Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

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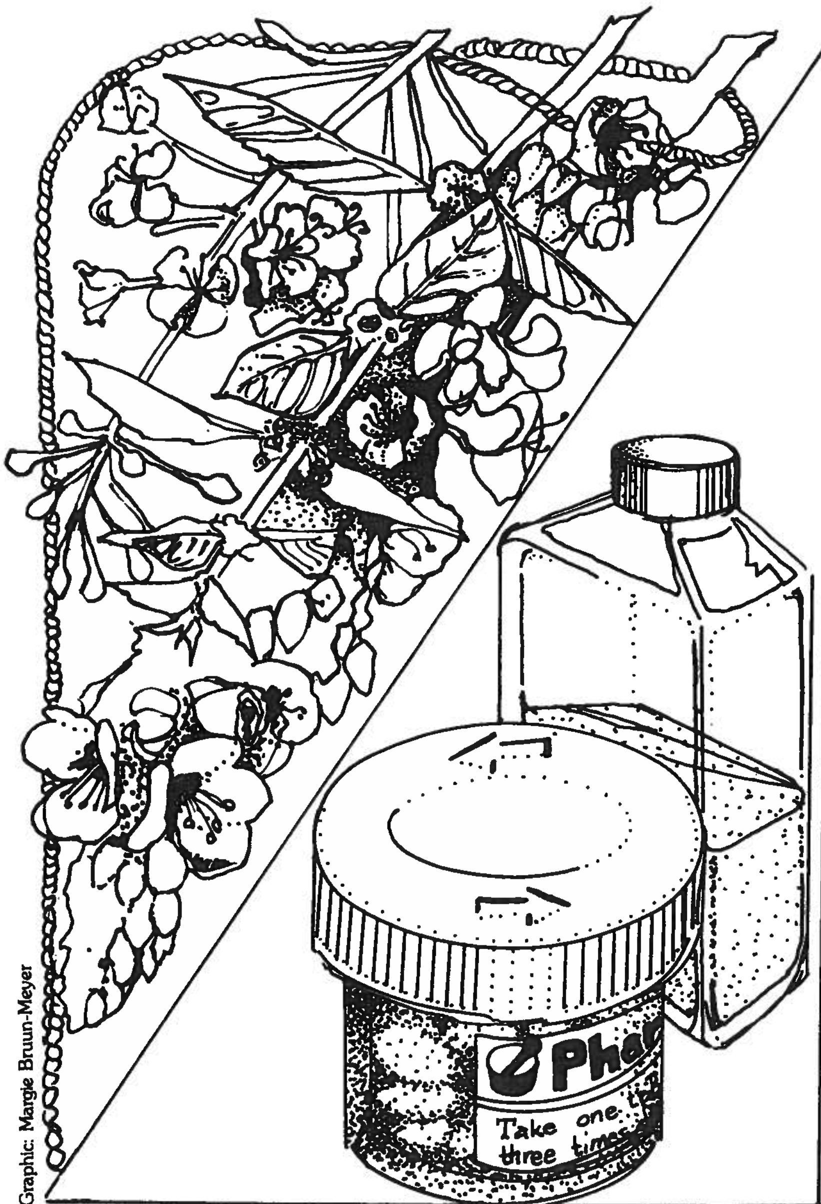

Graphic: Margie Bruun-Meyer

Collective Notes 2

In Brief

Health Wanted 3
Newsfronts 4

Columns

Healthwise 7
My Story, Our Story 9

Letters 8

Features

Undoing Medical Conditioning 10
Double Exposure: The Fight Against Reproductive Hazards in the Workplace 13

Reviews

The Canadian Patient's Book of Rights 18
Barriers Between Women 18

Resources 19

Collective Notes

Shortly before the last issue was published a friend told Jennifer that *Healthsharing* was very biased in favour of allopathy (the prevalent approach to medicine today). Her comment brought a number of long-held concerns into focus for us. We were in part surprised because we are highly critical of the present health system. At the same time it was a comment which we had been expecting because of our conditioning towards medicine.

Constantly as we struggle with women's health issues we confront our contradictory distrust of and reliance upon scientific methods. It is as if we hold a coin in our hands either heads up or tails up, but never manage to see both faces at once.

The fact that other women health activists are also grappling with these struggles is sharply evident in *Undoing Medical Conditioning,* the article by Melanie Conn and Rebecca Fox in this issue, which sheds light on the pervasive conditioning which leads us to accept science as truth and medical practices as immutable.

In the collective we have come to understand that the scientific method as we know it is based on a very specific way of looking at the world. Scientific method places heavy emphasis on our western assumption that the world can be understood as a series of events. We accordingly have a science which is based on a linear, cause-effect model. Because we can accept that water (A) when heated (A + B) boils (A + B = C), we also expect to take cancer as an event and find a single cause for it, or at the very least to find a unifying theory to connect a number of causes.

Our individual experiences have also lead us to realize, in varying degrees, that other cultures have quite different ways of looking at the world. Some of these other world-views focus on the simultaneity of events and look at history as a constant process of interaction. From this perspective every action plays some part in every other action and a cause-effect approach no longer makes any sense.

Stemming out of different world views are many divergent approaches to health. It is clear that some approaches are endorsed by the medical establishment while other approaches are granted no respect. Women Healthsharing assumes that valuable information exists both in the teachings which are accepted and those which are spurned.

We *feel* the need for *some* method to distinguish valuable information from valueless information, to distinguish clearly biased reporting from a relatively unbiased study. To do this we invariably find ourselves falling back on the scientific method.

But as soon as we do so, we limit ourselves. We frequently cannot evaluate health practices based on a different world view by using the scientific criteria with which we are familiar. We are therefore caught in limbo — either we establish new criteria or we accept statements made by alternative health workers with little or no assessment.

Since most of us in Women Healthsharing are sceptics by nature we do not trust something simply because it is an alternative, a turning away from something with which we are dissatisfied. We want to know that an alternative will be better in some way than the present situation. An alternative could just as easily be another version of something already known or it could even create a worse situation. We want to know the ramifications of each choice *before* we choose.

Thus arises our current dilemma. We find much of so-called acceptable medicine to be unacceptable; we want to be open to other approaches to health care, and yet we don't know how to judge other approaches. How do we begin to analyse the usefulness, as the Vancouver Women's Health Collective is attempting to do, of visualization therapy? How do we evaluate regression therapy, colour healing or faith healing, or even the more acceptable uses of acupuncture

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Special thanks go to Betty Burcher, Harriet Rosenberg and Rhonda Love for their help in putting together this issue. Thanks also to friends at Dumont, especially Moe Lyons for coordinating this issue and a special bouquet to Alison Stirling, for interrupting her holidays (again). Cover illustration by Margie Bruun-Meyer.

and herbal remedies? By using old criteria to assess new ideas we may be inhibiting our understanding and we risk preserving the status quo at a time when change is warranted.

Within collective discussions and our personal lives we range far afield; within the pages of *Healthsharing* we have stayed near the mainstream. Birthing rooms, choosing a practitioner and maternity benefits can hardly be called radical. Because we have experience and understanding of these aspects of health care we trust our ability to assess articles about such topics. We are comfortable in the critical role we have adopted and find it difficult to branch beyond this role in the magazine.

Within collective discussions and personal lives, however, our differences and struggles to expand are more evident. Each of us brings to our discussions slightly different backgrounds, politics and concerns. When discussing health treatments we have different expectations, use different criteria and may or may not demand some type of proof of a certain treatment's efficacy. Some of us are in excellent physical condition and some of us do embarrassingly little exercise; one of us has successfully curbed rheumatoid arthritis with diet; one of us just gave birth at home and some of us gave birth in hospital; our diets vary greatly; all of us, more often or less often, use some mainstream treatments.

When Women Healthsharing first came together as a collective we shared the dream of providing a kind of health information-sharing not then available to Canadian women. We agreed that our publication would not be scientific, that it would instead be a forum for exchange of news and experiences, not just more fact. Yet we are pushed into a quasi-scientific role by our own sense of responsibility toward the printed word and toward our readers. So while we don't always require scientific backing before trying out a treatment ourselves, we do require some scientific credibility for items we print in the magazine.

To begin to resolve this dilemma we are instituting two new items in *Healthsharing*. One, a column entitled *My Story, Our Story*, is introduced in this issue. *My Story, Our Story* is for you, the reader, to share your personal experience with other readers. It is a space in *Healthsharing* which will exist free of any scientific judgement, a space which will allow all of us to relate our frustrations, our joyous stories, our horror stories and our experimentation.

The second way in which we are attempting to come to grips with our biases and our inability to open doors as wide as we would like is with a series of articles entitled *Alternatives to Allopathy*. The series will kick off Volume II by examining the allopathic approach to healing and some of the existing alternatives to it.

Today our experiences jar with what we are told, our experiences conflict with theory. Rather than negating our experience, women need to build new theories, new attitudes, new beliefs and new practices.

One way to begin is to share — share your experiences, your concerns and your struggles. Let us know what issues you want addressed in the *Alternatives to Allopathy* series, what articles you might write, whether our struggle within the collective relates to your struggle.

Health Wanted

If you are having a specific health problem and aren't coming up with a solution or if you are researching a topic, write to Health Wanted c/o Women Healthsharing. We will print your request in Health Wanted so that readers can respond directly to you. Be sure to include a complete mailing address.

Alternative Treatments

The Vancouver Women's Health Collective is gathering information from women who are using herbs, nutrition, visualization, or other treatments. The collective is finding that these individual "case histories" detailing the healing process are very useful to consult in making choices about treatment. Please send information to Vancouver Women's Health Collective, 1501 West Broadway, Vancouver, B.C. V6J 1W6.

Tampon Problems

I'm looking for hard information on health problems related to using tampons. In particular, I need data on past and present ingredients including talc, asbestos, deodorants, perfumes, anti-coagulants, etc. Research or case histories on infections and toxic shock syndrome are welcome. Write to Jennifer Penney, 85 Galley Avenue, Toronto, Ontario M6R 1H2.

Pelvic Inflammatory Disease

One of our readers has been bed-ridden with chronic pelvic inflammatory disease (PID) for eight months. She has tried antibiotics, bedrest, surgery, (which removed adhesions) and some herbs without success. She is looking for information on alternative treatments for PID and would like to hear from other women who have recovered from PID. Please write to Maureen Moore, 4323 West 14th Avenue, Vancouver, B.C. V6R 2X9.

