put them where you need them, but they don’t have more say than anyone else does. So, it was an interesting experience, I think for everybody, especially for the doctors. And we just did it, opened up, and started, you know, having twenty women every weekend that came in and got procedures.

…I remember the very first time we did it. I mean, we just were all like, ‘Okay, here we go. Open the door. First one comes in. Sign the chart. You do this. I do this.’ You know, and so it worked. We paid off the notes. You know, Blue Mountain has gone on to be what it is. And the core of women who started that—most of them didn’t stay a whole long time. There was stresses and strains inside the organization for sure. And some of us stayed for awhile and then left. Other people stayed a little longer and then left. And it’s become more medicalized.
But again, it’s one of those things – it’s an institution now, so what do you do? But it got started, and...One of the things also that you really learn, or at least for me, I think is real important to pay attention to is that, like the women who come in and that you’ve done this for them, you can’t really expect them to understand exactly what it is that you’ve done for them, and that you shouldn’t have that expectation of them, because otherwise you’re gonna be bummed out, and they’re, you know, not gonna really understand why you’re bummed out. Because, for them, it’s just like, ‘I need an abortion. You’re a place that provides abortion.’ And I want to stand there and say, ‘Do you realize what we had to go through to provide this abortion for you?’ I mean, you know, what I’m saying?”

In the above passages, Judy describes the establishment of the BMWC. The clinic was started by women whom had educated themselves both formally and informally in the realm of health care. Informal education was as complex as learning technical abortion procedures, while formal education ranged from basic college degrees to doctorates in biology (as in Judy Smith’s case) and public health (as Barbara Birk did). The goals of these women were considered by many to be “on the edge” or radical compared to mainstream medicine. Therefore, Judy felt that experience and credentials were important to substantiate their endeavors. This “on the edge” mentality is what kept organizations like BMWC from coming under control of the medical system.

The founders of the BMWC also allied themselves with more liberal professionals. The clinic maintained communication with the health department
even though it the clinic was “progressive”. As Judy had mentioned one of the
main physicians recruited was also considered to be “on the edge”, but reliable.
The clinic was self-funded and most of the repairs and maintenance were done by
the women themselves. Because the BMWC had little or no ties to the
mainstream medical community at large, they were not bound by its policies,
regulation, ethics or social controls. The clinic was not looking for any sort of
acceptance or support from local medical institutions they were not subject to
ostacization or scrutiny from the medical community. Again, this demonstrates
while efforts of the health care movement may have been limited by the local
medical system, they were not controlled or determined by that system.

The clinic has proved to be a major accomplishment of the women’s
health care movement. Not only has it been greatly utilized since its opening
(serving more than twenty women the first weekend), but it has progress from a
small grassroots organization to a recognized institution. The perseverance and
institutionalization of the BMWC is, itself, a mark of achievement of the health
care movement.

Community Response

The success of the many endeavors health care movement in Montana
greatly affected the local communities. It instigated community response that was
both supported and rejected the movement. The following excerpts elucidate this
point. I begin with a quote from Sally Mullen which highlights the response from
the some of the medical and anti-choice communities.
"...so it would have been the eighteenth of February, there was an article in the Missoulian that [the BMWC] was gonna open, so everybody was sort of frantic, because even then there had started to be I think some, at least hints of violence against clinics. The- and [the clinic] did have support of the doctors who were gonna work there. The rest of the medical community always did hate Blue Mountain I think, and kind of looked down their noses at Blue Mountain."

"Well the picketing first started in December of '77... So picketing started really early and... they were very active politically in the legislative sessions... There was an active group here, what was their name? You know, those were the days when... it, well, those days aren’t gone. When the churches would take busses of people over to Helena for the legislative session, and... there was starting to be some kind of ugly literature dropped at the clinics, or given to women. Although in those days, the anti-choice people were more polite. It wasn’t really until the later 80s, mid to late 80’s when they started getting pretty rude. And then of course culminating in Operation Rescues. There were two of them at Blue Mountain. But yeah, there was a very active anti-choice contingency here..."

