

Healthsharing

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Drawing by Patsy Berton

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Notes from the Collective

The Healthsharing process has begun. You have voiced your enthusiasm for a women's health magazine and supported our belief that it is valuable to the women's health movement in Canada. Your response has been tremendous. Thank you.

In this new issue, we examine parenting, choosing health care practitioners and health decision-making. Are the current parenting courses dealing with the needs of parents? Do they offer valuable, realistic advice? Sharon Zigelstein and Ida Dancyger have some criticisms. Connie Clement looks at the process of choosing people to help us stay healthy — *whom* do we choose, for what reasons and how do we go about it? To complement this article, our *Healthwise* column features 'Assuming Responsibility for Your Child's Health,' by Colleen Archer. Being aware of our options *and* demanding our rights are two ways of helping to improve our health care. Kathleen McDonnell explores the dynamics of how health care decisions are made with Doreen Hamilton, a nurse who served on an obstetrical services committee in Metropolitan Toronto. Hamilton didn't like what she saw and heard, and eventually resigned from the committee. In this interview she tells us why.

In women's health, as in any movement for change, it is important to build networks for information exchange and support. The Canadian women's health movement needs to share knowledge, questions, news about the work we are doing and advances and setbacks to our cause. We also need to share our feelings, our concerns and our strengths. We see *Healthsharing* as a catalyst helping to create this network. Our name implies this vision. There are many ways that you can help this happen.

What positive steps are being made in your community? Would your experiences as a health care worker or consumer be valuable to other women? What are your health concerns? Send us articles about the things that are important to you — *Healthsharing* can share them! Write us about new books and films that are valuable and relevant to you — send reviews, if you are so inclined. Write about your organizations and the publications you produce. Invite women to conferences and events in your area by listing an event in

Healthsharing. Remember *Healthsharing* is a quarterly magazine, so announcements must be received well in advance.

At the same time that *Healthsharing* can help you, you can help the magazine. Put us on mailing lists to receive news. Encourage friends and organizations to subscribe. Promotion for the magazine is coming along, but if you can write an article for a local paper or prepare a spot for a radio station, let us know — we'll send news releases. We also need local distributors for the magazine; pressure your local bookstores and resource centres to sell *Healthsharing*, or if you can, be an area distributor yourself.

A "healthsharing" network can grow across the country. Such a network will be important in the continuing struggle to reclaim our bodies, our minds, our emotions, to take back control and to become a community of strong healthy women.

In sisterhood,
Women Healthsharing — Madeline Boscoe, Connie Clement, Gina Jones, Diana Majury, Kathleen McDonnell, Jennifer Penney, Susan Wortman.

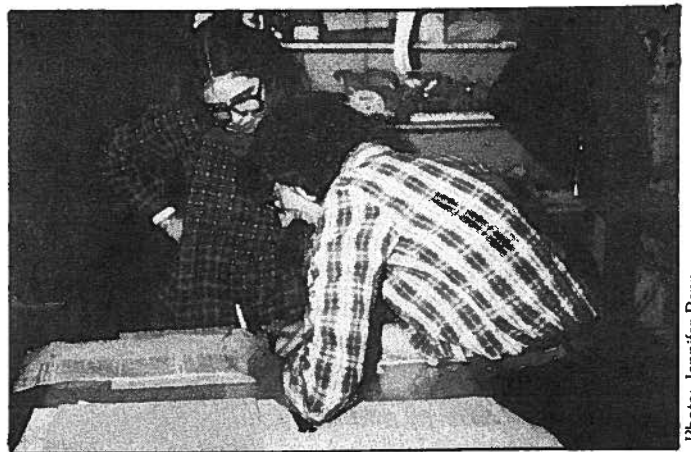


Photo: Jennifer Penney

Collective members Madeline Boscoe and Connie Clement hard at work on the first issue.

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Anti-Choice a Public Service?

Following a trend started by the Mormon Church and other organized religions, the Catholic Church has started producing "public service announcements." Instead of sticking to homilies on home life or parenting their 60-second ad deals with abortion. It shows a crowded midway at a fair. Then, with a steady beating heart in the background the crowd slowly disappears until the midway is deserted. Finally a voice says "Every three months as many people as you see here are denied the right to life through abortion."

The ad is being offered to all TV networks and stations as a "community service," therefore entitled to free air time. It is expected that they will appear across the country by the first week of March.

Ruth Miller of the Canadian Association for Repeal of the Abortion Law (CARAL), a pro-choice lobbying group, calls the commercials "a community disservice... designed to make women who have had or who will have abortions feel ambivalent and guilty." CARAL is calling for people to write the CRTC and television stations to protest this use of public air time.

Women Need X-Ray Warning

The Toronto Board of Health has asked the National Cancer Institute to revise the consent forms to be used in a Canada-wide breast cancer detection study involving mammography, or breast x-rays. The board said the current consent forms don't given the expected 90,000 volunteers, aged 40 to 59, sufficient warning of the risks they face from exposure to x-rays. The board is withholding endorsement of the study until it has more information on the risks of mammography, particularly to women under the age of 50.

Out with Sugar and Spice

The Beech Nut Company, which produces about 15% of all baby food on the market, has removed sucrose, a type of sugar, from all but one of its products. (The company also eliminated salt and reduced sugar in its products two years ago.) Other companies (Gerber and Heinz) have not acted as swiftly or completely.

Newsfronts

Planning More Birth Interventions

The Ministry of Health of Ontario is seeking responses and comments on a report produced by its Advisory Committee on Reproductive Medical Care. The report, called *Regionalized System for Reproductive Medical Care in Ontario* argues the case for the setting up of an expensive, computerized classification and referral system for pregnancy and childbirth based on how "high risk" a woman is considered to be.

The report has been criticized because of its lack of emphasis on "low risk" care, prevention and the decreased amount of consumer choice in childbirth that would result from implementation. (Out-of-hospital birth centres and home births were panned in the report.)

The Ministry of Health will make decisions about implementation in the late spring or early summer. Although this is a provincial decision, the report will be of interest to women outside Ontario because there are similar plans for the other provinces.

Copies are available from the Ministry of Health, 15 Overlea Blvd., Toronto, Ontario M4H 1A9.

Abortion Hassles

Confusion surrounding abortion in Canada intensified last fall in Nova Scotia. A 19 year-old woman's estranged husband threatened to seek an injunction to prevent a Halifax hospital from performing an abortion on her. None of this went to court however because the hospital, in the face of the threat, refused the wife the procedure. Lacking other means, she had to continue the pregnancy.

But while the court case was still threatened a member of the Nova Scotia "United for Life" anti-abortion group was granted permission to appear as a guardian *ad litem* for the fetus.

Ad litem guardianship is given to allow an unborn child to be represented in any litigation affecting its interests. For example guardians have been appointed to control property which unborn children may inherit. But because guardians *ad litem* have never been given control of the body of the fetus, legal experts feel that the court went beyond its jurisdiction in granting the guardianship. In all this confusion one thing is clear: a woman continued a pregnancy she did not want.

The Supreme Court of Ontario recently turned down a similar request for "guardianship" by Ottawa lawyer David Dehler.

DES Daughters Sue

Class action status has been granted to a multi-million dollar DES suit filed in Boston three years ago. The ruling will enable an estimated 13,000 to 53,000 "DES Daughters" who meet the suit's requirements to sue the six major drug companies who marketed the drug for "fear and anguish." DES was given to women until the early 1970's to prevent miscarriages. Daughters of these women have vaginal and cervical cellular abnormalities which have developed into cancers in some. Women who have developed cancer have successfully sued the drug companies.

Rape Victims Turned Away

Toronto's Queensway General Hospital refuses to examine rape victims who have no visible injuries because doctors might lose too much time testifying in court, the hospital's chief of staff says. A representative of the Ontario Coalition of Rape Crisis Centres, Christie MacCallum, said that it would be impossible for women to press rape charges if more hospitals followed Queensway's example, because family doctors can't do forensic tests that will stand up in court.

Birth Centre Closed

The Corporation des Medecins du Quebec has recommended closure of the Carolyn Centre (an out-of-hospital birth centre in Montreal). They claim the Centre didn't offer women and their newborns the same protection and security services as a hospital. Although the recommendation was not binding, Dr. Elrie Tucker, who ran the Centre, closed it on the advice of his lawyer.

Battered Wives

Wife battering is a fact of life in one in 10 households in Canada, according to a comprehensive national report released in late January by the Canadian Advisory Council on the Status of Women. Linda MacLeod who compiled the book, said "Most women never dream until they are physically battered that if they need help the likelihood is that no one will come. An image of the family perpetuated by our laws and traditions places the family outside the law and reinforces the right of men to beat their wives." More 24-hour emergency services and refuges are seen as a top priority, with back-up support services including expanded child care and educational programs. The book is available from the Canadian Government Publications Centre, Ottawa, Ontario K1A 0S9.

The Decline of the Pill

A confidential document recently prepared for the US pharmaceutical industry was reported as saying that the number of prescriptions filled by pharmacists for birth control pills dropped 24% between 1975 and 1978. Sales of Ortho-Novum, one of the most common brands, dropped 43%.

At the same time, prescriptions for diaphragms rose 140%.

Nestle Boycott Continues

The Nestle Company is attempting to convert into a public relations victory the setback they suffered at the recent WHO/UNICEF meeting on Infant and Young Child Feeding in Geneva.

