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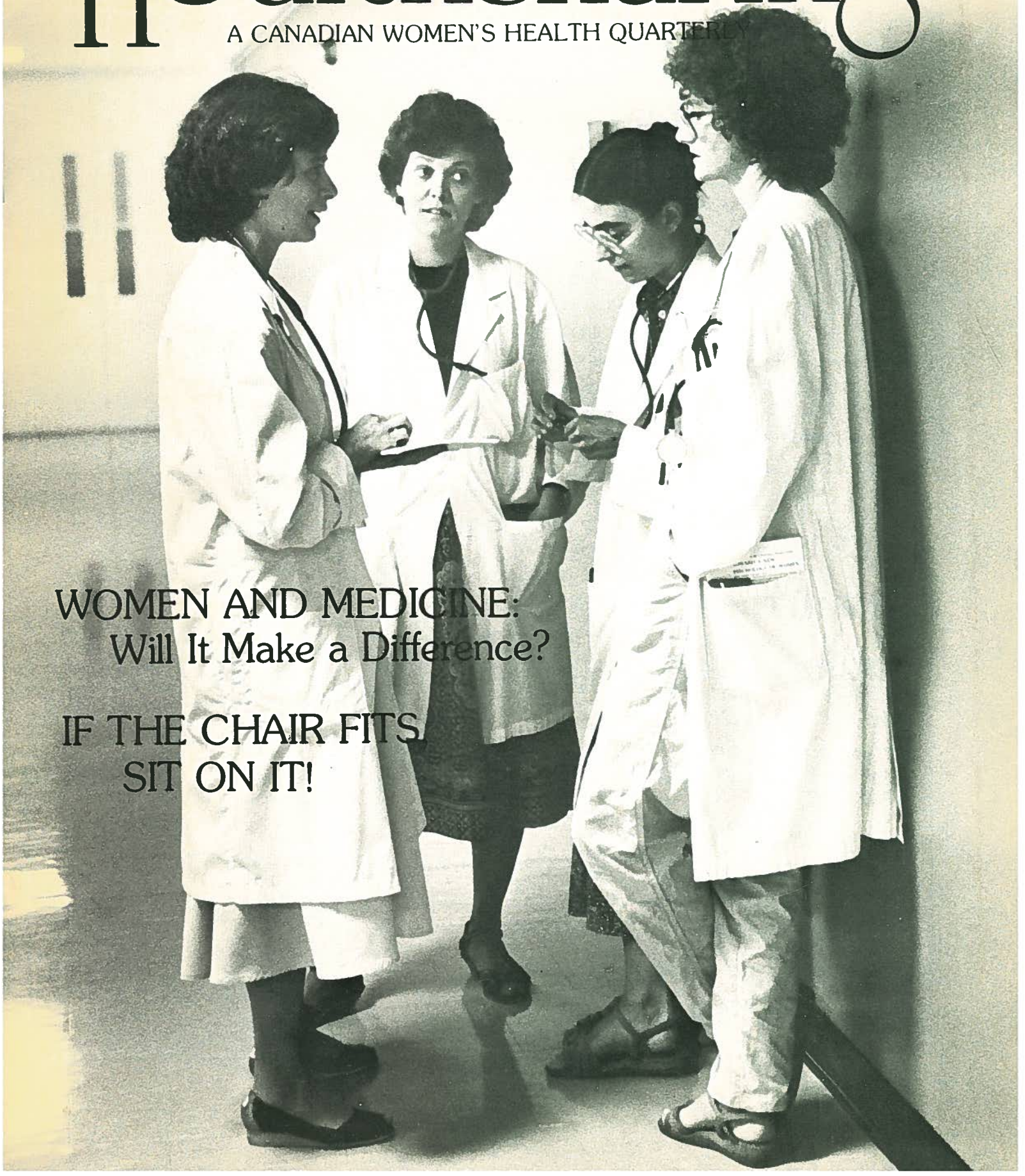
A CANADIAN WOMEN'S HEALTH QUARTERLY



WOMEN AND MEDICINE: Will It Make a Difference?

IF THE CHAIR FITS, SIT ON IT!

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

Mad

Resources & Events

Women and Multinationals — a conference

Women in Northern Ontario have organized a conference concerning the effect on women of multinationals in Canada. Single industry towns, the food industry and the pharmaceutical industry will be examined. Kari Levitt, a professor of economics at McGill University and author of *Silent Surrender*, a book about the role of multinationals in Canada, and Rhonda Love, professor of Community Health at University of Toronto will be among the speakers.

Due to financial restrictions, the conference is open to Northeastern Ontario women only; other women by invitation. It will be held October 16-18, 1981, in Sault Ste. Marie, Ontario. For more information contact Joan Kuyek, 232 Lansdowne Street, Sudbury, Ontario, P3C 4M3.

How to Stay Out of the Gynecologist's Office
by the Federation of Feminist Women's Health Centres

This valuable and relaxed new manual was written by lay health workers who have worked at women controlled clinics. It is a compilation of practical information on the prevention and treatment of common health conditions with home remedies and a comparison to customary medical remedies. It also includes "Taking the Mystery Out of a Medical Visit" and "A Woman's Guide to Medical Terminology", (with over 1,000 words).

You can order a single copy for $5.95 plus $1.25 for shipping and handling from Women to Women Publications, 6520 Selma Avenue, #551, Los Angeles, California 90028. Reduced prices for bulk orders.

Health, Safety and VDT's — a conference

The Labour Council of Metropolitan Toronto and Humber Centre for Labour Studies are sponsoring a conference on the health effects of video display terminals. Speakers include Paul Brodeur, writer for the New Yorker magazine, Jeanne Stellman, of the Women's Occupational Health Resource Centre and Dr. Milton Zaret, professor of opthamology.

The conference will be held October 16-18, 1981, at the Ontario Institute for Studies in Education, 252 Bloor Street West, Toronto, Ontario. Registration fee is $35.00. Write the Labour Council of Metropolitan Toronto at 15 Gervais Drive, Toronto, Ontario.

Report of the Task Force on Women's Health in Saskatchewan

This report was commissioned to assist Saskatchewan Health in developing a preventive programming strategy for the 1980's. Their conclusion was that the existing health care system does not meet the needs of women, and in fact runs counter to the best interests of women in such areas as overuse of surgery, the epidemic of adolescent pregnancy, workplace health risks, special needs of Native women and others.

Their recommendations include the establishment of twelve prevention oriented Women's Health Centres.

Copies are available from the Policy Research and Management Services Branch, Saskatchewan Health, 3475 Albert Street, Regina, Saskatchewan S4S 6X6.

Battered and Blamed — A report on wife assault from the perspective of battered women
by the Women's Research Centre and Vancouver Transition House

Because of its perspective, this is a unique study. It is based on interviews and other information from 148 residents of Vancouver Transition House. Also included are six case histories showing the variety of battered women's situations, a description of the operation of Transition House and a discussion of effective ways of working with battered women.

Useful to anyone working with battered women, but also for the rest of us, *Battered and Blamed* advances a clearer understanding of wife assault — a problem that affects us all.

Copies available from the Women's Research Centre, 301-2515 Burrard Street, Vancouver, British Columbia, V6J 3J6. Cost: $5.00

A Canadian Women's Health Network

The call for a national health network for women has been made twice in the past year at two major conferences. In Edmonton, November 1980, the Health in Action conference heard proposals for a network of women's health groups and individuals across the country. Echoed in Toronto at the Strategies for Well Being conference, the link between women health workers began to take shape. As a result of these two meetings, a committee of five women was formed to contact women across the country, study models of networks and search for funding to establish a national body. The Canadian Women's Health Network will take many months to create and needs the support and involvement of many women.

A Canadian Women's Health Network Can:

Connect existing health groups, local and regional networks and other women's groups interested in health issues;

Support the development and continuing growth of women's health groups and issues by sharing information and sharing strategies for participation and action;

Represent women at a national level regarding legislation, regulations and health programming;

Promote women's health interests by popular research, media work, educational meetings, conferences; and

Develop an maintain international contacts and networks.

Join in a growing movement. Let us know what you can offer. Your names, organizations and contacts are needed to be part of the health network.

Name _____

Address _____ Postal Code _____

Interest _____ Organization _____

1. What issues would you like to see a national women's health network focus on?
2. What services could a national health network offer to support the development of local and regional networks?
3. Identify ways in which you or your organization could contribute to a national network.

Send to:
Committee for a Canadian Women's Health Network
c/o Women Healthsharing
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WHEN

Women's Health Education Network

WHEN is a network of women interested in many health-care issues. Our goals are to share health-related information and to assist women in developing and maintaining a healthier life for themselves and their families. In addition to our information and resource networking, we hope to work with other women to develop and strengthen our community support systems.

- resource centre
- newsletter
- well-woman clinics
- network file

WHEN
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B2N 5N2
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Healthsharing

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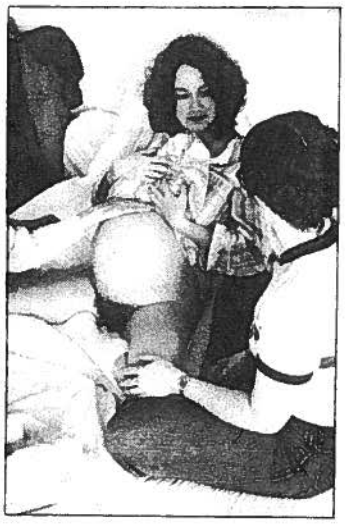

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HEALTHSHARING is published quarterly by Women Healthsharing, a Resource and Writing Collective, Box 230, Station 'M', Toronto, Ontario M6S 4T3 (telephone 1-416-968-1363). Collective members are Madeline Boscoe, Betty Burcher, Connie Clement, Diana Majury, Lisa McCaskell, Jennifer Penney, Susan Wortman and Sharon Ziegelstein. Issue Coordinator: Madeline Boscoe; Production Coordinator: Jennifer Penney; Office Manager: Bev Rodrique; Promotion Manager: Susan Wortman.

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Women Healthsharing endeavours to print only material with which we are in agreement; the collective does not necessarily, however, agree with everything said in every article or column.

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Collective Notes

The hand that rocks the cradle does not rule the world. If it did, human life would be held dearer and the world would be a sweeter, cleaner, safer place than it is now!
Nellie McClung, 1917

Nellie McLung was a great Canadian heroine. But on this issue she was wrong — or at least far too simple. For the women who have risen to political power in the world arena, such leaders as Golda Meir, Indira Gandhi and Margaret Thatcher, would not win medals in the peace-making department. (Nor, we might add, are they particularly well known as proponents of women's rights.) There are contemporary feminists who still argue that the way to make social institutions responsive to human needs is to get women into power. Following this argument, large numbers of women in medical practice and administration should change the shape of the health care system.

There *are* differences between male and female physicians. Elsewhere in this issue, Rhonda Love examines some of these differences as evidenced in studies of male and female medical students and practitioners; Lisa McCaskell and Betty Burcher review the popular book *Male Practice*, which connects some of the worst medical practices today with the dominance of male chauvinist physicians.

Most of our collective members go to women doctors because we find they are more approachable than men, take more time to listen, explain what they are doing and how they reach a diagnosis. They are less likely to patronize us and more likely to consider our concerns about medical intervention, drugs and so on. Are these differences significant enough to expect a dramatic shift in health care as women continue to increase their proportion of the medical profession? Unfortunately, we don't think so.

While the socialization of women to be sympathetic and caring may temper their practices as authorities in medicine, these differences in temperament undergo tremendous pressures in medical school and in the first years of practice. Women doctors are steeped in "disease care" just as males are. Their selection and training helps to ensure that high technology intervention is a major element of their practice (though perhaps delivered a little more sympathetically). Although a few women doctors have been pioneers in such fields as preventive occupational health, there is no evidence that women physicians are leading a general struggle against the prevalent environmental and social causes of disease.

Progressive women doctors (and men, for that matter) are constrained by the professional medical organizations which ensure a certain level of orthodoxy in medical practice and frown on any deviation. We all know of the pressure brought to bear on doctors who agree to attend home births, for example. These kinds of pressures can be particularly acute for those who have questionable legitimacy as professionals in the first place. Expectations of many patients, steeped in "the pill will fix me up" mythology also severely hamper the ability of a physician to change her practice.