The health care movement received a great deal of negative response from both the medical community and anti-choice groups. However, Sally points out that although she felt the majority of the medical professional did not support the undertakings of the health care movement, there were some who did. Besides the medical community, there was always resistance from the pro-lifers. Many of
groups were often affiliated with religious extremists and seem to have been
around as long as pro-choice organizations themselves. Their responses to the
women's clinics ranged anywhere from passive picketing to physical assaults to
firebombing the clinic.

"I think things had actually toned down a little bit [before the fire
bombing], in terms of picketing, cause the clinic went — I mean, I bet the clinic
was picketed maybe three hundred times through a series of six or seven years.
And after the two Operation Rescues, and all those arrests, I think that things
toned down in terms of the weekly picketing. Or they started behaving themselves
a little bit better, and... But I think things were just kind of going along. And the
one totally bizarre element was that Willa Craig, who had been the director for a
couple of years, had resigned and Gwyneth Mapes had been hired as the new
director, and the, the fire happened on the transition weekend. So Willa was done
Friday and Gwyneth started Monday. Will Stayed around and helped out, and...
but Gwyneth in the meantime was hired to do a job that really had completely
changed by the, that first day she started. So I think that was pretty unfortunate.
As far as the political stuff, I don't know — I, I can't even remember quite what all
was going on in '93, but I think that... well yeah, the violence had been
accelerating because... pre-, the anti-choice had been losing in the courts. And
so they started taking it into their own hands more I think. And certainly by then,
I know that, well we had invested in Kevlar vests actually after the fire, come to
think of it. But, there was just a real heightened sense of security I think..."
And, I mean it was. It was just one of those horrible feelings that...And just this sort of, you know, sort of this [unintelligible] and I had to get over there an so I went over and I remember seeing like, Louise and Mindy, and some of the old Blue Mountaineers in the parking lot. And I was working someplace else at the time, but I just couldn’t, I mean, I couldn’t go there for a while. And it was just, I remember I wrote a commentary for KUFM. I wish I could remember the line, cause I talked to my mom, who was still alive then and living in Billings, and she had this great line like, like ‘curse all the zealots and weep for Blue Mountain,’ or something like that. It was a terrible day, a terrible day in the community. I think it was and I was really reminded of it again. It’s amazing how it comes back with the fire at Carla and Adrienne’s. It was like that same sort of sense of total invasion. Of, you know, it’s like the boundary is busted, and something is really wrong. So anyway, it took, because of the change in management and the clinic had always just kind of puttered along on its own, and it didn’t have a huge slush fund or anything, but, and it also took some time to get the insurance money. And the staff was in shock. They were-I just remember seeing the, you know, deer caught in the headlights expression. And they were I think, I mean they probably had PTSD for a long time. But thanks to the goodness of the community, the practice was able...abortion stopped. All of that stuff stopped, but Beth Thompson was the internist at the time, and they were able to run that practice out of Missoula Medical Oncology, which just donated their office space. And then the administrative offices were down in the First Federal Building so it was a two-site deal."
"...I mean, one of the things that people always get mad at me cause they can’t write to me because my address isn’t in the phonebook. But that had nothing to do with it. I took my address out of the phonebook in probably 1982 or 3 because of this very fear. I knew there were people who would hate me, and, and I just didn’t want to be an easy mark. The, but yeah. People were sure afraid, and people were afraid to come in here too. And it took forever to have it happen. So, you know, it was March ’93, it was like two and a half years before the clinic was built [again]

Negative community response was a common event that began to escalate into more violent protest, as Sally expressed, with increased rulings against the anti-abortionist in court. Here the impact of the health care movement can be seen as it was increasingly gaining legal support at the same time its opposition was intensifying. When legal support was not enough, community support helped to keep BMC on its feet by volunteering office space and time so that the clinic could still offer some services. Although the clinic had much support, Sally describes the profound effect that violent opposition had on the clinic staff and clients.