Criticism of Nestle's aggressive marketing of their bottle-fed formulas in the Third World is widespread. Mothers liv-

ing in poor sanitary conditions, and with little money have been convinced of the "superiority" of bottle feeding by Nestle campaigns, resulting in illness and death for thousands of babies.

WHO Director General Dr. Halfdan Mahler said that the industry was "morally obliged" to change these marketing practices. Yet Nestle Managing Director Arthur Furer argues: "The gradual changes Nestle has introduced in the past five years are completely in line with the recommendations."

The Nestle Boycott incorporates all Nestle products including brand names such as Nescafe, Encore, Taster's Choice, Libby's, Maggi, Cross and Blackwell, Cherryhill Cheese, Old Fort Cheese and Pero. More information is available from INFAC (Canada), 1611 Quadra Street, Victoria, BC V8W 2L5. A film about the whole issue, *The Formula Factor*, is available from the National Film Board.

Sulfa Ineffective for Vaginitis

An advisory committee to the Food and Drug Administration has recommended that vaginal sulfa agents should be banned because they are ineffective. Sulfanilamides, like AVC cream, are one of gynecologists' most widely prescribed drugs.

Research found that *hemophilus vaginalis* vaginitis persisted in 86% of women treated with a sulfanilamide cream. It was also found that ampicillin (a common antibiotic) was only effective half the time. The one drug found effective was metronidazole (Flagyl) which has been linked to birth defects in children and may be carcinogenic.

Depo-Provera Comes to Canada

The Ontario Association for the Mentally Retarded says that Depo-Provera is being given to 230 severely retarded women in provincial institutions. The Association is opposed to such measures. Depo-Provera is a three-month injectable contraceptive linked to irregular bleeding, edema, depression, growth of facial hair, and in some cases permanent sterility, fetal malformations and cancers of the breast, cervix and uterus. There is no legislation regulating the use of Depo-Provera in Canada.

"Illegal" Abortions in BC?

British Columbia's Health Minister Rafe Mair announced before Christmas that his officials would be investigating whether BC hospitals were performing "illegal" abortions. He was "alarmed" by a Statistics Canada report that the province led the country in the number of abortions in 1978 — 33.6 for every 100 live births. (The national average was 17.4.)

Mair says he wants more and better sex education in the schools in order to reduce the number of abortions done in the province. He is prepared to withstand pressure from parents who disagree. Yet his government recently turned down funding to Planned Parenthood which carries out precisely such educational programs.

Fetal Alcohol Syndrome Update

A recent edition of the British medical journal, *Lancet*, reported that birth defects associated with alcohol intake during pregnancy may be caused by consumption of alcohol together with certain drugs. These drugs include metronidazole (Flagyl) used to treat vaginal infections during pregnancy. Also of concern are chloramphenicol, an antibiotic, and quinacrine, an anti-malarial drug.

It was suggested that the alcohol itself does not harm the fetus but a breakdown product, acetaldehyde, may damage cells and cause birth defects. Ordinarily, acetaldehyde is broken down by our bodies, but these drugs inhibit this mechanism. Some individuals are particularly susceptible to the effects of these drugs. Since this susceptibility is not readily identified, pregnant women are advised to avoid these drugs or at least the concomitant drinking alcohol at the same time.

Our Apologies:

- To Willie Mattocks who was called Willie Holmes in the *Birthing Options* article in the first issue;
- To Pat Foote-Jones and the *Women's Work, Women's Health Conference* for neglecting to credit them for our front page graphic.

Our Mistake:

- For recommending *Pero*, a coffee substitute, in the first issue. *Pero* is one of the products included in the Nestle boycott.

Healthwise

Assuming Responsibility for Your Child's Health

by Colleen Archer

Being a mother isn't easy and being a doctor isn't easy, and too often the two mix together like oil and water with a little vinegar thrown in. One doctor has stated emphatically that all mothers are a menace. A mother I know stated at one point in her life that all doctors are idiots. Both were wrong. There are excellent doctors, just as there are excellent parents, and the ideal is for such doctors and parents to work together for the child's welfare in an atmosphere of mutual respect.

Unfortunately it doesn't often work that way. Patients go to doctors fully expecting them to "fix" what's wrong, and the doctors are reluctant to admit they can't always do this.

The attitude that everything can be cured by a prescription is passed on early to our children when we tell them the doctor is going to give them something to make them better. Realistically the doctor doesn't always have such a magic potion especially in the case of such common ailments as colds and flu.

After spending a lot of time with many different doctors during my youngest daughter's first year of life, I came up with my own personal guidelines towards assuming a more responsible role in her day-to-day health care.

- Strive to maintain your child's general well-being through good nutrition and daily health care.
- Your child's file is legally the doctor's property, but you should get your doctor's agreement to allow you full access to it. In addition, be sure to keep a personal record of all drugs and inoculations she receives.
- Avoid going to the doctor with preconceived treatments in mind for your child. Both diagnosis and treatment should be fully discussed between parent and doctor, and a mutual decision made.
- Make your position clear regarding unwarranted medication. Doctors are well aware that many parents don't feel happy unless they come away with a prescription. Beware the use of penicillin, antibiotics or sulfa drugs "in case it might do some good." There should be a specific infection and a positive diagnosis before one of these potent drugs is prescribed. Only a laboratory check can tell your doctor the correct antibacterial drug to use.
- If you do accept a drug, follow the directions exactly. Follow the full course of treatment to be certain that the infection is fully cleared up. Don't give a child drugs from a previous prescription.
- Don't agree to x-rays unless they are *essential* to diagnosis and treatment. Many doctors routinely order x-rays for minor injuries though the results will not affect their choice of treatment. *No amount of radiation is "safe," particularly for children.* Where peripheral x-rays are necessary, demand a lead apron to cover the vulnerable trunk area. Ask if the technician is certified, and whether the x-ray equipment has been checked for excess radiation in the last two years.
- Get a second opinion (or more) if surgery is recommended. There's no guarantee how a child will react to a surgical procedure or the anaesthetic. (Our daughter was scheduled by a surgeon to have a fatty lump or lipoma removed from her head when she turned a year old until a pediatrician told us this procedure wasn't necessary. The lipoma has since disappeared.)

Assuming a more active role in the treatment of your child may not always be easy. Many doctors have a "leave it all to us" attitude that doesn't encourage questions or consultation. The issue is your child's life, however, and you have a right to know what's going on and to participate in decisions.

Colleen Archer is a freelance writer. Author of Women in Crisis, she is presently working on a Peterborough area Women's Yellow Pages.

Health Wanted

This column is to help you obtain needed information. If you're having a specific health problem and aren't coming up with a solution, if you're working on a research project, if you're exploring a particular concern in a collective, write to Health Wanted c/o Women Healthsharing. We are not able at present to respond to individual inquiries, but we will print your request in Health Wanted so that women across the country can respond directly to you. Be sure to include a complete mailing address.

Cervical Caps

We are trying to find out more about cervical caps in Canada. Anyone who has fitted caps, been fitted for a cap or unsuccessfully tried to obtain a cap please write Madeline Boscoe and Connie Clement c/o Women Healthsharing.

Midwifery Training

A friend writing from Inuvik has decided to take her public health nursing degree and then to take midwifery training in order to practice in small northern communities. Anyone who can offer leads to help her choose a progressive university nursing programme or midwifery training course please send information and contacts. Write to Frumie Diamond, Box 1728, Inuvik, NWT X0E 0T0.



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Letters

Dear friends,

I just received my first copy of *Healthsharing*. I hope you can realize how important a magazine such as this is to me, first as a woman and also as a nurse, especially working up here in such an isolated area.

One of my main interests before I moved was the way that I saw the birthing experience handled in the large city hospitals. Coming here to a rural area I had hoped to find a qualitative change in the way that birth was dealt with but I find the process to be much the same. At first I was quite disappointed but then I began to resign myself to what I saw happening and to become somewhat oblivious. Reading your article *Birthing Options* has reminded me that there are options and that there are women struggling to regain the right to have their babies in a way that is rational and safe for them and their bodies.

Leaving the magazine lying around in the residence has also sparked a bit of discussion among the nurses here — another positive event. So keep up the good work and thanks again from the wilds of north-western Alberta.

Lisa McCaskell
Fairview, Alberta

Dear *Healthsharing* —

Excited to read your newsletter, but need to correct some misinformation. Re: *Full Term Fetus a Person* note, the woman charged is *not* a midwife — she is an ex-doctor, now “spiritual healer” (from what I understand) and did not act as a midwife. The distinction is important to the Home Birth Movement, and the incident unfortunate for everyone.

Yana Maltais
Nelson Women's Centre, Nelson, British Columbia

Bonjour!

As I was reading our local paper last night I came upon an article describing your publication. At last, something that goes beyond the “usual” treatment of health subjects concerning women. Being a fourth year nursing student, I have already seen many injustices in the health care system delivered to women (in psychiatry, surgery, OB-GYN wards). Your publication appears to treat health care with a holistic approach, contrary to what our system dishes out.

Thank you!

