JUNE 1982

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Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

Working Through Despair

Losing Control: The Story of Hospital Work

Cervical Cancer: The Facts

Second Class Mail Registration No. 5327

April 20, 1982
Position Available:
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The Manitoba Federation of Labour (CLC) requires a full time occupational health nurse practitioner to practice in a community-based, union sponsored occupational health clinic. The programme requires an innovative individual, committed to a team approach and to workers' advocacy. R.N.s with experience and/or training in occupational medicine will be considered.

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Inside Healthsharing

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OUR READERS WRITE

ETCETERA

Collective Notes

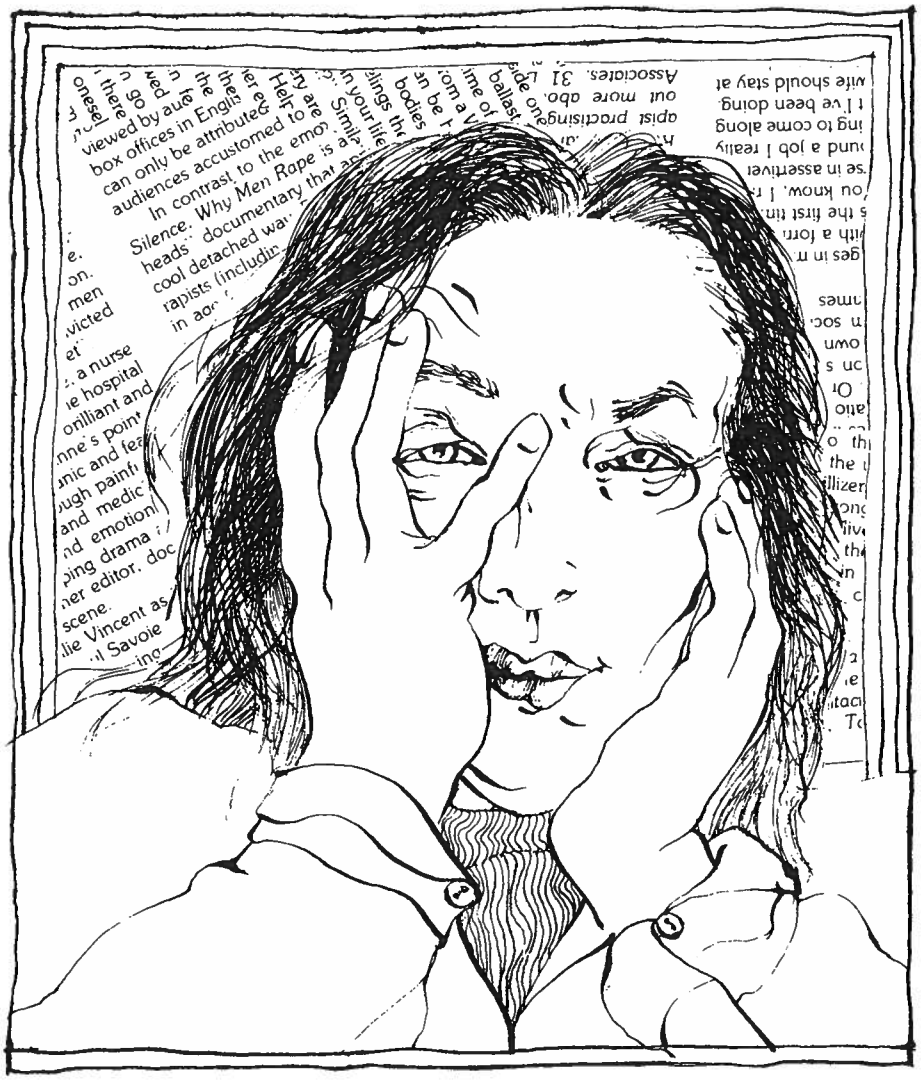
Burnout.

Energies at Women Healthsharing are at a low ebb just now. There are a number of important issues just waiting to be addressed, discussed, debated in this column. And we want to do it. However, our vigour has been sapped by a number of events: a new baby, the death of a mother, new jobs, a friend's suicide, the end of the school year.

We're also plain tired from the work of putting out a regular publication on a volunteer basis for close to three years.

So we thought we would take a break from our usual collective notes and give you, our readers, a glimpse of how we look and feel these days. We're looking forward to summer to renew our spirits and energies. In the fall, we'll discuss one of those burning issues. Until then. . . .

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



Graphic by Pat Foote-Jones

Healthsharing

Reaching a collective agreement to exhibit yourself from guilt and

published by
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Newsfronts

DEADLY DIOXINS IN WATER

A report in early April by the Ontario environment ministry showed that levels of dioxin are on the way up in Lake Ontario.

The deadly chemical, a byproduct of herbicides and disinfectants, was found in 11 lake trout from the Port Credit area just west of Toronto. The fish contained amounts of dioxin from 17 to 57 parts per trillion. Federal guidelines, criticized by some sources as inadequate, put the safety level at 20 parts per trillion.

It is estimated that one-quarter ounce of dioxin in water can kill 5 million people. In lesser amounts it can cause damage to the spleen, liver, lungs, brain and central nervous system. It is one of the most potent carcinogens known, and can cause serious birth defects.

The harmful proerties of dioxin first came to light when an explosion in an herbicide plant near Seveso, Italy occurred in 1976. The chemical was released to settle on the vegetation in the surrounding area. Within a few days the vegetation in the area withered and died, and animals began to fall ill. Eventually the whole community was forced out, the animals left alive were destroyed, and the area fenced off. It remains forbidden to enter the area on foot today.

The major sources of dioxin in Lake Ontario are known: the Hooker Chemical plant and its surrounding dump sites at Niagara Falls, N.Y.; the nearby Olin Chemical plant; the Dow Chemical factory in Michigan. Leakage from the Love Canal site was thought to be contained a few years ago, but appears to be a continuing source of contamination.

In light of the Reagan administration's emasculation of the U.S. Environment Protection Agency, and the failure of the Canadian government to make these concerns a priority, there is little hope that the near future will bring a stop to contamination of our water supplies.

ANOTHER DRUG

What is dubbed RU 486, blocks progesterone receptors and was invented by a French male biochemist who once worked with the inventor of the pill? It sounds like a sophisticated implement of was but is merely another chemical used to tamper with women's bodies and reproductive abilities. Described as the 4-day menstrual regulator, it can either maintain the menstrual cycle or cause an abortion. This steroid acts by occupying the chemical receptor site where progesterone is absorbed in the uterus. Without progesterone we are unable to maintain the built up uterine lining, hence bleeding or endometrial sloughing occurs. Voila, a period, or if we were pregnant, an abortion. Sounds simple.

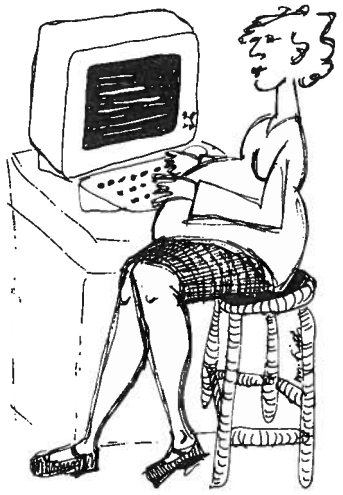
What is more complex is how the safety of drugs is established. Extensive testing is required which is both costly and time consuming. Hoescht, A North American pharmaceutical company, is trying to persuade the FDA to speed up toicity tests of this drug. We know how inadequate testing is at the best of times — often our health interests are not the motive forces. Women should be reluctant to even consider using RU 486 until all the risk factors have been studied carefully. It could be a long wait.

PREGNANT VDT USERS AT RISK

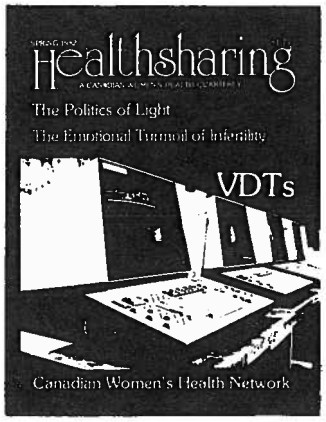
Women working with VDT's experience more miscarriages and tend to have more abnormal infants than non-VDT users. At least this is the case in the programmes branch of the solicitor generals office. In the last three years seven pregnancies resulted in four miscarriages, one premature infant and two infants born with unusual respiratory problems. These alarming figures have led pregnant VDT users in the programmes branch to transfer to other duties

Health and Welfare Canada has agreed to study the problem, but will not study VDTs. Why? Due to previous extensive testing the Radiation Protection Branch has stated that VDT's do not emit dangerous levels of Radiation.

The Public Service Alliance of Canada (PSAC) are not convinced. The VDT testing referred to has many loose ends they say, and PSAC is demanding a comprehensive study to examine all the possible factors involved.



NOTICE TO HEALTHSHARING SUBSCRIBERS



If you did not receive your last issue of Healthsharing, please contact us. We have had about 50 magazines returned to us in the mail. The labels had fallen off. The last issue was Spring 1982, and had a blue cover. Drop us a line if you missed it, and we'll send a copy to you right away.

ANTI-ABORTIONISTS SUED

Planned Parenthood, Newfoundland/Labrador, has brought a law suit for defamation against the Right-to-Life Association and Vera Fedorik, one of its members. In April of 1980 Ms. Fedorik appeared on a local open line show during which she accused Planned Parenthood of distributing pornographic pamphlets and films, teaching anatomy improperly and of operating sex education programmes without morals. These same accusations were reiterated in an article in *Atlantic Insight* magazine in which Ms. Fedorik was quoted. The Right-to-Life unsuccessfully argued at the beginning of the trial that Planned Parenthood had no case against them and there should be no trial. As of April 8, the trial was in its thirteenth day.

REGULATORY BODY AGAINST HOME BIRTH

Recently the Ontario College of Physicians and Surgeons has published a notice in their bulletin that may have implications for midwives and physicians involved in homebirth in Ontario.

The January 1982, Issue #3 of the *College Notice* under a headline entitled "Nurse-Midwives" stated: "Current interest in home birth has created an opportunity for certain individuals to offer their services as home birth attendants. Non-medical practitioners are not entitled to provide obstetrical services which are clearly within the practice of medicine. It is professional misconduct for a member to permit, counsel, or assist any person not licensed as a physician to engage in the practice of medicine.

Some physicians have been urged by their patients to attend them at home when they go into labour. The College would discourage this practice because it does not consider home birth to be safe or in the patient's best interest."

There has been no further interpretation of what this notice means in actuality. Recently the Alberta College of Physicians and Surgeons prohibited physicians from attending home births. Is Ontario following the trend of other provinces?

MD'S STRIKE

As we go to press, Ontario doctors have staged the first day of a province-wide walkout, designed to pressure the government into making huge increases in its medicare payments to the MD's.

The walkout follows weeks of tough and polemical negotiations between the provincial government and the Ontario Medical Association, and a series of rotating walkouts by doctors in different Ontario cities.

The government's current offer to the doctors — a 14.25% increase this year — would bring the average income to $97,000. But the MD's have watched their colleagues in British Columbia, Alberta and Saskatchewan wring 20% increases from their respective governments in 1982, and don't want to settle for less.

The Ontario government previously offered the doctors a five-year deal that would increase the average income by 84%, bringing it to at least $148,000 by the end of the contract. Not enough for the MD's.

The OMA's initial demands, in January, were for a "catch-up" increase of 62.5% in a one year deal and a 12.2% increase as protection against inflation.

Judging by letters in the Ontario press, there is very little public support for the doctors. Two views expressed in a recent *Globe* are typical: "What theory of distributive justice would convince you to give more to a group which, on average, already earns eight or nine times the income of those who work 40 hours a week at the minimum wage . . ." And: "Medicine is a basic human right in Ontario and to raise OHIP fees is a move toward robbing some people of limited means of that basic right.

While the OMA has been able to get substantial majority of doctors behind its demands, a small group of doctors working together in the Medical Reform Group opposes the OMA's tactics. Dr. Philip Berger explained the MRG's position. "Physicians have two contracts, an economic one with the government and a service contract with patients. It's unreasonable and inappropriate for them to take out a dispute with one on the other.

NESTLÉS NEW IMAGE

On March 16, 1982 Nestlés announced voluntary compliance with the World Health Organization's (WHO) mode for marketing breast milk substitutes. Marketing policy changes include non-promotional labelling and that products will be supplied to health officials only upon written request.

The Infant Formual Action Coalition Canada (INFACT) remains skeptical, therefore the Nestlés boycott continues. Until INFACT is sure the marketing changes are made and a formal agreement is reached between Nestlés and the International Nestlés Boycott Committee — Keep the pressure on Nestlés.