In many of the quotes already taken from Dolly’s oral history, she describes community response. From here treatment in the hospital after the birth of her first child, to the injunction filed against her. Dolly also discusses the community support she received from friends and the community during her legislative battle. Such support included the donation of thousands of dollars and
social support of traveling hundreds of miles to pack court rooms so that legislatures, judiciaries, and the media would see that there was support for midwifery and choice. Dolly also mentioned response from police department when she worked at WP. While the police previously had little interest in treating rape and abuse victims, they slowly began to accept the feminist methods to handling rape and abuse victims and actually recruited their services. Authorities were also quite supportive of the clinics when they were picketed. They made several arrests and were described as being very cooperative by one clinic director (Craig interview, 2003).

The response to the women's health care movement was just as radical as the movement itself. It sparked intense positive and negative community response. Negative responses came from those whom felt threatened by its success, while positive response came from those whom embraced the values and achievements of the movement.

Summary

The narratives selected for this chapter have described the women's health care movement from its early development through some of its major achievements. Excerpts discussing the early stage of the health care movement reveal its emergence from the larger women's movement and discuss its goals. These narratives then go on to identify some of the accomplishment of the health care movement such as changing legislation and forming clinics. Lastly, I have
highlighted stories which discuss the affect the movement had on the local
communities. Here both negative and positive community response was
described demonstrating that the women's health care movement did have a major
affect on many Montana communities.

In reviewing these narratives two important elements of the movement
become apparent. Education and access were of great importance in women's
health. Lack of education and access were a prime motivation for organizing the
health care movement. Throughout the movement providing education to
women, medical professionals, authorities, politicians and the general public was
key in achieving many of its accomplishments. Providing access to alternative
modes of health care was the most important accomplishment which took various
forms all through movement.

Access needed to be attacked from political, economic, educational, and
physical standpoint. Politically, laws had to be changed or created to protect
women's rights and legalize alternative approaches to health care as in the case of
midwifery. Economically, access to health care needed to be provided to those
whom could not afford private health care which was the principle form of health
care in Montana. This obstacle required economic support from sources other
than the patients and was an obstacle overcome by some of the movement's
organizations. Education needed to be tackle institutionally and dispersed
publicly. Physically, the activists of the women's health care movement had to
create the actual clinics, crisis centers and other organizations.
These narratives have provided a personal perspective to a major social phenomenon. Although the historical record displays some of the accomplishments of the women's health care movement it does not convey the daily struggles that were faced by these women, or express the emotions that accompanied their hard work. Through these narratives I have demonstrated the fundamental social impact the women's health care movement had in Montana, reaching far past women themselves into the medical community, political realm, and into the general public.

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1 Diane describe this story to me in the oral history I recorded with her, however the account presented here was taken from a speech Diane prepared for a public presentation (1985), because it was more in-depth than the account she gave in her oral history. I have reproduced this excerpt as accurately as possible. Although it was typed the document had handwritten revisions in the margins that were difficult to read. The tab spacing at the beginning of each paragraph were added by me to keep with the format I used with the rest of the oral history accounts.
In this thesis, I have documented the development of the women’s health care movement in Montana as an aspect of second-wave feminism. This was a vital health care movement in a rural region, which radicalized local communities with the development of new models and grassroots organizations. I chose a rural region because research on rural health care movements has been scant. My thesis reveals an intimate view of the development of a social movement that occurred in a less populated area. The origins of the health care movement, the development of organizations, and the expansion of these organizations into institutions has been amplified against the backdrop of such a rural and conservative state.

Furthermore, these local movements were the roots of the larger national health care movement. The national movement was comprised of local women, local problems, and local organizations which, in many cases, joined together to combat the systematic problems of health care. As new methods, such as assertiveness training and C-R groups, developed to counter social inequalities, the Montana health care movement was right there in step with the national activism. Therefore, my research in Montana supplements research on women’s health care movements by adding a rural regional perspective, and represents that perspective as a radical, and nationally connected, local movement.