Christine Villeneuve
Vanier, Ontario

Dear friends,

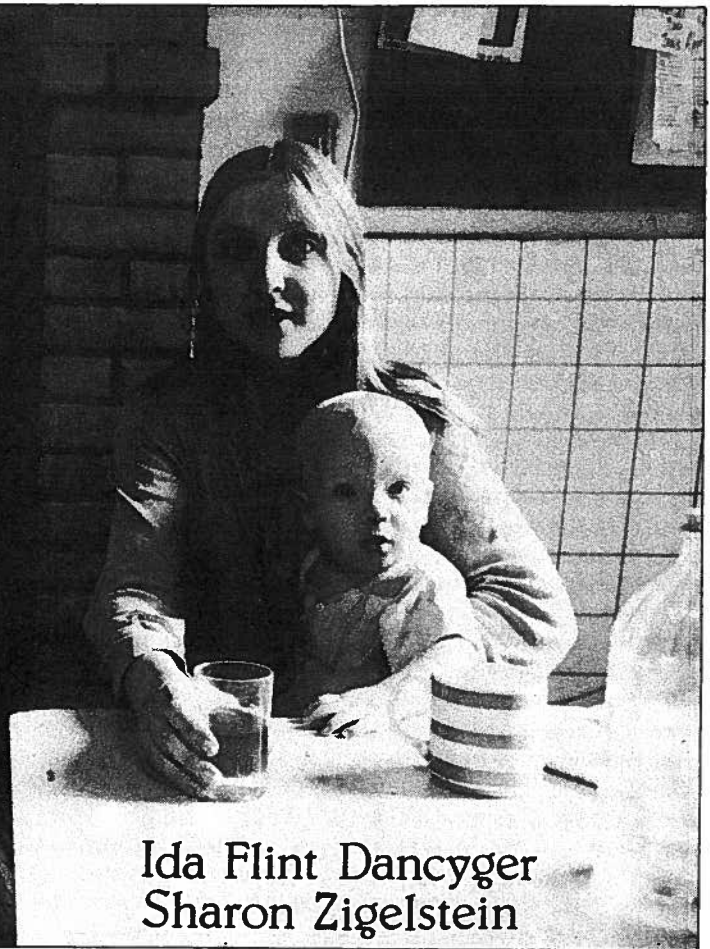
Many thanks for the copy of the first issue of *Healthsharing*. Judging by the rush by the staff here to read it, it is a magazine whose time has come. We are pleased to have had a small part in its beginnings and we look forward to the succeeding issues.

Best of luck for the future.

Jane Taylor
Women's Programme, Secretary of State, Ottawa, Ontario

Enlightening Parenthood

Photo: Paul Campbell



Ida Flint Dancyger
Sharon Zigelstein

The essence of the women's movement is an affirmation that women are whole human beings with many roles to play. One of these roles is, and will continue to be, the role of mother. While we embrace this role, we look to the women's movement for help and support in challenging the way our sexist culture has turned "motherhood" into an oppressive institution. Feminism has successfully debunked the myth that mothers who pursue roles other than that of parent are selfish and "bad" mothers. Likewise it has discredited the notion that the father's only role is that of "breadwinner" and has encouraged men to explore and develop the emotional and nurturing sides to their personalities and share equally in the parental role.

Out of these challenges has emerged a new concept of parenthood which requires child-raising to be shared between mothers and fathers and rejects sex-role stereotyping.

Because of these new concepts and new roles, parents of today are faced with the task of relearning parenting. To change our lives and improve our children's lives, we must critically examine the old notions of child-raising and seek to implement alternatives that will prepare us for the future.

The Legacy of the Expert

In post World War II society, tradition and instinct had become suspect; the age of the "expert" had arrived. Mothers at that time by and large fit the stereotype of the

woman as the primary caretaker of her children, isolated and alone in her home, cut off from tradition, mistrustful of her instincts and without adequate emotional support.

In response to this situation, a whole new cadre of experts emerged — from pediatricians to philosophers, psychiatrists to scientists. These experts, as Ehrenreich and English point out in their book *For Her Own Good*, developed a new science which "drew more and more on the judgments and studies of the experts, less and less on the experience of mothers — until . . . it (came) to see the mothers not only as the major agents of child development but also as the major *obstacle* to it."

This influence on our lives as parents has persisted to the present day. Male child-raising experts are still pouring out theories and hypotheses, dictates and warnings, advice and techniques on how to be the "perfect" mother and raise the "perfect" child.

In the forties, "behaviourist" psychology influenced child-raising. Mothers were advised to manipulate the environment to try to mold children into perfectly obedient, disciplined and conforming individuals. Mothers were responsible for maintaining rigid feeding and sleeping schedules, cautioned against overstimulating or playing unnecessarily with an infant and discouraged from breast feeding.

At the same time, developmental theorists Piaget and Gesell established developmental norms for children. We inevitably measured our children against these ideal norms and became preoccupied with perfecting their developmental timetable.

In the fifties, the revolutionary new book *Baby and Child Care* by Dr. Benjamin Spock appeared to change the course of childrearing in North America. While Spock seemed to liberate parents from reliance on scientific theories and rigid methods of infant and child care, his psychoanalytical training and Freudian bias in fact undermined his "trust your instincts" philosophy. Spock's book reflected the view that the problems of adult life were rooted in the experiences of childhood. His dire warnings to mothers on issues like toilet training and sexuality reinforced the view that mothers were solely responsible for molding their children's personalities.

A.S. Neill's book *Summerhill* was a precursor to new childrearing attitudes of the sixties. Addressing himself not only to educators but to parents as well, he told us that children need not grow to be successful in society as long as they were happy. He berated us for not allowing our children sufficient freedom and for stressing intellectual development over emotional and artistic development. According to Neill, there were "no problem children," only "problem parents."

With the passing of the seventies, we read the work of the latest guru, Harvard psychologist Burton White. In his book, *The First Three Years of Life*, White reversed the trend started by Neill and stressed once again intellectual as well as social development. He instructed mothers in great detail how to provide a stimulating and nurturing environment so children would develop superior intellectual abilities and social skills.

As parents eager to do the "right" thing and find the "best" answers, we lost our way in this maze of confusing and conflicting advice. The activism and the new consciousness of women in the sixties led to a realization of the shortcomings of this approach to child raising. This in turn led to a search for new answers and new models for parenting.

Back to the Classroom

Courses and study groups on "how to parent" are springing up in local libraries, schools and community centres across the country. The courses promise a new approach to childrearing and revolutionary techniques to help modern parents cope with the increasing pressures of parenthood.

But are these courses an improvement over the books and pronouncements of the experts? Do they reflect the new consciousness? Do the courses have in fact their own "expert" bias? Do they set up the "ideal" as something attainable or do they propose realistic goals and promote sound techniques that can be implemented? Do the courses reflect the narrow mother-child focus of the experts or do they see parenting within the larger context of the whole family and equip us with the appropriate skills in group process? Do they emphasize the parents' needs and roles and promote the development of self-knowledge and personal growth in parents as well as children? A description of the courses will answer these questions.

Most parenting courses in Canada fall into one of two major categories — those based on the book *Parent Effectiveness Training (P.E.T.)* by Thomas Gordon and those based on the book *Children: The Challenge* by Rudolf Dreikurs.

Touted as "the tested new way to raise responsible children," P.E.T. attempts to teach parents how to communicate effectively with their children in order to enhance mutual respect and understanding, minimize unnecessary