Healthwise

LOVE
Belinda Ellis is researching a book on the topic "feminists and romantic love". She needs women to fill in her questionnaire. Please contact her at: 69 Borden Street, Toronto M5S 2M8, or phone (416) 928-0355

BIOFEEDBACK AND MENSTRUAL PAIN
Biofeedback control of menstrual pain is being studied in Kitchener. Kathy Douglas, counselling coordinator at Planned Parenthood Waterloo Region and a candidate for a PhD in psychology, needs women to take part in the study. If you live in or near K-W call Kathy for more information or ask for a referral from your MD. Kathy can be contacted at 743-6461 or at K-W Hospital.

NORPLANT, the new DEPO?
Six Dutch women active in the campaign to ban the use of Depo-Provera are concerned about a new hormonal contraceptive, Norplant. The drug is implanted under the skin of the forearm for five years' "protection" against pregnancy. If you have any information at all about this drug, please write: Floor Martens and Christel Terwiel, Women's Health Centre, Maliesingel 46, 3581 BM Utrecht, The Netherlands.

APOLOGIES AND APPRECIATIONS

- to Irene van de Lagenaat, our advertising person for not mentioning her in last issue's masthead. Thanks Irene for doing a great job.
- A heart-felt thanks to Bev Rodrigue, our out-going office manager, for being a joy to work with and for doing such a super job of keeping us organized. We look forward to working with our new office manager, Elizabeth Allemange.

SHIATSU: Restoring the Balance

by Kathleen McDonnell

Most of are by now at least passingly familiar with acupuncture, the Chinese system of inserting and rotating needles at key points on the body. The technique has been used for everything from cutting the craving for cigarettes to providing anesthesia during major surgery. Though acupuncture is finding increasing acceptance among Western medical practitioners, for many it still has the air of a snake-oil cure. How can sticking a bunch of needles into somebody do anything — except make them squirm?

Now along comes *shiatsu*, often referred to as "acupuncture without needles". This ancient Japanese healing technique is even more apt to elicit scepticism because it involves nothing more drastic than touching the patient. North Americans tend to dismiss healing modes that don't involve some major disruptive action on the body. A needle has at least a bit of drama to it.

The fact is that both shiatsu and acupuncture are based on an ancient system of Oriental medicine which in many ways is the polar opposite of our Western allopathic tradition. Allopathic medicine views the body as a set of discrete organ systems and aims its "cures" at those specific organs and the attendant symptoms. Oriental medicine, on the other hand, approaches the body as a whole and views symptoms as evidence of an imbalance in the total organism. In this system the body is viewed as having its own "life force" or healing energy which flows along twelve channels or "meridians" connected to the principal organs. Ill health — mental or physical — is simply a manifestation of blocked energy on one or more of these meridians, which must be freed up to restore free energy flow and inner balance.

Shiatsu (literally "finger pressure" in Japanese) involves the application of pressure along these meridians. It is distinct from acupuncture, which focuses on specific key points on the meridians, and from Western massage, which works directly on the muscles to relieve tension. By applying finger pressure along the liver meridian on the front of the leg, for instance, the shiatsu therapist both stimulates the organ and helps restore it to normal function. This assists the body's own self-healing process as well. A typical shiatsu treatment lasts about an hour. It may involve an overall body work-up or concentrate more on specific meridians and organ systems, depending on the client's needs.

Shiatsu is not a cure-all, and won't be truly effective in the absence of other prerequisites to health such as good diet. But it has proven to be particularly useful for stress-related conditions such as hypertension, migraines, digestive problems, anxiety and depression. Being a non-invasive technique, it is perfectly safe and has no ill effects.

Shiatsu practitioners are generally licensed massage therapists who have taken additional training in the technique. Ask about the training and credentials of any therapist you choose to consult. But the beauty of shiatsu is also its simplicity; it can be taught to lay people and is a safe and effective home remedy as well.

A final word: You don't have to be sick to experience the benefits of shiatsu. Like massage it helps maintain overall good health, and feels good too.

Kathleen McDonnell is a Toronto freelance writer.

Working Through Despair

by Joanna Macy

illustrated by Mary Firth

It is just after Easter weekend as we prepare to go into production on Healthsharing. *In cities all over Europe and North America, there have been hundreds, thousands, even hundreds of thousands of people out on the streets, not in traditional Easter Sunday parades, but in anti-nuclear, anti-war demonstrations. The world-wide threat of nuclear weapons, particularly in the hands of Ronald Reagan and his goons, is hitting home.*

Usually, our collective prefers not to reprint articles which our readers can find in other publications. And though we get articles submitted to us by American women, we usually choose to publish work by Canadians. Our situation and struggles are somewhat different here, and Canadian women don't have the same opportunities to be printed as their American sisters.

We do make exceptions, and the article which follows is one of them. Joanna Macy's feature was first published in full as "Despair Work" in Evolutionary Blues, a California journal.

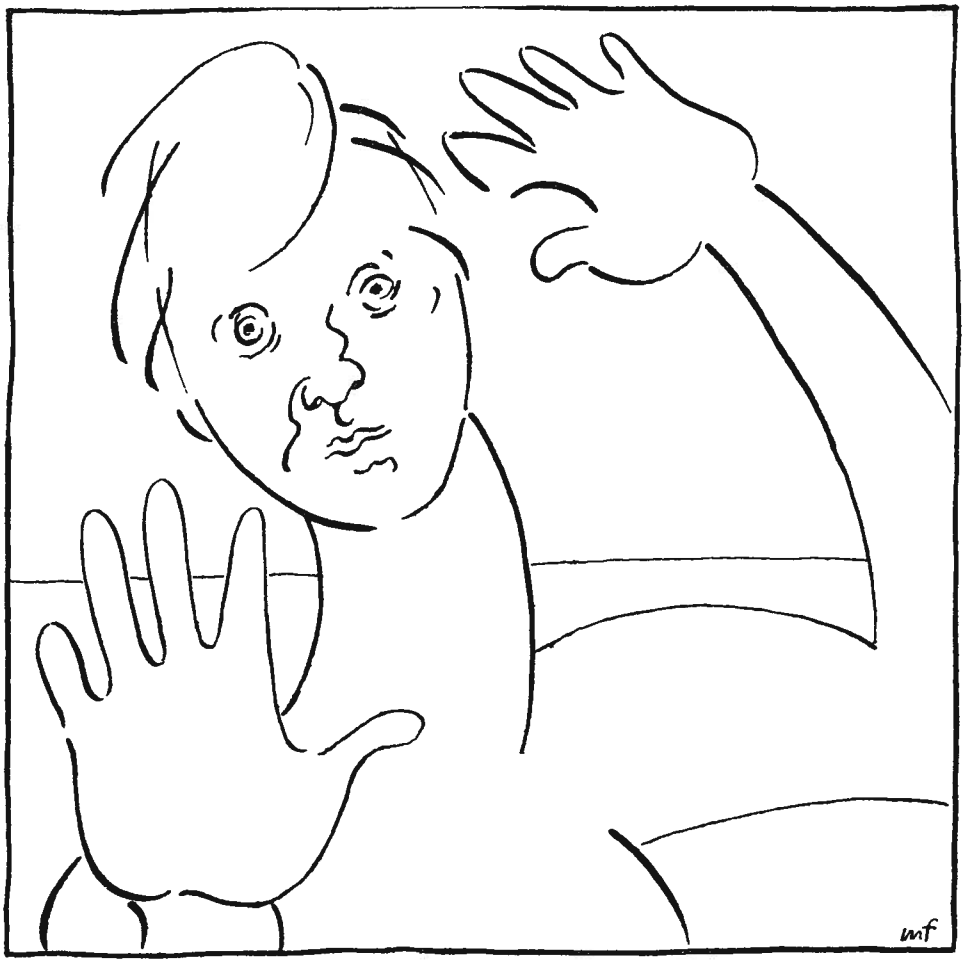
One of our reasons for printing it is, frankly, practical; two other articles we wanted to use for this issue need substantial reworking. But more importantly, those of us who first read this article felt that it was moving, insightful and timely. We hope you do too.

The excerpts which follow comprise less than half the original article. For the whole document, write for Issue 1, Evolutionary Blues, *Box 4448, Arcata, California 95521, U.S.A.*

For information on the types of workshops that have grown out of Macy's work, write: Interhelp, 330 Ellis St., Room 505, San Francisco, California, 94102.

A psychiatrist, studying attitudes about nuclear weapons among persons in the San Francisco area, recently found that almost all participants in her research considered nuclear war to be likely, if not inevitable. Everyone taking part in Dr. Carol Wolman's study believe it would be an unparalleled disaster, a holocaust they do not want to survive and that would probably extinguish life on earth. Most of them say also that they found the prospect too painful to confront personally or acknowledge publicly. Foreseeing the very possible extinction of our culture, their predominant response is not to cry out or ring alarms, it is to go silent, go numb.

What is noteworthy here is not that people are feeling despair; despair is well merited by the hair trigger machinery of mass death we continue to create and serve. What is noteworthy is the extent to which (North) Americans are hiding this depair from themselves and each other. We as a society are caught between a sense of



impending apocalypse and an inability to acknowledge it. A dread of what is happening to our future moves there on the fringe of awareness, too deep for most of us to name, too fearsome to face.

The suppression of despair, like that of any deep recurrent response, produces a partial numbing of the psyche. Dr. Wolman noted a striking absence of strong emotion in the group she studied; even when averring the likelihood of holocaust, expressions of anger or terror were muted, deadened as if a nerve had been cut.

The refusal of feeling takes a heavy toll. The toll is not only an impoverishment of emotional and sensory life — the flowers dimmer and less fragrant, loves less ecstatic. This psychic numbing also impedes the capacity to process and respond to information. The energy expended in pushing down despair is diverted from more creative uses, depleting resilience and imagination needed for fresh visions and strategies. Furthermore, the fear of despair can erect an invisible screen, selectively filtering our anxiety-provoking data. In a world where organisms require feedback in order to adapt and survive, this is suicidal. Now, just when we most urgently need to measure the effects of our acts, attention and curiosity slacken — as if preparing already for the Big Sleep.

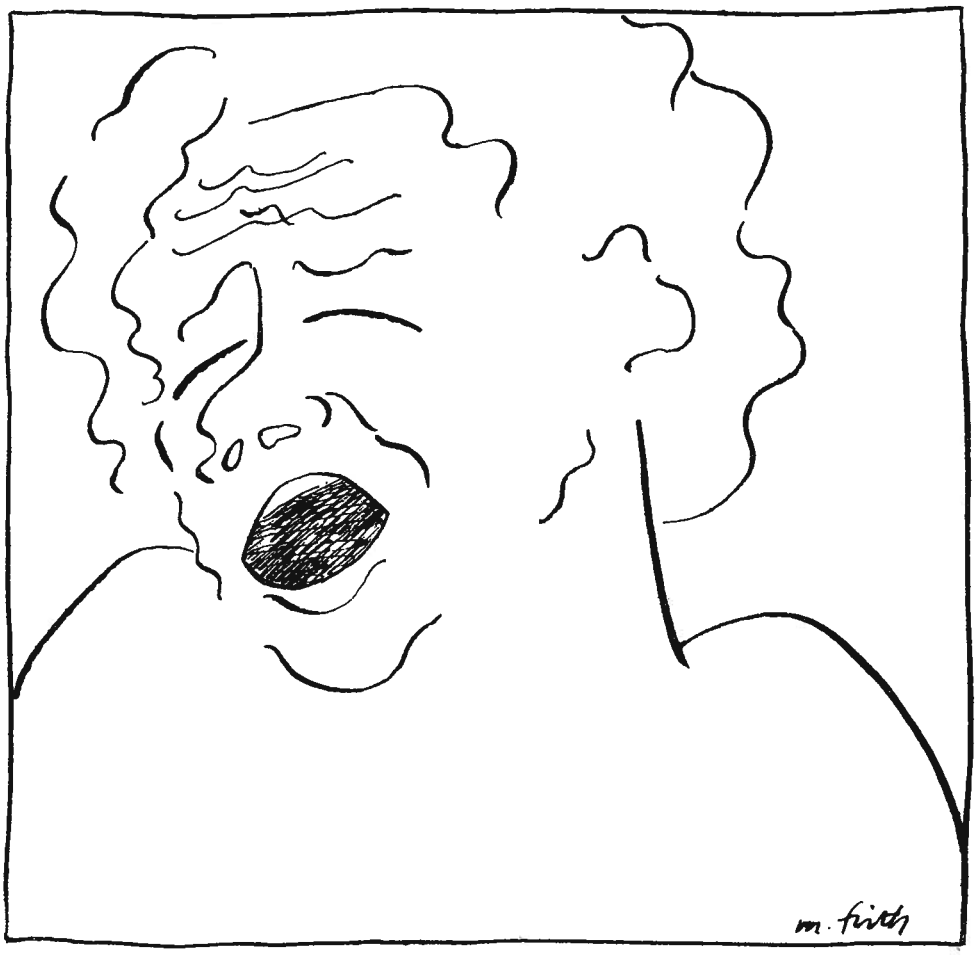
Despair cannot be banished by sermons on "positive thinking" or injections of optimism. Like grief it must be worked through. This means it must be named, and validated as a healthy normal response to the planetary situation we find ourselves in. Face and experienced, its power can be used — as the frozen defenses of the psyche thaw and new energies are released. Something analogous to grief work is in order. "Despair work", as I call it, is different from grief work in that its aim is not acceptance of loss — indeed the "loss" has not yet occurred and is hardly to be "accepted". But it is similar in the dynamics unleashed by the willingness to acknowledge, feel and express inner pain. Work with myself and others has convinced me that this is the case: that we can come to terms with apocalyptic anxieties in ways which are integrative and liberating, opening awareness not only to planetary distress, but also to the hope inherent in our capacity to change.