Obscene Phone Calls

As a former victim of obscene calls, I am collecting information for a major article. If you have been victimized please share your experience with me. Tell me how you felt, why you think you were singled out for this treatment, whatyou tried to do, the response of the telephone company or police. Please indicate if you may be quoted or prefer anonymity and confidentiality. Write to Jennifer Penney, 85 Galley Avenue, Toronto, Ontario M6R 1H2.

Newsfronts

Tampons and Toxic Shock Syndrome

A mysterious and sometimes fatal new disease that strikes young women has been linked in virtually all cases to the victims' use of tampons, according to a study released by the U.S. Federal Centre for Disease Control in Atlanta, Georgia.

Since September 1978 there have been over 130 reported cases, 10 of them fatal. All but three of the victims were women, including the 10 fatalities.

All the women victims used tampons, in contrast to a control group without the disease, which included a significant number of non-users of tampons. The relationship between tampons and the disease is not understood.

In most cases symptoms occur within 5 days of onset of menstruation. They include fever, vomiting and diarrhea, sometimes with a headache, sore throat and aching muscles.

Within the next two days, the victims go into shock — their blood pressure falls to dangerously low levels, often producing kidney failure and disorientation. They develop a patchy red rash that can result in peeling of the skin from hands and feet.

Some women have had recurring bouts of toxic shock syndrome, often in consecutive menstrual cycles.

Previously considered rare, the disease has been reported more frequently as descriptions have been circulated to doctors.

Menopausal Depression Debunked

A review of studies and data on outpatients under treatment for depression suggests that there is no increased incidence of depression in the menopausal years, and that depressions occurring at this time do not have a distinct pattern.

This conclusion is in opposition to the present belief of most doctors that menopause increases the risk of depression. Depressions at this time are supposed to be distinct from other types, and are termed "involuntary melancholia" in medical texts.

M.M. Weissman reported in Volume 242, (1979), of the *Journal of the American Medical Association* (JAMA) that there was no increase in mental disorders during menopause. In fact, a Swedish study found that mental problems peaked at ages 35 to 44 and then declined.

The Yale University Depression Research Unit found no increase in insomnia, anxiety, delusions or somatization (need to sleep) in depressed women in the menopausal years compared to the premenopausal (under 45) or postmenopausal (over 55).

The evidence supports a debunking of the menopausal depression myth among doctors and women in general.

Investigation of Ontario College

The Ontario government is investigating the response of the Ontario College of Physicians and Surgeons to complaints made by patients following the conviction of an Ottawa doctor for indecent assault. A woman assaulted by Dr. Robert Bruce de Mercado in September 1978 had complained to the college. Her complaint was ruled unfounded after the college talked with the doctor.

De Mercado pleaded guilty to police charges, however, and was convicted in May. He was placed on three years' probation and barred from practising medicine for that period. The general practitioner was also ordered to abstain from drugs not prescribed for him, to seek psychiatric treatment and perform 100 hours of community service.

Smoking Nurses Are Poor Role Models

Nurses smoke more than other health professionals, according to an article produced for the World Health Organization's *World Health Day,* the theme of which was "Smoking or Health: The Choice Is Yours".

The author of the article, Sir George Godber, cited a recent British study which showed that only a fifth of physicians and a third of teachers and midwives smoke, but fully half of nurses are smokers.

"The fact that nurses smoke as much as others in their age groups, and not at the lower rate of other health professionals, is particularly worrying," says Godber.

Nutritional Defences Against Coronary Heart Disease

Foods as divergent as walnuts and Chinese "tree ears" have recently been reported as protection against heart disease.

Two Dutch scientists, Drs. Foppe ten Hoor and Gootenbos, spoke to a seminar organized by the University of Toronto's department of nutrition and food sciences in May. They argued that linoleic acid, found in significant amounts in breast milk, safflower, cottonseed and soybean oils, walnuts, almonds and sunflower seeds, improves heart function, lowers blood pressure and reduces the tendency of blood to clot.

Finnish studies of institutionalized patients showed that when linoleic acid was increased from 4 to 12 percent of the diet, clotting time was increased, even on a diet high in dairy products and other animal fats.

When rats with high blood pressure induced by salt in their drinking water were given large amounts of sunflower seed oil, their blood pressure dropped. The rats also showed better heart rate and pumping action on sunflower seed oil than coconut oil (which contains only 2 percent linoleic acid).

Another researcher, Dr. Dale Hammerschmidt of the University of Minnesota Medical School, has reported the protective effects of tree ears, a black tree fungus used in Chinese cooking. In the *New England Journal of Medicine,*

Hammerschmidt described the results of blood tests he conducted on individuals who had recently eaten the food. He discovered that their blood was very slow to clot.

In Chinese folklore, tree ears have long been viewed as a health food that increases potency and contributes to long life. Coronary artery disease in China is uncommon, particularly in the Southern provinces, and Hammerschmidt speculates that tree ears contribute to this low incidence.

Women's Health Conference in Nova Scotia

The Women's Health Education Network (WHEN) in Nova Scotia hosted its first conference this spring. Deborah Kaetz, one of the conference organizers, said that WHEN was very pleased about the conference attendance.

Issues discussed during the meeting included the inconsistent quality of sex education across the province, funding problems of Byrony House (the only home for battered women in Nova Scotia), and the need for consumer representation on the planning board of the new Camp Hill Medical Complex in Halifax. WHEN also decided to undertake a study on the popular Well Women's Clinics which are presently being given all across the province.

A Suspicious Contracep

A new contraceptive — Contracep-1 — has made an appearance across Canada this summer. Contracep-1 is a foaming suppository, touted as a safe alternative to pills or IUD's. The manufacturer claims a 96-98 percent effectiveness rate. George Scholes, a director of the company, says that the product was tested in government-controlled brothels in Mexico.

Contracep-1 is similar to a contraceptive called Encare-Oval, presently distributed in the U.S. Contracep-1, however, contains less of the same spermicide (Nonoxynol 9) used in the Encare-Oval — 100 milligrams compared with 125 milligrams. This is particularly disturbing in light of the agreement by manufacturers of Encare-Oval (in an out-of-court settlement with the U.S. Federal Trade Commission) to stop advertising their product as an effective alternative to birth control pills or intrauterine devices. Instead they will be required to state that Encare-Oval is about as effective as vaginal foam, that some women and men may experience irritation from its use and that women "who have been told by their doctor not to get pregnant" should consult a doctor about contraception.

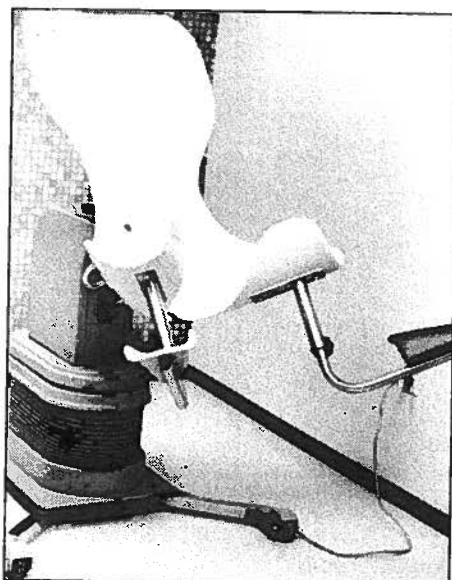
Planned Parenthood counsellors have expressed scepticism about Contracep-1. They suggest that Contracep-1 should be used only in conjunction with another birth control method such as condoms. Diaphragm users must still use contraceptive jellies.

Birthing Chairs

An alternative to giving birth on hard operating tables, a birthing chair, is now being distributed in Canada. The Birth EZ Birthing Chair is modelled on chairs used in medieval times. It allows women to sit upright and provides support for their legs and back.

Research shows that the sitting position has many physiological advantages over the lithotomy position currently favoured by doctors. These include shorter labours with less pain, fewer episiotomies, and enlarged pelvic measurements. This position allows the force of gravity to assist in labour and delivery.

The price? A mere $6,285.00. No midwife should be without one.



Birth EZ Birthing Chair

Psychiatrists for ERA Force New Orleans Boycott

A group of women psychiatrists within the American Psychiatric Association (APA) recently forced that organization to cancel plans to hold its 1981 annual convention in Louisiana, because of the state's failure to ratify the Equal Rights Amendment (ERA).

The group, called Psychiatrists for the ERA, put considerable pressure on the board of trustees to change its mind. Tactics included a threat to publicize the names of APA members who attended the New Orleans conference in *Ms.* magazine.

Dr. Jean Shinoda Bolen also told the trustees that if they went ahead with the New Orleans meeting, all members would be urged to stay away.

The women who won the change were jubilant over the victory after a number of years of struggle within what they describe as a Freudian- and patriarchal-dominated organization.

If You've Thought About Breast Cancer

Women scheduled for breast biopsies should make sure their surgeons have made arrangements to have an estrogen-assay receptor test performed in the event the diagnosis is cancer.

The receptor assay measures a cancer tumour's estrogen dependency. Since 1966 it has been known that there are different types of breast cancer which could be distinguished by their dependency on estrogen. That is the tumour is "fed" by estrogen thereby increasing the size and speed of growth. About one third of breast cancers are strongly estrogen dependent. The assay acts as a guide to selection of therapy and prevents unnecessary surgery. For example, removing a person's ovaries (which produce most estrogen) would only be helpful if the tumour was estrogen dependent.

Dr. Macbeth, Executive Vice-President of the Canadian Cancer Society, says the test is becoming standard procedure and should be done on all people having tissue removed.

Unfortunately at present the test is expensive, time consuming and requires special equipment and personnel.

Breakthroughs in techniques may change this, making the test available to smaller hospitals within the year.

Recently the Ontario government has started paying for these tests to be done. In the past it has been paid for in a variety of ways — by the woman, her doctor or various research grants.

Alternatives for Diabetics

Coccinia indica, a wild creeper used as a vegetable in Bengali, may soon be part of the treatment for maturity-onset diabetes. A study by Khan *et al,* reported in Volume 280, (1980), of the *British Medical Journal,* described an increased glucose tolerance in people receiving *C. indica* tablets as opposed to those receiving placebos. At present, maturity-onset diabetes is treated by diet, exercise and oral medication such as diabinese or tolbutamide.