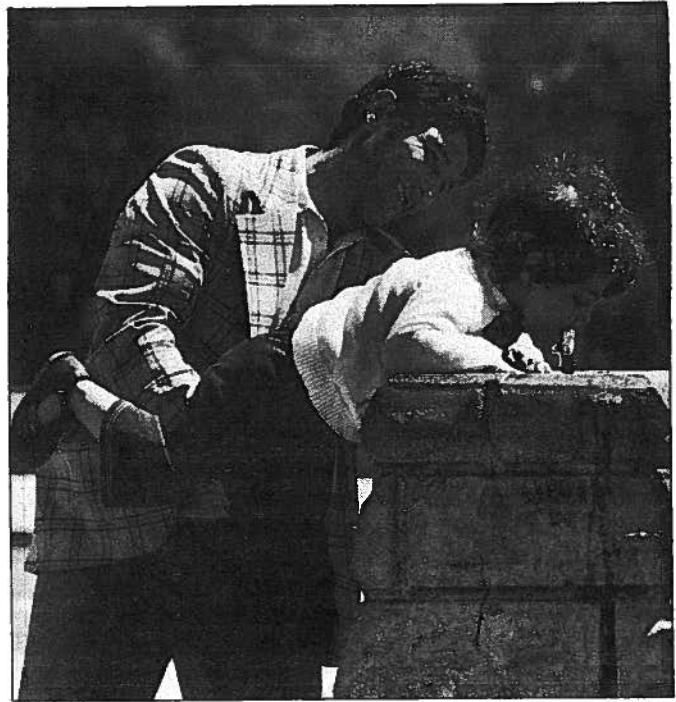


Photo: Frank Rooney

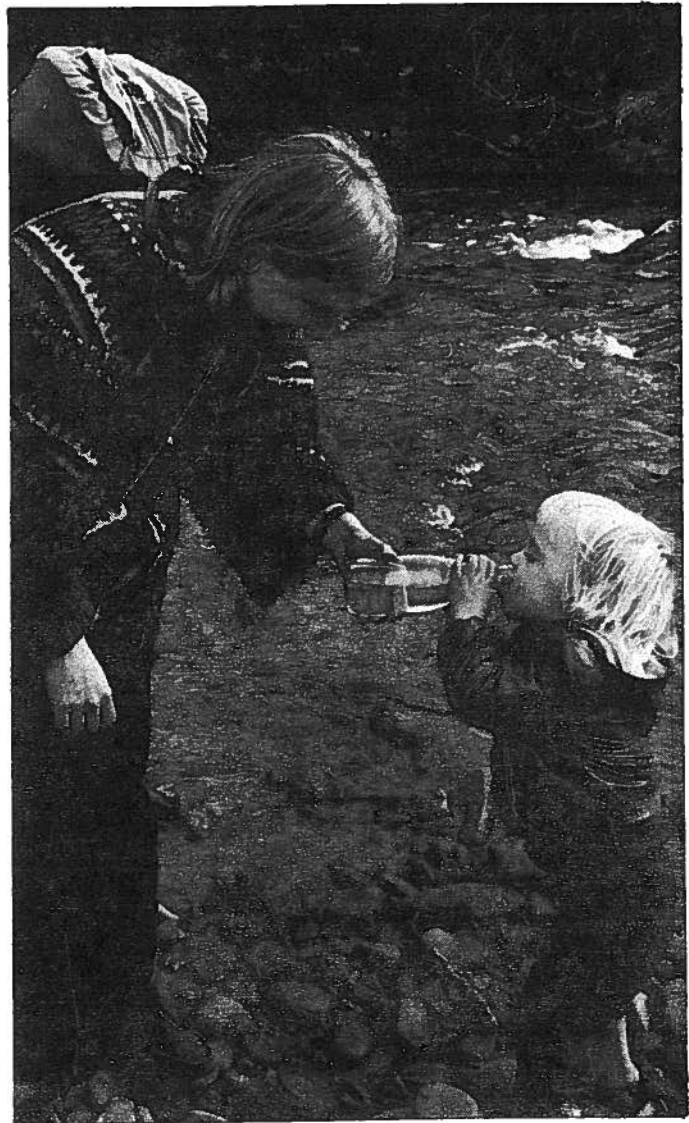


Photo: John Ruttner

conflict and abandon the use of power in parent-child relationships. The organization sponsoring these workshops is a California-based, profit-making corporation headed by Thomas Gordon called "Effectiveness Training Associates." This company operates like a commercial franchise which trains the course instructors and receives part of the fee from each course.

Children: The Challenge workshops teach parents "how to become a match for their children, wise to their ways and capable of guiding them without letting them run wild or stifling them." Here, power is seen as a force to be recognized, understood and used in the parenting process. These workshops are run by members of the Alfred Adler Institute. Unlike *P.E.T.* there is no profit motive or expansionist interest; the fees cover costs of leader and accommodation.

New Tools for Parents

Despite their differences in philosophy, format and content, both types of courses provide a powerful group experience for parents. Sharing information and experiences with other parents allows us to see we are not alone in our problems, fears and anxieties. The courses treat parental isolation as a legitimate problem and provide short-term support and assurance for parents.

Feeling the stress of staying home with two preschool children, Ruth took a *P.E.T.* course and reports, "I believe I learned more from the other parents than I did from the book or the leader. It helped to know that others had similar problems and shared similar experiences."

Another strength of the courses is that they debunk the myth that the family process should work "naturally" and doesn't need help. The groups see families as systems and focus on the interrelationships of family members. They stress open communication and the sharing of feelings, respect for each individual within the family and suggest techniques for the family to define rules and customs.

P.E.T. offers the "no lose" method of conflict resolution between parent and child, who discuss the basis of their conflicts and try to reach mutually satisfying solutions.

Children: The Challenge groups promote the idea of "family councils" which provide a structure for decision making within the family, with each member afforded equality in rights and responsibilities. Children participate democratically in assigning chores, discussing problems and arriving at solutions.

In addition, the courses squarely face the problem of parental discipline and give us practical advice for our roles as authority figures. Despite the discomfort of many of us in these roles, we quickly discover that we need to establish limits, define rules and "control" our children, for their physical and psychological safety, as well as for our own emotional survival. *Children: The Challenge* gives us helpful hints on how to demonstrate firmness without dominating our children through the use of "natural and logical consequences."

"Natural consequences" are those that follow automatically from the child's behaviour without any *interference* from adults. For example, if a child forgets to take her lunch to school, she goes hungry. If she refuses to wear her raincoat, she gets wet. "Logical consequences" are structured by the parents in cases where suitable natural consequences either

would prove dangerous or would not occur. For example, if a child refuses to brush his teeth, parents naturally can't wait for a mouthful of cavities to teach him the consequences of his action. A logical consequence is to eliminate all sweets. These techniques allow children to experience directly the consequences of their behaviour and lead to the development of self-discipline.

P.E.T. goes beyond *Children: The Challenge* in its analysis of conflict. Its concept of "problem ownership" enables us to clarify our role in a conflict and precludes our acting in an arbitrary, unthinking way to our child's "misbehaviour."

Parents "own" the problem when our needs are being frustrated by our child. And in this instance, we use an "I-message" to communicate how our child's behaviour is affecting us. No criticism of the child is implied.

For example, "I'm not going to enjoy the flowers I planted if they're trampled on" is the *P.E.T.* way of communicating to a child that she better stop trampling on the flower bed.

When the child "owns" the problem, the parent can use the technique of "active listening." Parents reflect back to the child what they perceive her to be saying. In response, the child elaborates and clarifies her understanding of the problem and may arrive at her own solutions.

Perils and Pitfalls

No doubt these courses offer a source of help with the day to day practice of childrearing and provide a kind of therapy for the participants. Nonetheless they are not the panacea they are promoted to be. One of the major problems with both courses is that they are still rooted in the "expert" tradition. Both are based on books written by male, child-raising experts, Dreikurs and Gordon.

Laurel Rothman, a social worker involved in family therapy, worries that "the courses tend to invalidate our own parenting experiences by setting forth as realistic, a model of perfection. This threatens parents, especially mothers, and results in making many feel inadequate and guilty."

Another major problem of the courses is that they tend to restrict their appeal and availability to the nuclear family of the middle and upper-middle classes. Although the standard "nuclear" family is becoming less and less the norm in today's society, the courses continue to work out of the context of the nuclear family. Single parent families, communal families, immigrant and ethnic families, families with stepparents and families with gay parents have had to look elsewhere for information and support.

These courses assume that parents, especially mothers, have sufficient resources (time and money) to provide a certain kind of environment. Elody Scholz, Executive Director of Umbrella Central Daycare Services as well as a single mother of two children, claims "techniques like 'natural and logical consequences' or the 'no lose method of conflict resolution' demand from the parent endless time, patience and sensitivity and assume that she has not another thing to do with her life than raise children. This creates guilt for the majority of single mothers and adds to their stress and fatigue."

Children: The Challenge groups pose an additional problem for a feminist parent. Underlying this system is the Adlerian belief that the drive for "power" is the basic motivator of human behaviour. Feminists who reject the assumption that

power is intrinsic to human nature, but is rather acquired and learned in our sexist, market culture, will be troubled by this approach. Dreikurs applies this cynical, manipulative view of human nature to family interaction. He assumes that children misbehave in order to get the better of their parents. He sees the parents' role as a matching of wits against their children in order to redirect their natural impulses toward more constructive and socially useful channels. Nonetheless many parents report they find Dreikurs' application of the power principle very useful with their children as well as in other relationships.

Alternatives to Courses

Although the courses meet some very real needs for parents, they do not provide a model which truly reflects the new concept of parenting today. The question that remains is whether parents can find alternative approaches which draw on the courses' strengths but is free of their weaknesses. One answer is the development of a self-help model that stresses collective problem solving and the sharing of information and experiences.

There are many forms which a self-help model can take depending on the needs of a particular parent at a particular time. An informal play group initiated by parents in a neighbourhood is an excellent way for parents of young children to get together for companionship, support and practical help, while providing their children with group play experience.

Another more permanent self-help model is the creation of Child-Parent Centres. With community support and funding such a centre can be set up in available space in apartment buildings, churches, schools or recreational centres. There is the "drop-in" variety where parents can come with their children to talk with other parents or just "take off" while the children play in a well-equipped playroom. The Children's Storefront in Toronto is just such a centre. In a more structured variation of this kind of group parents meet at a specified time either to chat informally or to participate in a formal program (speakers, films, exercises or crafts) while the children play together. "Creating Together" groups or the Y.W.C.A.'s "Take-A-Break" programs are examples of this approach.

Groups are being formed to provide help and support for parents in non-traditional families. Single parents have organizations where they can meet to share and discuss their concerns and ideas on raising children alone. One Parent Families Association of Canada and Canadian Partners Without Partners Inc. are two such national organizations. In the major urban centres across Canada, gay parents are forming groups to discuss their special concerns.

But most importantly we need parent support groups that provide *long-term* contact to combat parental isolation. We also need an outlet to help us recognize how our personal problems affect our parenting. Undoubtedly we can learn specific skills from the experts and the courses. However as parents we value most the emotional support that comes from a group that works on the assumption that parents know how to parent!

The Boston Women's Health Book Collective's *Ourselves and Our Children* describes the atmosphere and experience that such a support group can provide.

Group members talk about everything from how children develop to how to handle problems, to how children alter the relationship between a husband and wife, to how to get good child care. . . . Being in a group of this sort, where you are seen as both someone who can give help and someone who deserves attention from others, creates a stable, secure framework in which to work on issues of parenting that might otherwise be shoved under the table. Most members of groups like this feel that the experience has significantly deepened their understanding both of child development and of themselves as parents, and that it has helped them to get through what might otherwise have been a terribly lonely period in their lives.