INGREDIENTS OF DESPAIR

Whether or not we choose to accord them serious attention, we are barraged by data that render questionnable the survival of our culture and our species, and even of our planet as a viable home for conscious life. While varied, each scenario presents its own relentless logic. Poisoned by oilspills, sludge and plutonium, the seas are dying. OR carbon dioxide from industrial and automotive combustion will saturate the atmosphere, creating a greenhouse effect that will melt the polar icecaps. OR, by radioactive poisoning from nuclear reactors and their wastes, already nearing epidemic proportions, plagues of cancer will decimate populations, cause fearful mutations in survivors. OR deforestation and desertification of the planet now rapidly advancing, will produce giant dustbowls, famines beyond imagining. The probability of each of these perils is amply and soberly documented by scientific studies.

We read such portents against the sober backdrop of recent history. In a century which already features a hundred million human-inflicted deaths and where nations consider their own populations expendable, we live in "a new moral universe". Not only has our vaunted technology intensified human destructiveness beyond measure; it has also buttressed it with blind, bureaucratic machinery unafraid, as Amnesty International testifies, to use torture on a scale perhaps unsurpassed in history. The collective lunacy this represents saps confidence that those in power will have the wisdom, and compassion for the future, to take the steps necessary to avert destruction of our biosphere.

Despair, in this context, is not a macabre certainty of doom, nor a pathological conditon of depression and futility. It is not a nihilism denying meaning or efficacy to human effort.



Rather, as it being experienced by increasing numbers of folks, it is the loss of the assumption that the species will inevitably pull through. It represents a genuine accession to the possibility that this planetary experiment will fail, the curtain rung down, the show over.

The particular scenario, whether holocaust, suffocation, poisoning, makes little difference to the sensations when a likely avoidable end to human existence is seriously entertained. When they break through the censorship we tend to impose on them, these sensations can be intense and physical. Judy, who left her career to work as a full-time anti-nuclear organizer, says her onslaughts of grief come as a cold, heavy weight on the chest and a sense of her body breaking. Mine, which began several years ago after an all-day symposium on threats to our biosphere, were sudden and wrenching. I would be at my desk, and the next moment would find me on the floor, curled like a fetus and shaking. In company I was more controlled; but even then, in those early months unused to despair, I would be caught off guard. A line from Shakespeare or a Bach phrase would pierce me with pain as I found myself wondering how much longer it would be heard, before fading out forever in the galactic silences.

The sense that life's song might not continue beyond the moments we now harvest, that is the despair. But instead of rising up to make of it a "wall of refusal", we tend to hide it from ourselves and each other. Why?

SYMPTOMS & SUPRESSIONS

In India at a leprosarium I met a young woman, a mother of four. Her case was advanced, the doctor pointed out, because for so long she had hidden the signs. Fearing ostracism and banishment, she had covered her sores with her sari, pulled the shoulder drape around so no one would see. In a similar fashion did I later hide the depair for our world, cloaking it like a shameful disease — and so, I have learned, do others.

Even among religious folk, whose constructs of belief include suffering and crucifixion, despair can appear as a lapse of faith. A a vigil before a demonstration at the Pentagon against nuclear weapons, Daniel Berrigan spoke of hope in a vision of the new Jerusalem to carry us through. After a pause, a young man spoke up falteringly. He questioned whether hope was really prerequisite, because, and he admitted this with difficulty, he was not feeling it. Even among friends committed to the same goal, it was hard for him (and brave of him, I thought) to admit despair. It was clear he feared he would be misunderstood, taken as cowardly or cynical — a fear validated by the response of some present.

"There is nothing more feared and less faced," writes Jesuit essayist William Lynch, "than the possibility of despair". This is one reason, he says, why the mentally ill are so thoroughly isolated from the well. Yet, he says, "hopelessness is a more usual and more human feeling than we are wont to admit."

Despair is resisted so tenaciously because it represents a loss of control, an admission of powerlessness. Our culture dodges it by demanding instant solutions when problems are raised. "Don't come to me with a problem unless you have a solution." That tacit injunction, operative even in public policy-making, further inhibits people from expressing feelings of despair. It rings like my mother's words to me as a child: "If you can't say anything nice, don't say anything at all."

In the experience of Dr. Wolman's interviewees, this inhibition amounts to a social taboo. In explaining their silence and numbness over nuclear weapons, they pointed out that those who break this taboo are considered "crazy", or at least "depressed and depressing". Many of us in the anti-nuclear movement have experienced similar inhibitions in expressing our preoccupation with long-term, lethal radioactive poisoning of the planet. No one wants a Cassandra around or welcomes a Banquo at the feast. Nor indeed, are such roles enjoyable to play. So, as I have since found others have done, I shook and wept in solitude and continued in public to be the same up-beat person as before.

To feel despair in such a cultural setting brings on a sense of isolation. The distance between one's inklings of apocalypse and the tenor of business-as usual is so great that, though a person may respect her own cognitive reading of the signs, her affective response is frequently that it is she, not the society, that is insane.

Psychotherapy, as it is predominantly practiced, has offered little help for coping with these feelings, and indeed has often compounded the problem. Most practitioners have trouble crediting the notion that concerns for the general welfare might be genuine, and acute enough to cause distress. Assuming that all our drives are ego-centred, they tend to treat expressions of this distress reductionistically, as manifestations of private neurosis. To illustrate from my own case, which is far from unique: deep dismay over destruction of the wilderness was diagnosed as fear of my own libido (which bulldozers were taken to symbolize); painful preoccupation with U.S. bombings of Vietnam was interpreted as an unwholesome hangover of Puritan guilt. Such "therapy," of course, only intensifies the sense of isolation and craziness despair can bring, while inhibiting its recognition and expression.

At a recent conference of the Association for Humanistic Psychology I met Maxine, a veteran of the human potential movement. On the day after a talk in which I mentioned in passing the notion of despair work, she shared with me her sense of relief at hearing these comments. She said she had been wondering why she did not feel better, since she had been freed-up, stimulated, relaxed, self-realized, and self-actualized from just about every type of growth therapy going. With a kind of sober relief she could recognize now the social roots of her feelings of anxiety, accepting and validating the fact that she felt "at a loss" about her work and her children's future in it. Although this recognition produced no solutions to global problems, she said she felt quieter, more centred and more conscious.

Joan, a Jungian analyst, tells of the increasing incidence among her patients of dreams of apocalypse. Likening them to C.G. Jung's dream on the eve of the first World War, when he beheld Europe bathed in blood, she says these current ones are filled with symbols of mass death and planetary destruction. Such dreams, though painful, can get us in touch with the nature of present despiar. Of a different order are the fantasies of apocalypse offered in mass entertainment today.

The biggest money-makers in the film industry, as Andrée Conrad points out in "Disaster and the American Imagination", are movies that feature cataclysmic events and violent mass death. Earthquakes, rampaging sharks and killer bees, erupting volcanoes and towering infernos, doomed craft in air and sea, loaded with panicked passengers, vie in imageries of terror. The scenarios they present give structure and outlet to unformulated fears of apocalypse, and in so doing, provide catharsis. But it is a dangerous catharsis, Ms. Conrad observes.

Hooking our anxieties onto isolated and unlikely emergencies, frequently handled with technological heroics, these entertainments give their audience sitting safely ensconced in a comfortable theatre the illusion of having dealt with what is bothering them. On fictitious, improbable themes, they air and exorcise our dread, while inuring us to the prospects of mass death and raising our horror threshold another notch. They blur the boundaries between fantasy and reality, making the next day's news seem like more of the same — alarms to be passively watched till the credits appear and we can stop for a beer on our way home to bed.

Disaster films can be seen as pornographies of despair. In the same way X-rated "adult" flicks cheapen the sexual hungers they trade on, the towering infernos and devouring jaws dull and misdirect our need to do genuine despair work.

This work is needed because our culture makes it hard to get in touch with the genuine dimensions of our despair, and because until we do, our power of creative response to planetary crisis will be crippled. Until we can grieve for our planet and its future inhabitants, we cannot fully feel or enact our love for them. At the root of these inhibitions lies a dysfunctional notion of the self. It is the notion of the self as an isolated and fragile entity. Such a self has no reason to weep for the unseen and the unborn, and such a self, if it did, might shatter with pain and futility.

So long as we see ourselves as essentially separate, competitive and ego-identified beings, it is difficult to respect the validity of our social despair, deriving as it does from interconnectedness. Both our capacity to grieve for others and our power to cope with this grief spring from the great matrix of relationships in which we take our being. Just as our pain is more than private, so is our resilience. We are, as open systems, sustained by flows of energy and information that extend beyond the reach of the conscious ego. This can become evident to us as we confront despair and work through it.

DESPAIR WORK: VALIDATION

The first step in despair work is to disabuse oneself of the notion that grief for our world is morbid. To experience anguish and anxiety in the face of the perils threatening humanity is a healthy reaction. Living tissue is sensitive. This pain, far from being crazy, is rather a testimony to the unity of life, the deep interconnections that relate to all us beings.

Such pain for the world becomes masochistic only when one assumes personal guilt for its plight or personal responsibility for its solution. Certainly by participation in society each shares a collective accountability; but to assume the burden of personal blame is unbearable, and furthermore, it builds resistance to the acknowledgement of distress. It is also a kind of power trip. Despair, like grief, is letting go of the manipulative assumption that conscious ego can or should control all events. Each of us is but one little nexus in a vast web. As the recognition of that interdependence breaches our sense of isolation, so does it free our despair of self-loathing.

Even so, one can feel deep psychic disarray in internalizing the possibility of planetary demise. It is a prospect of such radical discontinuity as to unglue our minds. How to confront what we barely dare to think? How to think it without going to pieces?

It is helpful to despair work to realize that going to pieces may not be such a bad thing. Indeed it is as essential to evolutionary and psychic transformations as the cracking of outgrown shells. Kazimierz Dabrowski calls it "positive disintegration". It can bring a dark night of the soul, a time of spiritual void and turbulence. But the anxieties and doubts are, Dabrowski maintains, "essentially healthy and creative". They are creative not only for the person but for her society because they permit new and original approaches to reality to be made.

What "disintegrates" in periods of rapid transformation is not the self, of course, but its defenses and ideas. We do not need to protect ourselves from change, for our very nature is change. Defensive self-protection restricting vision and movement like a suit of armor, makes it harder to adapt. It not only reduces flexibility, but blocks the flow of information we need to survive. Our "going to pieces", however uncomfortable a process, can open us up to new perceptions, new data, new responses.

Our religious heritages can also serve to validate despair work, offering constructs and symbols attesting to the creative role of this kind of distress. The Biblical concept of the suffering servant speaks to the power inherent in opening one-self to the griefs of others.