The "Queen Bee Syndrome", common to many women professionals, and encouraged by their male counterparts, may be a factor. Career oriented women who "make it" sometimes have little sympathy for those stuck in less prestigious work or difficult social situations. "I made it. Why can't she," the thinking goes.

We do not want to denigrate the women doctors who are struggling for change in the health care system. They are courageous — we need to support and work with them. But their goals and ours will not be realized by sheer numbers of new women in medicine. This can only be achieved with clear feminist perspectives, political goals and by working in concert with other health care workers, activists and community members to make the kind of changes we want to see in the health care system.

APOLOGIES

- **Actinomycosis, the uncommon pelvic infection mentioned in Getting Rid of the Crab (Summer, 1981), is a fungal infection, not a bacterial infection as reported.**

Madeline Boscoe
Betty Burcher
Connie Clement
Diana Majury
Lisa McCaskell
Jennifer Penney
Susan Wortman
Sharon Zigelstein

Newsfronts

Native Health Clinics

Native people in the community of Sandy Lake, located in the Sioux Lookout Zone, have established their own health care centre. The centre is named the Pameetewin Project, which means homecare, and provides care to the 1,200 Cree and Ojibway who make up the community.

The five women who work on the project have identified the major health problems of the native community there as being: lack of a clean water supply, inadequate sanitation, poverty and over-crowding.

Focusing on prevention and self help, the service provides instruction and care in personal hygiene, pre- and post-natal care, and care for the elderly. The project also serves as a liaison between the isolated community and outside doctors.

Dr. Elizabeth Roberts, who practised in the area is quoted as saying, "The community members know their own problems best. We are perhaps too weighted towards trained personnel. The so-called untrained health workers through life experience, can have as equal and important an impact on the community."

Asbestos in Gloves

Yet another occupational health hazard has been discovered. Two American health experts at the annual conference of the American Industrial Hygiene Association gave evidence showing that workers who use asbestos gloves for handling hot materials are being exposed to potentially dangerous amounts of asbestos. Tests on some gloves used in a university laboratory gave off levels of fibres up to eight times higher than the maximum allowed in work places.

Apparently, as the gloves wear out, they often begin to shed fibres which then may either be inhaled or ingested by workers in close proximity. Dangerous amounts of asbestos fibres have been found on table tops where gloves were placed after being taken off.

Asbestos fibres are a known cause of cancer and other lung diseases and are considered dangerous when swallowed. B.S. Samini, when presenting this evidence to the conference, was quoted as saying "The use of asbestos gloves in any occupation exposes the wearer to potentially hazardous levels of asbestos. You really don't have to use asbestos gloves. We strongly urge the adoption of substitutes."

Pro-Choice Victory Appealed

A court decision which ruled that it is not unlawful to counsel and assist women to obtain abortions is being challenged. The ruling in the Maguire vs the City of Calgary case, which tested the legality of City funding for the Calgary Birth Control Association (CBCA), is being appealed by Maguire, a Calgary lawyer.

Judge Mary Heatherington, after lengthy pre-trial negotiations, in-court testimony and written documentation, pronounced her decision last October. The City relied on three primary witnesses: the past-director of CBCA, a medical witness and a pathologist. Maguire relied on two former clients of CBCA: one, a woman who had second thoughts after seeking and obtaining an abortion, and the other, a set-up "client" who presented a false story to the counselor at CBCA.

Heatherington ruled that it is not unlawful to counsel, encourage and assist pregnant women to obtain abortions and further, that when the City of Calgary grants funds to the CBCA it is not providing money for unlawful purposes or acting in any way illegally.

Cathy Bentley, executive director of CBCA, told *Healthsharing* that Maguire filed an appeal this spring. Thus far, no court date has been set.

Strenuous Exercise Lessens Menstruation

Two recent reports confirm what many runners already know: Periods become irregular or temporarily cease altogether when women become involved in regular strenuous exercise.

In late May Dr. Donald Delaney reported at the American Academy of Pediatrics conference in Washington, D.C. that adolescent athletes are likely to experience amenorrhea. Amenorrhea among teens shows up in cases of simple weight loss, anorexia nervosa, marathon running, jogging, ballet, rowing, gymnastics and discontinuance of oral contraceptives.

In addition, Dr. Edwin Dale of Emory State University in Georgia recently completed a comparison of 112 runners with 56 non-runners. Among the long-distance runners 66 percent had normal periods; among joggers, 77 percent had normal menstruation; 90 percent of non-runners had regular cycles.

These figures contrast with the even higher rates of amenorrhea cited by Delaney: 51 percent incidence of amenorrhea among women who run more than 30 miles weekly, 33 percent among women who run less than 30 miles per week, and only three percent of amenorrhea among controls.

The irregularity or lack of periods is thought to be a result of insufficient body fat to store estrogen and allow ovulation and menstruation to occur. Lack of periods does not, however, mean that a woman is sterile and does not have to use contraception. Although women who don't have periods are less likely to become pregnant, a woman could ovulate at any time making it possible for her to conceive.

Amenorrhea in runners and athletic teens is temporary. Regular periods generally resume or commence several months after exercise is reduced.

Reduce Stress — Pet a Pet

A recent meeting of the American Animal Hospital Association learned that pets can help their owners cope with stress. Alan Beck, director of the University of Pennsylvania's Centre for the Interaction of Animals and Socity, cited scientific and anecdotal evidence highlighting the importance of pets to people. Beck quoted a study of heart attack patients which showed that 94 percent of those who owned pets survived while only 62 percent of those who did not own pets lived. Petting dogs and cats has been found to lower a person's blood pressure, he said.

Pets have been put into old age homes, placed with autistic children and with the criminally insane — in most cases resulting in improved morale and behaviour.

Beck believes that these findings show veterinarians must be considered part of the human public health team. He states, "It also raises the issue that animals, like their livestock brethren, are not simply luxuries or an artifact of cultural development, but are very much a part of survival."

Callused and Sweaty

The incidence of foot deformities and infections is on the increase, especially among women. The most identifiable culprits are the use of synthetic materials and the demands of high fashion.

An article in a recent New York Times quoted a spokesperson of the American Podiatry Association: "we're seeing more bunions these days and deformities of the big toe, particularly among women. . . . Spike heels and pointed toes pinch toe nerves,

and cause neuroma, a tumor of the third or fourth toe, not to mention puffy ankles."

Synthetics, which don't let the foot breathe, are increasingly employed in one-piece molded footwear, which don't conform to the shape of each foot as well as leather. Synthetics are related to a higher incidence of bacterial and fungal infections, such as athlete's foot, than is leather. Infections are especially common among children and when closed plastic shoes are worn without socks. Skin infections can be relatively easy to treat, but toe nail infections can take years to eradicate.

Allergies to synthetic footwear are a recent but widespread problem. According to the Globe and Mail, Women's College Hospital in Toronto has developed a set of 30-40 specific tests for foot allergies. Allergies are generally indicated by itchy, red patches on the feet.

Low-heeled, relatively wide-toed shoes are advisable. All shoes should be fitted carefully and, when affordable, people should buy leather shoes. If wearing synthetic shoes, washing feet morning and evening or bathing feet in a rubbing alcohol/water solution will reduce the likelihood of infection, according to Dr. Glen Copeland, at Women's College Hospital.

Third International Women & Health Conference

On June 6-8, 1981 the Third International Women and Health Conference was held in Geneva, Switzerland. Five Canadian women were among the approximately 300 participants from 27 countries. In contrast to the 1977 and 1980 conferences which assembled only women from western countries, Third World women made up one third of attenders.

While the conference was well attended, it did not meet the expectations of all Canadian participants. Muriel Vachon, staff member at MATCH, a Canadian organization focusing on women and development, told *Healthsharing* about some organizational drawbacks. Workshops were large, each being attended by 60-100 women who spoke different languages; translation was only provided for plenary sessions. Because workshop topics tried to be fairly global, discussion remained general and specific documentation did not occur. Cultural differences and the large percentage of European participants also made it difficult for some women to address needs of their countries.

Canadian and Third World women organized a parallel workshop to discuss links between our countries. Participants attempted to outline health needs in less-developed countries and priorities to be fought for within Canadian non-governmental organizations.

Stop that Diet

The much believed link between long life and so-called ideal weight is being called into question. A recent Associated Press story cited a review of 16 studies which found little relationship between age at death and obesity. According to Dr. Reubin Andres, Director of the National Institute on Aging (U.S.), some studies actually found that people 10-30 percent above ideal weight lived longer.

Couple these findings with recent adjustments in the insurance business and we have to wonder if weight charts aren't just another scam to make a buck — a tool of the many armed big business of dieting.

Metropolitan Life Insurance is preparing new height-weight charts which will increase desirable weights by ten pounds or more. The original charts, which are widely used by schools, nutritionists and physicians throughout North America, were developed in 1959. They were based on immediately post-depression statistics and have never been updated. No wonder we're expected to be so thin!

Metropolitan Life's aim is to bring the charts into line with current statistics, which reflect the results of improving nutrition. Specialists working in the field of eating disorders, such as chronic dieting and anorexia nervosa — both of which are by and large phenomena of women, hope that the end result will be a reduction in the number of people unnecessarily dieting.

Number of Disabled Growing in Alberta

Readers of the Medical Post recently learned that, according to Dr. Gustave Gingras, the incidence of brain damage among adults in Alberta is twice that of the North American norm. Dr. Gingras, a Canadian authority on rehabilitation, was in Edmonton to consult and advise on program expansion at the Glenrose Hospital, Alberta's largest rehabilitation centre.

While explaining the need for the Glenrose expansion and development of other satellite rehabilitation facilities in smaller centres, Dr. Gingras pointed out that Alberta's industrialization and urbanization make it a high-risk areas for head injuries. He was quoted as saying that if you add the number of injured workers to the number of people injured in automobile and motor bike accidents, you will probably have the largest number of disabled persons in the country.

The doctor's presentation focused on the need to improve existing rehabilitation facilities, to provide more facilities and to improve education about physical medicine and rehabilitation in universities and faculties of medicine.

No mention appears to have been made for the need to improve occupational health and safety standards. No criticism was made of the companies whose workers are injured and disabled due to unsafe working conditions, non-existent job training, twelve hour shifts worked in the minus 40's Celsius during winter months and the use of young unskilled workers to perform dangerous and highly skilled tasks.

Women Discuss Rural Health Needs

Approximately 250 women met to discuss rural women's health needs at a conference held in Kentucky the weekend of June 19-21. The conference, sponsored by the U.S. National Women's Health Network, although involving some Appalachian women as resource people, drew mostly urban activists.

At the conference Appalachian and Native women compared notes about the role of women healers in their communities. Miners talked about black lung disease and harassment. Workshops were held on numerous issues — occupational health, national issues, lobbying, childbearing, building health services, nutrition, etc. Attention was focused on ways to combat the present swing to the right, especially the need to maintain services in the face of Reagan government cutbacks.

Frumie Diamond and Peggy MacDonald, two of six Ontarians and Québécoises who attended, spoke to *Healthsharing* about the conference. They were disappointed at the insular attitude of most American women with whom they spoke — curiosity about Canadian activities was nearly nonexistent. Because of the focus on lobbying and funding much of the information learned cannot be easily applied at home. Even so, "it was definitely worthwhile to go."

Chlamydia Widespread

Chlamydia, a sexually transmitted disease with symptoms similar to gonorrhea, is more widespread than previously thought. Only in the last several years has the disease been able to be isolated in the laboratory, allowing researchers to gain a more accurate idea of the disease incidence.

Chlamydia is found most frequently among men and women in their twenties and early thirties. Although chlamydia was once thought to be a relatively innocuous vaginal infection, it is now known that it can lead to infertility in women and urinary tract infections in men.

According to Sue Wood, staff person at the Klinic in Winnipeg, few women know they have the disease without undergoing testing. Unfortunately many labs are unable to test for chlamydia, leaving physicians to distinguish the disease from gonorrhea based on response to penicillin, a standard treatment for gonorrhea.