Even with the support and help these new networks can provide, our parenting experiences will never be completely satisfactory until our institutions can accept and support the new trends in parenthood.

For the majority of us who have chosen to add the role of parent to our lives, the pressures and problems we encounter seem at times almost insurmountable. But with the right kind of support and realistic advice we can discover the joy and fulfillment that comes from being a parent.

Our task for the future then lies not only in relearning the skills of parenting but in creating a parent support network to help parents as well as advocate the needed social changes which will support a new, enlightened and liberated parenthood.

(Anyone interested in information regarding the formation of a parent support group in her community can contact Sharon Zigelstein c/o Women Healthsharing.)

Ida Flint Dancyger, a mother of two daughters, is a psycho-educational consultant and a freelance writer. Sharon Zigelstein, a mother of two sons, is a former teacher and a freelance writer.



Photo: Jane Eden

Top Row: Emily Dancyger, Jesse Zigelstein. Bottom Row: Erica and Ida Flint Dancyger, Sharon and Benjamin Zigelstein.

Health Care Choices: Making Yours

Connie Clement
Drawings by Patsy Berton



In the past decade, women have become increasingly concerned about our health, and that of our friends and families. Criticisms of the conventional medical system are widespread, and a new wave of lay healers and unorthodox practitioners has begun to flourish. Yet many of us continue to see the doctor our mother consulted, the doctor down the street or the next door neighbour's doctor for nearly all of our health needs.

For more satisfactory health care, we may have to change this practice. We should take the responsibility to determine not only what our needs are, but who might best help us meet these needs. As critical "consumers," we can choose from a wide range of resources — medical doctors (including general practitioners and specialists), physiotherapists, masseuses, nurses and nurse-practitioners, therapists with many different backgrounds and approaches, dieticians, herbalists, radiologists, dentists, dental-hygienists, and naturopaths. It's up to each of us to find them and use them to our best advantage.

"Where are all these people?" you ask, "They're not in my community." It's true that you may not have such an extensive range of practitioners where you live, but chances are that there are more health resources available to you than those which immediately come to mind. How often have you turned to the pharmacist at your corner drug store for advice? Pharmacists undergo extensive medical training and are proficient at distinguishing drugs, understanding drug usages, dosages and side-effects and combinations of medications. But they are rarely asked. When was the last time you called your local chapter of the Lung Association to ask about a respiratory problem, a chemical you breathe in at work or are about to use at home or the effects of second-hand cigarette smoke on you or your child?

A large part of obtaining quality health care lies in knowing what kinds of services are available, where to obtain services and how to make the most of them. This article will offer a look at the range of services and practitioners which might be available to you and offer some tips about what to look for when choosing a practitioner. (Colleen Archer's

Healthwise column, "Assuming Responsibility for Your Child's Health," also in this issue, provides suggestions about how to get the kind of care you want from your child's physician, once you have chosen.)

Looking at the Options

To illustrate the range of resources which might be available, imagine that you experience indigestion, especially during periods of stress. Your choices are many and varied. A nurse practitioner could assess your life style and help you alter the way you handle stress. A nutritionist could examine your diet to suggest general improvements or perhaps the elimination of foods which provoke your indigestion. A physician might offer a muscle relaxant for symptomatic relief, or perhaps tranquilizers to tide you through the time of stress. A massage therapist might work out the tensions in your body through massage. An herbalist might suggest alfalfa and red raspberry leaf tea to ease the stomach pain. You might decide to combine two or more of these approaches in order to relieve the immediate symptoms and at the same time, to learn how to reduce the chance of reoccurrence.

The same kind of situation holds true for someone experiencing an emotional problem. Because few of us living in Canada today have much exposure to death many of us find ourselves traumatized and unable to adjust when faced with the death of a loved one.

When Mary's husband of seventeen years died she became very depressed, quit her job and socialized less. When she consulted her doctor she was put in touch with a helpful and understanding psychiatrist. When Jessie became withdrawn after her daughter's illness and subsequent death, she was not so lucky. Her doctor put her on anti-depressants, which she continued to take for two years until her minister convinced her to join a discussion group run by a pastoral counselling service.

Where would you turn for help if you felt unsure and alone after the death of someone important in your life?

Would you think of calling your local 'Y', a women's resource centre, a gay phone line or a multi-cultural centre to see if any of them sponsored or knew about self-help groups dealing with death and dying? A number of specialized health-related service-associations, such as the Canadian Cancer Society, offer self-help groups for victims of disease or their families.

Another example which illustrates the variety of options open is the situation of a woman who regularly experiences painful periods accompanied by premenstrual tension. She consulted several doctors who told her it was psychosomatic. Their advice varied only slightly — they either told her to take aspirin or prescribed a stronger analgesic. After a move to another town this woman went to a doctor who took the time to explain various psychosomatic and physical theories about dysmenorrhea and premenstrual tension. Together they decided that she would take progesterone to lessen her symptoms.

If she had had access to other resources she might have avoided taking a hormonal treatment. An herbalist could have told her about raspberry leaf or bancha leaf and tamar tea. A nutritionist might have recommended that she take dolomite calcium and decrease her intake of caffeine and sugar during the week before her expected period. She could have gone to a masseuse for lower back massage. A women's health group might have put her in touch with a feminist yoga instructor to learn exercises which relieve menstrual cramping. A different doctor or a nurse-practitioner might have suggested an increase in very ripe bananas or fresh orange juice to help increase potassium levels. A friend might have suggested taking a sauna or having an orgasm to help increase her menstrual flow.

Access to Alternative Resources

So what if you're like the woman with menstrual cramps and you don't know about health resources other than your GP. "How can I find out about all these people?" you ask.

It's quite possible that you may not have access to all these practitioners. Access to health services varies depending upon income, geographical location, language(s) spoken, cultural and personal values and lifestyle, and how articulate or assertive each of us may be. A woman living in Corner Brook doesn't have access to as many health practitioners as someone living in Winnipeg. Someone living in Toronto, Montreal or Vancouver, because of the size and cultural mix of her city, will have a greater variety of health resources from which to choose than will a woman living in Moosonee or Revelstoke.

However, just because you don't live in a large urban centre don't assume that all your doctors are like-minded or that alternatives to consulting a GP don't exist. People in Prince Rupert bring in a Gestalt therapist to lead workshops. For a short time Nova Scotia boasted travelling well-women clinics working out of station wagons.

That new doctor in your town may be just who you're looking for. Conversely, your old family doctor may know more about your medical history, your lifestyle, and your beliefs and s/he may even make housecalls to boot! You may discover that your old neighbour who lives on the next con-



cession and spends all her time in that beautiful herb garden in the summer is a gold-mine of information.

Information Networks

One of your most important sources of information is your circle of friends and acquaintances. If you're looking for a new person or institution to consult about your health, ask around. Find out who your friends consult — ask people at work, people in your dance class or curling club, people you know at school or church. See if the same name or few names keep being mentioned. Ask what your friends like and don't like about the practitioner(s) they use. Ask how long they have been seeing someone they recommend — a friend who has been using the same clinic for eight years has more experience with that clinic than another friend who raves about a clinic after one visit. Ask about the things that are important to you.

Your friends' feelings and anecdotal information may often provide insights about a practitioner which are not available elsewhere. Friends can steer you clear of non-communicative or arrogant practitioners and they can give you leads to explore. But remember that because your best friend simply loves the chiropractor she sees, that person will not necessarily be the best chiropractor for you.

You can also make use of numerous agencies and individuals who can refer you to practitioners. This may be very important if you have just moved to a new community. Find out if there is a local women's centre, a HELP phone line, a community information centre or a family planning service. If these agencies don't have specific information about practitioners, or if they limit their records to just MD's and you're looking for a different kind of practitioner, they should at least be able to direct you to the information you want.

Most United Way or social planning offices publish a listing of social services. Your local Medical Academy, hospital or public health unit should have a list of doctors taking new patients. If there is a wholistic or alternate health association in your area it can probably put you in touch with other

practitioners. Don't forget to talk to the librarians at your public or hospital library — they'll know if a directory of health services has been published in your region and will help you with any national directories which list various associations and/or memberships.

You may have special requirements which you want a practitioner to meet. For instance, it may be important that you see a lesbian doctor, or a therapist who has children, or an herbalist who speaks Spanish. You may have more luck contacting a lesbian organization, parent-child centre or an immigrant women's group than a general agency. Not only are you more likely to find someone who knows about such practitioners, you're also more likely to talk with someone who understands why your criteria are important.

You may need a specialized type of service. For instance, if you're having trouble conceiving you'll want to find out if any gynecologists in town specialize in subfertility. Here your Academy of Medicine or family planning clinic can help out if you don't have an MD. Or you may want help overcoming an addiction. In this case you might want to check out the Addiction Research Foundation, or contact a withdrawal treatment centre. Again, a women's centre may be able to help you assess various practitioners or institutions before you commit yourself to a treatment.

Making Your Choice

"Okay, okay," you say, "I've phoned five places. I've got the names of three chiropractors who sound all right. But I've never been to a chiropractor. I don't have any medical training. How can I judge them?"

Begin by interviewing people. Phone the three, or two, or six people on your short-list. Be sure to ask the receptionist or practitioner if it's a convenient time to talk. If not, explain why you're calling and ask the practitioner to return your call. If s/he doesn't call back it may be because s/he is overly busy, doesn't have the kind of attitude you're seeking or because the office is poorly organized. Whatever the reason, this may be a good indicator that you want to look elsewhere.