As I was conducting my research, I couldn’t help but wonder why did such a radical health care movement develop in such a rural and conservative
state? Montana did not have the large radical communities of other states had, nor did it have the resources. The population was more dispersed, and it was difficult to distribute information and services. As I began listening to the narratives of the local activists, certain themes emerged to answer my questions.

From the narratives I identified three recurring reasons that addressed how and why the health care movement developed here. They included the influx of young radicals to Montana, The University of Montana which attracted activists and served as a core for many the organizations, and, the poor state of health care in Montana all aided in the formation of the health care movement. During the 1960s and 1970s, there were a number of individuals moving to Montana who brought with them radical ideas to improve their new home. Many of these individuals were moving to Montana because it offered a rustic lifestyle (Smith 2002). Judy Smith, for example, moved out here to get away from the big city, and she brought radical beliefs and activism. Others, like Diane Sands, moved here from smaller towns around Montana (and other states) because they desired a more urban environment (Sands 2001).

The University of Montana attracted a number of people from outside and around the state with opportunities of education and employment. Vibrant young minds were gathering together in an academic environment at a time of great social turmoil (Sands 2001, Dirks et al 1994). Activism took many forms at The University of Montana. From pacifist vigils and radical protests to housewives campaigning against local unregulated industry, Missoula became a hot spot for activism. Diane Sands referred to it as “the Berkeley” of Montana.
growing, and many individuals chose to live in such a town because it offered a more liberal environment. Although the health care movement took place predominantly in the urban areas of Montana, its efforts were extended out all across the state.

The third reason supporting the emergence of the health care movement was the poor state of health care in Montana. Being a rural state with a poor economy, Montana offered little in health care, especially to those of low economic status. Poor women had few places to turn when they needed health care, especially women living in rural areas who had limited access to health care facilities. Another factor to the poor state of health care was the conservative bias of many physicians and hospital policies toward birth control. Of those women who could afford a private physician, many could not discuss reproductive issues with their doctor. If they wanted birth control, or if their menstrual cycle was irregular they had no one to whom they could turn (McCracken 2002). The combination of these three factors provided the foundation for a social movement.

Under these conditions, the feminist activists initiated, both deliberately and inadvertently, a health care movement. A number of individuals such as Diane Sands and Judy Smith sought to make a difference and impact the community. Others like Joan McCracken, provided services without a feminist agenda. They merely experienced problems in health care and recognized that many of those problems were more common among women. Issues like lack of access to health care, environmental problems affecting health, and a lack of autonomy. Nonetheless, as the health care movement grew, it began growing
and gaining momentum. What started out as informal discussions and small changes expanded into formal institutions and organizations which addressed women’s health medically, politically, economically and socially.

The health care movement in Montana has proven to be successful through its accomplishments in creating new institutions, particularly for low income women. This analysis of the movement takes into account social factors and achievements within women’s health care. Such analysis considers personal identification of the success of the movement, community response, and the persistence and growth of women’s health care institutions over the past thirty years.

The acknowledgement of success by the activists of the health care movement in Montana is of great importance. These women wanted to change a system that they perceived as systematically ignoring and omitting them. Their accomplishments, while aiming to change a larger system, were specifically intended for the women themselves: to provide access, education, and choice in health care to women. Health education, like the movement itself, grew and changed. It began as informal discussion groups, where many women first learned how their bodies worked, and progressed into a more formal mechanism with a diversity in topics. Education on women’s health care grew to include theoretical discussions- redefining health and technological training of medical procedures. It then expanded to include not just women, but the general public and professionals as well.
Access became a direct result of education as learning about alternative means of health care was clearly not enough. Knowing about birth control was not going to stop pregnancy, women need places to get contraceptives. Choice in health care was an ultimate goal for many women's health care organizations and was a combination of access and education. It was essentially giving women a say in their health care by educating them and providing them with options. This was not something women had in health care prior to the health care movement.