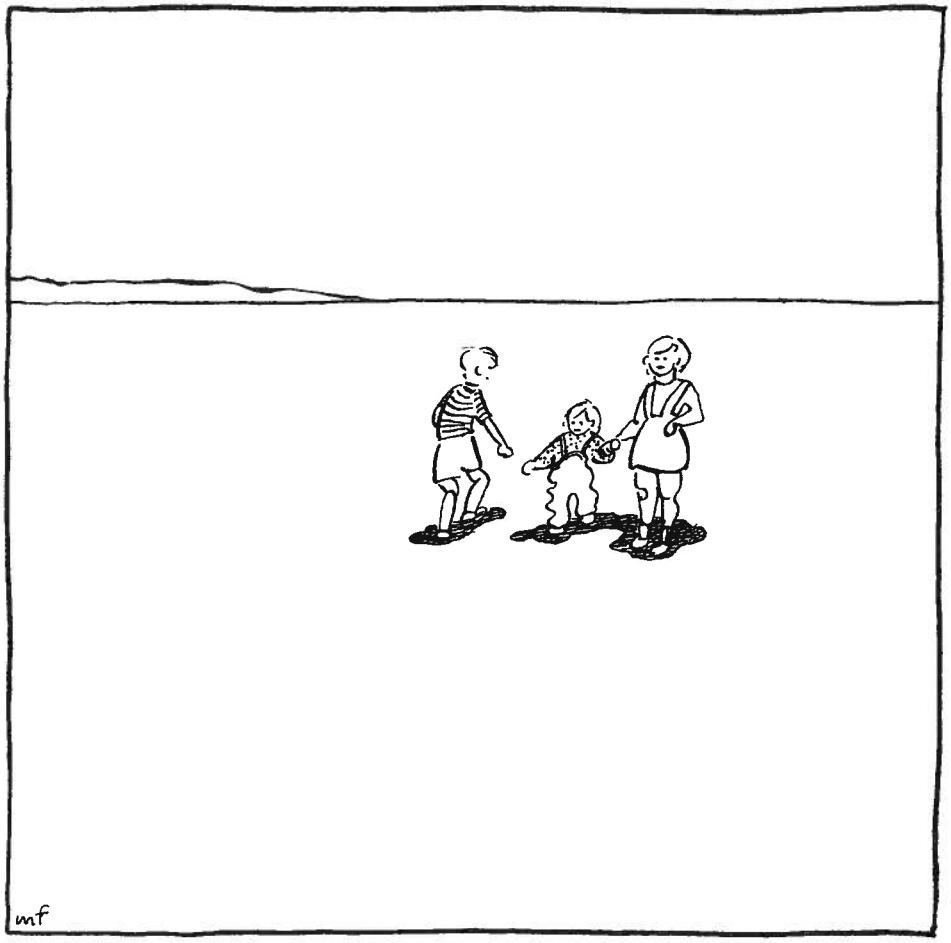
The hero of the Mahayana Buddhist traditon is the bodhisattva, who turns back from the gates of Nirvana, vowing to return again and again to the world of woe until all beings are enlightened. By his compassion he is endowed with supranormal senses. He can hear the music of the spheres and understand the language of the birds. By the same token, by virtue of his extended sensitivity, he hears as well all cries of distress, even to the moaning of beings in the lowest level of hell. All griefs are registered and owned in the bodhisarrva's deep knowledge that we are not separate from each other.

DESPAIR WORK: FEELING

The second requirement in despair work is to permit ourselves to feel. We can allow the griefs and apprehensions that are within us to surface to consciousness. No matter how safe and comfortable our personal lives or engrossing our private concerns, grief for those who suffer now, and may suffer in the future, is present in us on some level. Given the flows of information circling our globe, our psyches, however inattentive or callous they may appear, have registered the signals of distress. We need only to be encouraged and empowered to open our consciousness to them. We cannot experience them without pain, but it is a healthy pain — like the kind we feel

when we walk on a leg that has gone asleep and the circulation starts to move again. It gives evidence that the tissue is still alive.

As with a cramped limb, exercises can help. I have found meditational exercises useful, particularly ones from the Buddhist tradition.. An example of what can happen is Marianna, a participant in a workshop I led. After two initial exercises which involved quieting down and centering on the breath, I introduced a meditation on compassion. The exercise involved, first of all, giving oneself permission to imaginatively experience the sufferings of others, in as concrete a fashion as possible, and then taking these sufferings in with the breath, visualizing them as a dark stream drawn in with each inhalation, into and through the heart.



Afterwards Marianna described to me her experience in this mediation. She had been resistant to the first two exercises and her resistance, which she had expected to continue throughout this one, had localized as a pain in her back. In encouraging the participants to open themselves to their inner awareness of the sufferings of others, I primed the pump with some brief verbal cues, mentioned a mother with dried breasts holding a hungry infant . . . That awoke in Marianna an episode she had buried. Three years earlier she had listened to a record by Harry Chapin with a song about a starving child; she had had, as she put it, "trouble" with it. She put the record away never to play it again, and the "trouble" remained undigested. With her recollection of her experience with the song, the pain in her back moved into her chest. It intensified and hardened, piercing her heart. It seemed for a moment excruciating, but as she continued the exercise, accepting and breathing in the pain, it suddenly, inexplicably, felt right, felt even good. It turned into a golden cone or funnel, aimed point downwards into the depths of her heart. Through it poured the despair she had refused, griefs reconnecting her with the rest of humanity.

Marianna emerged from this with a sense of release and empowerment. She felt empowered, she said, not to *do* so much as to *be* — open, attentive, poised for action. She also said that she believed she permitted this to happen because I had not asked her to "do" something about the griefs of others, or to come up with any answers, but only to experience them.

Sometimes, the blocked emotions of despair become accessible through dreams. The most vivid in my experience occurred after a dull job of perusing statistics on nuclear pollution. Before going to bed I had leafed through baby pictures of our three children to find a snapshot for my daughter's high school yearbook.

In my dream I behold the three of them as they appeared in the old photos, and am struck most by the sweet wholesomeness of their flesh. My husband and I are journeying with them across an unfamiliar landscape. The land is becoming dreary, treeless and strewn with rocks; Peggy, the youngest, can barely clamber over the boulders in the path. Just as the going is getting very difficult, even frightening. I suddenly realize that, by some thoughtless but unalterable prearrangment, their father and I must leave them. I can see the grimness of the way that lies ahead for them, bleak and craggy as a red moonscape and with flesh-burning sickness in the air. I am maddened with sorrow that my children must face this without me. I kiss them each and tell them we will meet again, but I know no place to name where we will meet. Perhaps another planet, I say. Innocent of terror, they try to reassure me, ready to be off. Removed and from a height in the sky, I watch them go — three small solitary figures trudging across that angry wasteland, holding each other by the hand and not stopping to look back. I see with a surrealist's precision the ulcerating of their flesh. I see how the skin bubbles and curls back to expose raw tissue, as they doggedly go forward, the boys helping their little sister across the rocks.

I woke up, brushed my teeth, showered, had an early breakfast meeting, took notes for a research proposal. Still the dream did not let me go. As I roused Peggy for school, I sank beside her bed. "Hold me", I said, "I had a bad dream". With my face in her warm nightie, inhaling her fragrance, I found

myself sobbing. Statistical studies of the effects of ionizing radiation, columns of figures on cancers and genetic damage, their import beyond utterance, turned now into tears, speechless, wracking.

One can wonder what good it does to allow ourselves to feel the possibilities we dread. But for all the discomfort there is healing in such openness, for ourselves and perhaps for our world. Our pain is a response to present facts, and to accept it reconnects us with our fellow beings, as well as with our own deep energies.

DESPAIR WORK: IMAGING

To acknowledge such despair to ourselves and others, we need symbols and images for its expression, and for the energy that sharing can release. Images, more than arguments, tap the springs of consciousness, the creative powers by which we make meaning of experience. In the challenge to survival we face now, exercise of the imagination is especially necessary because existing verbal constructs seem inadequate to what many of us are sensing.

In a workshop on planetary survival I explored means by which we could share our apprehensions on a feeling as well as an intellectual level. I asked the participants to offer, as they introduced themselves, a personal experience or image of how in the past year the global crisis had impinged on their consciousness. Those brief introductions were potent. Some offered a vignette from work on world hunger or arms. A young physicist simply said, very quietly, "My child was born". A social worker recalled a day her small daughter talked about growing up and having babies; with dull shock she encountered her own doubt that the world would last that long. Some offered images: fishkill washed up at summer cottage, stripmines leaching like open wounds. Most encompassing in its simplicity was John's image: the view from space of planet earth, so small as it glittered there that it could be covered by the astronaut's raised thumb. That vision of our home, so finite it can be blotted out by a single human gesture, functioned as a symbol in our week's work. It helped us cut through the verbiage of reports, and the temptations of academic one-up-manship, to the raw nerve in us all — desperate concern.

In the sharing of despair, that our imagery permitted, energy was released that vitalized our scheduled sessions and extended them into mealtimes and night. The non-stop talk around cafeteria tables and under trees was laced with laughter as pent-up feelings were aired and compared. With our despairs recognized and validated in each other, came resurgence of commitment to our common human project.

Recognizing the creative powers of imagery, many call us today to come up with visions of a benign future — visions which can summon and inspire. Images of hope are potent, necessary: they shape our goals and provide the fuel for reaching them. They can, however, be asked of us too soon. Like the demand for instant solutions, such expectations can stulify — providing us an escape from the despair we may feel, while burdening us with the task of aridly designing a new Eden. Genuine visioning happens from the roots up, and these roots for many are shrivelled by unacknowledged despair. Many of us are in an in-between time, groping in the dark with shattered beliefs and faltering hopes, and we need images for that in-between time if we are to work through it.

Sometimes it takes a while, in the slow alchemy of the soul, for hope to signal, and longer for it to take form in concrete plans and projects. That is all right.

DESPAIR WORK: WAITING

So we wait, even in our work, we wait. Only out of that open expectancy can images and visions arise that strike deep enough to summon our faith in them.

In my feelings of despair, I was haunted by the question, "What do you substitute for hope?" I had always assumed that a sanguine confidence in the future was as essential as oxygen. Without it, I had thought, one would collapse into apathy and nihilism. It puzzled me that, in owning my despair, I found the hours I spent working for peace and environmental causes did not lessen, but rather increased. I also seemed to detect among some of the most acitve, committed leaders of these movements, signs of the same hope loss I experienced. What fuel were they running on? The question was not academic; I wanted another hope in place of the hope I lost.

I asked Jim Douglass, the theologian and writer who had left his university post to resist nuclear weapons; jailed repeatedly for civil disobedience in this effort, he leads the citizen's campaign against the Trident submarine base. We were sitting on the stopes of a shabby house in West Vancouver, catching sun between meetings of the Pacific Life Community. He had said he believed we had five years left before it was too late — too late to avert the use of our nuclear arsenal in a first strike strategy. I reflected on the implications of that remark and watched his face, as he squinted in the sun with an air of presence and serenity I could not fathom. "What do you substitute for hope?", I asked. He looked at me and smiled. "Possibilities," he said. "Possibilities . . . you can't predict, just make space for them. There are so many." That, too, is waiting, active waiting — moving out on the fogbound trail, though you cannot see the way ahead.

Waiting does not mean inaction, but staying in touch with our pain and confusion *as* we act, not banishing them to grab for sedatives, ideologies, or final solutions. It is, as a student of mine quoted, "staying in the dark until the darkness becomes full and clear." The butterfly, I am told, eats its way out of the cocoon. In despair, if we digest it, is authenticity and energy to fuel our dreams.

DESPAIR WORK: COMMUNITY

To work through a sense of hopelessness for the future of humanity seems to be a process requiring a good measure of courage, and also some patience. Fortunately, one does not need to look to one's own present supply of such commodities; they are provided by the very dynamics of the process itself. For in letting go of old defenses new strengths are found. They are also found in community. In the synergy of sharing comes power. This is true in the sharing of most deep feelings and perhaps particularly so in the case of social despair, rooted, as it

is, in our sense of interconnectedness with others.

Despair work is not a solo venture, no matter how alone one may feel. It is a process undertaken within the context of community, even if a community of like-minded others is not physically present. This is important to remember, given the tenor of our culture and the sense of isolation it attaches to despair. Just to know that one's feelings are shared gives a measure of validation and support.

Many kinds of community can be used for the doing of despair work. On-going groups devoted to personal or spiritual growth are well suited by virtue of the openness and trust they tend to build. Many of those that now meet for purposes of consciousness-raising or the study of psychological or spiritual disciplines, could provide the environment for the kind of sharing that despair work involves. Groups that have constellated for purpose of social action may also be appropriate, particularly the kind that have emerged in the peace and safe-energy movements. "Affinity groups" set a high priority on mutual trust and support, which are essential in strategies of nonviolence.

Special workshops, conducted over a weekend or for a day, or even a few hours, are very useful. These have been developed to provide a safe setting and structured process for sharing our deep feelings about the present situation in ways that overcome psychic numbing, isolation and burn-out. By breaking taboos against despair and permitting it to be openly expressed in imagery, ritual. tears, rage and plain talk, these workshops release blocked energy. It is healing to find that deep anxieties for humanity can be spoken without appearing ridiculous, morbid or socially destructive. In that release and communication comes stronger commitment to our common task of humane survival.

In gatherings or workshops devoted to intensive despair work, certain conditions or "rules" have emerged as important. An undisturbed space and uninterrupted time are required to foster the trust necessary for this kind of sharing. Even more crucial is that the focus be kept on feelings, not ideas. In this context the discussion of views and opinions is counterproductive; it can be an avoidance mechanism and it is divisive. Debate and argument are often a dodge, an evasion of the fear or anger or grief that threaten to erupt. Only by staying on the feeling level can we confront and release our despair — and find the deeper unity we need. In that unity our roles fall away. In each of us, whatever our politics, livelihood or lifestyle, lurks anxiety about what is happening to our world, our future — and it is that which we must honor and own.