Healthwise

How much lead did you take into your body today? What about your children?

by Donna Samoyloff

Lead poisoning is serious. It is caused by absorption of lead through the digestive tract, skin and lungs; absorption is increased by the presence of Vitamin D. Early signs are mild diarrhea, anemia and irritability — symptoms which some medical texts describe as "colic-like". Advanced effects include stupor, damage to the nerves and convulsions. A significant proportion of those who recover from lead poisoning have residual brain damage.

Despite all the publicity in recent years concerning the dangers of lead poisoning, the average person is still exposed to hazardous amounts of lead day in, day out. Here's where it comes from.

Canned food: Most canned food contains lead. The solder used to make tin cans is the culprit: it is commonly 50% tin, 50% lead and turns silvery or grayish on exposure to air. Lead from solder dissolves into the food. How much? A 4-oz. serving of canned "baked" beans contains 50-60 micrograms of lead. That's one-third the tolerable level for children as outlined by the Food and Drug Administration in the U.S. Children may also consume significant amounts of lead in evaporated milk.

Dishes and glasses: Lead monoxide and red lead are used as glazes and colouring on glassware, cookware and ceramics. Recently there have been warnings about lead paint on the outside of glasses distributed by McDonald's restaurants. The hazard was spotted in Massachusetts, the only state which tests all surfaces of such articles by immersion. In Canada, the federal Department of Consumer and Corporate Affairs tests only the interior of dishes and glasses; no immersion tests are conducted.

Lead in paint: Compounds of lead are used to make many different colours of pigment for house paint. Red, brown, black and some hues of yellow contain lead. Studies done in U.S. urban centres in the 1960's showed that in poorly-maintained buildings, children could and would ingest considerable quantities of lead paint chips; 20% of children in such environments showed evidence of lead ingestion and 3-5% had potentially toxic levels of lead in their blood. Industry spokespersons say that there isn't as much lead in paint these days, but there is still plenty of old paint around. That hand-me-down little red wagon from the grandparents is particularly suspect: red lead is bright orange-red and used in various metal-protective paints.

And there are still other sources of lead you may contact daily. Printing inks contain some lead. That means you can absorb traces of lead by merely handling newsprint. Lead monoxide is used to form the active material on lead-acid battery plates.

Canada is one of the world's principal producers of lead. The largest single source is the Sullivan mine near Kimberly, B.C.; it is also mined at Calumet Island in the Ottawa River, near Sherbrooke, P.Q., and in the Gaspé.

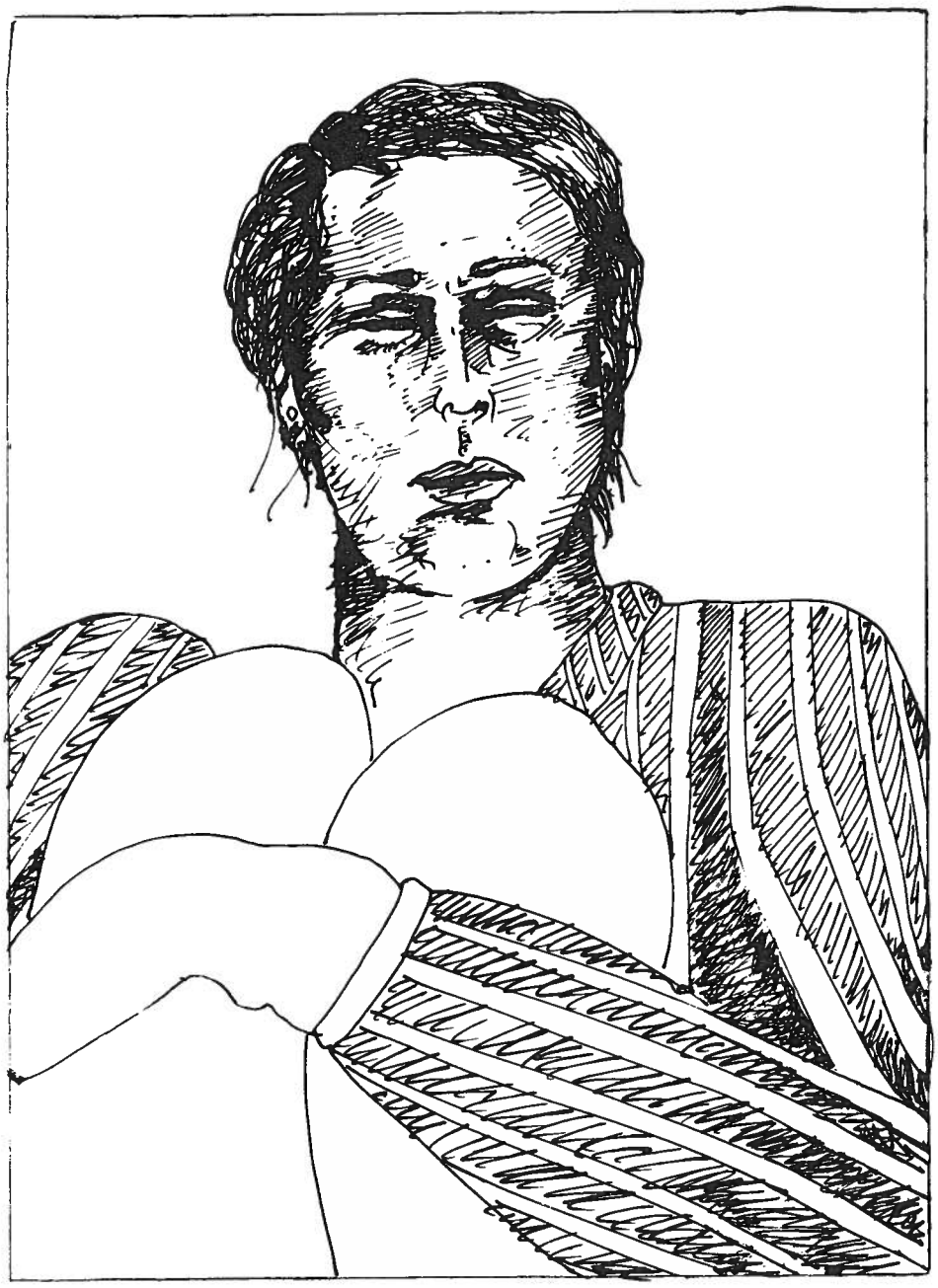
A little here, a little there. Typically, an adult ingests 0.30 milligrams of lead daily. If lead ingestion exceeds 0.60 milligrams per day, excretion through the kidneys, feces and sweat diminishes. Lead builds up in the body, especially in summertime when increased levels of sunlight mean our bodies make more Vitamin D and absorb lead more readily.

It's difficult for all of us to avoid exposure to lead entirely: at the very least, it makes sense to avoid contact with those goods which contain lead compounds and to limit the proportion of canned foods in our diet.

Donna Samoyloff is a concerned parent living in Toronto.

Everybody Knows Someone Who...

by Anne Rochon Ford
drawings by Kathleen McNally



In the change room of a local high school a group of girls prepare for an hour of gym. One girl sits on a bench, hunched over with arms clutching her lower abdomen. Her face has lost its colour and she is rocking back and forth rhythmically. One student says to another "She's just faking. I've got my period too, y'know, and you don't see me doing that. She's just trying to get out of gym. My father's a doctor and he says it's all in your head."

A young woman passes out on the escalator of a large department store and is carried by two customers to the First Aid office and laid down on a cot. A nurse loosens the woman's clothes and puts a cold washcloth on her forehead. The two customers leave, one saying to the other, "It's her monthlies — why doesn't she just stay home when she's like that?"

Scenes like these take place daily the world over. Wherever there are menstruating women, there are sufferers of dysmenorrhea (painful periods); *everybody* knows someone who endures dysmenorrhea month after month. Some women experience pain that is so acute that they are completely incapacitated from it. With some others, the pain is minor and regular activity is not interrupted.

What most women who suffer from some form of dysmenorrhea appear to have in common is a sense of embarrassment and guilt about their condition. Whether they are incapacitated by it with every menstrual period or only occasionally, women have been shamed into thinking that this is not "legitimate" pain. A mother of 3 grown children who has suffered from severe dysmenorrhea all her adult life recently told me that the pain of labour was nothing compared to what she had endured every month with her period.

here are two categories of dysmenorrhea. *Secondary dysmenorrhea* is painful menstruation stemming from a disease (chronic pelvic infection, fibroids, endometriosis or reaction to an intrauterine device). It is generally found only in adult women. *Primary dysmenorrhea* is painful menstruation in women without any pelvic abnormality. It can begin as early in a young woman's life as one to two years after the onset of her first menstrual period (menarche).

Primary dysmenorrhea can further be broken down into two types: congestive and spasmodic. Most of the harsher symptoms of congestive dysmenorrhea (irritability, depression, lethargy, breast tenderness, weight gain, backaches, constipation) occur primarily in the four to five days prior to the onset of the menses. They are generally part of an overall menstrual condition known as the Premenstrual Syndrome.

Spasmodic dysmenorrhea is characterized by symptoms which occur almost exclusively when menstruation starts. These symptoms include: uterine cramps, abdominal pain sometimes accompanied by nausea and vomiting, dizziness occasionally followed by fainting, diarrhea, and pain in the lower back and thighs.

It is difficult to obtain accurate figures on the number of women who suffer from severe spasmodic dysmenorrhea, because so many have simply learned to keep quiet about it. In her recent work *No More Menstrual Cramps and Other Good News,* Penny Budoff claims that ten percent of the 3.5 million American women who suffer some menstrual discomfort regularly are completely incapacitated for one to two days each month because of pain. But the literature on dysmenorrhea is full of varying statistics on the number of lost work hours.

In fact, researchers new to the subject are astounded by the surprising lack of information about dysmenorrhea. The pain of menstruation is still believed by many to be psychological and the amount of research done on the subject is pitifully scant. Great mystery and misunderstanding have surrounded women's menstrual cycles for thousands of years. Weideger, in her work *Menstruation and Menopause,* and Delaney, Lupton and Toth in *The Curse: A Cultural History of Menstruation* give comprehensive overviews of the myths and taboos surrounding menstruation. Past practices include the abandonment of menstruating women to menstrual huts and beliefs that menstruating women were so contaminated as to spoil crops, sour milk and worse. In some primitive cultures the bleeding vagina was even believed capable of castrating a male; in others the blood represented a ruptured hymen.

Taboos die hard and much misunderstanding still pervades our culture, try as we might to believe we have progressed beyond such primitive thinking.

Hippocrates, around 4th century B.C., did propose some possible explanations for the causes of dysmenorrhea. He suggested that it resulted from a woman never having given birth, claiming that "since her womb lies less open, her menses are more difficult". Many women will attest to the fact that dysmenorrhea is often only temporarily relieved through childbirth, even though some doctors continue to suggest it as a possible solution to the problem.

Historically, the premenstrual syndrome has been given much more attention by researchers than has dysmenorrhea. Studies of the subject are always laced with facts and figures regarding the connection between the premenstrual phase and a high rate of suicides and homicides by women. While premenstrual tension gave doctors a reason to label some women as hysterical, severe dysmenorrhea gave them proof positive that women were weak and had a low pain tolerance.

The message that all pain connected with menstruation is psychological is still frighteningly pervasive in the medical profession. A recurring theme in the textbooks is that women who suffer from dysmenorrhea are immature and have not learned to come to terms with "their feminine role".

For example in the fifth edition of *Diagnosis and Treatment of Menstrual Disorders and Sterility,* published in 1967, such a message is quite clear: "The persisting taboos and ignorant superstition, unending modern evidence of ancient folklore that surrounds all aspects of the menstrual cycle, make the psychogenic aspect of dysmenorrhea inevitable. Some of these factors are superficial disturbances of the ego, such as an easily perceived fear of pain; others are deep-rooted not discernible, and are undetected in a lifetime — for example the difficulty that some women have in accepting their feminine role".

In a study published in 1967, attempts to find a link between the dysmenorrheic woman and certain personality variables found "a slight positive correlation between dysmenorrhea and anxiety and neuroticism". Studies such as this fail to bring out the fact that the pain from one menstrual period can generate sufficient fear of one's next menstrual period to compromise the woman's mental health.