Feminist Media Conference — Good News and Bad

Women from two dozen publications attended the National Feminist Print Media Conference held in Ottawa June 26-29. Two representatives from *Healthsharing* took part.

Conference attenders learned the sad news that *Branching Out* and *Upstream*, both of which have carried major articles about women's health, are ceasing production. Their absence will be sorely felt by the women's health movement.

On the positive side, the conference provided a forum for extensive brainstorming and information sharing about such basics as collective process, advertising, design and investigative reporting.

Our Apology:

*** to Sylvia Macuinas, whose photograph of Leslie Storozuk we used in the last issue of *Healthsharing*. We neglected to credit the photo.**

HEALTH ACTION

A Conference on Health and Women

October 4 & 5, 1980 Edmonton, Alberta

This conference will examine the role women play as consumers and influencers of health in the family and community. It will analyze the health care system and identify where changes are needed. It is hoped that the conference will create a working relationship among people concerned about issues affecting women's health.

WORKSHOPS

* The Philosophy of Self-Care * Women's Mental Health * Health Issues in Female Sexuality * Women's Health and Women's Work * Physical Activity

SPEAKERS

* Barbara Ehrenreich (co-author of *For Her Own Good, 150 Years of Experts' Advice to Women, Witches, Midwives and Nurses,* and *Complaints and Disorders*) * Judy Norsigian (of the U.S. National Women's Health Network and the Boston Women's Health Collective) * Shirley Wheatley (nurse practitioner) * and many more

For more information write to: *Doreen Shore, c/o AADAC Community Extension Services, #406 Boardwalk, 10310 - 102 Avenue, Edmonton, Alberta, T5J 2X6.*

Or phone: *Linda Rasmussen (403) 477-7958 or Ellen Seaman (403) 455-4664.*

Registration Deadline, September 19: Fee, $30.00

canadian **$1.50**

DIMENSION

WHERE ARE THE SOCIALISTS?

They're leading the struggles within the trade unions, the schools, the churches, the women's movement, the farm movement, the ecology movement, and the native peoples' movement; among writers, artists, poets, publishers and athletes.

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Healthwise

Tofu? No Foolin'

by Kathleen McDonnell

You've probably seen it swimming around in tubs of water at your local Chinese shop or health food store. You may even have been so daring as to purchase a few cakes, which you proceeded to take home and stir-fry in your wok with some vegetables. You may have wondered why it didn't hold together in nice, firm chunks the way it did at the Chinese restaurant. And it didn't help matters when your family or housemates took one look and said, "Yuck! What's this stuff? *Health* food?!!!"

Well, yes, in fact. Tofu is one of the healthiest foods around. But that doesn't mean it has to be yucky too. If you gave up after your first attempts at cooking tofu, or if you haven't even had the nerve to try it, you really don't know what you're missing. Tofu, with the right preparation, can be a delicious and amazingly versatile food. You can make burgers out of it, use it in "cheesecake", even make (meatless) meatballs from it. You can make low-fat mayonnaise and sour cream out of it, and substitute it for ricotta cheese in dishes like lasagna. It makes great patés and delicious quiches, with fewer eggs or none at all. Far from being confined to Oriental-style cooking, tofu fits in comfortably with the whole range of North American cuisine. You can even make junk foods out of it!

So what is tofu, anyway? You may know it as "bean curd" and that describes its origins fairly accurately. Tofu is made from soybeans that have been soaked, cooked and pureed, then pressed to yield a white liquid, soymilk. To this soymilk is added a coagulant which causes the formation of curds. The curds are formed into cakes, pressed to expel excess water, and there you have it — tofu. The process was developed by the Chinese around 164 B.C. and imported to Japan in the eighth century. So it's taken over 2,000 years for tofu to make its appearance in North America.

It's a good thing it has. We North Americans are the great Protein Hogs of the planet Earth. To support our meat and dairy foods "habit" over half of the world's arable land is taken up with growing livestock feed. Although large numbers of people in Third World countries are suffering from some measure of protein deficiency, a lot of them must spend their time growing cash crops — such as livestock feed, tobacco and coffee — instead of food for themselves. So at least part of the responsibility for the problem of world hunger we hear so much about rests with us meat and dairy eaters.

However, one tofu eater doth not a revolution make. If you need other incentives to take the plunge, consider the health benefits of the soybean. It's the most complete protein in the vegetable kingdom, and you don't have to complement it with grains or dairy products like you do other legumes. Soybeans are cholesterol-free, low in fats and carbohydrates and, thus, low in calories too. They're an excellent source of calcium, iron and the B vitamins. Compared to meat and dairy products, soybeans are relatively free of toxic residues of herbicides and pesticides, substances which collect in the tissues of animals at the top of the food chain.

Tofu has relatives waiting in the wings, too. Soymilk is great for people who can't digest dairy milk. Tempeh, another soybean product from Indonesia, and soysage, a vegetarian sausage made from the pulp by-products of tofu-making, are not widely available yet but will be soon. For recipes and more information on tofu's infinite possibilities, consult *The Book of Tofu* by William Shurtleff and Akiko Aoyagi and *The Tofu Cookbook* by Cathy Bauer and Juel Andersen. Happy Tofoolery!

Kathleen McDonnell is a Toronto freelance writer and a member of Women Healthsharing.

SHERRAN RIDGLEY

On Friday the 13th of June, Sherran Ridgley, a Toronto feminist and health activist was suddenly stricken with an aneurysm. She died on Thursday June 19th at St. Michael's Hospital. Those of us who knew Sherran personally and through work and struggle will feel a deep sense of loss for a long time. She was a person of energy and commitment. She was involved in a wide variety of health and community work including the following: The Kids, Food and TV Ad project funded by the Toronto Board of Health, the Woman, Alcohol and Drugs Caucus, the Toronto Women's Health Group including the attempt to establish a free standing abortion clinic in Toronto, health planning in the Bahamas, the Birth Control and V.D. Information Centre outreach trailer, the Board of Hassle Free Clinic, the Community Parole Project in Don Vale, the Canadian Association to Repeal the Abortion Law, and the setting up of the Dundas Day Centre. Her commitment to feminism, social justice and community development were expressed in action and thought throughout her life. She enlarged our horizons.

Letters

We reserve the option to print letters to Healthsharing with minor editing for length, unless they are marked "not for publication."

Dear Friends,

Some women have been working with me reviewing all the medical literature, surveying the manufacturers and generally compiling an archive of tampon information. We've also spoken at length for over two years with the U.S. FDA to get tampons and other so-called feminine hygiene products labelled for their contents. We hope, by making manufacturers reveal what's IN tampons, to make women aware of what they are putting in their vaginas! Sponges are great. Takes a while getting use to, but everyone I've discussed sponges with is enthusiastic. And we've noticed reduction in flow, which may be caused by ceasing exposure to the chemicals which tampons DO contain. You would be amazed at what we've read on the lists submitted to the U.S. Patent Office for manufacturing tampons. There must be similar patent lists available to the public eye kept in Ottawa. The National Women's Health Network in Washington is going to take over directing the Project. Further information on tampon project or replies from women interested in having product labelling write Elayne Clift, National Women's Health Network, 2025 1st St., NW, Washington, DC 20036 and WHI, 4659 Mass. Ave. NW, Washington, DC 20016. Include envelope for reply.

Sincerely,

L.W. Peat O'Neill, Toronto, Ontario

Dear Women Healthsharing,

As a nurse and health educator, I am vitally interested in health in general and women's health in particular. A small group has formed here in Regina to draw up a proposal to look into a women's health centre.

Sincerely,

Elaine McNail, Regina, Sask.

Dear Healthsharing,

Presently I am involved in the development of a Women's Care Program. Our goal is to teach health care to 190,000 working women of Winnipeg. The program deals with women's health issues as related to each body system. For example: use of cosmetics as related to the health of our integumentary status; use of healthy and unhealthy coping patterns to everyday stress as related to the health of our nervous system; everyday nutrition as related to the health of our digestive system; hypertension as related to the health of our cardiovascular status; cigarette smoking as related to the health of our respiratory status; birth control, vaginal infections, self-breast examination, etc. as related to the health of our reproductive status.

Thank You

Angela Tenenbein, Planned Parenthood, Winnipeg, Manitoba.

Dear Women Healthsharing,

I'm a childbirth educator in Mississauga teaching classes for unmedicated births — both hospital and home-oriented. I'm also training as a lay midwife, and have relied greatly on women for knowledge and support. (I have also found a few M.D.'s who cheerfully share their knowledge and skills with me, but they're a rare breed.) I look forward to receiving your magazine and I'll be sure to tell others about it.

Thank you

Heather Burton-Simopoulos, Mississauga, Ontario.

J. Castelli, *Women*, a journal of liberation

In the near future *Healthsharing* will be doing exchange mailings with some Canadian publications, especially other feminist magazines. If you do *not* want your name and address given to another publication please let us know as soon as possible. We hope that exchange mailings can increase the number of *Healthsharing* subscribers and at the same time provide you with information about publications you might enjoy receiving.

My Story, Our Story

In this issue, Healthsharing introduces a new column called "My Story, Our Story." It's about every woman's personal experiences in dealing with the health-care system horror stories, tales of getting entangled in the system's web, confronting professional sexism, alternative solutions, and success stories. We've entitled this section "My Story, Our Story" in the belief that each individual woman's experience reflects our collective experience. Please send your stories to My Story, Our Story c/o Women Healthsharing.

STRESS INCONTINENCE

Wyn Price-Jones

I am fifty years old and I have finally had a problem solved for me by a competent gynecological surgeon. It developed so gradually that I adjusted my life without knowing it and I just didn't realize how much of a problem I had until last summer while on a trail ride in the Rockies. The young engineer on the horse in front of me turned around in his saddle to ask, "Wyn, why don't you ever let your horse trot?" That was when I decided I'd better get my plumbing fixed so I didn't pee my pants every time my horse trotted or I ran, jumped, sneezed or whatever.

So last fall I consulted my general practitioner. I explained that I had done Kegel exercises (pelvic floor strengthening exercises) until I was blue in the face without results, so I was seriously considering surgery. Could he please recommend a good surgeon? I wanted someone who was not only competent to solve my problem but also neat with his stitchery since I am a nudist and I am just vain enough not to want an ugly scar. My G.P. suggested that I contact Dr. A, a very good gynecologist whose work was highly regarded and neat.