In the process a deeper discovery is made. Through our despair something more profound and pervasive than our despair comes to light. It is our interconnectedness, our inter-existence. Beyond our pain and because of our pain, we awaken into that. For our feeling of despair for the planet and its beings are concerns that extend beyond our separate egos. Therefore they testify to our essential unity — and by owning them we re-experience that unity, emerge into it afresh. In that dawning we recognize that the very crises of our time can open us to new dimensions of awareness, a sense of mutual belonging so real that the response is one of wonder, even joy.

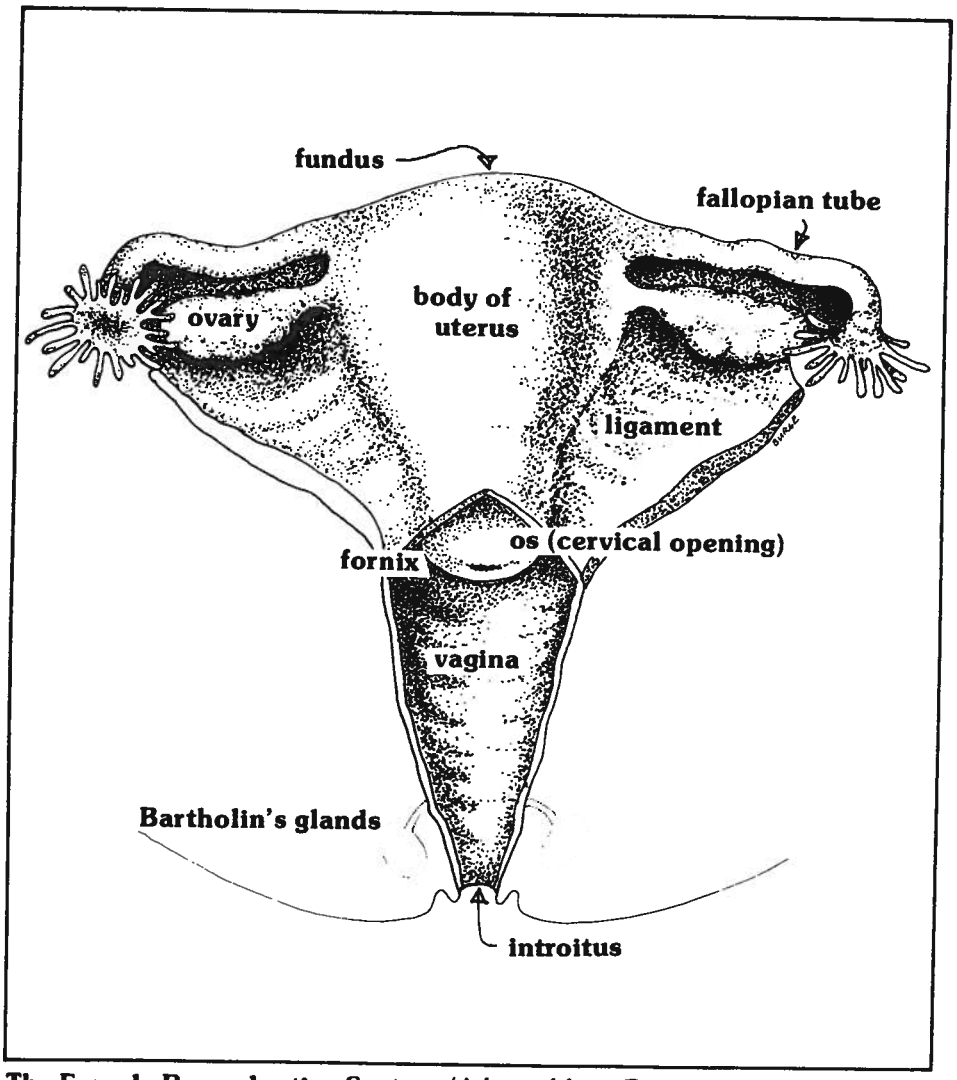
Despair work, experienced in this fashion, is consciousness-raising in the truest sense of the term. It increases our awareness not only of the perils that face us but also of the promise inherent in the human heart. Whether we "make it" or not, whether our efforts to heal our world succeed or fail, we live then in so vivid a consciousness of our community that the most obvious and accurate word for it is love. And that seems, in and of itself, a fulfillment.

Joanna Macy is a teacher and writer active in movements for social change in the U.S. and the Third World. Her book, Dharma and Development, *appears later this year.*

CERVICAL CANCER: THE FACTS

by Cheryl Adams

illustrated by Jules Burge



The Female Reproductive System (Adapted from Boston Women's Health Book Collective, *Our Bodies, Ourselves,* Simon and Schuster, New York, 1976.

This year over ten thousand women in Canada will be diagnosed as having cervical cancer. And they'll be scared out of their wits by the word cancer itself, which seems to spell certain, premature death, and by the prospect of having their reproductive organs removed, in many cases before they've had a chance to be used.

A doctor's response to a woman's "Will I die?" could well be "Not from cervical cancer, you won't." Virtually all cervical cancers are curable when caught in their early stages. No one who has an annual or biannual Pap test will die from cervical cancer.

There is a great deal of controversy surrounding the theories about the cause of cervical cancer. The incidence of cervical cancer is highest in two age groups — the 25 to 29 year olds who generally have *carcinoma in situ* (non-invasive cancer) and the 60-65 year olds who generally have invasive cancer. Race is also a variable. When matched for other potentially influential factors (nationality, level of education, sexual history) researchers generally agree that Oriental women have a higher incidence of cancer than non-Jewish whites, and in turn, non-Jewish whites have a higher incidence of cervical cancer than Jewish women. Different studies have found a correlation between the incidence of cervical cancer and such variables as age at first menstrual period, age at first coitus, age at birth of first child, number of pregnancies and number of sexual partners. There is no consensus on how these factors may be responsible for the development of cervical cancer. About the only thing researchers can agree on is that cervical cancer is linked, somehow, to heterosexual activity. If you are a virgin, your chances of getting cervical cancer are almost nil.

Researchers who believe that the development of malignant cells is connected to viruses are looking for a link between Herpes and cervical cancer. (Herpes is a virus which is probably transmitted through sexual activity. See Healthsharing, vol 3, no 1) Herpes anti-bodies are found in the malignant cervical cells of some, but not all, women with cervical cancer. But the same anti-bodies may be found in the cervical cells of women who don't have

cervical cancer, so the connection between herpes and cervical cancer is not clearly established.

It has been known for a long time that Jewish women have cervical cancer less often than other women. Circumcision of Jewish males removes the foreskin of the penis, preventing the retention of smegma, the secretion of the lubricating glans beneath the foreskin. Smegma has been implicated as the perfect environment for viruses which are passed to the vagina and cervix during intercourse. However, Jewish women continue to have a lower rate of cervical cancer even when their partners have not been circumcised. Muslim women in some countries have a high rate of this type of cancer although Muslim men are ritually circumcised. Confounding the speculation about the circumcision connection are the data gathered by American researchers. One third of their male subjects were found to have answered incorrectly when asked about their circumcision status. If men don't know, the answers given by their partners are likely to be even less reliable.

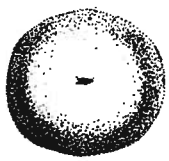
Males are also implicated in the theory which maintains that sperm cause cancer. Because sperm have the ability to invade complex layers of cells and membranes to reach the ovum, they may invade cervical cells in the same fashion. Experiments mixing sperm with cells have produced changes in the cells similar to changes in cells mixed with carcinogens.

While the medical researchers continue to disagree with each other in their guarded, scientific manner ("We find it difficult to reconcile our findings with the Swedish study of 1974. . . .") the popular media show no such hesitation. All the causes of cervical cancer are lumped together and the conclusion drawn — "Promiscuity" causes cancer. If women believe what they read in magazines like Maclean's which featured an article entitled *Sex, Cancer and the Perils of Promiscuity,* they could conclude that cervical cancer is not a disease, but a punishment. While it is true that women who have had early first intercourse (under the age of eighteen) and/or multiple partners have a higher incidence of *carcinoma in situ,* the disease also strikes the sexually conservative. Every woman who is or has been heterosexually active is at risk.

The front line for detection and cure of cervical cancer is the Pap test. In this test, a few cells are scraped from the cervix in a painless office procedure and then sent to a laboratory where they are examined under a microscope for signs of abnormality. Just as most tumours are non-cancerous (non-malignant), abnormal cervical cells may be the result of non-cancerous conditions such as infection, inflammation and irritation. When no cause is apparent, non-malignant cell growth is called *dysplasia.* Estimates vary, but about one-third of dysplasias will disappear if left untreated. Some disappear with treatment, and a small number are the precursors of cancer. It is not clear whether dysplasia 'turns into' cancer, or simply comes before it in a small number of cases.

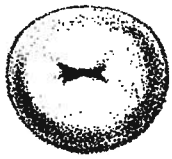
The Pap test may indicate the presence of a few malignant cells on the very top layer of cells — *carcinoma in situ.* Because at least 20% of *carcinomae in situ* will become invasive cancer within ten years, it is at this point that some sort of treatment is indicated, both as a diagnostic tool to ensure that the cancer is not yet invasive, and as a method of removing the cancerous cells.

THE CERVIX



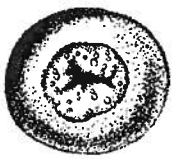
Normal Nulliparous Cervix

The nulliparous cervical os is small and either round or oval.



Normal Parous Cervix

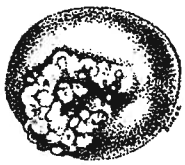
After childbirth, the cervical os has a slit-like appearance.



Ectropion (Erosion)

The area around the os can be a plush red rather than the usual shiny pink. It may bleed easily when touched. This is usually due to an ectropion (that is, the presence of cells like the lining of the cervical canal.) An ectropion is not abnormal but may be difficult to distinguish from early carcinoma without further testing.

Adapted from Barbara Bates, A Guide to Physical Assessment, *2nd edition, J.B. Lippincott Company, Toronto, 1979.*



Carcinoma of the Cervix

Carcinoma of the cervix usually begins at or near the cervical os. The tissue may bleed easily. It then can extend to an irregular cauliflower type of growth. Early carcinomas may look like ectropions and may even be present in a cervix that appears normal.

A colposcopy is used to refine the diagnosis for women who have all kinds of abnormal Pap tests, not just those suspected of being cancerous. The colposcope is a specially built microscope which permits examination of the vagina and cervix. Because of the expense of the colposcope and the need for expert users, colposcopies are generally done on an outpatient basis at a hospital or central clinic.

If the colposcopy finds severe dysplasia but no malignant cells, a doctor may recommend cyrosurgery. Despite the name, cyrosurgery involves no cutting. In this procedure the cervix is cauterized by exposure to very cold temperatures. This freeze-burning may be painful and followed by cramping and discharge. Infection may develop after this procedure and intercourse is prohibited for several weeks following.

A cone biopsy is performed when malignant cells are found *in situ* or when dysplasia is severe. A cone shaped piece of the cervix is removed by instruments inserted vaginally. The cone is centred on the area defined by the colposcopy and is then examined by pathologists to determine conclusively whether the cancer is invasive. Because Pap tests enable cancer to be detected early and because it takes up to ten years for an *in situ* cancer to begin to invade the surrounding tissue, the news from the pathology report is almost always good: *in situ* cancer, all removed within the cone.

After surgery for *carcinoma in situ,* a woman's chances of having it again are exactly the same as her chances for getting it the first time — higher if she has had many partners and began sexual activity younger than eighteen, lower if she has had fewer partners.

Cone biopsies are "real operations", done in hospital with either local or general anaesthetic. One-quarter of women experience some form of complication ranging from mild infection to hemorrhaging. The first few days after surgery must be spent in hospital where conditions can be closely monitored and rest can be assured. Intercourse and strenuous activities are prohibited for several weeks following a cone biopsy.

This surgery is the preferred treatment for women who want to have (more) children. However, the scarred cervix occasionally contributes to problems in achieving conception, maintaining a pregnancy and delivering vaginally. The cervix may not be able to contain the cervical mucus which, at the time of ovulation, conducts sperm up through the cervix. It may dilate too soon causing a miscarriage or premature delivery, or may not dilate enough to accommodate the passage of the baby's head. One-tenth to one-quarter of women who have had cone biopsies will experience one of these problems. Fortunately, they can usually be overcome — by persistence in the case of conception, by rest and medication to halt premature dilation, and by cesarian delivery when a cervix does not dilate.