It is not surprising, then, given the dearth of strong factual information about such a common condition, that most women who suffer from dysmenorrhea are unaware of the physiology, not just of this particular condition but of the process of menstruation in general.

When pregnancy does not occur, the uterine lining (endometrium) breaks down and is expelled from the uterus. In some women, this expulsion is accompanied by muscular spasms, usually an indication that the uterine muscle is not receiving enough oxygen. For decades, it was convenient to believe that the pain caused by these cramps was manufactured in a woman's mind. Few scientists attempted to find any physiological explanation of the pain.

Contemporary studies have found that conceivably there is a hormonal imbalance in dysmenorrheic women. Specifically, since dysmenorrhea only appears to occur in cycles in which ovulation has occurred, and since progesterone production is essential for ovulation, perhaps dysmenorrhea is a result of an over-production of progesterone and a deficiency in estrogen. This is why women using birth control pills which alter those hormone levels often find relief from menstrual cramps.

Even more current research, brought to public attention primarily through the efforts of Penny Budoff, an American general practitioner, centers around the connection between dysmenorrhea and prostaglandins, the medical buzz-word of the 80's. Prostaglandins are fatty acids which perform a variety of hormone-like actions, but in particular affect the smooth muslce tissue found in the gastrointestinal tract, the aorta, the trachea and the uterus. It was found that just as estrogen and progesterone levels rise and fall throughout the menstrual cycle, so too do the prostaglandin levels, specifically prostaglandin F2-alpha and prostaglandin E2, which respectively constrict and dilate blood vessels.

It is believed that in the dysmenorrheic woman, the ratio of these prostaglandins is unbalanced. There is an overabundance of prostaglandin F2-alpha

causing constriction of the uterus. Furthermore, this excess prostaglandin occasionally spills over into the intestinal tract, causing nausea and vomiting.

Concurrent with the research on prostaglandins and their effect on smooth muslce tissue has been experimentation with a variety of drug compounds which have been found to inhibit prostaglandin production. These nonsteroidal and anti-inflammatory drugs include mefanamic acid (Ponstan), ibuprofen (Motrin), and naproxen (Anaprox, Naprosyn). In a number of cases, these drugs had been used for years in the treatment of arthritis, both in Europe and North America.

The popularity of these drugs has increased tremendously over the past two years. Indeed, in the short term, results of tests performed by the respective drug companies are very impressive. Side effects appear to be quite minimal. Efficacy rate is extremely high.

But there are questions. The first is the extent of the testing done to date. Several of the more recent sources examined stressed the need for further testing, particularly of the long term effects from usage of the drugs. Secondly, in the haste to find drug cures for the problem, little, if any, attention has been given to *why* dysmenorrheic women have higher prostaglandin production than non-dysmenorrheic women.

While the prostaglandin-inhibitor drugs may in the long term by less harmful than possibly addictive analgesics prescribed heavily in the past (see L. Storozuks article, "The Perils of Painkillers", *Healthsharing*, Summer 1980), one must ask oneself whether or not women are being used as guinea pigs until further testing is done, just as so many women were with the Pill.

Alternatives to allopathic treatments DO exist. Most, if not all of the alternative natural treatments for dysmenorrhea have existed much longer than most if not all of the drug therapies. The approach through natural healing, however, is a much more conservative approach to health care than allopathic treatment and does not produce outstanding results overnight. In addition any therapy, natural or synthetic, which brings improvement to one person, may be of no help to a second, and may cause disconcerting side effects in a third.

Many alternative treatments for dysmenorrhea involve nutrition. There are several variations on a "menstrual diet" (generally recommended for the week prior to the onset of the menses) advised by practitioners of non-allopathic healing. Its fundamentals include: high protein intake; reduced carbohydrate, sugar and salt; natural diuretics (cranberry juice in particular); natural bowel relaxants (prunes, senna-leaf tea, bananas, figs); high iron consumption (kelp, kidney beans, soya beans, organ meats); and high calcium intake.

Many women suffering from dysmenorrhea are found to be lacking in a few essential vitamins and minerals, in particular calcium, iron, B_6, C, E and folic acid. If a woman is lacking these, she should take supplements. Probably the most commonly recommended is calcium, a natural muscle relaxant. When taken in combination with magnesium and Vitamin D for proper absorption, many women have found considerable alleviation from the muscle spasms. Herbal teas have been found to be effective in treating mild menstrual cramps. These include such natural relaxants as raspberry leaf, motherwort, squaw mint and pennyroyal.

Eastern folk medicine has also made a considerable contribution to the array of alternative treatments for dysmenorrhea. Many women have found complete relief from menstrual cramps through acupuncture. Seaman and Seaman devote an entire chapter of their book, *Women and the Crisis in Sex Hormones,* to the wonders of the ginseng root, used throughout China for a variety of ailments. The authors speak specifically of its effectiveness as an alternative to synthetic estrogen replacement therapy in menopausal women. If in fact the dysmenorrheic woman has a faulty estrogen/progesterone balance, it may follow that ginseng might be effective in this connection.

Operating on the sound principle

that a uterus which is working inefficiently is often one which is not receiving enough oxygen, Erna Wright, in her book *Painless Menstrual Periods*, outlines a comprehensive exercise program to help strengthen the uterus. Her routine includes deep breathing exercises comparable to those learned by pregnant women to aid them through labour. Similar exercise programs are often outlined, though in less detail, in Hatha yoga sourcebooks.

Orgasms are very successful in relieving the pain temporarily, as they help to smoothe out the contracted muscle. One can also find temporary relief by consciously deferring the pain to another area of the body (for example, putting one's feet in extremely cold water). Margaret Mead, in her seminal study of New Guinean tribes found that "the Arapesh do not recognize menstrual pain at all, possibly because the extreme discomfort of sitting on a thin piece of bark on the damp, cold ground in a leaky leaf hut on the side of a mountain, rubbing one's body with stinging nettles obscures any awareness."

It is important, however, to distinguish between these two latter techniques which help temporarily, and most ot the other alternatives recommended which are essentially preventative.

What is most important to remember about almost all of these alternatives to allopathic treatment is that: 1) results are usually slow in appearing (a woman altering her food and vitamin intake may not see an improvement for a few months) and 2) each individual woman must determine her own particular routine or method of treatment, often through trial and error. Many women *DO* find relief from the symptoms of severe dysmenorrhea through alternative, non-drug methods. The history of these treatments, in many cases, goes back to the days when the secret powers of certain foods and herb combinations was in the hands of women healers. By consciously choosing not to pursue the medical route of treatment, women are taking that lost power back into their own hands.

With the rise of the Women's Health Movement in Canada, women are working to destroy the ill-founded myths and taboos that surround the process of menstruation. With the research done that has uncovered the link between prostaglandins and menstrual disorders, women can now feel confident that their pain has a basis in physiology. Armed with this information, women can now face with assuredness doctors, employers and public health legislators who practise "menstrual politics".

The Women's Health Movement has three tasks before it with respect to dysmenorrhea: 1) to continue to carry out research into alternative treatments for this condition (in addition to pressuring for further testing of the existing drug therapies), 2) to resist the temptation to ignore the temporary physical weakness experienced by women who suffer from severe dysmenorrhea and 3) to spread the word that "freedom from cramps is not a sign of virtue".

If we are capable of accomplishing this in our lifetime, our daughters may look forward to a society in which the process of menstruation is regarded as an enjoyable experience.

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Dysmenorrhea: An Issue Resurfacing

The girl clutching her abdomen in the change room and the young woman passing out on the escalator are not fictitious characters. They are me.

Since a year after I began menstruating at the age of 10, I have suffered from acute dysmenorrhea, save for a four-year reprieve when I was taking birth control pills. I've fainted in schools, in churches, in offices, in cars, on subways, in the company of friends, in the company of strangers and alone. I have had little to moderate success with the alternative treatments I have mentioned above, although I have heard success stories associated with all of them. I do not foresee using anti-prostaglandin drugs because I don't feel sufficient testing has been carried out on them. I continue my search for an alternative that will work for me, recently having learned that I am not properly absorbing calcium due to an underactive parathyroid gland. The parathyroid is responsible for the maintenance of proper calcium levels in the blood and the assimilation of calcium into the muscle.

That this condition essentially forces me to go into hiding for one day a month is only one of my concerns. What worries me particularly are the assumptions people make about me and about women generally because of dysmenorrhea. For those who are already convinced that women are not as physically able as men, seeing me at the onset of my period will only confirm what they believe. (It is disconcerting enough that most men don't believe the pain is real. It is twice as disheartening when other women are doubtful.)

It is for this reason that the issue of dysmenorrhea has been for the Women's Movement a difficult one with which to grapple. It was perhaps less of an issue (or perhaps a buried issue) 10 years ago when more women were less reluctant to take the Pill to relieve symptoms of dysmenorrhea. Now that increasing numbers of women have decided that they would rather have the pain of dysmenhorrea than live with the side effects of the Pill, the issue is re-surfacing. Women are seeking out alternatives. Women are becoming more aware of the mechanics of their menstrual cycles, not only to determine their fertile times but also the first day of menstruation so that they might plan certain activities or non-activities around it.

With increasing evidence to show that menstrual pain is not psychological but very physiological, it is perhaps more important now than ever before that all women help to fight the strong social forces which have dysmenorrheic women feeling embarrassment and shame because of their condition. And take heed to a comment made by a wise, older women who sat with me through one of my "bouts": "One of the worse things we can do to another human being is not to believe their pain".

IF THE CHAIR FITS, SIT (

by Jennifer Penney / drawings by

A typist sighs, and massages the small of her aching back one more time. A garment worker keeps getting off her chair to adjust the cushions she has brought from home and tied to the back and seat. A receptionist rubs hard on the foot that has just gone to sleep, trying to return the circulation. A telephone operator clasps her hands over the top of her head, pulling it down to try and stretch out her contracted neck muscles. A data processor finds herself nauseous half-an-hour after a healthy lunch.

What do all these women have in common? Their work involves sitting for most of the day in chairs that don't fit the size and shape of their bodies. The vast majority of women workers find themselves in this situation, and their discomfort is no picayune matter. Poorly designed office furniture can be harmful to our health and certainly makes it difficult to work efficiently.

Like most workplace equipment, furniture is designed for the "average man". But the body dimensions of the "average man" are a statistical invention which fails to match up with the very real proportions and sizes of virtually all women and the majority of men. Imagine making a shoe for the "average man" and trying to get the whole population to wear it! But that's what is done with office furniture which we may have to "wear" for eight hours a day or more.

As a result, many women workers end up with chronic low back pain, debilitating muscular tension in the neck and shoulders, varicose veins or even digestive problems.

How does your work furniture measure up? If you want to find out how your chairs and tables affect your health, take this checklist to work and go through it while sitting at your desk.

Do your feet rest comfortably on the floor?

Chair seats are too high for many women. As a result, we end up dangling our feet or are forced to perch on the seat edge to put our feet on the floor and relinquish the support of the back rest. This forces our back muscles to work hard all day stabilizing our trunks in a set position. Seats which are too high will also put considerable pressure on the thighs, which are not designed to support the weight of the body. The seat should not be higher than the inside length of your lower leg from heel to back of knee. In fact, a slightly lower seat is preferred for flexibility of leg positions.

Are your thighs compressed by the edge of the seat?

Many chairs are moulded with a hard edge that presses into the thigh. This pressure will restrict the circulation of blood, causing it to pool in the lower legs and creating a potential for varicose veins. Compression of the nerve trunk which runs along the underside of the thigh will result in discomfort and may cause your leg to "go to sleep".

Can you put your fingers between the edge of your seat and the back of your knee when sitting back in your chair?

A seat which is too deep will cause you to slide forward on your thighs and slouch back or lose the support of your back rest. Either posture will strain your back muscles and may lead to chronic lower back pain and possibly to deterioration of the discs in your spine. The seat should be deep enough to allow you changes of posture, but not so great that it cuts into the back of your knee.

Does the back rest fit comfortably into the small of your back and provide support while you are working?

The muscles in the small of your back need support when you are sitting for long periods. Otherwise you may try to take pressure off them by hunching forward. This position puts a strain on the neck muscles. It also reduces the area below the diaphragm and may cramp the stomach and intestines, leading to digestive problems. The back rest should be curved to allow your buttocks to protrude backwards when you are sitting upright in the seat.