The second point of analysis is of community response, which reinforces the perspectives of feminist activists. The response of the community is of important consideration as it identifies an acknowledgement of the movement by those who did not necessarily partake in it. Protesters reflect success, or at least impact, of a movement as they feel threatened enough to speak out against the actions with which they disagree. Likewise, the opposition of the medical community demonstrated the impact of the movement on health care. Those in the medical community supporting the movement point out that it had medical validity. Some of the narratives discuss police support to the health care movement, both through protection of its services, such as the clinic, and utilization of its services, such as Women's Place (and the treatment of rape victims). This yet again reinforces diffusion of the women's health care movement out into the community.

The last means of measuring the success of the movement is in recognizing how many of the organizations that were formed by the health care movement persevered into the 1990s. Organizations such as the BMC, the
YWCA, Planned Parenthood, and the MPPC have sustained, developed into new organizations, and grown into major institutions. These organizations are markers of success, demonstrating that the health care movement has not only impacted the local communities, but grown into a larger, self-perpetuating entity.

BMC, for example, has gained momentum and has drastically changed since its foundation. It has extended its services to men, expanded its services past reproductive issues, and become more dependent on payment for its services. On the other hand it is still providing the abortion and basic gynecological services it began with. Although services cost more, BMC still attempts to provide affordable services to those who could not otherwise afford it.

Similarly, midwifery has contributed to many changes locally and statewide. Because of their struggles throughout the health care movement, midwifery has not only been accepted by the community, it has become a legally protected practice in 1989. With these accomplishments came a change in the course of midwifery. Legislation, while protecting midwives, called for licensing which has required supervision by a board, which both supports and restricts midwives. Throughout all its struggles, midwifery has continued to thrive. Dolly Browder went from fighting for midwifery to be a legal practice to training new midwives every year. She has expanded her services from midwife to mentor. As midwifery has grown, it too has changed. While it has become more accepted it has also become more regulated and mainstream.

Thus far, I have summarized the findings of my research. The narratives that I presented in this thesis have portrayed a very active health care movement.
in Montana. While the women’s health care movement in Montana was no doubt effective, significant institutionalization provokes questions regarding the effects of the health care movement on contemporary issues. Namely, how does the past resonate in the present?

While the institutionalization of a successful grassroots organization seems to be contradictory, it also seems to be inevitable. Although the institutionalization of a movement requires some sacrifice of autonomy it replaces that with stability and disperses the models and methods of the movement to the general public. This is evident in the availability of “women’s health care” in mainstream medical facilities in Montana.

It has been my experience, and one I have taken for granted until now, that I benefit from the women’s health care movement quite frequently. I am a single woman, living in Missoula, MT. I attend The University of Montana and receive the majority of my health care in Missoula. I get my annual exams at the university health services from a female nurse practitioner. While a majority of the physicians there are male, I have access to qualified women staff members if I desire. Obtaining birth control at this university is no longer controversial, in fact I can get free condoms any time at health services, no questions asked, and counseling on other birth control options.

Domestic abuse is no longer a mute issue. There are a number of organizations one can turn to including Student Assault Recovery Center (SARC) which is located on campus. Testing for Sexually Transmitted Disease (STDs) is
now a publicized issue with flyers for testing, some free and anonymous, all around campus.

Off campus, there is still BMC and PP for access to more affordable women's health care for those who are not students. Both places offer annual exams, counseling on an array of women's health issues from drug abuse to abortion, access to birth control, STD testing, and the morning after pill and abortions. There is also a choice in birthing for pregnant women. Not only is midwifery legal and generally accepted, it is listed in the yellow pages. Women can chose from home birth, a hospital birth with a midwife or the traditional hospital birth.