When a Pap test which has been confirmed by a cone biopsy shows that cancer is invasive, a hysterectomy is necessary. But because *in situ* cervical cancers become invasive very slowly, women who have regular Pap tests will very rarely need to have a hysterectomy. The term "hysterectomy" covers a number of surgical procedures in which the uterus is removed. Depending on why a hysterectomy is performed, the cervix, ovaries and fallopian tubes may or may not be removed. In the case of cervical cancer, the cervix is removed along with the uterus. Some doctors are supportive of pre-menopausal women who wish to retain their ovaries in order to avoid experiencing "surgical menopause", during which discomforts usually spread over a period of years occur within a very short time. Any type of hysterectomy is major surgery and carries with it the risk of infection and hemorrhaging.

Having cervical cancer is a terrifying experience, regardless of the reassuring statistics. When I discovered that I had cervical cancer, I felt sure that I'd be the one-in-a-trillion women in my age group and with my sexual history to have invasive cancer. I worried that my doctor, a feminist and an eminently trustworthy woman, would find something terrible and unexpected during the cone biopsy and remove my entire reproductive system without my consent.

Although I was well-informed and knew that the risks of having my worst fears confirmed were infinitely small, I needed to prepare for all the worst possible contingencies.

Fortunately, my family and friends were willing to listen and accept my fear as legitimate, although not based in fact. As one wise listener said, "The only minor illness is one which someone else has."

Women who have cervical cancer need support and acceptance. While the medical profession continues to debate the causes of the disease, we must regard the media verdict of promiscuity as both premature and misleading. And we must fight the stigma which is fast becoming attached to cervical cancer so that a woman will not avoid having a Pap test because she thinks it is a shameful admission of "promiscuity" or necessary only for those who are "promiscuous".

Who should have Pap Tests

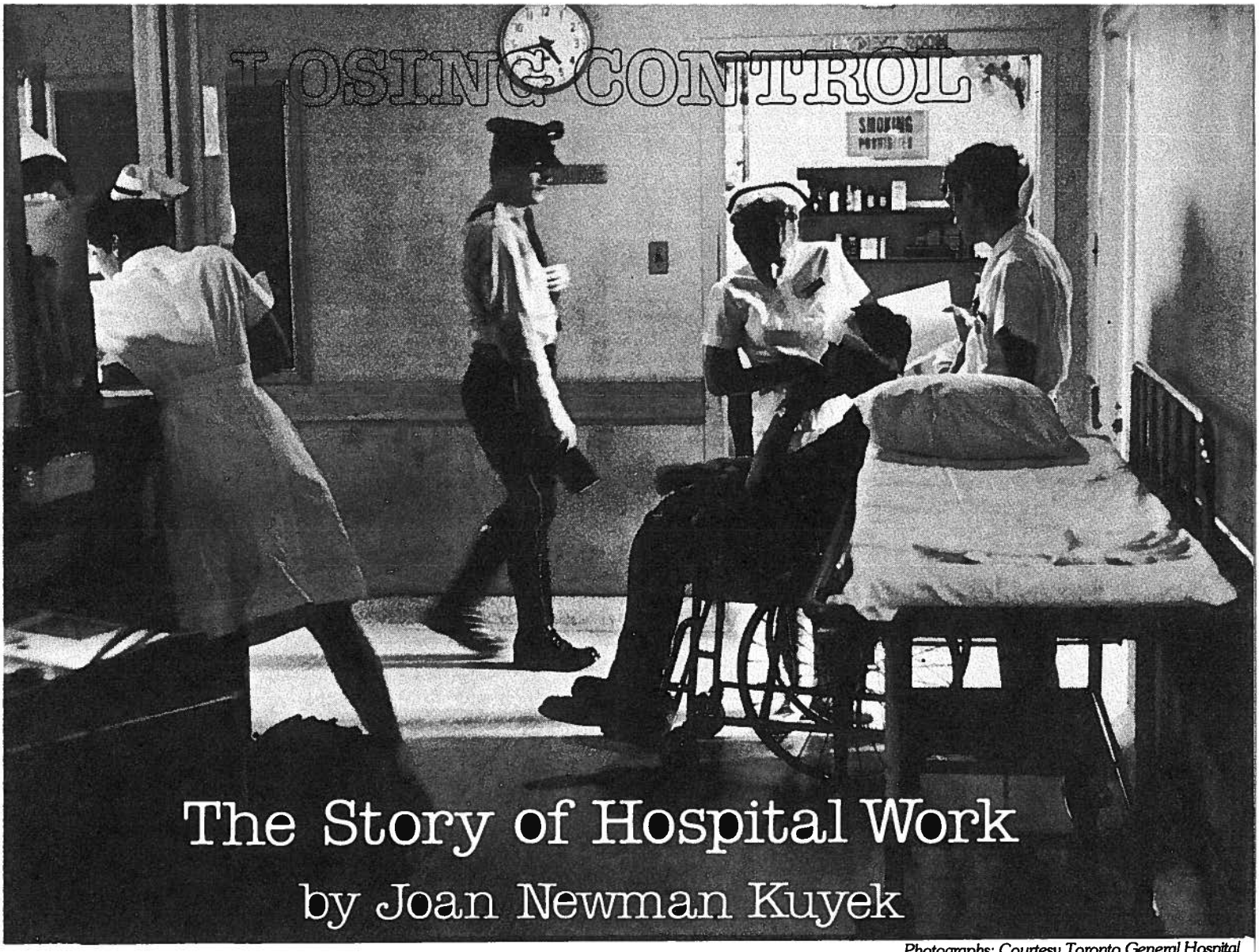
Regular Pap Tests should begin—
- **when heterosexual activity begins**
- **when a woman has been identified as being a DES daughter**
- **when a woman turns eighteen, regardless of sexual activity**

Annual Pap Tests should continue —
- **for heterosexually active women**
- **for women who have recurrent vaginal infections**

Twice or thrice yearly Pap Tests are necessary —
- **for DES daughters**
- **herpes 2 carriers**
- **women who have had cervical cancer**

Pap Tests every two years may be elected by women who—
- **have had negative (Class 1) Pap Tests annually for two or three years AND**
  - **who do not have intercourse**
  - **or have just one regular partner**

No Pap Tests are necessary for women who —
- **have had a hysterectomy which removed the cervix.**
- **are over sixty and have participated in a regular screening programme without any atypical results being found.**



The Story of Hospital Work

by Joan Newman Kuyek

Photographs: Courtesy Toronto General Hospital

The hospital has become a place where we as patients feel powerless, dehumanized and often mistreated. Our complaints are usually directed at the hospital workers and doctors who pass in and out of our rooms in bewildering numbers, each tending to a narrowly defined area of our "care", and in many instances, appearing unable to *care* at all.

At the same time, we are witnessing a rapid escalation of the struggle among hospital workers and doctors for better wages and working conditions. We've seen naked attempts on the part of hospital boards and provincial governments to break the power of the unions through restriction of the right to strike, funding cutbacks, introduction of technological innovations which eliminate jobs and an onslaught on the power of individual doctors to manage patient care.

It's hard for us to sympathize with health care workers, however, when we perceive them as unwilling to meet our needs. And yet, our concerns as patients are inseparably linked with the structure of hospital work and the well being of workers. A quick scan of the historical development of hospital services will show why this is so.

The original hospitals in Europe were very different from those in our experience. In Roman times, they served as dormitories for travellers and vagrants. During the Middle Ages, they became charitable institutions to care for the destitute: the sick, the insane, orphans and amputees. (Right up to the twentieth century, people who could be cared for at home, who could afford to stay out of hospitals, did!) The first hospital in Canada, established by Jeanne Mance in Montreal early in the 1600's, was based on this model.

As the middle classes and "professions" developed in the eighteenth century, doctors and lawyers for the first time began to enjoy an elite position within society. Their status was based on their access to education, usually less scientific than philosophical in nature, which they used to classify diseases. The hospitals, run by religious orders, provided a veritable hothouse of diseases for the investigator and with time it became the place where doctors did their teaching, research and experimentation.

In the 19th century some of this study bore fruit; the nature of hospitals changed as doctors began to undertake the active treatment of illness. New facilities and auxiliary medical personnel were required, which were

outside the resources of the doctor's office. More and more the hospital became the physician's workshop. Surgery, for example, became a hospital-based medical service and the privilege of using the operating room was extended to doctors in the community. In return, doctors were expected to provide free care for the indigents in the hospital. Hospitals established in Canada at this time were most often religious institutions; some were "public hospitals" supported by charity with boards made up of leading citizens from the community.

At the same time, doctors were consolidating control over medical services. Midwives, homeopaths, and other healers were discredited. In Canada by 1929 the Royal College of Physicians and Surgeons was established under an Act of Parliament. A non-profit organization that elected its own governing body, the College had exclusive control over the education, licencing and discipline of physicians.

Until World War II, hospitals were largely dependent on various forms of voluntary labour to meet their needs. Nuns and student nurses provided most of the work that kept the institution functioning. Most of the staff worked long hours in return for board and room in the hospital residence and a pittance in pay. An ideology of self-sacrifice predominated in the training of nurses and other staff: Interest in material reward was considered demeaning; disobedience was "unbecoming" or even "sinful".

The staff was organized hierarchically. The overall management of patient care was determined by doctors based in the community who instructed the nursing staff. The quasi-charitable hospital boards were mostly concerned with ensuring a steady flow of contracts to the local entrepreneurs who were represented on the board. Hospitals were a lucrative market for local entrepreneurs: real estate, insurance, construction materials, stationery, linen, chemicals, food, laundry. In fact, almost any good or service a business could produce was used by the expanding hospitals.

By 1920, wealthy and middle-class patients were frequently admitted to hospitals in the private and semi-private rooms that had been added to the charity wards. This reflected the increased ability of science to treat disease and the greater willingness of the public to pay for it.

The Second World War marked a turning point in the development of hospitals and medical services. Rapid construction of new hospitals combined with the introduction of new technologies to transform the hospital into a complex, modern factory. Urged on by wartime needs, corporations had developed an array of new medical products and were now demanding markets for them. Government funds for hospital construction and expansion made this possible. There was a boom in the use of incubators, aseptic delivery rooms, therapeutic radiology, streamlined kitchens and pharamaceutical treatments.

In the years following the war, hospital operating costs multiplied crazily. In Ontario alone spending increased from $130 million to $4.8 billion in just eight years. The rapid influx of funds and new technology created thousands of new jobs, and sped up the division of hospital work into small specialized units. Paramedical staff grew to include laboratory technicians, radiological technicians, medical records librarians, electroencephalograph operators, electrocardiograph technicians, physiotherapists, occupational therapists, radio-isotope technicians, inhalation therapists, heart laboratory technicians, assistants in clinical investigation units and so on.

These technological giants were, of course, increasingly beyond the capabilities of local boards to finance. Greater and greater amounts of money had to come from the provinces. With this money came control, and one by one, the provinces set up special departments or commissions to coordinate the hospitals they funded. These departments allocate money for construction and operation, control research, planning and evaluation and, last but not least, administer hospital insurance. This sort of centralized control helps ensure that the hospitals will remain a steady market for the goods of medical equipment companies.

That many of the innovations in medical care had little to do with what is good for patients and a lot to do with creating profits is well illustrated by the rise of the fetal monitor. Despite the fact that these devices have had *no measurable impact* on birth mortality rates, and despite innumerable complaints from women that they are uncomfortable, frightening and often misinterpreted during labour, fetal monitors are being bought and used at ever increasing rates in North American hospitals. Their use accompanies the rising rate of delivery by Caesarean section, again with no

noticeable effect on infant mortality.

Fetal monitors are manufactured by Hewlett-Packard and American Home Products. Hewlett-Packard also produces instrumentation for weapons systems. American Home Products manufactures Sani-Flush, Black Flag insecticide and Easy-Off. These two companies are now looking forward to fetal monitoring by telemetry performed on an outpatient basis, so that every hospital and physician's office will require the equipment. Tomorrow's women in labour may find their attendants to be not a doctor or midwife, but a machine.

Just as the management of hospitals had to become more centralized, so the organization of work within the hospital had to be restructured. There are many ways in which work can be organized: co-operatively, in teams and in workshops for instance.

The model that was taken up by hospitals, however, was an industrial one made famous in 1905 by Henry Ford: "scientific management". Throughout North America and Europe, the first factories were workshops for craftspeople. These craftspeople had all the knowledge about their craft and so were able to control their own pace of work and the quality of that work. This greatly frustrated the owners of industry, as they wished to get the greatest possible production out of the workers in the shortest possible time. Frederick Winslow Taylor was the major theoretician of scientific management, the new system of management which broke down the control of these craftspeople and transferred it to management.

Taylor believed that the greatest obstacle to production was "systematic soldiering", the deliberate effort on the part of workers to conceal just how fast the work could be done. He insisted that the central task of management was to take away from the worker the knowledge of how the task was performed, reduce each task to its component actions, time them, assign each task to a different detail worker and then dictate to the worker the precise manner and speed in which the task was to be done.