Women who have to turn from side to side while working (to answer a telephone, reach for files, etc.) should check the width of the back rest. If your breasts run up against the chair back when you turn you could bruise the tender breast tissues.

)N IT!

Julie Burge

Can you sit comfortably on your "ischial tuberosities"?

The ischial tuberosities (or i.t.'s, as I prefer to call them) are simply the bony protuberances of the pelvis that your friend will complain about if you sit in her lap. These are the parts of the body intended to be sat on. The tissue in the vicinity can withstand pressure without restricting blood supply to the legs. You probably won't be sitting on your i.t.'s if your chair seat is too hard; the surface of the seat should be padded with a dense cushioning material. The texture of the seat covering should be porous and also rough enough to prevent sliding about, but not so rough as to irritate your skin.

Does your chair "welcome" you, or do you feel that it's work to stay seated?

It could be that the back or seat of your chair is tilted too far forward. Most people are comfortable when leaning back so that the angle between the seat, when compressed by the weight of the sitter, and the back rest is slightly more than 90 degrees. Similarly, the surface of the seat should either be horizontal or slope very slightly backwards. Otherwise a constant effort must be made by the legs to keep you from sliding off the chair. (If you want someone to feel unwelcome, give him the chair with shorter front legs than back, and a slippery seat surface!)

Do you run up against the arm rests when you shift position or alter your tasks?

Arm rests are often just a pain in the elbow and restrict necessary movement. If your work involves much reading and/or discussion, however, they can provide additional support for your body as you change positions in your chair. The chair arm should not require you to lift your shoulders uncomfortably high to rest your elbows, though a slight shift in shoulder posture is not problematic.

Do you have to lift your elbows to put them on your work surface?

If you do, the work surface is too high. This probably makes you adopt a tense posture, hunching up your shoulders, and results in fatigue and painful neck and shoulder muscles. A table or desk top at elbow height may seem unusually low for someone accustomed to higher working surfaces. But for anyone required to do manual work such as typing, data processing, sewing or fine assembly, an adjustable table top that can be lowered (or raised) may save a lot of aches and pains.

Can you stretch your legs out, or tuck them under your seat without restriction?

Sitting all day is unhealthy enough, but if even our seated body movements are restricted, our bodies will rightly complain to us with cramped, tight muscles, decreased circulation, tingling nerves and probably, bad tempers. It is preferable not to have a bar connecting the two front legs on our chairs, or shelves under our desks that stop us from stretching our legs forward.

How does your workplace measure up?

My assessment made me get up, stretch my legs and neck muscles and walk around for awhile. Tomorrow I'm going to remove a shelf from the bottom of my typing table, cut a few inches off the legs of my desk, and look for a good second-hand secretarial chair on wheels. But I work in a study at home and I don't have to convince an employer that good seating affects my well-being and productivity!

If you are stuck with furniture that doesn't fit right you have a number of options for action. Check around your workplace to see if there's a chair that fits you better. If there is, and no-one else has first dibs on it, take it to your work position and put your name on it.

Ask your co-workers if they have a problem with the seating. If you have support, a request to management for better-fitting furniture will be taken more seriously. (A few office furniture manufacturers are now beginning to make easily adjustable furniture to fit a variety of body dimensions. Most would be delighted to send down a salesperson to explain the advantages of well-designed seating to your boss.)

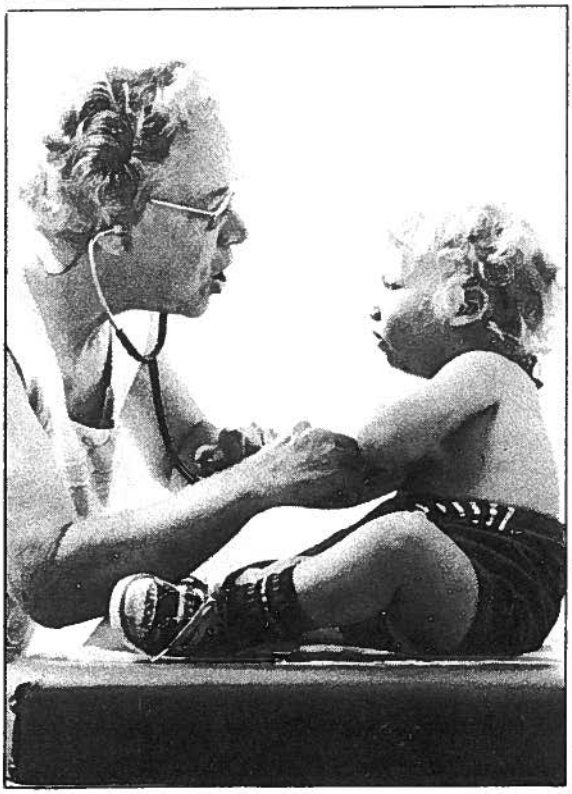
If you belong to a union, the issue should be brought up there, too. Union health and safety committees could investigate the problem more thoroughly and bring the issue up at the bargaining table if necessary.

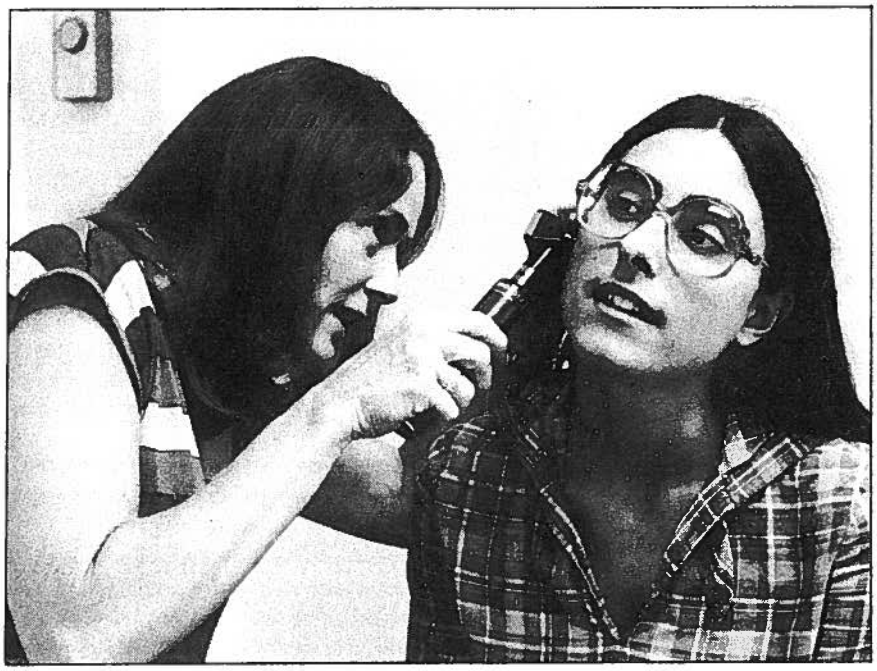
If your seating gives you a bum steer, stand up and speak out!

Jennifer Penney is a Toronto freelance editor and writer. She is working on a book, The Struggle for Good Work.

WOMEN IN MEDICINE: Will It Make a Difference?

by Rhonda Love





hen our children are grown and looking for a family physician, their chances of finding a female physician will be much greater than ours are now. This projection reflects the changes occurring in the education system which produces Canada's medical doctors.

In the past decade, the proportion of female medical students has risen from 7% to 40%. The Association of Canadian Medical Colleges (ACMC), the organization which gathers the statistics about enrolment and student progress, estimates that in 1990 medical college classes will consist of equal proportions of men and women. This change should manifest itself by increasing the proportion of women who are practising medicine from the current 12% to 50% by the year 2021.

But what does this influx of women into medicine mean? The major question is: Will they affect the quality of medical care available to Canadians? It appears no one in Canada has systematically investigated this issue.* However, there is information from other countries, particularly from the U.S., which may give us some clues about what to expect here.

One of the first things that becomes obvious when researching this question is that females are essentially invisible in most studies — both as researchers and as those researched. The two major classics in the study of medical education, *The Student-Physician* (1957) and *Boys in White* (1961), do not include any information on the women who were students in the studied classes. Judith Lorber explores this in her article "Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients." Even though current studies have begun to notice that women exist, Lorber suggests that researchers, even those who have considered sex of the practitioner as important, have not adequately investigated either the sex of the doctor or the relationship between sex and age, education, religion or ethnic background.

Having mentioned the difficulties with the available data, I will discuss the following issues: enrolment patterns in Canadian schools, specialty choices, productivity *vis à vis* gender, the experience of medical school and potential changes in the dominant position of medicine.

Photos by Jennifer Penney.
Clockwise from the top: Ellen Buchman and Donald Cole from York Community Services Medical Unit, general practitioner Joan Ban with patient Susan Wortman, pediatrician Pam Grayson with Devan Penney.

Enrolment. The male and female applicants to medical school look very similar to each other in terms of pre-admission education qualifications and scores on the Medical College Aptitude Test, a standardized admissions examination. The majority of both groups do not have a university degree and less than one point separates their examination performance. This lets us speculate that, contrary to many myths, women may not have to be "twice as good" as men to succeed. This doesn't preclude of course, that they may have had to be "twice as good" to get to the admission stage.

Although total enrolment in Canadian medical schools levelled off in 1975, the proportion of women continues to increase. Women are becoming more successful in getting places each year. Men, however, appear to try harder to get accepted; that is, they are more likely to reapply than women (38.1% to 29.1%), but women who resubmit applications are just as likely to be accepted as the men (25% to 26%). There is little information available on performance during medical school but it is known that once women get into medical school they are no more likely than men to leave before graduation. This should put an end to the familiar sexist contention that women shouldn't get in because they won't finish their education.

Specialist Choices. Although male and female applicants appear similar at admission, at graduation there are some important differences. Men and women do not enter the same specialties. Women are under-represented in the surgery specialties (with the exception of obstetrics-gynecology and opthalmology) and are most prevalent in the internal medicine fields of dermatology and pediatrics. They also account for more than one third of those in preventive medicine, family medicine, physical medicine and rehabilitation, and psychiatry. Women are less than five percent of the physicians practising cardiology, neurosurgery, orthopedics, and cardiovascular and thoracic surgery (see the table below). These differences are very similar to those in the U.S.

Women in both countries are also more likely to practise in institutions and to be salaried than to work in the office-based fee-for-service mode. As a function of both specialty choice and type of practice, women physicians tend to earn about 50 percent less than do males. This varies significantly according to hours worked, specialties and availability of medical insurance.

While many of us may applaud the women's specialty choices, they have not chosen what the profession considers the high prestige specialties. We might wonder why this is so.

According to Lorber, the standard explanation given about why women are in the low status positions within medicine is because medical careers, especially the most prestigious fields, are demanding and women leave their careers to raise families.

However evidence does not support the myth. Studies show that even though female physicians frequently state "pregnancy and family problems" as a chief reason for curtailing activities, the statistics indicate reductions in work load are related only to marriage, not to the number of children a female physician has. It appears the real strain on female married physicians does not come from being a mother but from being a wife. Unfortunately, we have not done all the studies that would allow us to confirm or explain this.

Productivity. In Canada, Charlotte Gray wrote in the *Canadian Medical Association Journal* (October, 1980) "the patterns of male and female productivity are converging rapidly and the pattern of female practice is changing." She quoted a 1976 study from the University of Western Ontario which says women who graduated in the 60's were far less likely to stop working than the women who graduated before them from the 1920's onward. In addition, only 17 percent of the 60's graduates interrupted their practice for child rearing compared to 33 percent of the earlier graduates. A 1973 study of the students

**There may be studies of which the author is unaware. If you know of any, I would appreciate the reference(s).*

Women in Selected Specialties*

Specialty	% Female
Pediatrics	41.9
Dermatology	40.8
Medical Microbiology	39.5
Preventive Medicine	36.4
Psychiatry	34.9
Family Medicine	33.5
Physical Medicine and Rehabilitation	33.3
Anesthesiology	27.1
Obstretrics & Gynecology	21.8
Opthalmology	16.3
Neurosurgery	1.7
Cardiovascular and Theracic Surgery	2.1
Orthopedics	2.2
Plastic Surgery	6.3

* Source: ACMC Canadian Medical Education Statistics, 1978/80.

who graduated from the University of Toronto indicated that almost all of the women were working at least 75 percent of the time; men reported similar working patterns. This limited information says women physicians do not curtail their productivity greatly as a result of being mothers.