With all these services, I would argue from personal experience that I do benefit greatly from the women's health care movement. Being an implant graduate student one might question whether or not it is my status, or education that allows me access to all these services. Because I grew up being educated about my body and health, live in Missoula close to many health care facilities, and I can afford health insurance, I have been typified by most people as a liberal and a feminist. Whereas, if I grew up in poverty, or in an isolated town in Montana, or with little education about women's health, I might not have the same access to health. However, it has surprised me, time and time again, the response I get from local women when I tell them about my research. I work in a local "working man's bar", a place were I quite frequently get, "oh you're not one of those feminists are you?"; yet a number of women in there have told me about their experiences with women's health care services around town, "Oh my records
are still at Blue Mountain all burned.” A couple women have told how important the health care movement was for them. Or they say, “You know who you should talk to…” because they were involved with some health organization or issue. They tell me about experiences with nurse mid-wives and getting health care from local clinics. These are all personal local stories from women who do not consider themselves feminists, yet who reap the benefits today from the health care movement.

A final means of assessing the effects of the health care movement on today’s health care, is to read Terry Kendrick’s Status of Women in Montana Report (2002). From this report, it appears that the status of women’s health has improved in Montana due to the models that were implemented by the women’s health care movement. There has been a continued increase in health education, public awareness of women’s health issues such as breast cancer, and access to women’s clinics around the state with a decrease in teen pregnancy and surgical abortions. Although there has been an increase in access and education as a whole, rural women are still lacking these services.

Today, according to Kendrick’s report, many women still have to drive eighty miles to reach a health care facility, and they have few options in choosing a health care provider. There is often limited access to services apart from hospital treatment such as facilities that deal with domestic violence, or preventative health care. The number of individuals who lack proper health insurance is also on the rise, hence limiting access to health care and medication. Incidences of rape, sexual assault and domestic violence have been on the rise,
which may be due to more women reporting crimes from an increase in education and access to services as well as from an increase in crimes themselves. Nonetheless, about seventy-five percent of rape and assault go unreported (Kendrick 2002:16-20). While there are still many problems within women’s health, they are issues that may not have been identified without the tools of the women’s health care movement.

One of the biggest problems which I have recognized with women’s health care today is the lack of historical education on the women’s health care movement. I feel that access has been taken for granted, as if it has been here along. Personally I was unaware of the history which has afforded me so many of the privileges which were not around thirty, even twenty years ago, and felt quite ashamed of my ignorance. Sally Mullan addresses this problem:

“I sometimes like to think about what would happen if tomorrow abortion became illegal, because you have generations now of young women who don’t know anything about the struggle to get it legal in the first place. But, on the other hand, they also assume that it is their absolute right to have one. So I think it would probably politicize them in a quite a heartbeat- I hope anyway.”

One of the goals of this thesis have been to record this history, told by those who created it, so it is not forgotten. In doing so, this research lays a foundation for future research. From it we can assess the impact of a social movement on a greater system, both now, and in the past. For example, it could be combined with Kendrick’s Status of Women as a tool to explain the statistical portraits of women’s health care in Montana.

Nonetheless, this information is incomplete and should be augmented. Interviewing Native Americans, physicians, and those who opposed the
movement would add a different perspective to my analysis, which I would have appreciated. A statistical analysis of the changes in women’s health care brought about by the health care movement and a comparison of the women’s health care and biomedical models would be useful as well. Further research is still needed addressing rural health care in places like Montana since most health care is centralized around urban areas.

Clearly there is an ever-present need for more research in health care, and anthropology should be used as a tool in laying the foundation for future research, as I have done here. Anthropology can be used as a means to gain an emic perspective on research problems; it can relate isolated and esoteric research to human experience and it encourages a holistic approach to analysis. As I have demonstrated here, merely understanding the women’s health care movement as a systematic response, a medical issue, or social phenomenon would be incomplete. Instead, using anthropology, I have interpreted it as a dynamic historical process which continues to shape the events of today.

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1 The topic of eco-feminism and health has not been addressed at length in this thesis, however there have been a few organizations in Missoula that have addressed the correlation between certain types of pollution and women specific disease. Gals Against Smog Pollution (G.A.S.P.) were a group of women, spouses of professors at The University of Montana, who challenged the local mills and fought for better air control in the 1960s and 1970s. Women’s Voices for the Earth (WVE) is a current organization in Missoula that addresses contemporary environmental issues and is run by Byrony Schwann.
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