Your concern that you don't have any specialized training and can't distinguish an effective treatment from a poor one may be very justified. However, there are a number of standard, simple ways which lay women can use to evaluate any practitioner, no matter what their field of expertise. Training, fees, hours, accessibility to your home or work place, setting, attitudes and beliefs are all important. How important each particular factor is will vary depending on you, your values and your health needs.

Training — Where or with whom did a practitioner train? Is that teacher or teaching facility respected? This may be difficult to check out, but try other health care workers in the same field, or health activists and professional associations if there are any in the practitioner's area of work. Among MD's, affiliation with a teaching hospital may indicate a broad exposure to illnesses and treatments.

How long was the person's training? What percentage was book study and what percentage was practice? Did the practitioner focus on any specialty within her/his field? How does the practitioner keep up-to-date?

Fees — Is the practitioner covered by government medical insurance? If not, you may want to know if that's because s/he opted out or because s/he is not eligible. Canadian health insurance plans are biased in favour of MD's. In spite of the noise raised by some MD's about insufficient fee schedules, MD's' financial position is safe-guarded by the fact that insurance plans include few practitioners with alternate training. This may mean that you can't afford to visit anyone other than an MD, but shop around — you may be pleasantly surprised when you find an acupuncturist with low-income rates or an MD with the acupuncture training you're seeking.

If a practitioner is not in an insurance plan, find out if you have work insurance which will help with fees and under what circumstances. What does the practitioner charge per session? Will a naturopath charge you more if you consult her/him about two or three concerns at once rather than just one problem? Will the fee vary depending on the length of the session? Does a therapist have different rates for individual and group counselling? Does the therapist charge extra if a session runs overtime?

Does a practitioner employ a sliding scale of fees based on income or have special rates for low-income people? You might get a cut-rate if you're a student or senior citizen. Does the practitioner expect payment at the time of your visit or will you be billed? Will s/he accept cheques or credit cards or only cash? Can you arrange to pay in installments? Do you have to pay the full or a partial fee for a visit if you need to cancel?

Hours — What hours does the practitioner keep? Be sure to ask about lunch hours and evening hours, especially if you'll be seeing the person regularly and will have to fit visits around working hours. How can you reach the practitioner at other times? Is s/he receptive to telephone calls about general concerns or only emergencies? Does the practitioner use a 24-hour answering service? How often does s/he check in with the service? Is a back-up practitioner on call when the practitioner is busy or on holidays?

How far in advance do you need to book routine appointments? Can you be fitted in quickly in a crisis or emergency situation? How long are you likely to wait once you get to the practitioner's office? Don't be fooled into thinking that a long



wait means you're seeing the best person in town. It's more likely to indicate poor organizing or a lack of respect for your time.

Setting — Does the practitioner work in a convenient location for you? How long will it take you to get to and from the office? Is the office along a bus line or is there adequate parking? Does the office meet your standards of cleanliness and neatness? Are there interesting and informative reading materials in the waiting room?

Does the practitioner you are considering work in a group practice or alone? Some people feel that practitioners working closely together benefit from frequent information sharing and peer accountability. At some clinics, however, you see whomever is on call — find out if there is some way you can see the same practitioner regularly.

What kinds of records are kept? Will a practitioner be able to refer to your file in a few years and review your general health, specific symptoms and treatments, success or failure of treatments and your concerns? Will the practitioner allow you access to your records? Will s/he forward them to another practitioner upon your request?

Attitudes and Beliefs — Even though you may be consulting someone about problems which you define as purely physical concerns, it will still be important to have some understanding of that person's outlooks. It is unlikely that the two of you will build a relationship of mutual trust if you don't share at least some common beliefs. It is important that a practitioner define health and her/his role in much the same way you do. It is equally important that your practitioner accept your involvement in caring for your health — this means respecting your values, your description of symptoms and your desires or hunches about treatment. Effective health care is a co-operative process between you and the practitioner. It is not enough that s/he dispenses treatment. Rather, to ensure the best results, the treatment should be understood, meaningful and acceptable to you.



"in lay terms? I don't even know any lay terms!"

Although many practitioners strive to be empathetic and non-judgemental, these ideals cannot always be achieved. It may be important, therefore, for you to know a prospective practitioner's views about multiple relationships, lesbianism, divorce, communal living or abortion, depending on your lifestyle or beliefs. You may also want to know specific information about the person you are consulting, especially if you will be doing counselling together — is s/he married, divorced, gay, a parent? Some counsellors believe that this information is not pertinent, or that it may actually interfere with their work with you. You will have to weigh how important it is for you to know these personal characteristics.

Making a Decision

Ask yourself what you learned from the interviews. Weigh the specific information about training, fees and hours with your personal reaction towards each prospective practitioner. Did you trust the person or feel that you could grow to trust her/him? Did the practitioner listen to you? Were your questions respected? Were they answered seriously? Could you raise the questions you had? Did you feel comfortable with the practitioner? Will the practitioner be open to you complementing her/his services by consulting another practitioner or using home remedies when warranted?

There are no hard and fast rules for choosing one practitioner over another. If you've gotten this far you'll probably have a relatively clear sense of which practitioner seems best suited for you. If, in time, you find you're not getting the care you expected then check out your second choice. You'll already have done all the legwork.

Yes, the article assumes that you can combine assertiveness and politeness. And yes, most of us are a long way from being able to walk into a stranger's office and ask all the questions outlined here, especially when that stranger might be antagonistic. You may be lucky enough to hear about practitioners who believe you have the right to make informed decisions about whom you consult and the treatments you receive — they do exist. Chances are, though, that you'll be faced with choosing from among several practitioners, none of whom is wildly enthusiastic about your questions. If so, then figure out which questions are most important to you. Make notes so you won't forget them and just ask those few questions.

Don't be daunted. Your questions and the answers you receive from friends, agencies and practitioners will help you find a practitioner with whom you'll work well. Trust your intuition, review the hard facts you've discovered, and take your time making a decision. The first person you see may seem adequate. Keep shopping — the third person you interview might be splendid!

Connie Clement is the volunteer coordinator at Planned Parenthood — Waterloo Region and is a member of Woman Healthsharing. Many thanks to Allie Lehman.

Taking on Goliath: An Inside Look at Health Planning

Kathleen McDonnell talks with Doreen Hamilton

Through 1978-79 Doreen Hamilton, a public health nurse who was at that time Maternal and Child Health Consultant with the Toronto Public Health Department, sat as a member of the Joint Committee on High-Risk Pregnancy. The committee was a joint effort of the Hospital Council of Metropolitan Toronto and the University Teaching Hospitals Association, and produced a report calling for the establishment of a regionalized perinatal network in Toronto along the lines of a programme now operating in Cleveland, Ohio. The system involves setting up a sophisticated "tertiary care unit" for high-risk births, and universal registration of pregnant women with a central computer bank.

Hamilton argued that the benefits of such a costly scheme were unproven, and that preventive measures had been shown to be effective in reducing pregnancy complications and infant mortality. When her arguments made no impact on the committee, she made the debate public, and eventually resigned her job over the issue. She is now actively involved in organizing a campaign to stop the regionalization scheme. In this interview, she talks with Women Healthsharing member Kathleen McDonnell about her experience of the health planning process.

Women Healthsharing: *Can you tell me why the committee was formed and why you were appointed to it?*

Doreen Hamilton: When I tried to answer that question I could never find out. There's this advisory committee on reproductive medicine that advises Timbrell (Ontario Health Minister Dennis Timbrell) on these matters. I don't know why the Toronto group was formed. It was always rather fuzzy.

WHS: *Are you saying you don't know why this whole separate body was set up when there was already this advisory committee that would have been the logical group to look at something like improving obstetrical services in Metro Toronto?*

DH: It was almost duplicating. It was duplicating.

WHS: *Who were the other people on the committee?*

DH: There was a chief pediatrician, two obstetricians from suburban hospitals, a hospital administrator, a family practitioner and myself. These people were brought in by Dr. Carver, Dr. Harkins and John Aitchison.

WHS: *And who are they?*

DH: Carver is the Chief of the Pediatrics department at the University of Toronto, and Harkins is the head of obstetrics and gynecology at the university. Mr. Aitchison is a trustee of Toronto Western Hospital and president of Bell Northern Software, a firm that produces computer forms. He has a long history in IBM, primarily in New York, I believe.

WHS: *Your perception was that these three took a leadership role, and seemed to be the moving forces behind the committee?*

DH: Yes, my perception is that these three men decided on the Cleveland model before the committee was formed, and then tried to impose their choice on the rest of us.

WHS: *Could you explain the Cleveland model briefly?*

DH: Cleveland has a regionalized perinatal network with computerized records and educational services coming from the specialists in the tertiary care centre down to the other hospitals. I'm very against that. I think that if obstetrical services are run and headed by super-specialists then you get an entirely distorted view of childbirth being filtered down to everybody else. The other thing they have is what they call a "champion" of the network — this \$70,000 a year man, a doctor, who goes around selling the network to the doctors.

WHS: *Trying to encourage them to participate in it?*

DH: Yes, that's right.

WHS: *Participation involves them consenting to register their patients, to fill out these detailed risk-scoring forms and file them with the network?*

DH: Right, they get back the data and use the computerized record for their own medical record. This is the advantage to the physician. They don't keep their own records. They just check off on these forms and then get back a print-out of all the information. This is the motivating factor they use to entice doctors to take part.