A recent physician productivity study in the U.S. found similar patterns for physicians who are also mothers. Only seven percent of the women were not engaged in medical work because of responsibilities for children; more than half of the women had worked full-time continuously since graduation from medical school. In all, the women worked 90 percent as much as the men did since graduating.

Dr. Carole Guzman, speaking for the Federation of Medical Women of Canada, told participants at an October, 1980 conference on medical education that even if the 60 percent of the female physicians who have children reduce their workloads for about 10 years, the effect on total Canadian physician productivity will be only a 2.25 percent reduction. As she suggests, this is hardly a figure to worry about when a physician surplus is anticipated.

The differential responsibilities men and women have for childrearing have plagued all women who want to work outside the home. Female professionals with children are perhaps the least affected by these problems because they often have reasonable access to child rearing assistance. Even so, professional women too are dogged by the contention that because they will be less productive than male counterparts they are less welcome in their profession. Studies such as those cited here demonstrate the lack of basis for this contention.

Ghettoization. Another dubious reason given for female ghettoization in medicine is that specialty fields chosen by women represent "women's work" or that these areas are somehow less demanding or competitive. However, most of the specialties don't fit these ideas so neatly. Obstetrics-gynecology and pediatrics, which can be most easily labelled women's work, hardly have regular hours and must be both demanding and competitive (particularly as birth rates decline). Those specialties with controllable hours, such as dermatology and opthalmogy, are hardly typical women's work.

A third reason given for women's choices of specialties has been that women are more interested in those specialties which offer a high level of interpersonal interaction between patient and physicians. If this is so then it isn't surprising to find a preponderance of women in family practice, psychiatry, pediatrics, and obstetrics and gynecology. But it doesn't at all explain why women would choose low interaction specialties like public health, anesthesiology, rehabilitation medicine, pathology and medical microbiology.

There is some evidence that Canadian female medical students may stay away from research-oriented careers. In 1978 Eva Ryten, a research associate for ACMC, studied medical students' career expectations. She discovered that nearly half of the women students and 38 percent of the men indicated general practice as their first career choice. Almost six percent of the males but only three percent of the females chose research for a career. According to Gray, Ryten found women were ". . . less concerned with the financial rewards of medicine (often associated with research) and more concerned with face-to-face relationships with patients. The men were concerned too, but were also prepared to admit to financial ambition." This, of course, still leaves the unanswered question of whether women medical students are actually less interested in money or are instead less likely to talk about the financial rewards of their choices.

The simple truth is that most of the above reasons for female ghettoization are based on stereotypical notions of women as more oriented toward people than tasks, non-competitive and unambitious. We may wish this were so, but we know that such a "nice" person just might not make it to or through medical school (or any other upper level academic work). There are scant data upon which to base conclusions about interactions between personality characteristics, specialty choices and sex.

However, there is another approach to the question. Instead of studying the characteristics of the individuals we can examine the characteristics of the institution to determine effects on individuals' choices.

The schooling experience. One important factor in the future success of a physician is the support and encouragement a student gets from teachers while being educated. Throughout the past few decades, Oswald Hall, a Canadian sociologist, has been writing about how students become professionals. He uses the term "sponsorship" to label the system by which medical practitioners and professors select and groom certain students for success. This sponsorship may include selective counselling and guidance to active assistance and support in obtaining the best internship or research post, referring patients or ultimately having the student inherit the former sponsor's post or practice. In its extreme, it is the same entrepreneurial practice that guides the small businessman to train his sons in "the business".

We can be sure that such a process exists in our schools. Although there are ways of reducing the personal element in choosing internships, it cannot be, and perhaps should not be, eradicated. Emily Mumford's book, *Interns: From Students to Physicians*, describes the way in which American women medical students are streamed away from internships in prestigious technology-dependent university-based hospitals. Women are streamed toward public health oriented hospitals where the focus is on quick diagnosis and return of the patient to family and community. Interns are expected to go into general practice upon leaving such residences.

An important difference affecting expectations for future practice is that specialists are dependent almost entirely

upon colleagues to refer patients to them, whereas general practitioners are much more dependent upon the support of and referrals from their patients. It may be then that general practitioners become more interested in helping their patients than in helping other practitioners.

Although there is no direct information on the experience of Canadian medical students and their sponsors, we may not be too wrong in speculating that the system is similar to the U.S. It is remarkable that even though the medical systems of the two countries differ in both the level and method of physician remuneration, the internship patterns are almost identical. An educated guess is that while the payment differs, the profession's values are similar and these values perpetuate a sexist, masculinist, elitist system.

Of course, differential sponsorship is only one method of treating men and women differently. Every medical school has its horror stories about playboy-type pin-ups flashed on the screen during anatomy lectures, of women students being ridiculed, ignored or treated as incompetent, of patients not believing a female student is a doctor and of harassment from male students. Fortunately, the administration in most schools does not support and may even punish overt sexism. This does not completely stop those who are determined to insult women but it destroys their political power.

Unfortunately, within medical schools women are divided among themselves just as they are in other walks of life. Female students who are offended by sexist practices often have to justify their feelings, not just to men, but to other women who have chosen not to complain.

Changes in the offing. This brings us to the important and complicated question of what changes we can realistically expect because of the increasing number of women in medical school. One argument is that getting any woman into medical school is better than not getting any in. This argument usually continues that the proportion of women in medical school should reflect the proportion of women in society. The suggestion is that at least the representation is fair. However fair it may be, it leaves a lot of unresolved issues.

A major concern should be around what *kind* of women (and men) do we want to be physicians and what kind of education of do we want them to receive? If we believe medicine suffers because it is too dependent on high technology and drugs, do we really want students who have come through physical sciences curricula? If we want our physicians to be more humane, do we want to continue an education system that dehumanizes them?

On this last point, Martin Shapiro, in his book *Getting Doctored*, has chronicled the experience of a Canadian medical student. He asserts that the system produces a competitive and self-centered physician who has been robbed of her or his humanity by a brutal education. Regardless of a particular individual's desire for change, the system perpetuates itself.

The effects of this rapid increase in the number of women in medical school is not clear. We can speculate that if women are less interested in financial gain, more likely to want salaried positions in institutions and more interested in general practice than in research and high status specialties, they may change the entrepreneurial face of medicine. Three Canadian researchers, David Coburn, George Torrance and Joe Kaufert, have suggested that, if these things are true, the profession's resistance to government involvement may decrease. They also suggest that this may *not* occur, that instead the increase in women may "produce feminine enclaves without radical change in the power structure of medicine."

If, however, there are changes in the power relationship between the profession and the government, we can anticipate a decline in the dominant position that medicine plays in the health care field. If the state gains more power, the profession will lose some, if not most, of its control over remuneration, the conditions of work, selection and treatment of clients, licensing practices and educational processes. This would seriously erode the class position of physicians and perhaps eventually alter the role of medicine in general.

Those of us who are involved in a daily struggle with conventional medicine may be skeptical that such changes are to be forthcoming. Coburn, Torrance and Kaufert believe that medicine's dominance is on the decline. This decline is seen as part of a larger decline in the position of self-employed professionals, farmers and small business owners in Canada. And, inside the profession itself, they say "medicine does show some of the same tendencies towards fragmentation as it did in the . . . nineteenth century."

If the power of medicine as a profession is presently on the decline, we have many unanswered questions about the impact of the increase in the numbers of women. Will the women be seen as the cause of the decline and subjected to even more harassment by those who are opposed to the changes? Will women recognize that the opportunities for a radical change are at hand and capitalize on them? Will the women come to see themselves as part of a beleaguered profession and fight against the changes? Will men see medicine as less attractive and not enter the profession?

We simply do not know the answers. But we can decide directions we would like medicine to go and take advantage of the present flux. Those of us who are concerned about such issues as medical control of health, the increasing reliance on technology and the turning of *social* problems (e.g. mental illness, alcoholism, "deviance") into *medical* problems, should be paying careful attention to who gets into medical school, what happens to them while they are there and what kinds of work they choose after graduation.

If we have friends who are considering or are already in medical school, we can attempt to support their efforts at change. We can realize that "just any" woman may not bring change. But many change-oriented women and men may affect the education system and the profession. At a more obviously political level we can give support to those groups who are attempting to influence the profession and the education of doctors. Whatever level of action or strategy we choose, it is important to act now while the issues are unsettled. Our efforts won't be welcomed by those resistant to change, but this may be our opportunity to remove *health* from the control of *medicine*. It could be a powerful victory if women choose to fight.

Most of the ideas on medical dominance are from an unpublished paper by Coburn, Torrance and Kaufert.

Rhonda Love teaches Community Health in Toronto.

My Story, Our Story

My story, our story is every woman's experience — our collective experience — with health.

SCREEN TEST

by Vonne Solis

The following story is my experience of a culposcopy — a test for cervical cancer. The procedure involves a microscopic machine that enables the specialist to examine the cervix at close range, to detect pre-cancerous or cancerous cells. It is hooked up to a video screen enabling the patient to witness the doctor's probing of the cervix. A biopsy (a tiny clipping of the cervix) is also taken for laboratory testing. The entire procedure is painless.

"So you want to be a star!" It wasn't quite what I had anticipated as the doctor, groomed impeccably in his starched whites, stared me in the eye.

Adjusting myself to the usual position for examining, I attempted a grin while trying to control the vibration of my knees. Perspiration oozed from my pores and my backside clung to the crisp, clean sheets.

I breathed deep the obnoxious odor of sterility seeping through the walls, and quickly scanned the room. As much as it tried to present a picture of familiarity and comfort with pastel colors, softly-patterned drapes and dim lighting, I remained stiff like a slab of concrete ready to be chiseled.

I tried not to notice the tray of instruments on my right, guarded diligently by a small woman, but rather let the touch of her hand on my own lend reassurance to the ordeal I faced.

Just beyond my feet stood the huge, celebrated machine, its attachments gleaming and ready to assault.

A glove snapped tight to my wrist, and in a panic I jerked my head to one side. A blank video screen met my stare, but like a coward I squeezed my eyes tight, welcoming the dark.

Murmured voices and a tinkle from the tray heightened my anxiety and I felt a wave of nausea.

I became aware of the doctor's voice, blurred with the concentration of his task, suggesting I view the screen. Expecting a cruel display of modern technology, I slowly raised my lids.

Splotches of red and white on the screen danced before my eyes and as I realized the images to be me, emotional spasms of conflict forced my attention away.

Was white good or bad? Frantically I searched my brain while the muscles in my stomach convulsed.

Why didn't the doctor say something as he gently probed and dissected?

There didn't seem to be a noise in the room except for the questions locked in my throat, screaming for release.

I lay there.

How unjust to be stricken with this morbid disease when my life had just started.

I flicked my eyes open to the video once more, tingling with nerves. Images raced through my mind of the changes to be made, the shock friends would suffer, my family.

I jumped as a stiff tap on my arm from the nurse snatched my senses from abstraction and the pressure from my middle seemed to lessen.

Cold chills skimmed over me and the flush of seconds ago paled.

I wondered what rational interpretation I would get this time.

The doctor's eyes found mine and his forehead crinkled for an instant as he raised his brow. "You just might make Hollywood!"

Cloth rubbed against my knees and, surprised, I discovered my nightgown had been smoothed down. As if to heed a silent command, I pulled myself up slowly and slipped to the floor.

Staff bustled about the room in preparation for the next victim, and I stood staring at the doctor's back. He turned. "Any questions?"

Thousands!

Timidly, I shook my head, clasped the back of my gown with one hand and gracefully made an exit.

It appeared I had survived my first test for cancer.

Vonne Solis is a freelance writer who lives in North Vancouver.