Several weeks later I went to see Dr. A. He examined me thoroughly and asked countless questions. He agreed I had stress incontinence, even though my bladder had never bulged into my vagina which usually happens when the cause is a weak pelvic floor. My pelvic floor was fine. The cause of my problem was the angle of the urethra and a very low-placed bladder. The problem is probably aggravated by a heavy uterus pressing down on the bladder.

Dr. A told me he preferred to do the surgical repair abdominally with the incision in the region covered by pubic hair. He had operated on other nudists who wanted minimal scarring and said they had been pleased with the results. But, of course, he would do a hysterectomy at the same time. I objected. He explained that without a hysterectomy the chances of success for this surgery were eighty-five per cent but with a hysterectomy the success rate climbed to ninety per cent or more. So, of course, he always did a hysterectomy with this surgery and he would also remove both ovaries at the same time to reduce my risk of cancer. I asked Dr. A if he would consider doing the repair alone if I were willing to take the extra five per cent risk of failure. His reply went something like "Why wouldn't you want a hysterectomy anyway? A woman your age certainly doesn't want to have any more babies. What do you need your uterus and ovaries for? If it's the hormones you're worried about you will lose them anyway when you go through menopause a year or two from now." He then suggested that if I was not convinced a hysterectomy was necessary, I should seek a second opinion.

Dr. B examined me as had Dr. A and asked basically the same questions. He assured me I didn't need a hysterectomy since my reproductive organs appeared healthy. Dr. B, older by thirty years than Dr. A, assured me he had good success with this surgery done vaginally. Then he went on to explain that when doing this type of surgery he always "took a tuck in the front and back of the vagina and removed the excess tissue so as to tighten it up." He always did this "for the girls."

I was pleased to hear from Dr. B that I didn't need a hysterectomy. But on the way home I began to think. Did I need a tuck or two in my vagina? My vagina had never seemed lax to me or my husband.

I was in a dilemma for several weeks. Finally I went back to my G.P. and told him about Dr. A with his hysterectomy and Dr. B with his "tucks." My G.P. was not pleased with my attitude. He said, "In spite of what you may think, we male doctors are not out to do unnecessary hysterectomies or other surgery on women. If you feel that way why don't you see a lady gynecologist."

That is what I did. Dr. C examined me and agreed I had stress incontinence caused by the position of the bladder and urethra, not by a weak pelvic floor or flabby vagina. Since my reproductive organs were healthy there would be no need to do a hysterectomy.

In early January I had the repair operation done vaginally. It was not painful. I had a catheter in place for seven days and went home from the hospital on the eighth day. I was able to walk a mile a day in the hospital to keep in shape. I went back to my normal routine on the tenth day (except for figure skating and heavy lifting). I am very pleased with the results. I can now sneeze without winding my legs together. I am learning to run again. I continue to figure skate every week as I had done before; only now when I fall I don't have to go home to change my outfit!

Modern surgery is marvellous! It has improved my life immeasurably. But why was it so difficult for me to get the necessary repair surgery without the extras suggested by Dr. A and Dr. B? If I hadn't been such a strong-willed woman I would now be minus my reproductive organs.

I hope that in sharing my experience more women who need bladder repair surgery will seek help, and that when they do seek that help they will be armed with the knowledge, that when extra surgery is urged upon them, it may not be necessary and that it may be possible, if they look about, to find a competent surgeon who will do the minimum surgery necessary to solve the problem.

UNDOING MEDIC[A

by Melanie Conn

IN THIS SOCIETY, we undergo a good deal of conditioning in many areas of our lives. Through this process of conditioning we are taught, sometimes subtly, sometimes not-so-subtly, to view certain things as fixed, unchanging, not open to question. One example of this is sex-role conditioning, in which we are encouraged to measure maleness and femaleness according to certain norms: women are passive, men aggressive; women work in the home, men work outside it. Sex-role conditioning is now being challenged on many fronts, but there are other forms of conditioning, equally insidious, that mould our thinking in other areas of our lives, and that have only begun to be questioned. Perhaps the most powerful conditioning is that which we receive in the area of health care.

At the Vancouver Women's Health Collective we have in the past year begun to explore this fact of our medical conditioning. Our discussions on this topic were stimulated by a growing awareness of "alternative" treatments for abnormal pap smears — tests to detect cervical cancer or early cell changes thought to be pre-cancerous. The alternative treatments we kept hearing about included the use of herbs, nutrition therapy and visualization (a type of meditation in which the healing power of the body is positively imagined). At first, we didn't pay too much attention to this new information, because cervical cancer is one of the few cancers with a good cure rate, and because the conventional treatments we already knew about — freezing the cervix, removing a section of it, and hysterectomy — usually worked. Gradually, it became important for us to look at our reasons for not paying much attention or giving equal credence to the new treatments that women were using to revert abnormal cervical cells back to normal. We had a number of discussions which led eventually to a series of public forums in which we explored our "conditioning around Western medicine" — how it happens, how it shapes our views on health, disease, and the kinds of medical treatment we receive.

ONE OF THE MOST insidious and powerful influences in our medical conditioning comes from advertising. Through our daily lives we are bombarded with messages both direct and subtle on how to behave, how to look, what to buy. So it is no accident that we mechanically take aspirin for a headache instead of stopping to consider the source of the pain and perhaps deciding to try a relaxation technique instead. Often we cannot take the time for such consideration or medication, because the pace of our lives supports our reaching for the pill bottle.

Drug companies have spent millions of dollars on advertising so that when we notice that throb along our temples we think of acetylsalicylic acid. We are not the only ones who are prey to this conditioning: doctors' main source of information on drugs is also pharmaceutical companies. After all the direct-mail promotion, medical journal ads and free samples from drug company salemen, it's not at all surprising to see that new drug on our prescription.

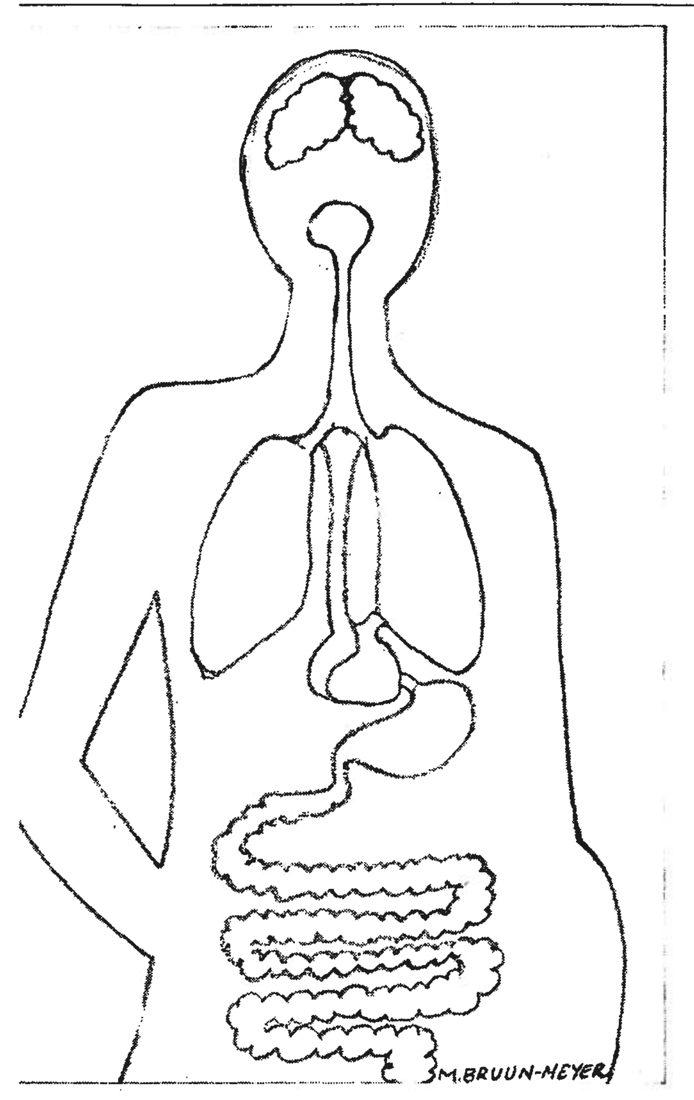
Most important is our vulnerability to the lack of accurate information on the safety and real effectiveness of these products. It is a step forward in our health consciousness when we start to ask questions, when we stop to look at what we're buying and why.

But when we do go after evidence to support a conventional treatment, we come up against "The Scientific Study". We grow up with the idea that medicine is an exact science, that proof positive exists for every treatment and procedure. When we take a closer look at the dynamics of medical research, however, we find it's not as simple as all that. Scientific studies, lo and behold, often contradict each other. Not all studies are of equal merit, either; there are good, carefully controlled studies, there are sloppy, poorly conducted studies, and a whole range of studies in between. Studies can be biased by a number of factors, from the initial hypothesis to the methods of collecting the data to the way in which the data are presented. Studies which are funded by self-interested groups like drug companies are often biased at

Graphic: Margie Bruun-Meyer

L CONDITIONING

ınd Rebecca Fox



the outset.

An example of the vicissitudes of studies: for many years there was conflicting information about the diaphragm and its effectiveness as a birth control method. While women were being primed for the new "wonder" methods — the pill and the IUD — the diaphragm was being dismissed as outdated, "what our mothers used to use". In 1973 a good study was done at the Margaret Sanger Institute in New York showing the diaphragm to be 98 percent effective. The difference between this study and previous ones was that the women using diaphragms in the Sanger study were all well-fitted and carefully instructed, a time-consuming process. The only pregnancies included in the Sanger statistics were those where the women had actually used the diaphragm at the time of conception, in contrast to earlier studies.

WE HEAR A LOT about preventive health care as a potential alternative to conventional medical treatments. But the "health" industry's profits are much higher for treating illness than for preventing it. Conventional treatment almost invariably involves drugs, and often means filling hospital beds and the use of expensive equipment.

Screening has been conventional medicine's response to the demand for preventive health care. We have been conditioned to believe, for example, that an annual physical exam is our surest bet to continuing good health. But there is no clear evidence that annual check-ups positively affect the health status of any given population. The procedure reveals relatively little, since most diseases can be detected only after symptoms occur. In the case of some diseases, like lung cancer, early detection makes little difference in the life expectancy rate.