WHS: *If the movers of the committee had already decided on this model, then what was the work of the committee supposed to be?*

DH: We were supposed to agree to it. It became very apparent that the input of the people who were not of the "big three" was not being used. I was ignored, because my viewpoint didn't fit. The momentum was all geared up that this was the way it was supposed to happen.

WHS: *Did you go into this with the feeling that this might be a good thing? Or were you skeptical from the beginning?*

DH: I was pretty open-minded when I went, and I was most amazed with the method that was being used to decide things. I looked carefully at all the data that was presented, and at the same time I was reading other stuff. It was a gradual process of realizing that they weren't taking a fair approach, in my view. They weren't looking at it in a problem-solving way. I confronted the chairman with that. I talked about the problem-solving method, which in my view involves defining a problem, and collecting data and analyzing it. Mr. Aitchison said that the way he saw problems was to decide on a solution and then find data that supported it.

WHS: *So you started asking questions. How were your comments dealt with?*

DH: Well, I was insulted by one of the doctors several times. He would say insulting remarks whenever I would say something, implying I didn't know anything. No one else actually did that. The way my remarks were handled by the chairman

was to move on. The secretary never recorded my input. It was as if I didn't exist.

WHS: *So it seemed to you that the way you were dealt with was to ignore you as much as possible?*

DH: Yes. I was seen not to matter.

WHS: *Did that have anything to do with the fact that you weren't a physician?*

DH: Oh, sure, of course. It was a doctor's league, a doctor's fraternity. And I was present, but seen and not heard. And yet, at the end, they would be able to say that the Toronto Health Department was part of the process. There was a lot of in-group talk and a fair amount of anti-woman talk. For instance, once I was talking about the value of prenatal classes. And I overheard one of the doctors chuckling to a couple of others during a break. He just put down the whole idea of prenatal classes, and using husbands as coaches. Saying that the men he'd talked to had been with their wives during labour, and it was the worst experience of their lives.

WHS: *And these are the men who are making our decisions on childbirth?*

DH: Yes, this was from an obstetrician.

WHS: *But you stayed with it. What happened to keep you going, to the decision to actually go public with a minority report? That was quite a step to take.*

DH: Initially I thought, I must be wrong, I must be crazy. I shared their view that I was just a nurse. But then there was a meeting to which all the obstetricians and gynecologists in the city were invited, and Mr. Aitchison presented it to them. That was when my eyes were opened, because, golly, there was so much opposition from the doctors. And then I observed that even that opposition didn't matter either, it was the big march coming through. I could see how people were feeling powerless — that regionalization was going to happen, and we might as well face it. But I was consulting with some friends of mine privately, and one suggested a minority report and really encouraged me to do it. I didn't have enough nerve, myself, to do it. But this person brought it down to the ethics of the situation.

WHS: *That it was almost your professional duty to do something?*

DH: Oh, yes. His point of view was that health planning should not be done like this, and I agreed. But he said it with such force that I just knew I had the responsibility to do it. So then I wrote it and delivered the minority report to the Board.

WHS: *What sort of support did you get from the Department of Public Health? What was the feeling about what you did?*

DH: As far as supervisors were concerned, it was as if I hadn't done anything. It was all hushed up. I had to go over their heads and take it to the Board of Health myself, because I knew they would never approve it.

WHS: *Did you go to them and say, I have evidence that this regionalization scheme is not the best thing?*

DH: Oh, I had been telling them all the way along. But they weren't willing to think about it seriously. Their approach has always been to go along with the doctors.

WHS: *And they expected you to do the same, to basically go along with what the committee was doing, even though you didn't agree with it?*

DH: Sure.

WHS: *So you did get some support from some of your colleagues but officially what you were doing didn't really exist.*

DH: Yes. This was when I really took a risk. When I first went to the Board of Health, I was breaking all the rules, and I wasn't sure what they were going to do with it. But I was really pleased to see that they said, we think you're right.

WHS: *What was the response at the committee itself? Did you tell them in advance that you were doing this?*

DH: I told them that I didn't agree with what they were doing, and that I thought it should be put into public debate. And I walked out, and told them I was going to make it a public debate.

WHS: *After your presentation to the Board, did you keep going to committee meetings?*

DH: Oh, yes, I kept going. But now I was outcast by them too. Then we moved into the Phase II report, and they wrote in the preamble to it quite a lot of preventive stuff. That I saw as throwing me, I don't know what . . . a bone, in order to keep me quiet. But I'd never got a final look at what was decided until October 1, when the budget was published.



Kathleen McDonnell

Photo: Jane Eden

WHS: *Nobody on the committee had seen a budget up until then?*

DH: No. It was all done outside. Then I looked at the budget and saw this one percent. . . . They had put in one nutritionist, two public health nurses and one social worker to do preventive work for all of Metro Toronto. And I just thought, shit, this is not good enough — \$79,000 out of \$6 million. I didn't know what to do then. I was just reeling, knowing this was happening and not being able to stop it. So I took a month's leave of absence. And at that time I decided I didn't want to work for the Department of Public Health, because when my superiors had to choose between public health and going along with the medical establishment, they chose going along with the medical establishment. So I quit. It was after that, when I was out of the situation, that I realized once again that I should speak out. So I went to the chairman of the Board of Health and told him I wanted to present another brief on this subject.

WHS: So what has happened since? Is regionalization going ahead?

DH: No, that's the extraordinary thing about what's happened. They talked to Timbrell and got the nod — they were assured of funding. But because of the public opinion that was generated by my quitting my job, and the number of letters that Timbrell has received from people — there were women, particularly, who were concerned — what has happened is that Timbrell has decided to delay his decision about the whole matter, until this new task force I've been appointed to has a chance to put together a document on the cost of providing preventive services.

WHS: This task force — how did that come about?

DH: It was set up by order of the Board of Health, and is an interdisciplinary group. We said, how can we improve perinatal mortality and morbidity? And we're looking at all the evidence. And then we're going to say what kind of programme can be suggested in view of the available data.



Photo: Jane Eden

Doreen Hamilton

WHS: So at this point it's not clear what the result will be. You've managed to slow things down, that's clear.

DH: There will be a public forum in April, and Timbrell has said he wants to meet with me after that. I think that's extraordinary. I've also been getting calls from prominent physicians, they want to talk to me, and I say okay. But it's a riot, because I've gone from being the little nurse who didn't know anything to everybody wants my ear all of a sudden. I'm fascinated with the process.

WHS: Was it ever raised at the Joint Committee that there should be consumer involvement?

DH: No, it was totally out of the question. They wouldn't even consider it. But now I think we've broken the whole thing. There was this thrust, and now I think it's completely dispersed. It just shows you how much politicians, who have the actual decision to make in the end, are influenced by public opinion. It just shows that if consumers organize they can get the health care they want.

WHS: Let's talk a bit about the forces on the other side. Who wants this regionalization scheme, and why? Did the corporate interests on the Joint Committee have anything to do with this?

DH: I don't have any proof about corporate interests, but I just feel categorically that business people shouldn't have any part in health planning, period. There is this assumption that if technology improves childbirth, then we want more and more technology. And it isn't just happening in obstetrics. All health care has gone super-wild. It's a time of soaring health costs, and the health of people is not being improved. What's going on? We have to get into a more preventative, wholistic approach.

WHS: What about the role of hospital rivalries and status in setting priorities and making decisions on the Joint Committee?

DH: There's a phrase that's been coined — "hospital imperialism." I was able to observe on this committee the university teaching hospitals making everyone else feel like they were second-grade, and the other hospitals resenting this very much.

WHS: And was this a focus for it because it involved high-status, high-technology? For instance, that the hospital that would get this tertiary care unit would rise in status?

DH: Oh yes. That's why it was such a dynamite issue, because everybody wanted it, it's so glamorous. That's our current value system. Whoever gets the high-tech is the big gun.

WHS: Was there also some fear that certain hospitals would lose the more high-risk cases? That they'd be sent to the larger hospitals?

DH: Yes. The way it was expressed was, "we don't want to be just midwives." In other words, they didn't want to just deal with normal pregnancies, because that was too dull. The other cases were more "interesting" and they didn't want to lose them to the downtown hospitals.

WHS: Would you say you were radicalized by this whole process?

DH: Yes, I was radicalized during it by people who were supporting me privately. There were certain key people who made me feel that the ethics of this were very important. Without that kind of help I would never have done it. I've learned the power of personal conviction. I feel this optimism about social change. If we really get our acts together, our political system is set up that honest, conscientious work on behalf of citizens does influence politicians.

WHS: Has it changed your ideas about the health system in any fundamental way? Did you think before this experience that health planning and decision-making were done in a "rational" manner that was in the best interests of the public and all that?

DH: Yes, sure. Now I don't say that all health planning has been done in this way. But it's obvious that we are getting away from patient-centred care. I feel we have to get back to the attitude that what the patient receives is the key thing. We're into an era where we have to get into preventive and wholistic health, and I believe that so long as doctors are in charge of health departments that they won't be able to do it. Because you can't run an innovative, creative system with people who are rigidly sticking to the medical model, traditional hierarchies and traditional public health thinking. Consumers are way ahead of the medical and nursing professions on this. There's a revolution under way. And I'm part of it.

Reviews

Working for Your Life

by Mary Morison

Over the past twenty years women's participation in the labour force has almost doubled. This increase has had a profound influence on women and their roles in society, on the organization of work, and on the concerns of workers and governments.