Reviews

Male Practice

Reviewed by Lisa McCaskell and Betty Burcher

Male Practice is a provocative and at times frightening book. Written by a male doctor, Robert Mendelsohn, the stated purpose of the book is "to expose the mistreatment of women by their doctors. . . ." In Mendelsohn's words: "I wanted to do more than inform you. I wanted to disgust you, shock you, and frighten you. I wanted to make you very, very angry!" Dr. Mendelsohn consistently achieves his goal.

The book is easily read and non-academic. In an anecdotal and somewhat chatty approach, Mendelsohn guides us from one example of horrifying mistreatment to another. With no time to catch our breath or to put his examples into perspective we race from misuse of diagnostic tests, to the overuse of x-rays, to the dangerous prescribing habits of doctors. We read of the ram-

pant use of surgery on women and how our power to control childbearing has been stripped from us.

Mendelsohn uses facts and figures liberally to add to the shocking picture he paints. In his chapter on the use and misuse of diagnostic lab tests, he cites these figures: "Pap tests produce false negative results about 20 percent of the time. . . . On the other side of the coin, false positive results occur in 5 to 10 percent of the tests." Both types of errors may lead to treatment or lack of it that is life threatening. When discussing x-rays we are told that "Women are twice as likely as men to get cancer from their potentially deadly radiation effects." We are also informed that "Thirty percent of the x-rays taken in the United States — nearly 300 million a year — are ordered in cases where there is no valid medical need."

The chapter on prescription drugs validates our concerns about over-prescribing to women patients. Of the 160 million prescriptions for tranquillizers, sedatives and stimulants written in 1979 in the U.S., 60 percent of the mind-altering drugs, 71 percent of the antidepressants, and 80 percent of the amphetamines were prescribed for women.

Dr. Mendelsohn opens his chapter on hysterectomies with the statement that, "if Modern Medicine continues on its present course one of every two women in the country will part with her uterus before she reaches the age of 65." The facts, figures and horror stories go on until we are numbed.

What are we to do? It is when trying to answer this question that some of the problems with Mendelsohn's book become apparent. The root of all medical evil, according to the author, is male chauvinism. In his own words, "Clearly, sexist behavior is at the heart of the medical abuse that women suffer." Although his opening chapters do contain a denunciation of the institution of "Modern Medicine", it is never expanded into an analysis of the medical system. A critique of the medical system is instead overshadowed by repeated references to male chauvinism and the damage it has wrought. Although numerous examples are given of the way "Modern Medicine" functions as an integral part of Western capitalist society, Mendelsohn himself seems to miss the point. Male chauvinism is not seen as a symptom of problems in this society and

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this medical system but as the problem itself. This analysis, or lack of it leads to an equally simplistic solution. We must struggle to reform the male chauvinistic doctors wherever we find them.

For this particular struggle, Mendelsohn gives us encouragement and ammunition. Every woman who reads this book is on her way to becoming a better informed medical "consumer". In Mendelsohn's viewpoint, by being assertive and by demanding information and responsible and humane care, we will force doctors and hence "Modern Medicine" to reform. While reform is valuable, and responsible, non-sexist doctors are certainly preferable to the variety we are all well-acquainted with, it is not enough. It will take more than the consciousness-raising of individual physicians to substantially alter a medical system dedicated to profit, to "curing" sickness, and to dramatic drug and surgical intervention.

Male Practice is a valuable book especially to those who are growing suspicious of the benevolence of our medical system for the first time. It will be a useful tool for any woman who is faced with tests, procedures, drugs or surgery that she knows little about. But for those who are seeking alternatives to allopathic medicine or who are striving to change our present medical model, a deeper analysis is needed.

Male Practice by Robert S. Mendelsohn, M.D. is published by Contemporary Books, Chicago, 1981. $13.95 in hardcover.

Lisa McCaskell is a Registered Nurse working in Toronto, and a member of Women Healthsharing.

Betty Burcher is a nurse working for Parent Resources in Toronto, and a member of Women Healthsharing.

Heart and Hands

Reviewed by Theo Dawson and Vicki Van Wagner

The lost female art of midwifery is being reborn; *A Guide to Midwifery: Heart and Hands* is a landmark in its rebirth. In her book, Elizabeth Davis has articulated many of the experiences, techniques and sensitivities that other North American midwives have been discovering.

It is special in many ways. Unlike any of the previous works on midwifery, the book deals with the nitty-gritty of practising in conditions common to most midwives on this continent. Davis begins with good advice on the politics of becoming a midwife, and describes the difficulties of learning and apprenticeship: "There can be no doubt that lately midwifery has become a fad. . . . In order for a person to stay with such demanding work, it should feel more like a calling."

Her suggestions for ways to begin studying and to gain experience are excellent, as is her guide to the literature available on childbirth and obstetrics. She explores relationships between apprentices and senior midwives and among practising midwives. Davis depicts the difficulty in cooperating when competition, divergent styles and/or personalities, and isolation divide midwives. She gives an authentic description of both how to set up a practice and of trying to work out family and personal needs while midwifing.

The book is unusual also in the way it looks at the "spiritual midwife". She claims that the demands of attending births, and the intuitions and sensitivities which must develop in a midwife, will require a "greatness of spirit" of those who practise. Yet she is very strong in her caution against spiritual midwifery.

She warns that, "Spirituality after all is a very personal ineffable aliveness

unique to each of us. . . . Concepts concerning spiritual behaviour or spiritual attitudes imply generalized value judgements and are of no help to individual women. The danger of the midwife who considers herself spiritual is that she will impose her beliefs on others, thus disrupting each unique opening and discovery process. Her counsel will be ineffective, and her touch will lose potency."

In dealing with the popular, sentimental idea of free spiritual midwifery, Davis shows lots of common sense. It is very difficult to mix financial pressure and the close, emotionally based relationship between midwife and client. Yet women doing relationship-based work with no economic reward sounds only too familiar doesn't it? In her own practice, Davis has worked out a compromise which seems to be common to other midwives. Because of the need to pay the bills, and importantly, because she values the work of midwifery highly, Davis advises midwives to charge fees realistic to their needs, but not to refuse people who sincerely want their services, because they cannot pay.

As a practical guide to midwifery, *Heart and Hands* has many strong points. Davis looks at most conditions in pregnancy and labour as involving the whole woman, and suggests treatment which is responsive to the individual case. One of her strengths is her insistence on the importance of being flexible and supportive of the needs and decisions of the individual woman.

Davis takes very seriously the concept that psychological obstacles can be the source of problems in pregnancy and labour, and documents situations and solutions from her own experience. Characteristically though, she cautions against "psyching out" when purely physical conditions may be creating a problem, and insists that these must be monitored carefully. Her techniques and opinions are shared in a manner similar to a group of midwives sitting down to talk over their practices. Davis is honest enough to teach us by admitting to her own mistakes and misjudgements as well as her successes.

The quality of the practical information in this book will make it an important reference in situations which require either medical or intuitive know how. The photographs and drawings are excellent and bring a graphic reality to many of the techniques and scenes she describes.

Perhaps because she is writing from California, where lay midwives have been working for a longer period of time than in our area, Davis advocates certain practices which we have not yet used, and have questions about. She is in favour of correcting deflexion of the fetal head prenatally, and of manual rotation of posterior presentations. While she does emphasize the delicacy which needs to be used in interventions such as external version for breech babies, she does not acknowledge the controversial nature of these other techniques. We would like to hear from others with experience and opinions on these procedures.

Many times in the book, Davis has to juggle her wish to dispel some of the romanticism about midwifery and her need to express the beauty she finds in her own work. We found that she achieved a balance which will make the book useful, not only to midwives, but to anyone involved in childbirth, either as parents or professionals.

A Guide to Midwifery: Hearts and Hands by Elizabeth Davis is published by John Muir Publications, Santa Fe, New Mexico. $11.95 in paper back.

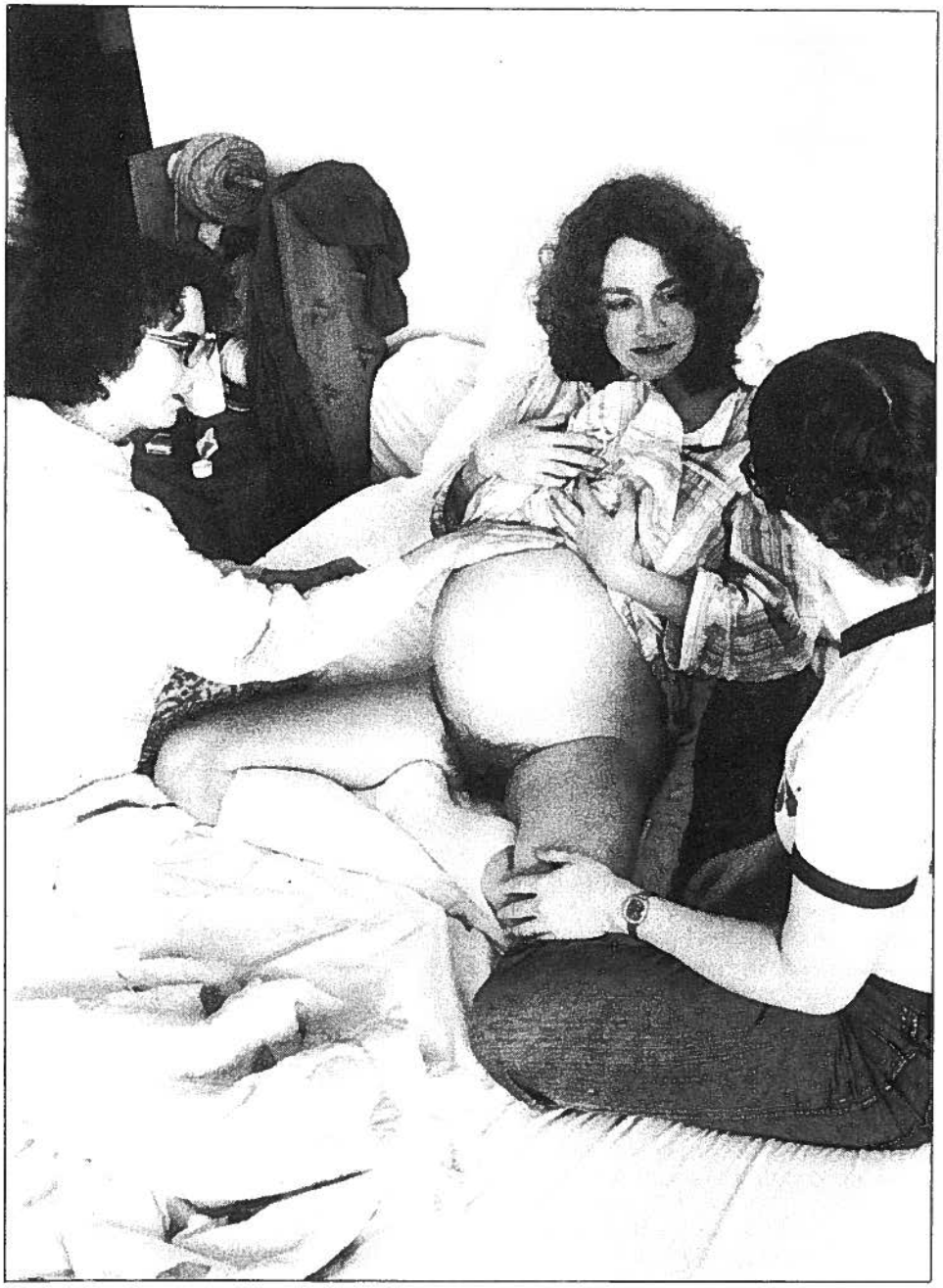

Photo: Frank Rooney

Theo Dawson and Vicki Van Wagner both attend births in Toronto.

Regional Reports

The postal strike and lack of activity in the summer have cut down on the number of Regional Reports for this issue. However, our correspondents continue to keep us informed on issues and activities in their regions and we greatly appreciate their contributions. We are looking for new correspondents, particularly in regions not presently being reported on. If you are interested in becoming a regional correspondent for Healthsharing, please write to Diana Majury, c/o Women Healthsharing.