Furthermore, some forms of screening may be downright dangerous to our health. Mammography, or breast X-rays, was to be medicine's chief weapon against breast cancer, in preference to breast self-exam, an effective, cheap, woman-controlled procedure. Some studies now suggest that routine mammography of women who have no symptoms may actually increase their risk of contracting breast cancer.

The real hook in the conditioning we receive around screening is that we (and our doctors) genuinely believe that we're responsibly taking care of our health. In actual fact, we may be exposing ourselves to unnecessary procedures and ignoring other significant indicators of health and illness.

The politics that prevent the preventive health model from becoming more than an experiment extend deeply into our very perception of the meaning of health, and limit doctors' understanding of health as well. Doctors are not trained to assess our state of health or to assist its maintenance. Rather, they see us *as* our complaints and isolate the illness, focussing on the absence of health. We've learned to think of our everyday concerns — persistent vaginal infections, intermittent headaches and depression, low back pain — as trivial problems. We're embarrassed to take them to the doctor, who rarely sees them as part of the fabric of our total state of well-being.

But our conditioning around doctors is perhaps the most powerful, and the hardest to unlearn. We have grown up to trust them to make decisions for us, in the belief that they are skilled and dedicated humanitarians whose professional standing reflects their superior intelligence and years of technical training. The step from the doctor's office to some form of self-help can seem a rather large and intimidating one. One of the major breakthroughs of the women's health movement has been precisely in the development of self-help techniques, and in its emphasis on seeing ourselves as whole persons both in sickness and in health. We've learned to look at birth control, vaginal health and the menstrual cycle not as medical "problems" but as an integral part of our sexuality and whole being.

ANOTHER PROBLEM is our lack of practice in perceiving our bodies as basically healthy systems. We feel utter panic when something goes wrong. We can't imagine that we, our bodies, can co-exist with an infection or pain

long enough to combat it without immediately calling in the troops: heavy doses of potent prescription drugs or surgery.

"Nature is a slow healer", the herbal books tell us. But we have become so accustomed to "fast, fast, fast relief", erroneously equating the disappearance of symptoms with the elimination of disease, that slower, gentler methods are hard for us to trust. In our own discussions at the Health Collective, we found that while we occasionally used or were prepared to try alternate remedies, such as herbs or visualization, we weren't willing to "fool around" when it was a question of our children's health or if we had a serious condition, such as cancer. We weren't willing to wait out the time necessary for the treatments, and our bodies, to deal with illness.

The familiarity of the conventional methods encourages their use. We may be amused by the cartoon anatomy in the TV ads, but the route they depict—mouth-stomach-bloodstream (where the medication radiates "relief") — dominates our perception of the healing process. Sipping tea or applying a poultice to the *outside* of the affected area seem strange, old-fashioned and ineffective approaches to curing our ills.

Furthermore, our dependence on conventional methods reinforces itself. In the case of antibiotics, we have become so used to routine treatment with them that in some cases we find ourselves less resistant to minor infections than we used to be. It then becomes necessary to use even stronger antibiotics that have more toxic effects. Strains of harmful bacteria, once easily controlled through antibiotics, are no longer affected by them.

Another issue related to the "fast powerful relief" message has to do with the source of the medicines we're used to taking. Although we have some degree of choice with over-the-counter drugs, we have been trained to believe that if we're "really" sick, we need "powerful" drugs. Our training further tells us that powerful drugs are those that are regulated by law, and dispensed by qualified professionals from licensed pharmacies, after being prescribed by a doctor. An herb that grows in the garden or a mixture that can be made for a few pennies simply doesn't have the weight of a conventional drug for most of us.

WE'VE ALSO LEARNED to believe in the specific action of drugs: aspirins relieve pain, antihistamines dry up mucous membranes, birth control pills suppress ovulation. In comparison, the widely disparate claims for most herbs seem outrageous. How can the same herb, like comfrey, be good for vaginal infections, arthritic pain, respiratory infections and as a skin conditioner? As it happens, the whole notion of "side effects" is a semantic one; all drugs, like herbs, have a wide range of effects on the body. In fact, the so-called "major" effect of many conventional drugs was discovered by accident while researchers were investigating other effects. For example, the antihistaminic effect was discovered as a by-product of a sedative. But now we're told that drowsiness is a "side-effect" of antihistamines as though it were a lesser effect, when in fact it's simply one that the drug company is choosing not to promote when it's selling us a "cold remedy". And as many women have bitterly learned, the suppression of ovulation is only one effect of the birth control pill. Oral contraceptives affect every system of our bodies in some way, and some of those effects are dangerous to our health.

So our conditioning dissuades us from trying remedies that seem to have too many applications to be plausible, encouraging us to dismiss them as "quack remedies" and the result of "old wives' tales". But that same conditioning obscures for us the action of conventional drugs on our bodies, and often misleads us about their toxic effects.

HEALTH CARE HAS BECOME a very private matter in our culture, and our isolation from each other reinforces our conditioning to accept conventional medicine. We're not around other people when they're sick, and they're not around us when we are. A vast communal body of knowledge of health and home remedies that once existed within families and communities is now largely lost. Parents don't teach their children about sickness and health because they simply don't know very much themselves. When you haven't been around a teething baby, you don't talk about it or hear different theories and remedies until your own child is crying in the night. What we have now is a vast array of "experts" like Dr. Spock, a poor substitute for a community of supportive and experienced neighbours.

Our intuitive sense about our bodies has also taken a beating from our medical conditioning. We've learned not to trust our own inner sense of what's right and wrong, even in small matters. At one of the Health Collective's public discussions a woman said that "in her heart" she knew her child's fever was the result of teething, but she called the doctor anyway to calm her worries. He prescribed antibiotics.

AT THE VANCOUVER Women's Health Collective we are beginning to integrate an effort at breaking this hold of our medical conditioning into our everyday work. In the process of examining our own attitudes and talking to other women, we've found a different, more positive view of "alternative" healing methods has emerged.

This doesn't mean that we recommend herbs to every woman who comes in the door. In fact, we reject the "practitioner" role of saying do this or that particular treatment. Instead we use the self-help model and apply it as widely as possible in our work. We try to help women make their own choices, and encourage them to look through our files, which include information on conventional treatments as well as herbs and nutrition. Our library now has standard medical texts and a good selection of books on herbs and self-help healing. We also do a lot of skill-sharing, such as teaching women to examine their own vaginal smears under the microscope.

A positive result of our discussions around "conditioning" is our eagerness to talk with women about their reluctance to consider less conventional treatments. Having explored our own scepticism and fears, we can understand exactly where they're at. But our goal is not to exchange one set of "sure cures" for another. What we strive for is to free our minds and hearts from the training that has prevented us from making genuine choices about our health.

Melanie Conn and Rebecca Fox are workers at the Vancouver Women's Health Collective, which has organized self-help groups and other women's health activities in the Vancouver area since 1971.

Photo: Ontario Federation of Labour

Photo: Amalgamated Clothing and Textile Workers Union

DOUBLE EXPOSURE:

The Fight Against Reproductive Hazards in the Workplace

by Marianne Langton

"Why not?" the government ads asked back in International Women's Year. Women can do the same work as men, give them a chance. Rachel Barriault was one of the women reaping the benefits of this short-lived tide of equalization. In the summer of 1974, she and a handful of other women were hired by Inco Metals to work in its Sudbury nickel refinery.

Within six months, Rachel was transferred from the packaging and shipping area to a coveted position in the IPC, the section of the refinery where nickel is treated with carbon monoxide gas. Not only did she earn more money in the IPC, but the working conditions were more pleasant as well. "It was so clean, you could eat off the floor", she says.

But six months after her transfer, the company had discovered an answer to the question "Why not?" One day, Rachel reports, she and the shop steward were called into the manager's office. "He told me that the company had instituted a new policy whereby women would not be allowed to work in the IPC unit," she recalled. "The problem was the antidote which had to be administered if someone was exposed to poisonous nickel carbonyl gas. Apparently they thought it would have harmful effects on the fetus if a worker took it when she was pregnant. The manager was really stern. He said, 'I don't even want you to go back to get your lunch box'."

Rachel estimates that she earned about $2.00 per hour less after she was transferred out of the IPC. "All I did after that was shovelling", she says. "I wanted to work a forklift but because the job involved picking up loads in the IPC I wasn't allowed to. I was upset because guys with less seniority than me would get transferred into better jobs. I couldn't get any job that demanded responsibility or was exciting."

The substance which kept Rachel locked in a dead-end job was a drug called dithiocarbamate, or dithiocarb for short. It is administered in the event that a worker is exposed to nickel carbonyl gas, a byproduct of the refining process. Although the effects of nickel carbonyl poisoning are not immediately severe, they can prove fatal within 6 to 12 hours if dithiocarb is not given. In 1975, Dr. Ken Hedges, then the Medical Director of Inco's Ontario Division, noted that dithiocarb had never been tested for teratogenicity (ability to cause birth defects). As a precautionary measure, he therefore instituted a policy forbidding women of childbearing capacity from working where they might be exposed to nickel carbonyl.

Inco has not been alone in excluding women from jobs which may involve occupational hazards to reproduction. This has emerged as a concern in a number of industries across Canada where women have begun to enter jobs formerly held only by men.

Management argues that such exclusionary practices are not intended to be discriminatory — women just happened to have the bad luck to be the vehicles for carrying

insured worker loses the right to sue his or her employer for any impairment incurred on the job. But the legal rights of children of workers are not covered by this restriction. Reporting to the Canadian Centre for Occupational Health and Safety, lawyer Michael Izumi Nash advises "(I)n the common law of Ontario, it is quite clear that a child who has suffered damage while in utero may sue for those damages after birth through his or her guardians". If a fetus should die as a result of workplace conditions, obviously it would not be able to sue. But, Nash speculates that under Ontario's Family Law Reform Act, "parents, grandparents, brothers or sisters could maintain an action against an employer where the child was stillborn or later died as a result of injuries caused to the child in utero."

Though as yet there have been no such suits, employers both in Canada and the United States are sensitive to the possibilities. Some have quite deliberately decided that they would rather hazard charges of discrimination than a lawsuit over a birth defect. As one U.S. Exxon official commented, "We would rather face an Equal Employment Opportunity inspector than a deformed baby."

But, as Reg Basken of the Oil, Chemical and Atomic Workers, points out, "It seems that they are taking precautions (for fetuses) because proof can be given relatively easily". In the cases of Diamond Shamrock Alberta Gas, where women have been excluded because of fears that vinyl chloride would cause birth defects, "It could be 25 years before it hurts anyone else".