With scientific management, workers lost control of the purpose and quality of their labour and were tied to a pace of production over which they had no control. As this system of management was solidified in the hospitals, health care workers became part of the "industrial proletariat".

Work was already organized hierarchically in hospitals: control over the management of care rested with the hospital boards. It was not difficult at first to introduce scientific management under the guise of technological progress as new specialized jobs were introduced into hospitals. Then more established jobs such as nursing, were subdivided among nurses, nurses' aides, and orderlies, ward clerks and so on. By the early 1950's the gutting of health care workers' jobs was complete. The following quote from an unpublished paper by George Torrance describes the kind of kitchen which was a reality in almost every hospital in North America.

"Like the hospital as a whole there tended to be dual lines of authority, one involving professional dieticians, engaged in producing special diets and in research and teaching and the other involving production managers and those having responsibility for the preparation of most of the meals.

"The main work of the department revolved around the preparation of upwards of 5,000 staff and patient meals a day. To accomplish this a coordinated routine had to be worked out. This involved breaking down tasks into their smallest components, rotating workers among these repetitive jobs and relying on close supervision to ensure that the final product was of uniform quality. Although there were a fair number of skilled jobs in the kitchen (cooks, bakers, butchers, etc.) most of the jobs were semi-skilled and delegated to female dietary aides and male cleaners, porters and dishwashers.

"The food service aides rotated among ingredient-preparation jobs and took part in the regular operation of a conveyor belt on which were assembled the meals for the patients on the floors. . . . One long term veteran claimed that he had never been upstairs to the patient-care settings in all the years he had worked in the hospital."

The education required to prepare hospital workers for their tasks varies with the requirements of the job: the lowest paid are trained on the spot, the technicians are trained at community colleges, the "professionals" at universities. All the different tasks have different rates of pay with different status. Most of the skills cannot easily be transferred outside the hospital environment, and training for one job does not prepare the worker to learn another

more easily. The worker is trapped into the detail work that she began with, and is divided from other workers in the hospital by employer-defined job descriptions.

The organization of work in a hospital is inextricably linked with the way patients are treated in that system. Within industry, workers resist scientific management through absenteeism, slow-downs and sabotage. If workers in hospitals are driven to this degree of alienation, what happens to the patients?

Most people want to work and they want to do useful things with their lives. But the pleasure in working comes from the spark of imagination between conceiving of a task and executing it. When planning is taken from workers, they become automatons, putting one foot endlessly in front of the other. Strict control from the outside replaces motivation from within.

The proletarianization of health care workers brought with it unionization and demands for a decent standard of living. By 1978, 43% of hospital employees were unionized and hospital strikes in Canada averaged six a year. The changed role of hospital work pitted the workers against hospital management on economic issues (because management rights clauses restrict bargaining to these issues only). Management began to search for ways to cut labour costs and increase productivity. As is common in industrial settings, the easiest way to increase productivity is often to eliminate workers. In the hospital this is being done by the introduction of microelectronics to the office, the pharmacy, the library, the reception area, and the diagnostic facilities.

Until recently, doctors have been exempt from this proletarianization and have enjoyed the privileges of priests or nineteenth century craftspeople. Within the hospital system, doctors still do not fall within the line system of authority. They are organized into a "staff system", which doctors describe as a "group of independent equals individually responsible for the care of their patients and collectively responsible for the policing of the quality of medical care provided by their number in the hospital workshop". The doctors in a hospital report separately to the Board of Trustees and run their own affairs by departments. They give independent orders to nurses and to other members of the hospital bureaucracy.

But this system has been breaking down. First because of the number of doctors on the hospital payroll and the increase of their specialization: radiologists, pathologists, rehabilitation specialists and so on. Second, the public is increasingly using the hospital for services which used to be obtained in a doctor's office: emergency facilities, specialty care, outpatient clinics.

In addition, their independent power does not sit well with hospital managers dedicated to cost efficiency and control.

Doctors increasingly find themselves in conflict with hospital policy on matters such as birthing procedures, length of stay and nursing care.

In the 1960's, universal health insurance seriously undermined doctors' managerial role by forcing them to account for billing, tests, expenditures and referrals. Some provinces have gone further, taking over policing powers, medical curricula and other functions originally controlled by Colleges of Physicians and Surgeons.

The multiplication of technologies and pharmaceuticals has left most doctors ill equipped to evaluate the long term effects of such remedies on their patients. Specialization has created a situation where the patient is increasingly dehumanized. Patients are sectioned off into parts ("the gall bladder in room 210") and parcelled out to highly paid specialists.

Those doctors who are willing to use the new technologies are rewarded: They work fewer hours, see more patients for shorter periods of time and make more money. While poor people make more use of emergency departments and outpatients clinics, wealthier patients go to doctors' offices. Doctors no longer do home visits or do adequate follow-up on patients — it is too costly. Any doctor seeing 40 to 60 patients a day will be desperate for instant solutions to problems and is not going to have the time or energy to examine such things as alternatives to chemo-therapy and surgery. Generally speaking, doctors no longer control patient care.

The position in which doctors find themselves is part of a deliberate policy by government to make them manageable workers in the hospital factory. They are the last craft that must be brought into line to complete corporate control of health care. The struggle which doctors translate into economic demands is actually a struggle about the control of medical services.

Doctors and other workers at all levels of the health care industry are seriously disturbed by the existing breakdown in patient care and by the seeming distance between their self-interest and the self-interest of their patients. Good health care cannot be provided by workers who are not aware of or responsible for the end product of their labour. It cannot be provided by people who have no sense of creativity or pleasure in their work.

It has become imperative that health care workers and the community sit down and develop new methods to organize work within the system, using workers' self-management and community control models. Then, perhaps, purpose and creativity can be expressed in caring for sick people, and the dehumanization of patients and workers we accept as inevitable will be seen for the historical aberration it truly is.

My comments are an offshoot of a lecture that Mercedes Stedman and I prepared for the Strategies for Well-being Conference (Toronto, February 1981). Both of us had done considerable research previously on the organization of work in industry and we became very excited to see that the health care system could be analyzed with the same tools. George Torrance, we later discovered, has done a great deal of research in this area already. For further information on scientific management in the hospital, I would refer the reader to him.

Joan Newman Kuyek is a community legal worker in Sudbury, Ontario. She has been a community organizer for sixteen years, and is the author of The Phone Book: Working At The Bell.

My Story, Our Story

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

Diabetes as a Symptom

by Ruth Mechanicus

I do not presume that all cases of diabetes are symptoms of underlying stresses. I know, however, that in my own case diabetes was a symptom of stress. When I began to deal with the underlying stress — rather than deny it which I had done up to then — and thanks to many people who helped me and taught me how to deal with my stresses, my diabetes began to disappear.

Fifteen years ago I was in early middle age, a middle class wife, mother of three, in a marriage that was stressful to both of us. Neither of us had the skills to talk about our stresses and only I wanted to change and believed that that could be done. I had had many physical complaints and was a fairly regular patient for one condition or another, when finally I was diagnosed as a mature onset diabetic.

I was given a 2000 calorie diet and put on oral medication. It made a terrific difference in my energy level, it helped clear up a long standing vaginal yeast infection — it gave me a new lease on life.

Some three years later our marriage broke up. I found myself a single parent and a single person, not very well equipped for either role. But I was willing to try and learn and had the great good fortune to realize that I needed help.

I went to seminars sponsored by the Toronto Institute of Human Relations and became a counsellor. In the process I discovered the existence of bioenergetic psychotherapy which says that people suppress feelings in childhood by suppressing their breathing. For example, in a given family a little girl is not supposed to express angry feelings because Mum and Dad aren't comfortable with their own anger. Then the little girl may tense up and hold her breath whenever she feels angry and wants to scream or have a tantrum. If she does that time and again, then eventually she won't feel her anger anymore; her anger has gone into hiding, has become unconscious.

At the same time she has developed a permanent muscular tension in her body from suppressing that anger. She now, subconsciously, is careful not to breathe in those places where she might feel her anger, and so her breathing is cut down. This also means that part of her body doesn't get all the oxygen it needs. Part of her body is therefore undernourished, may look white rather than pink, may feel cold or clammy or exhibit some other symptoms of lessened health.

I went into bioenergetic therapy and training, began to let go of some of my long held feelings, did exercises to increase my breathing and became aware of energy blocks (suppressed feelings). I began to suspect that I could do with less medication than I was taking.

I started to experiment with taking less medication but came to a point where I started to feel "horrible". I had felt this before, but had never tried to understand what was going on. I wasn't in pain, and yet at the same time I was. I was terribly tired, but not of the kind of tiredness that would go away after a good rest.

I asked a friend to give me a back massage and as soon as he put his hands on my shoulders I realized that I was very, very tense. That made me think: what was I tensing up against, what was it my body wanted to keep in, couldn't or wouldn't let of? I went back to my usual amount of medication, but the questions begged answers.

I toyed with different approaches, but finally settled on asking the Toronto Tridec Clinic and its dietician, Mrs. Holland, to design a diet that would allow me to try to get off medication. The dietician was most helpful and took much time to analyze what I was eating per day and how it could be best divided over the 24 hours so that my half-functioning pancreas would neither be overburdened nor underemployed.

The day spent at the Tridec Clinic was most significant for me. Most of the people I met seemed emotionally dead, sitting in their chairs and saying very little except to complain about their various symptoms. They exuded a spirit of resignation and hopelessness and talked about their doctors in a way that small children might talk about their parents: their fate was totally held in the hands of these powerful people.

A lecture by one of the doctors made a great impression on me. She talked about a diabetic patient of hers who had dried his wet feet too close to a burning woodstove, had gone to bed with his socks on and was unable to take off his socks in the morning since he had burned his feet by being too close to the stove and the burns had glued his socks to his feet. What was so remarkable for me was that this man had not *felt* that his feet were too close to the stove and burning. He had lost the capacity to feel hot and cold with his feet. I understood that this man's feet weren't alive enough anymore, that his feet had too little blood circulation, too little oxygen, to be able to feel.

I am sure that there are all kinds of other explanations, medical, physiological, etc., for this phenomenon. I also know that my way of seeing and understanding it is as valid in its own way: people who have had to shut down emotionally do this by tightening up, by withholding their energy. And eventually parts of them "die", for lack of oxygen, for lack of nourishment.

I went home with my diet and slowly, over the following months, went off medication at auspicious moments, e.g. after a vacation when I felt rested, relaxed and courageous enough to push a little further into my own inner and forgotten emotional life.

When, eventually, I gave up the last of my medication I had weeks and weeks of severe pain in my upper back and shoulders and did a lot of crying and screaming. But then one day it was gone and although it occasionally returns, it never comes back to the degree and duration it did then.

Apart from this, I really did not have any setbacks but continued to be less at the mercy of my pancreas. In the beginning I stuck religiously to my prescribed diet, but gradually I could afford to relax. I went from two small breakfasts to one, and then from meat and eggs to a diet of more complementary proteins and now virtually eat when and what I like, with the exception of too many sweets.

Naturally, in the process I have had to become much more realistic about myself, who I am and who I am not. I have had to drop unrealistic expectations about my "strength" but also about my "weaknesses". I am less strong than I once thought I was, but also less weak. I have learned to be more truly responsible for myself, but also that I am not as alone as I used to feel.

Best of all, perhaps, at this point in my growth, I have better skills to feel my feelings and to discharge them, sometimes appropriately, sometimes inappropriately. But doing the best I can and knowing that in order for me to stay as healthy — both in a physical and in a psychological sense — as is possible for me I am responsible for my life. I have to accept who I am, including where I came from and what that did for me and to me.

Ruth Mechanicus is a psychotherapist in private practice with a special interest in the somatic expressions of emotional tensions.

Reviews

Diligence, Excellence and Obedience

Reviewed by Linda Ryan Nye

Somebody Has To Do It: Whose Work is Housework? *Penney Kome, McClelland and Stewart, Toronto, 1982.* $9.95 paper.

You would think housework is the one subject that women know all about. After all, we were assigned the job years ago and have been carrying it out with diligence, excellence and obedience ever since.

But like everything else in our lives, housework has come under the microscope, and the discoveries continue to surprise and disturb us. Cries that our work is undervalued, underpaid and unhealthy have become common, and feminists regularly argue the pros and cons of wages for housework and pensions for housewives.

What has been sorely needed is a close, careful look at our attitudes, and men's, and an analysis of the facts and the myths. The jacket of Penney Kome's new book, *Somebody Has To Do It,* promises just that.

Bold print tells us her book "examines the extent to which men really help out with household chores, the absence of pension , sick pay, job security and paid vacations for housewives, the appalling financial prospects for widows and divorcees, and the refusal of the world to acknowledge household management as *work*".

She does in fact do all that and more. In the easy reading style of her *Homemakers'* "Woman's Place" column have come to expect, Kome lays out the history and hysteria of housework and motherwork in the words of those who know it best; and then she opens the door to ways of climbing out of that homemakers' hole.