At the same time there has been an increasing awareness of occupational health hazards in the workplace. In 1979, the Labour Occupational Health Project in California released *Working for Your Life*, a film about occupational health and women. *Working for Your Life* is a colour film, an hour in length. Women doing a wide variety of both traditional and non-traditional jobs talk about their work, the problems they face and the strategies they are adopting to change their working conditions.

A waitress complains of fatigue, rush periods. So too does a bus driver. A woman in a pie factory tells of the injury she suffered when her hand was caught in a machine. She describes the profound effect this has had, not only on her work and on her ability to do the housework, but also on her self-image.

Throughout the film women talk about their lack of information about the hazards they face. An electronics worker: "I don't know what this is; I have only been here a week." A lead smelter worker: "I didn't know I was 'leaded' until they moved me out of the lead area." In some cases the illnesses themselves are not identified. A male worker at a shoe factory where women were taken to hospital suffering from "hysteria": "Would they have called it mass hysteria if men had been passing out?"

But the film also raises issues which arise from the particular concerns of women in the workplace.

1. Women do different work than men and therefore the hazards they face may be different.
2. Women work a double day and therefore face the dual responsibilities and stress of home and work.
3. Jobs done by women have been thought of as "safe" and therefore never studied for hazards.
4. Most studies of occupational health have been of "men's work" and where women were present they were excluded by study design.
5. Until recently women workers have been largely unorganized and unable to press for changes in a collective way.
6. Health and safety "concerns" have been used to discriminate against women applying for non-traditional jobs. (Companies have refused to hire fertile women to

work with lead, for example, arguing that lead may harm the fetus.)

7. The same "concern" for the fetus has not been demonstrated where women form the majority of workers, among radiation technicians or operating room personnel, for example.

Working for Your Life is an important film. It examines some key issues in occupational health and safety, and it looks at the particular hazards faced by women workers. Most other health and safety materials focus only on industrial work.

It is flawed, however. The film often loses coherence as it jumps from workplace to workplace, leaving the development of themes to the viewer. It is also too long. This limits its usefulness in educational settings, for it leaves little time for discussion of the issues raised and the workplaces examined. Finally, the film, in assuming a level of awareness of toxic substances and their effects which many workers do not have, leaves questions of content unanswered. One viewer asked me: "Why should that worker be worried about working with lead for thirty-five years?"

This is not to say that the film won't be useful or shouldn't be used. It is only to express regret that such an important subject is not done complete justice.

Working for your Life is a 57 minute colour documentary film. It can be borrowed from the Ontario Federation of Labour, Occupational Health and Safety Training Project, 15 Gervais Drive, Suite 703, Don Mills, Ontario M3C 1Y8. It can be purchased from LOHP Films, University of California, Centre for Labour Research and Education, 2521 Channing Way, Berkeley, CA, USA 94720.

Mary Morison is a researcher and instructor with the Ontario Federation of Labour Occupational Health and Safety Programme.

Working Paper on Sterilization

by Diana Majury

Coercive sterilization has become a contentious issue in North America over the past decade. Although it has been a less visible issue in Canada than in the United States, there is evidence that significant numbers of women (and fewer men) have been and are being sterilized without their full and informed consent in this country.

In an attempt to come to grips with this question, the Law Reform Commission of Canada recently published its Working Paper on Sterilization. Unfortunately, a serious weakness is apparent in the Commission's approach at the very start. For although the paper purports to deal principally with "non-consensual" sterilization, it deals almost exclusively with the sterilization of women and men with "mental handicaps," a term used to include both mentally retarded and mentally ill persons.

This equation between non-consensual sterilization and the mentally handicapped ignores the fact that such involuntary procedures are not restricted to persons with mental handicaps. The Paper recognizes that the mentally handicapped are particularly susceptible to coercion, but does not acknowledge that there are other groups, including low income, immigrant and native women, who are also frequently coerced into unwanted sterilization.

The first chapters deal with the problems inherent in attempting to classify a person as "mentally handicapped" and the denial of civil liberties which often stems from such a classification. Throughout the Paper the Commission rejects this classification as sufficient grounds for the imposition of sterilization.

The Paper also outlines the various positions advanced for and against non-consensual sterilization and examines the social, bio-medical and moral arguments used to support each position. However, most of these arguments are presented without any critical analysis and one is left, at the end of the Paper, wondering on which arguments and theories the Commission based its conclusions and recommendations.

The Commission concludes that "benefit to the individual" is the only legitimate reason for the state to intervene "in the procreative ability of the mentally handicapped," thus "protecting a person judged incapable of protecting himself." The Commission proposes establishing Sterilization Authorization Boards with the power to order the sterilization of mentally handicapped persons incapable of giving valid consent or under sixteen years of age. Minimum criteria, and the inapplicability of other methods of birth control, must be established before sterilization can be authorized.

The Board is to evaluate the benefits to the "patient" and determine if there is "a compelling interest to justify the operation." However, the Commission does not define "compelling interest." The phrase is fraught with potential for arbitrariness and discrimination.

The Commission is aware of the potential for discrimination against women, ethnic groups, low income and institutionalized persons inherent in compulsory sterilization. As a solution they recommend that an independent external evaluation of the Sterilization Authorization Boards be carried out every two years by human rights commissions (noted at present only for their ineffectiveness).

The Commission also recognizes the possibility of abuse and coercion in supposedly "consensual" sterilizations of mentally handicapped persons, a group particularly vulnerable to coercion by doctors, parents and officials in mental hospitals and welfare agencies. Accordingly, they recommend that hearings be held to determine the person's capacity to consent to the operation in cases where the individual may be especially susceptible to coercion, or when the request for sterilization is presumed to have come from a third party.

The Royal Commission states clearly that the classification of a person as mentally handicapped is never a sufficient ground in and of itself to require that person to undergo sterilization. However, despite the powerful arguments which they outline against non-consensual sterilization, they are unwilling to take the next step and say that under no circumstances does the state have the right to require that a non-consenting person be sterilized.

Before writing its final report for submission to Parliament, the Commission is seeking comments from the public on this Working Paper. It is critical that we respond. The Paper is available in French and English, free of charge, from the Law Reform Commission of Canada, 130 Albert Street, 7th Floor, Ottawa, Ontario K1A 0L6.

Diana Majury is a lawyer working in Windsor and is a member of Women Healthsharing.

Resources & Events

The New Women's Health Handbook, edited by Nancy MacKeith

This is a simple guide to self-help medicine for women, covering all aspects of women's health, including nutrition, childbirth, cancer, emotional problems, drugs and contraception.

To order, contact Women's Press, Suite 313, 280 Bloor St. W., Toronto, Ontario M5S 1W1. \$5.95 per copy.

Health Alert, Health and Safety Newsletter of the Labour Council of Metropolitan Toronto.

The January, 1980 (Vol. 4 No. 1) issue of *Health Alert* focuses on radiation and the workplace.

To obtain, contact the Labour Council of Metro Toronto, 15 Gervais Drive, Suite 407, Don Mills, Ontario M3C 1Y4. Free.

Continued . . .

Women Healthsharing
Box 230, Station 'M'
Toronto, Ontario M6S 4T3

Cuban Health and Safety Study Tour

A trip designed for trade unionists and others interested in occupational health and safety is planned to Cuba from April 7 - 21, 1980. The itinerary involves visiting a variety of workplaces and meeting with Cuban trade unionists and management at the work sites. There also will be time for fun and frolic. The cost of the tour, including three meals a day, airfare, taxes, transfers and hotel accommodation, is \$850.00 (double occupancy).

For further information, contact Gary Cwitco, Occupational Health and Safety Project, Centre for Labour Studies, Humber College, 201 Humber College Blvd., Rexdale, Ontario M6W 5L7.

The Female Athlete: A North American conference

A conference about women in sports and recreation is being held in Vancouver from March 21 - 23, 1980. The conference is for recreation specialists, physical educators, coaches, health professionals, sports administrators and all women who participate in physical activity at the recreational level.

For more information write to Continuing Studies, Simon Fraser University, Burnaby, British Columbia V5A 1S6, (1-604-291-4565).

Concerned About Nuclear Power?

April 26 is the date set for rallies and marches across Canada and the U.S. to demonstrate people's concern about nuclear power. Events are still being organized throughout the country.

To find out more about events in your area, or to help

organize a demonstration, contact your nearest anti-nuclear group. Some provinces now have province-wide coalitions with offices in major cities which might be able to direct you to other activists.

In a Nutshell, Newsletter of the Mental Patients Association

The September 1979 issue of the newsletter focuses on Electro-Convulsive Therapy (E.C.T.) and describes the investigation into shock treatment done by the Association. Other articles question the effectiveness of E.C.T. and describe alternatives.

To order, write the Mental Patients Association, 2146 Yew St., Vancouver, British Columbia V6K 3G7.

Free Posters

Facts about women and addiction are graphically illustrated in three colour posters. The subjects of the posters are: Women and Minor Tranquilizers, Women and Stress, and Women and Alcohol. They are available in French and English.

To order, write Quality of Life Resource Directions, 2466 Dundas St. W., Toronto, Ontario M6P 1W9. Send \$.50 to cover postage.

Additive Alert, by Linda R. Pim

This handbook outlines types of food additives, indicates some additives which may be unsafe, unravels the complex web of food additive laws in Canada

Available from Pollution Probe Foundation, 43 Queens Park Cres. E., Toronto, Ontario M5S 2C3. \$2.95 per copy.