What About "Women's Work"?

Women concerned about both job safety and equality of opportunity have complained that employers' attempts to protect them from reproductive hazards are being applied selectively, to prevent women from entering "non-traditional" jobs, while allowing some of the most potent hazards to remain in the occupations which comprise the "female job ghetto".

For example, hospital and health care workers are exposed to a broad range of workplace hazards, such as ionizing radiation, infectious agents and anaesthetic gases, which have been linked to high incidence of miscarriages and birth defects. Women working as hair-dressers, in dry cleaning operations and in many other situations are exposed to chemicals which may interfere with fetal development.

But where the majority of workers are women, employers have rarely voiced concern about substances hazardous to reproduction. "There's no hue and cry about keeping women from working as X-ray technicians or in operating rooms," says Cathi Carr, Employment Relations Officer with the Ontario Nurse's Association. In a few cases, says Carr, hospital management has taken the initiative to reduce workplace exposure to reproductive hazards. Peel Memorial Hospital, in Brampton, for example, has purchased equipment which will reduce operating room concentration of the anaesthetic gas nitrous oxide. Though such management initiatives may be rare, they indicate that where it is not practical to change the nature of the workforce by excluding women, measures can be taken to change working conditions.

Canadian workers who have found themselves barred from jobs because of reproductive hazards have found little satisfaction in seeking redress from the government. In 1976, women transferred out of GM's battery plant in Oshawa filed discrimination complaints with the Ontario Human Rights Commission. The Commission dismissed the case in an ambiguous ruling that did not exonerate GM, but admitted its own inability to deal with the medical questions involved.

Though this ruling was issued nearly four years ago, the Ontario government has still not established guidelines for action in such cases. "It's still a hot issue", says Dr. Harry Aitkin, Director of Special Studies and Services Branch for the Ontario Ministry of Labour, "and one which the federal-provincial Committee on Occupational Health is dealing with at the moment". Dr. Aitken expects this committee, which meets once a year, to soon finalize a position on discrimination based on reproductive hazards. He says that the Ministry is opposed to such discrimination, and adheres to the principle that the workplace should be as safe as possible for all workers. But, he admits, this is a principle which has no legal expression, and workers such as those in GM's battery plant have no more legal recourse today than they had in 1976.

Neither has the federal Human Rights Commission taken a stand on such cases. At present, at least five complaints involving reproductive hazards are before the federal Commission, against companies which include Ontario Hydro and Hudson Bay Mining and Smelting. Commission spokespeople refuse to comment on these cases while they are pending.

The U.S. Example

In the United States, exclusionary practices by employers have prompted labour and women's organizations to form the Coalition for Reproductive Rights of Workers (CRROW). In its statement of purpose, CRROW has committed itself to "exposing the corporate policy of eliminating workers rather than hazards. It will seek an end to the unacceptable choice between a job and the right to reproduce."

Partly due to pressure by organized labour and groups such as CRROW, U.S. government agencies have taken a harder line on this issue than have their Canadian counterparts. Last October, in a precedent-setting move, the U.S. government cited the American Cyanamid Company for violating health standards by excluding fertile women from its plant in Willow Island, West Virginia. In its citation, the Occupational Safety and Health Administration (OSHA) fined the company $10,000 and ordered it to make the workplace safe for both men and women who might bear children.

In February of this year, the U.S. Equal Employment Opportunity Commission (EEOC) published proposed guidelines for handling reproductive hazards. Although these proposals have been criticized by CRROW for being too limited, they nevertheless extend far beyond Canadian initiatives in this area. The proposed rules would set limits to circumstances in which employers may remove women from jobs that might involve reproductive hazards, and would require them to conduct scientific tests to determine whether the substances in question could

the future generation. "There is not much evidence that adult females and adult males react differently to toxic chemicals," explains Dr. Ernest Mastromatteo, Inco's Director of Occupational Health. "But the fetus seems to be more susceptible than the adult.... I suppose that from the point of view of women's career aspirations it's unfortunate that they have to nurture the fetus. But the biological factor cannot be changed." While Dr. Mastromatteo will admit that the company has an obligation to make the workplace relatively safe for its workers, he does not believe that this responsibility extends to the fetus. "To make the workplace safe for the fetus would be ideal but not practical", he says.

Dr. Mastromatteo's perspective is shared by his counterparts in other industries. At Ontario Hydro, women of childbearing capacity cannot work in the nuclear plants as operators, mechanical maintenance personnel, and control technicians because these jobs involve exposure to radiation at levels higher than those allowed fertile women by the Atomic Energy Control Board. Why not reduce the radiation level instead of excluding women from what Hydro estimates to be 2,000 jobs? "That would require extensive redesign of the whole plant", explains Grant Childerhose, Hydro's manager of Radioactivity Management and Environmental Protection. "It would not be practical. It would increase the number of staff and capital costs. We're concerned about what the taxpayers would have to pay."

"Excluding women from these jobs doesn't depend on us," adds Dr. Tom Hamilton, Hydro's Manager of Health Services. "We're just following AECB regulations."

The regulations he's talking about are part of the federal Atomic Energy Control Act which sets ceilings on the amount of radiation to which workers may be exposed.

The limit for all atomic radiation workers is 5 rem per year, but for women of reproductive capacity the act adds a further restriction limiting the radiation dose to 1.3 rem per quarter and to .2 rem per two weeks. In other words, for women workers the radiation dose must be spread out more evenly over the course of the year. The reason for this, explains Dr. Hamilton, is that in the initial phases of pregnancy, the woman probably does not know that she has conceived. These regulations were intended to protect the fetus during this time.

Fear of Lawsuits

Employer concern for the children of workers often seems hypocritical to workers who have spent years struggling for improved health and safety measures. Some charge that it is fear of legal action, rather than paternal regard for child welfare, that motivates such protectionist policies. Under the Workmen's Compensation Act, an

HOW WORKPLACE HAZARDS AFFECT REPRODUCTION

Unlike industrial accidents in which limbs are mutilated or severed by unsafe machines, or the more visibly disabling occupational diseases such as black lung, damage to a worker's reproductive system is usually insidious and unsuspected. Signs and symptoms may develop, but their cause will not usually be attributed to a person's occupation. This is especially true of agents such as x-rays, manganese, or PCB's (polychlorinated biphenyls) which exert adverse effects on the reproductive system *before* conception occurs (see chart). These substances can cause menstrual disorders in women, decreased interest or ability to engage in sex and lowered fertility or sterility in men and women alike.

Before conception, sperm and egg cells can be damaged by exposure to substances called *mutagens* (mutation-causing agents) such as vinyl chloride, used in the production of plastics. Depending on the severity of the genetic changes which result, mutagens can cause disease or birth defects in future children, or prevent fetal development and lead to miscarriage or stillbirth. Many mutagens are also *carcinogens* (cancer-causing agents).

Once conception takes place, the fetus is susceptible to damage by substances known as *teratogens* (defect-causing agents) such as lead, mercury, cadmium, benzene, organic dyes and halothane, which can filter through the placenta and produce miscarriage, stillbirth or gross abnormalities. Some teratogens, like radiation, *directly* affect and damage the fetus. Moreover, the pregnant woman is more susceptible to the damaging effects of teratogenic substances to her own health because of the physiological demands of pregnancy.

The effects of reproductive hazards don't stop at birth, since substances can affect an infant if her mother is breastfeeding while exposed to hazardous substances such as tetrachloroethylene (a dry cleaning solvent). And a child's development can be affected by substances such as asbestos dust or pesticides brought home on parents' working clothes.

(Excerpted from "Double Exposure: The Fight for Reproductive Rights in the Workplace" by Ruthann Evanoff, in HealthRight, *Volume V, Issue 3.)*

POINTS AT WHICH WORKPLACE HAZARDS MAY AFFECT REPRODUCTION

PRIOR TO CONCEPTION	AT CONCEPTION	DURING PREGNANCY	ON THE NEWBORN	ON THE CHILD
Menstrual disorders Interference with sexual functions Lowered fertility Mutations — genetic damage in male & female germ cells can be passed on to children and result in disease or birth defects. Can also cause miscarriage or stillbirths.	Difficulties in conceiving a child (e.g. by interfering with the sperm's ability to fertilize the egg)	Teratogens can cause miscarriage, stillbirth, cancer, disease, or birth defects as a result of substances crossing the mother's placenta and reaching the developing fetus (e.g. certain drugs, chemicals and viruses) or by direct action, such as radiation exposure	Toxic effects on development of baby as a result of chemicals transmitted to child in mother's breast milk	Toxic effects on development of child from exposure to substances emitted into the environment around a workplace, or brought home on a parent's clothes

(Excerpted from "Workplace Hazards to Reproduction" by Jennifer Penney, in Health Alert, *November 1978.)*

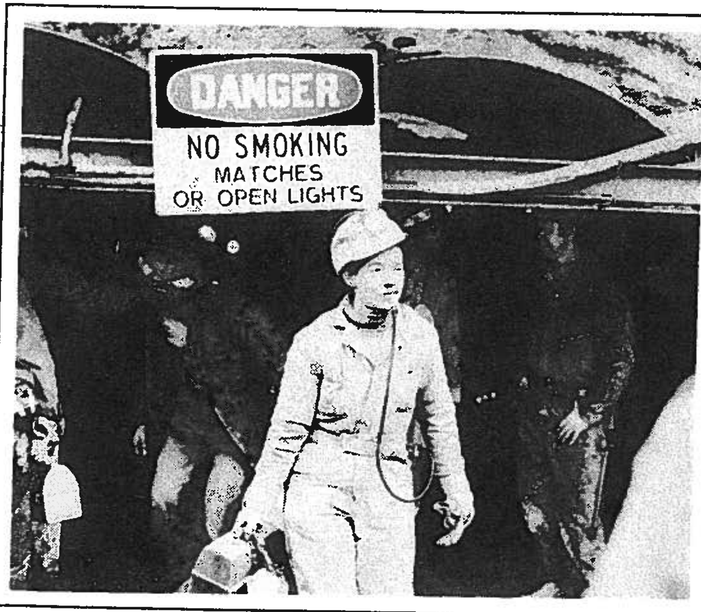


Photo: Betty Medsger, *Women at Work*

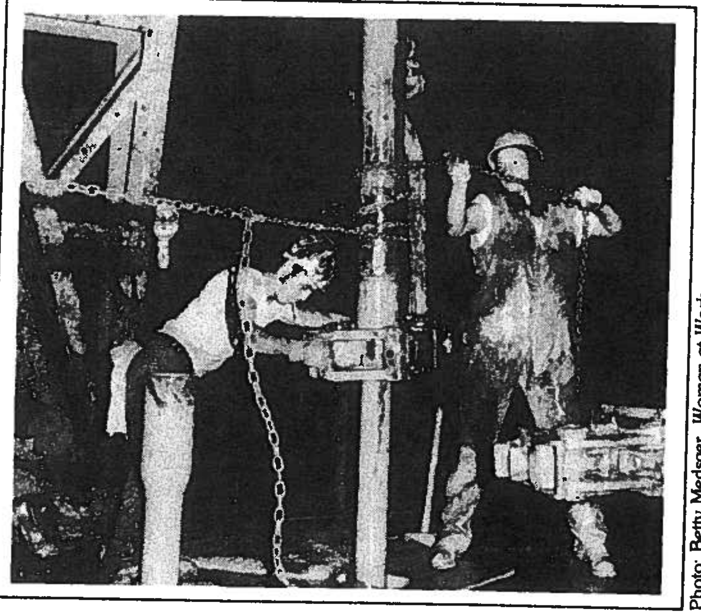


Photo: Betty Medsger, *Women at Work*

indeed cause deformities in children. If so, they would then have to show whether the hazard causes birth defects only through its effects on the mother.