NOVA SCOTIA — Deborah Kaetz

Relocation of Maternity Hospital: Consumer participation in hospital planning and the future location of Halifax's Grace Maternity Hospital are 2 issues which have concerned BONDING (Better Obstetrics and Neonatal Decisions in the New Grace) since its founding meeting in March 1980. The group is led by Jan Catano, past chairwoman of Prepared Childbirth Association, Nova Scotia, and provincial coordinator of the ICEA (International Childbirth Education Association) and Dr. Linda Ruffman, Professor of Sociology at St. Mary's University. BONDING has lobbied government to respect the needs of mothers and babies *before* they move or build the new hospital. The Grace is Canada's only exclusively maternity hospital.

Nevertheless the Buchanan government has doggedly pursued its plans to construct an 850-plus bed, high technology hospital on the grounds of what is now the Camp Hill Veterans Hospital. The proposed Camp Hill Medical Complex was planned by Built Environment Coordinators to amalgamate five city hospitals, including the Grace.

Part of BONDING's dissatisfaction stems from the deleterious effects such a large scale facility may have on patient care and the implications of moving maternity care into a large disease-oriented institution. In addition it is feared that the benefits available at the current Grace site, next to the Isaac Walton Killam Hospital for Children, will be lost. In the Atlantic region served by the Grace, the neonatal mortality rate for babies weighing 1,000 grams or over and up to and including 7 days of age is 2 per 1,000, the lowest rate in Canada.

Largely due to the efforts of BONDING, the hospital planning committee has added a consumer representative and set up a consumer subcommittee empowered to form working groups to make representations to the planning board.

Listeriosis: An outbreak of a rare infection caused by the bacteria *listerioia monocytogenes,* which can affect pregnant women, fetuses and newborn infants was reported in the province in early July. The infection can cause stillbirth or, in a newborn, can lead to meningitis. So far 16 cases of the disease have been confirmed in mothers and/or newborns and four cases in non-pregnant adults. Public health officials are concerned and have issued a release warning women and doctors.

The clinical features of listeriosis include flu-like symptoms accompanied by a high fever. The disease is treatable with antibiotics. Diagnosis is based on blood and vaginal cultures. *Listerioia monocytogenes* are genital bacteria, but are not spread genitally. It is not known how the bacteria are transmitted. In humans the disease peaks in July and August. Nova Scotia usually has one or two cases a year. The unusually high number of cases which have developed this summer cause concern.

ONTARIO — Anne Rochon Ford

Toronto Women's Health Network: One outcome of the Strategies for Well-Being conference in Toronto in March was the creation of the Toronto Women's Health Network. The network has met three times and while there is a good deal of enthusiasm about future action, the group will not attempt to develop collective philosophies and strategies until the fall. In the meantime however, monthly meetings are characterized by a great deal of information sharing, with women attending from a variety of backgrounds related to women's health. Interested Torontonians should contact Anne Rochon Ford (967-9467) or Lyba Spring (625-3665) for news of upcoming meetings.

PRINCE EDWARD ISLAND — Annie Thurlow

Menopause Project: A project called "Your Health in the Middle Years" is being undertaken this fall by the Prince Edward Island Committee on Women's Health Issues. Designed to fill the gap in information for menopausal and post-menopausal women, the culminating activities will be a slide-tape presentation and a series of brochures dealing with such issues as menopause, changing roles and nutrition and fitness. Project workers are interested in obtaining any information — pamphlets, films or suggested readings — and ask that information or suggestions be sent to the Committee on Women's Health Issues, 81 Prince Street, Charlottetown.

Therapeutic Abortion Committee Cut: A vote by the membership of the Queen Elizabeth Hospital in Charlottetown has overturned a hospital board decision to allow a therapeutic abortion committee (TAC) at that facility. The Queen Elizabeth Hospital, still under construction, is to be an amalgamation of the two existing hospitals — one, a Protestant hospital which had a TAC, and the other, a Catholic hospital which did not.

The vote came as a result of a strong campaign on the part of the PEI Right to Life Association. Attendance at the meeting numbered merely 1,800, the vast majority of whom voted against the establishment of a TAC. The vote leaves the

Regional Reports

province with only one small hospital which has a TAC and places in jeopardy those who require an abortion in a life-threatening situation.

Many of those who disagree with the decision have expressed concern about speaking publicly on the issue due to fear of repercussions. People speaking in favour of the establishment of a TAC at the meeting where the vote was held were greeted with booing and shouts of derision.

ALBERTA — Ellen Seaman

The Fight for Home Births Continues: A small but active chapter of the Association for Safe Alternatives in Childbirth (ASAC) has been challenging the Alberta College of Physicians and Surgeons on the home birth issue. Alberta has the strictest rules of any province regarding home births. Physicians have been prohibited entirely from attending home births and since, of course, midwifery is not licensed, safe birthing alternatives are drastically reduced.

ASAC has waged an effective letter-writing campaign, both to the College and the press. A petition, currently in the process of being collected, already has over 1600 names.

At the end of April, ASAC presented a brief to the College which resulted in a promise from the College that they would set up a task force to study the issue of home births. However, ASAC now feels that the College is dragging its feet on this promise. ASAC's current efforts are aimed at ensuring that the physicians fulfill their commitment and that the task force contains consumer input.

ASAC is a membership organization which, among its other activities, publishes a monthly newsletter. The membership fee is $5.00. Further information may be obtained from Geraldine Smyllski, 10435-154 Street, Edmonton, Alberta (403) 483-3488.

BRITISH COLUMBIA

VICTORIA — Susan Moger

Hospital Boards Remain Abortion Battleground: Concerned residents of Victoria are readying themselves for the upcoming September 10th election to fill three seats on the board of Victoria General Hospital. The seats are currently held by pro-choice supporters, all of whom are running for re-election. The Coalition for Choice on Abortion and the Canadian Abortion Rights Action League have been recruiting people to join the hospital association. It is felt that this year the pro-choice group will have as strong a lobby as the anti-choice group did last year. However, should the three seats in question go to anti-choice supporters, they will then have control of the hospital board.

Midwife Convicted: Margaret Marsh, the first person ever prosecuted for midwifery under the B.C. Medical Practitioners Act, which has been in force for 96 years, was found guilty and fined ten dollars. The court case highlighted the vagueness and ambiguity present in the Act when it was disclosed that midwifery is not defined in it. The Act makes it unlawful for anyone other than a licensed physician to practice midwifery and doctors are not trained as midwives.

Marsh's conviction for practising midwifery brought an end to three years of legal encounters that began in 1978 when Marsh, a former physician, attended the birth of a child in its parents' home in Victoria. The child died and Marsh was charged with criminal negligence in connection with the death. She was eventually acquitted on that charge.

VANCOUVER — Beth Hutchinson

Doctors Get Raise: The B.C. doctors, already the highest paid in Canada, after months of fighting for more money, have settled for adjustments to the fee schedule amounting to a raise of approximately 40 percent. This follows threats of extra billing by the doctors and counter threats of legislation to ban extra billing on the part of the Ministry of Health. The settlement has been followed by a 35 percent raise in medicare premiums.

Cutbacks: The Ministry of Health is now cutting back on long term care assistance. This assistance, for people with chronic conditions, is used primarily by the elderly and by women. The Ministry has been vague about the actual cutbacks, but at the present time all clients of the program in Vancouver are being reassessed as to their needs and no new clients are being accepted, except in emergency situations. The B.C. Coalition of the Disabled, along with other groups, is protesting these cutbacks.

Abortion Struggles Continue: Anti-choice boards of directors have been elected at both the Surrey and Richmond hospitals. Doctors at these hospitals are protesting the anti-choice decisions and single issue orientation of these boards. Throughout the province and in Alberta, abortions are becoming less available, resulting in more women coming to Vancouver or going to the United States in order to obtain an abortion. Needless to say, the amount of time and money required for this is not available to all women.

Farm Workers Seek Compensation Coverage: Farm workers in B.C. are presently not covered by the Workers' Compensation Act, even though they constantly face many dangers on the job, including pesticides (some of which are known to cause cancer, respiratory disease, birth defects, miscarriage and sterility), accidents with machinery and long exposure to heat. The Canadian Farm Workers Union is demanding that workers' compensation be extended to cover all farm workers. This demand is being supported by several groups, including the Vancouver Committee on Occupational Safety and Health (Van COSH) and Women's Action on Occupational Health, a group which does research and presentations about occupational health, concentrating on women workers.

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Letters

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

Menstrual Sponges

I just received the summer issue and once again I noticed the debate about the cleanliness of menstrual sponges. About a year ago I switched to sponges. I keep them clean by soaping them well with detergent at the beginning of each period, rinsing them well and then soaking them for a few minutes in a glass of white vinegar to normalize the PH. I rinse them really well after that too.

It amazes me that we're so concerned about how clean these wonderful things are while diaphragms and I.U.D.'s are inserted without a second thought!

Patricia Nolan
Peterborough

Congratulations

For months I've seen copies of your excellent newsletter on my desk as it travelled around our office in circulation. I've never been so impressed with any magazine's contents and now that you've improved your format — even more so. Congratulations!

Janet Sadel
Editor, YW Resource
National Newsletter of the YWCA of Canada

Self-help project

Since sending a renewal a couple of days ago, I have read every word in the Spring, 1981 issue and now realize that I need at least one more copy.

There is a small group of women in the Courtenay district, about 25 miles north of here on Vancouver Island, who have a small house, work and meeting place, for a Women's Self-help Project. They are all young and I am not, but they have welcomed me in and are glad to use feminist-type literature which I bring. They definitely should have a sub to Healthsharing.

Have just discovered that under our provincial government's much publicized Dental Service Plan, the list of maximum services for each appointment for which the govt. is willing to pay, is being used as a minimum by some (if not all) Dental Clinics. I have encountered refusal by a young "operator", called a Dentist, to replace fillings missing from my mouth, without allowing him to be my psychiatrist, pediatrician, father confessor, etc., and because he insisted that x-rays are always done "just in case". So thanks for that wonderful issue. Now you see why I need several more.

Dorcas H. Blair
Bowser P.O., British Columbia

Class Action Applauded

I was excited to read about your decision to join the class action suit against A.H. Robins (*Collective Notes*, Summer, 1981). The manufacture and control of birthcontrol devices—like the Dalkon Shield is too much in the control of men in executive positions who seem to be more interested in profits than the health of the women who use their products. They don't have to deal with the infections, heavy periods and other side-effects caused by their use.

It's an inspiration to see a group of women gaining power in the struggle against *proven* unsafe birth control devices and showing manufacturers that women are not going to stand for it any more.

Keep up the good work.

Linda Lounsberry
Toronto, Ontario

Breastfeeding Not Birth Control

I enjoyed reading *Controlling Conception—Naturally* by Vicki Van Wagner (Summer, 1981). I was glad to see that Van Wagner did not recommend breast feeding as a form of birth control, but was concerned by the incompleteness of information presented.

Several years ago a debate was carried on throughout several months of *Science* regarding the influence of body weight and fat levels. Lactation may be an effective birth control method in many developing countries because women's fat reserves are insufficient to allow both milk production *and* ovulation. Such levels of undernourishment are uncommon in North American women, and thus even with frequent suckling, ovulation would be more likely to occur.

In some African tribes, where lactation is the primary method of spacing births, women suckle their infants at least once in every five to ten minute period for several seconds at a time. Researchers are now trying to determine if the time interval between suckling may be more critical than the length of each suckling episode.

Women should *not* assume that breast feeding will prevent their becoming pregnant—no matter how thin they are or how often they suckle!

Edie Hubbard
Young's Point, Ontario

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.

Ant-prostaglandins and Dysmenorrhea

I would welcome information on any experiences (good and bad) of anti-prostaglandin drug treatments as well as information on any changes on the severity of dysmenorrhea after stopping birth control pills. Please write to Ann Ford, 24 Webster Ave., Apt. 7, Toronto, Ontario M5R 1N7.

Women's Right to Choose

I am trying to keep up to date on forums, demonstrations and activities in support of a women's right to choose abortion, both in Canada and around the world. These can also be activities with a broader theme where the pro-choice position is featured along with other women's issues. If you know of any, please send newspaper clippings or a post card with the date, type of activity, number of people present, details, etc. to B.J. Richmond, 123 Charlton Ave. E., Apt. 201, Hamilton, Ontario L8N 3W3. I will be compiling this information for future articles on abortion.