Were similar guidelines to be adopted in Canada, the action of companies such as Inco and Ontario Hydro would be prohibited. As Ernest Mastromatteo has admitted, dithiocarb, the substance responsible for Rachel Barriault's transfer at Inco is not even a known teratogen, but is only *suspected* of causing birth defects.

It is also significant to note that the U.S. regulations would prohibit employers from excluding all women of childbearing capacity from jobs involving reproductive hazards. Such a clause may be expected to bring strong objections from employers, lawyers and civil servants who point out that the fetus may be most susceptible during the first weeks of pregnancy when the worker does not know that she is pregnant. The present AECB regulations specifically group all "females of reproductive capacity" together as a class, subject to distinct limits for radiation exposure. This regulation has prompted some controversy as to what a female of reproductive capacity means. Though some have assumed that a woman sterilized through a tubal ligation would be exempt from this category, the AECB has not made this clear. Hydro officials acknowledge that several job applicants await clarification of this issue, prepared to undergo sterilization procedures if that would ensure their eligibility for employment. Apparently, the AECB fears that conception would still be possible after tubal ligation, and is therefore reluctant to exclude sterilized women from this category.

Women who anticipate having children are understandably leery about taking any job which has a remote chance of causing birth defects. But others who have no immediate plans for a family resent being considered potentially pregnant by employers and government bodies. They point out that rules affecting all women of childbearing capacity fail to recognize an individual woman's right and responsibility to decide for herself whether she will have children. "I asked the Medical Director at Inco if I could keep my job if I was on the birth control pill," says Rachel Barriault. "But I was told that the only way they would consider it was if I were sterilized."

Men at Risk Too!

For many workers and unions, the major issue raised by exclusionary employment practices is the failure of the employer to provide a safe workplace for all employees. They point out that hazards that affect women reproductively are likely to also affect men. In at least two Canadian plants where workers are exposed to lead, unions are fighting employer policies on these grounds. The United Steelworkers have filed a complaint with the federal Human Rights Commission over the exclusion of women from its Flin Flon smelter. And last December, the United Auto Workers fought a case before the Ontario Labour Relations Board on behalf of workers in Oshawa's GM plant. In both these cases, the union argued that lead is as dangerous to men as it is to women.

In presenting its case before the Labour Relations Board, the U.A.W. cited studies showing that lead impairs fertility in men and causes the production of abnormal sperm. The union pointed out that the U.S. Occupational Safety and Health Administration (OSHA), has concluded that "blood lead levels should be maintained below 30 micrograms/100 grams in both male and female workers who wish to plan pregnancies." The current standard for workplace exposure to lead in Ontario could result in worker blood levels of 80 micrograms/100 grams.

Toxicologists who support protecting men as well as women note that many companies have failed to make the proper distinction between a teratogen, which damages the fetus, and a mutagen, which causes genetic changes in male or female reproductive cells. Substances such as lead are both teratogenic and mutagenic. They may result in a damaged fetus by affecting either the sperm or the egg before conception, or by harming the fetus itself after conception. On the weight of such evidence, OSHA has determined that "There is no basis in

the record for preferential hiring of men over women in the lead industry, nor will (the standard for lead) create a basis for exclusion from work of any person, male or female, who is capable of procreating."

Notwithstanding such arguments, the U.A.W. lost its case before the Ontario Labour Relations Board. In defining the issue, arbitrator E.E. Palmer maintained that the exclusion of women of childbearing years from excessive exposure to lead was not in itself discriminatory, unless it could be shown that lead affects men and women equally. Nevertheless, in his ruling Palmer noted that a fertile man may have the right under Bill 17, Ontario's new Occupational Health Act, to refuse to work where he might be exposed to dangerous levels of lead. Such a case, however, would have to be fought under another grievance.

An End to Discrimination

Unions and women's groups have called for clear cut policies which would put an end to employer practices that bar women from equal employment opportunities and expose workers to hazardous conditions. Says Victor Rabinovitch, Health and Safety Director for the Canadian Labour Congress, "what's required is improvement of the environment, rather than discrimination against workers of any sex. Personal protective equipment or administrative controls (including transfer of workers) must be seen as temporary measures at best, and must be followed by actual removal of the hazards at their source. Where working conditions are seen to pose a hazard to a pregnant woman or her child, it is the responsibility of the employer to transfer her to a safe job for the duration of the pregnancy, with no loss of pay, seniority, or benefits. If this is not possible, it is necessary to develop a Worker's Compensation scheme to insure that she will suffer no loss of pay."

The Quebec government is the only one in Canada to have passed a law guaranteeing women some of these rights. Under Quebec's new Occupational Health and Safety Act, a pregnant or nursing worker who obtains a medical certificate citing workplace hazards to herself or her child may request a transfer to a safe job. If the employer is not able to transfer her, she may take a leave of absence and receive compensation benefits.

Government and industry policies concerned with occupational health have until now borne the imprint of the traditional attitude that women who bear and raise children belong at home, not at work. In setting standards for workplace exposures to hazardous substances, authorities have looked only at their effects on workers themselves, not on their future children. As U.S. occupational health expert Vilma Hunt has commented, "When the standards were being set, society had not awakened to the fact that women were working and procreating at the same time." Neither, one might add, had it recognized that the health of future generations must be preserved by protecting all workers, male and female, from workplace threats. Slowly, through the struggles they are waging with employers and with governments, Canadian women and workers are forcing society to awaken to these facts.

Marianne Langton works at the Times Change Women's Employment Service and is a member of the Toronto Occupational Health Resource Committee (TOHRC).

Thanks to Healthright, New York, for design ideas and the title of this article.

DEMANDS FOR SAFE WORK

Just before going to press, *Healthsharing* received a copy of a new position paper by the Canadian Advisory Council on the Status of Women. Entitled "Reproductive Hazards in the Workplace," the paper gives an overview of the issues also discussed above in Marianne Langton's article, and makes extensive recommendations for improving workplace conditions to combat reproductive hazards. A member of Women Healthsharing, Jennifer Penney, was involved in discussions with CACSW in preparation for the final draft of this paper.

We exerpt some of the CACSW recommendations below.

The CACSW recommends:

* that the federal government amend the Canadian Human Rights Act and the Canada Labour Code to prevent discrimination in hiring, job placement, promotion and other conditions of employment based on factors related to reproductive physiology, such as reproductive capacity, pregnancy or childbirth; that exclusionary policies and practices arising from such issues be prohibited by law; and that the legislation be monitored and enforced on a continuing basis;
* that government standards establish a single standard for each hazard which would ensure maximum protection for the most susceptible worker of any age or either sex;
* standards ensure that laboratory or other testing of all new substances or processes include screening for teratogenicity, mutagenicity, carcinogenicity, and evidence of effects on lactation before introducing them into the workplace;
* that, in all workplaces over a designated size, properly trained health and safety committees composed of worker and employer representatives with the sexes proportionally represented, be established with authority to monitor and enforce all standards on a regular basis;
* that, when procedures utilizing known hazards are in operation, immediate steps be taken to minimize exposure of the worker by substituting harmless or less harmful substances, re-designing the workplace in order to isolate the hazard, providing suitable and effective personal protective equipment and/or clothing until other measures are implemented;
* that in situations where risk is identified for specific workers because of their reproductive physiology, immediate attempts be made to eliminate the hazard from the workplace, employees be informed immediately of the risk, persons who are at risk be granted the right to refuse work and to leave the hazardous work area immediately without the loss of income, job security, fringe benefits, etc.;
* that where federal money to carry out occupational health studies on humans is granted to any research body or individual, the research design and the results must include both female and male workers when both sexes are employed in the particular workplace;
* that research money be designated for use in studies of employment sectors with a high proportion of female workers.

Reviews

The Canadian Patient's Book of Rights

reviewed by Lissa Donner

Don't be fooled by the title of this book. Of the 140 pages, only 13 contain an actual statement of patients' legal status and concise, factual information about issues such as consent, responsibility, negligence, death and abortion. The other 127 pages are devoted to the author's opinion that patients need not have their rights legislated, and that in fact this would harm patients more than it would help them.

Early in the book Rozovsky argues that "the breakdown that occurs [between doctor and patient] is not fundamentally a matter of rights; it is a matter of how people treat other people, how they feel for them and how they communicate with them.... A bill of rights cannot make a doctor kindly, a nurse reassuring or a technician friendly." I agree. Legislation cannot do these things, but it can stop a doctor from withholding information, and force all medical workers, including doctors, to explain the procedures which they use. Rozovsky assumes that these things occur in the shadowy, translucent world of emotion, where nothing can be predicted and nothing analyzed, since the only cause is "feelings". But where do feelings come from? Are they not based on a perception of another's power, or lack of it, and of what is acceptable behaviour towards that person?

The feminist movement has addressed this issue of the interface of the personal and the political, but Rozovsky ignores the criticisms which women have made of the medical profession. Many women have written about the paternalistic and withholding practices of doctors, practices based on the physician's power and seen most acutely in the relations between male doctors and female patients. Instead, Rozovsky, like many others, takes the political issue of power, and attempts to dilute it into the psychological issue of interpersonal relations.

For him, the question of patients' access to their own medical records is another problem of "communication." According to Rozovsky, what patients want is not detailed information (which may frighten or depress them) but an empathetic, sharing physician. Personally, I want both, and I cannot be an active participant in my own health without both. But then, Rozovsky does not see the need for informed consumers engaging in mutual planning with doctors, nurses, social workers, nutritionists and physiotherapists either. He does not challenge the paternalism of the medical profession towards its patients, nor towards other health care workers. He also accepts the medical profession's sexist assumptions about women's presumed incompetence.

One case which he describes is that of a pregnant, separated woman, who is granted an abortion by a hospital therapeutic abortion committee. Her doctor refuses to perform the abortion without the consent of her estranged husband. Rozovsky states, "This dilemma is not one that society or the law can solve. Only the medical profession can answer it." It appears that years of women's insistence that our bodies are our own, to control as we wish, have not penetrated Rozovsky's medico-legal world. The only acceptable solution is that women be regarded as independent, competent and responsible, and be treated as such. Again, it is an issue of the right to self determination, and the power with which to enforce it, and not an issue of poor (in this case marital) communications.

Rozovsky does accurately point out that given the present situation, most patients would not enforce a bill of rights for fear of retaliation. But rather than taking this point as evidence of the need for skilled patient ombudswomen and men, he uses it to argue against the codification of patient rights. This, and Rozovsky's other argument that medical relations are personal, and therefore not able to be legislated, are the same arguments which have been used against all civil rights legislation.

Legislation alone will not solve the problems of patient-doctor relations, any more than the Equal Rights Amendment will eliminate sexism in the United States. But it will force doctors to begin to change their style of practice. It will give patients the confidence to see themselves as consumers of a service, with the legal clout to protest if they are not treated as such, and not as pilgrims to an oracle.

The Canadian Patient's Book of Rights, by Lorne Elkin Rozovsky. Published by Doubleday, Toronto in 1980. $8.95 in paperback.

Lissa Donner is working towards a master's degree in social work. She is on the Board of Directors of Klinic, a community health centre in Winnipeg.

Barriers Between Women

reviewed by Ida Flint Dancyger

If the Sixties was the period of revolution for the Women's Movement, the Eighties is the period of evolution and consolidation. Toronto psychologist Paula Caplan has written a book for the Eighties. Her new book, *Barriers Between Women*, examines women's relationships to other women with particular attention to the daughter/mother relationship. The sources of the barriers in women's relationships are explored in a psychological as well as historical, social and cultural context.

Caplan's premise is that barriers between women are rooted in the hostility underlying the daughter/mother

relationship. Assuming the reader is not familiar with the theoretical background in this area, Caplan looks back to Freud's theories as well as the writings of leading women theorists (Karen Horney, Margaret Mead, Simone de Beauvoir, Betty Friedan and Shere Hite).

Caplan explores the traditional views of the source of the daughter's hostility — the daughter's awareness of her similarity to her mother, the Freudian concept of "penis envy" and the infant's "insatiable", immoderate demands for love and nurturance which the mother fails to meet. She then provides an extensive analysis of the chronological stages of the daughter/mother relationship and the conflict inherent along the way. Caplan notes that "conflict *per se* is not harmful". For girls and women, however, conflict, aggression, competition and anger are "branded as unfeminine" by society and therefore discouraged.

Another concern affecting the mother-daughter relationship is the fear of homosexuality. Research shows that the mother's fear of promoting homosexual love also pushes her to distance herself from the baby girl. It is interesting to read that mothers in fact can more easily enjoy breast feeding a male baby than a baby girl.

During a girl's adolescent years, her increased aggression and sexuality lead to new conflicts with her mother. The mother is seen as an agent of society in suppressing and restricting the daughter's sexuality. During adulthood the competition intensifies as the daughter becomes more sexually mature. A mother who is self-confident and has encouraged her daughter to develop herself in other than physical attractiveness and seductiveness will avoid some of this conflict.

Throughout the analysis of these chronological stages, Caplan examines and destroys some of the myths held by society about motherhood. The myth of "maternal instinct" or "bonding" is not exclusively a mother-child phenomenon, but can in fact apply to the development of close relationships between infants and fathers or another adult who has close contact with a child.

The experience of being a daughter in today's society causes women to relate to each other with suppressed resentment, hostility, suspicion and competition that ultimately create barriers in adult female relationships. What then can be done to lower the barriers between women that are born in the mother/daughter relationship? Lowering these barriers requires social change as well as changes in the way members of the family unit interact. Both parents can teach their daughter that her worth comes from many sources (not just her ability to nurture others). Mothers should be freed of the Ideal myth of motherhood. Women must encouraged to believe that anger, competition and conflict is human and not unfeminine. Fathers and mothers *must* share child-rearing and thus help to demythologize motherhood and fatherhood. There must be a breakdown of sex-role stereotypes within the family. And we must all go beyond myth and tradition.

The strength of Paula Caplan's book is that she has mixed empirical data and personal anecdote to try to promote change in our attitudes and consequently changes in our roles as women, mothers and members of society. The book is well-written and clear. And I hope it will fulfill Caplan's goal. In her own words, "I hope my book will promote dialogue between women."

Barriers Between Women, by Paula Caplan is available from SP Books, a division of Spectrum Publications, 175-20 Wexford Terrace, Jamaica, New York 11432. Price: $15 hardcover.

Ida Flint Dancyger is a Toronto psychoeducational consultant.

Resources & Events

The Monthly

WHEN, the Women's Health Education Network of Nova Scotia is publishing a newsletter called *The Monthly*! Good information about what's happening in Nova Scotia (hospital planning, women and health conference, well women clinics, etc.), as well as health shorts and resources.

To join WHEN and receive *The Monthly*, send $3.00 to Box 311, Truro, Nova Scotia.

Women's Action on Occupational Health

A feminist resource group in Vancouver has begun to collect information on occupational hazards, legal procedures and organizing ideas around women's occupation health issues. They are also undertaking research on pesticides and clerical work, as well as a public series on issues of concern to women workers. They plan to produce a regular bulletin on women workers' health issues.

They seek your input — health issues in your work, your organizing experiences, questions and ideas. Contact the *Women's Action on Occupational Health* at 1501 West Broadway, Vancouver, B.C., (604) 736-6696.

Passage to the Great Adventure: A Traveller's Handbook for Counsellors and Educators of Women

A unique step-by-step working manual, focussing on counselling women for change. Its goal is to expand the personal consciousness of the counsellor/educator while providing group and self-help exercises, questions, homework, journal assignments and discussions of importance to the client/student.

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

Available from the Women's Workshop, P.O. Box 7083, Station E, London, Ontario, N5Y 4J9, (519) 439-8205. 100 pages. October 1979. Cost $7.95 plus postage and handling.

Where There Is No Doctor — A Village Health Care Handbook, by David Warner

This handbook was written for people living in Third World countries where there is no doctor. Written in simple language and illustrated with many drawings, it is a basic "how-to" for everything from common illnesses to more serious problems. It also includes sections on how to assess the health of a village, home cures and traditional beliefs, common drugs, midwifery, nutrition and prevention. The book is available in English, Spanish, Portuguese and Swahili.

English editions are available in Canada at $8.25 through Development Education Centre, 121A Avenue Rd., Toronto, Ont., M5R 2G3. Other language editions can be obtained through the publisher, The Hesperian Foundation, P.O. Box 1692, Palo Alto, California 94302 U.S.A.

No Life for a Woman, produced by Bonnie Kreps

This film portrays women's life in a single industry town. The women tell of their daily fight against boredom and depression — with humor, anger and near despair. The film also shows the results of their struggle. They have organized a weekly drop-in, daycare and a women's centre. One of the women has been elected to city council on a women's issues platform. The actions these women have taken offer some solutions to isolated women everywhere.

No Life for a Woman, a Serendipity Film, is 26 min., and can be rented free of charge from the National Film Board.

Allergy Shot

A wonderful small magazine addressing many aspects of allergy related problems. The Spring 1980 issue contains articles concerning a Supreme Court decision on food and beverage labelling, brown rice, and a long term study on hyperactive children. It also contains gluten free recipes, book reviews and an Aunti Histamine puzzle!

Allergy Shot is available quarterly from the Allergy Information Association at 25 Poynter Drive, Room 7, Weston, Ontario, M9R 1K8.

Birth Books — Resources for Growing Families

An excellent resource for parents and professionals. This is a new mail order catalogue containing mainly books, but also pamphlets and teaching aids on all aspects of the birthing and child-raising experience.

The catalogue is available upon request from Birth Books, P.O. Box 836, Peterborough, Ontario, K9J 7A2.

A Widow's Handbook, by Jane Robinson

This handbook examines the emotional, economic and societal implications of widowhood, specifically of widows in Newfoundland and Labrador. In addition to analysis of society's treatment and expectations of widowed women, the handbook offers practical advice about funeral arrangements, releasing money from bank accounts, wills and government assistance in Newfoundland and Labrador.

This valuable and supportive 52 page handbook is available free from: Newfoundland and Labrador Women's Institutes, P.O. Box 4056, St. John's, Newfoundland, 1979.

Women's Running — Coming of Age in Canada, by Ellen Agger

Agger's second booklet traces the development of women's running in Canada up to the 80's. She examines why running has become popular, barriers to women's participation and time improvements women have made in the bourgeoning racing scene. She also looks into the future of women's running.

Available for $.75/copy or 10 for $6.00, from the Fitness Workshop, 348 College St., Toronto, Ontario M6G 1L5.

Sexuality . . . decisions, attitudes, relationships

A thought provoking, non-simplistic booklet for teens about the decisions, choices and feelings about sexuality. The contents include discussions on values, sex roles and relationships. A valuable publication that goes far beyond the mechanics of sex and birth control.

Sexuality is published by Planned Parenthood of Southeastern Pennsylvania and is available from their Resource Centre at 1220 Sansom Street, Philadelphia, Pennsylvania 19109. The cost for 1-25 copies is $1.00/copy; 26-100 is $0.80/copy and 100+ is $0.75/copy. Please add 15% handling charge, (minimum $0.25).