Many of the facts are not new, but put altogether they take on new power. Page after page you hear women describe their work and their feelings. You discover along with them just how much work they do, how skilled the work is, and how little it is understood or appreciated.

And how to most of us feel about housework? Somebody has to do it!

Penney Kome argues that that somebody does not have to be women, that we have been on the unpaid losing end of the industrial society long enough. She points to the Industrial Revolution as the historical catalyst that divided — unnaturally but successfully — paid and unpaid work, work outside and inside the home, men's work and women's duty.

Women became the "crypto-servants" that freed men to be the paid and valued workers. We bought the role though we did not choose it, and even today we claim it as our own along with the paid positions that more and more of us are undertaking.

Recently I was asked to speak to high school students about the women's movement because their teacher was growing concerned that her female students were defining liberation as the freedom to take on two jobs — housewife and secretary — and do them both well. It seems we are adding a "working" job to the traditional duties of being superwife and supermom.

We will now look after a husband, children, a house and pets — and a boss. And all this without much of a support system or benefits package.

The message that comes through loud and clear, sometimes humorously and sometimes pained, from the lives

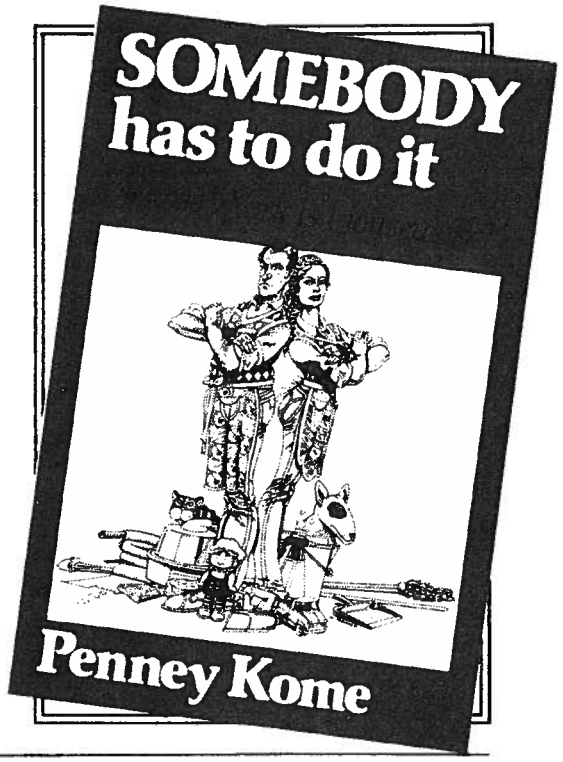
of the Canadian women Kome interviewed is that taking sole responsibility for housework, especially if it is coupled with motherwork, leaves us crippled emotionally and economically. Imagine what we are doing to ourselves when we add outside paid work to our list of duties.

Thankfully Penney Kome does not leave us helpless and in despair. She offers homemakers a thoughtful guide to beginning the peaceful revolution of renegotiating a lousy social contract we never signed. Her suggestions are positive, possible and just might help us find our way out of an unjust situation and into an equal partnership in our home and in our society.

As I read this book I found myself listing all the friends I want to give it to: my mother, so she will know that she was not crazy all those years; my father, so he will understand what she went through; and my married friends so that they will being immediately to adjust their housework and childcare contract.

Somebody Has To Do It is a book that somebody needed to write. Thank you, Penney.

Linda Ryan Nye is a project manager for the National Survival Institute, an environmental organization based in Toronto.



Fighting Anxiety in Twenty Steps

Reviewed by Adelyn Bowland

Women and Anxiety: A Step by Step Program for Managing Anxiety and Depression, *Helen A. De Rosis, Doubleday Canada, Toronto, 1981.* $7.50 paper.

Psychiatrist Helen De Rosis would have us believe anxiety can be handled by a self-help "step-by-step program", utilized alone in the privacy of one's own home. There is little doubt of the impact which the concept of self-help, a mainstay of the women's movement, has had on healthcare, and "how-to" books can be useful. However, where feminism emphasizes collective self-help, De Rosis emphasizes working alone.

This is a method which deals with the emotions through the intellect, a pragmatic, goal-oriented approach. De Rosis prefers to see anxiety as the problem, rather as a symptom of a problem. She includes no analysis of the sources of anxiety as arising, at least partially, from the powerless position in which women usually find themselves. There is little recognition of the role of the unconscious. De Rosis moves breezily along, spending much of her time on how to make marriage work. As far as the author is concerned, it is quite possible for a woman to be a happy full-time housewife; she admits that housewives derive their self-definition from the servicing of husbands and children and that this is potentially undermining of a woman's autonomy and self-esteem. Then she optimistically assumes that a newly self-defined, self-actualizing woman who is a full-time housewife can remain with a man who has for years firmly believed in her inferiority if a woman can just "try . . . her wings elsewhere".

The simple twenty-step program outlined in *Women and Anxiety,* which has an almost confessional, moralistic tone, may perhaps work for some very superficial forms of anxiety. This is a type of behaviour modification, and the assumption is that one may change oneself by merely changing one's habits. The emphasis is on enumerating, deciding, finding out. Very little concern is shown for allowing oneself to experience actual *feelings.* Perhaps emotions are a little too scary for De Rosis. I know they are for most of us. And that is precisely the reason we must face them, however unacceptable they are to us, if we want to change ourselves.

Having said this, I must admit that some of De Rosis's theory attracts me: she thinks that anxiety is not necessarily negative but an inevitable and necessary part of life, and sees a possibility of using anxiety as a positive force. For all her talk about husbands and marriage, De Rosis emphasizes that closeness to oneself is the absolute necessity, and states: "Perhaps a test for mental health might be the extent to which you could *choose* to be with someone or to be alone, and how well you felt with either choice" [my emphasis]. She also believes that growth is a basic need, even "a natural urge".

I also like De Rosis's point of view that we are the major authors of our existence. This is a typical idealist "therapy approach", and no doubt in a better world, this would be the case. The positive aspect of this view is that it emphasizes that women don't have to be victims, don't have to see themselves as victims, and can in their own lives, and collectively with others, begin to claim power.

To change oneself is a political act requiring intuition and dedication. De Rosis's book espouses mere accommodation both within oneself and in one's relations to others. If what you want, or need, is a revolution within, try another book. Or better yet, try a good therapist.

Adelyn Bowland is a lawyer and a graduate student at Osgoode Hall Law School.

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NEWFOUNDLAND — Barbara Luby

Upcoming Health Consultation: The Women's Health Education Project (WHEP) is gearing up for its "consultation" to be held June 4, 5 and 6 at Sir Wilfred Grenfell University in Corner Brook, Newfoundland.

Consultation workshops will use the information gathered from women who participated in a survey of health attitudes conducted in late 1981. The approach will be participant oriented, based on the perspective that health issues must be identified by women in their communities.

WHEP has, during its first year in existence, established a network of women across the Province. More importantly, it has done so by stressing personal communication, responsiveness to community-identified needs and a respect for the characteristics of women in isolated Newfoundland and Labrador communities. Having laid the groundwork, the challenge for the Project will continue to be to nurture, strengthen and activate this network.

The results of the health attitudes survey are now available in booklet form through the Project office on a first-come, first-served basis: WHEP, P.O. Box 4192, St. John's, Newfoundland A1C 5Z7.

NOVA SCOTIA — Deborah Kaetz

Extra Support for Parents: Since October 1980, the Junior League of Halifax has been carrying on a unique support program for mothers. The program, called Extra Support for Parents, provides one-to-one volunteer support for mothers-to-be and new mothers. It operates out of the prenatal clinic of the Grace Maternity Hospital.

Volunteers are assigned a new mother and commit themselves to at least 2-3 hours per week of support. This may entail help with basic needs such as finding an apartment, furniture or clothes for the child. Volunteers make referrals for nutritional counselling, family therapy or family planning information. They are always on call between formal visits.

A spinoff from the core program is the establishment of an ongoing support group for single teenage mothers which meets every other week at the Bethany Home in Halifax.

Buckle Up Baby: Another program initiated recently by the Halifax Junior League is an infant car seat rental. U.S. studies have shown that very small infants (0-6 months) are highly vulnerable in a car accident and many infant deaths and injuries could be prevented by proper child restraint. Because such infant seats are expensive ($50-$80 in Canada) and their period of use is so brief, most parents tend to do without. The Junior League will rent seats for $25 for nine months, $10 of which is refundable when the seat is returned. More information may be obtained from Woozles Bookstore, 1533 Birmingham Street, Halifax.

Conferences: Two consumer oriented health conferences were held in Nova Scotia this spring. On April 17th, the fledgling Nova Scotia Health Coalition held its first annual meeting with a focus on the organization and financing of provincial health care. The Coalition is a loosely-knit, growing group of representatives from health, labour, professional, paraprofessional and citizens' organizations who are working toward improvement and greater consumer involvement in health care.

The Women's Health Education Network (WHEN) held its yearly conference at the Nova Scotia Teacher's College in Truro on April 24 and 25. This year's theme was "Yes I Can!" control my own health care. One of the joys of WHEN's annual conference is the opportunity which it provides for women living in rural and urban areas to come together to share their projects, frustrations and hopes for the future.

PRINCE EDWARD ISLAND — Annie Thurlow

Women Educating Themselves About Addiction: The troubling and often ignored problem of women and addictions is the concern of a committee formed last year on Prince Edward Island. Comprised of women from the health professions and the general community, the committee has targeted community awareness and better facilities for addicted women as its primary areas of concern. The main thrust of the committee has been the establishment of a speakers' bureau to provide speakers to any group interested in hearing about women and addictions. According to committee member Carol Pound, the speakers' bureau has met with unqualified, if somewhat overwhelming, success. So heavy has been the demand for speakers that the committee is now training more people to meet the requests. In November 1981, the group sponsored two one-day conferences about drug and alcohol problems faced by women.

Pound says she feels that these exercises in community awareness are important. Very often women are "secret addicts" or addicted to substances, such as diazepam, commonly known as Valium, which they do not perceive as addicting or harmful. It is for these reasons — to help people realize the true scope of the problem — that the group has placed such a heavy emphasis on education.

While in many provinces the task of education about addictions has been undertaken by various levels of government, Pound says she believes that P.E.I. is the only

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place where a committee of concerned women has taken on the job. She feels the community base accounts to a great extent for the group's success and hopes it will serve as a model for others.

ONTARIO — Anne Rochon Ford

Toronto Women's Health Network: Still going strong after one year, the Toronto Women's Health Network recently agreed to formalize its membership. The group meets monthly to discuss specific health issues and current developments in health care of particular interest to women. Meetings recently have focussed on the status of home births and home birth attendants in Ontario. The Network also recently sponsored a public screening of *Not a Love Story,* a film about pornography, and hopes to continue to offer public screenings of other relevant documentary films. Women in and around the Toronto area who are interested in knowing more about the Network and Network activities can phone Lyba (652-3665) or Anne (964-9467). Annual membership is $7.50 and includes as monthly newsletter.

MANITOBA — Lissa Donner

Doctor's Strike?: Doctors who are members of the Manitoba Medical Association (MMA) are engaged in rotating job actions in support of their demands for increased fees and for what they are terming "binding arbitration". The actions have involved the closure of local doctors' offices for 2-3 days. It sounds like a strike, except that these "strikers" stand to make *more* money while on strike than during a regular day in the office by seeing patients at hospital emergency departments and in their homes. In Manitoba, physicians may bill the Health Services Commission $20 *above* the regular fee for service for "special calls" performed outside of the doctor's office. When workers go on strike, they are often forced to settle out of financial desperation. Manitoba physicians stand to benefit financially from their alleged strike.

And for what are they "striking"? Higher fees, although doctors already earn on average 500% more than the average industrial wage, and for arbitration *binding only on the Province.* What the MMA means by "binding arbitration" is that should negotiations fail the fee schedule would be set by an arbitrator. However, since MMA members reserve the "right" to extra bill their patients for amounts above the arbitrated fee schedule, they do not intend to be bound, but wish to bind only Manitoba taxpayers.

When unions negotiate a contract, everything is an issue for collective bargaining — conditions of work, hours of work, job descriptions and classifications, as well as rates of pay. The MMA, on the other hand, will negotiate only with respect to fees and a closed shop clause which would force all Manitoba doctors to join their organization. This would include salaried physicians who would not receive any of the benefits of negotiated agreements. The real problems of health care in Canada — piecework medicine, the lack of preventive programs, the overwhelming sexism and elitism of physicians, and a system of health care financing which supports all of these — are ignored. None of these items will appear on the bargaining table. This is the true health care crisis.

SASKATCHEWAN
REGINA — Pam Gilverson

Moving Towards A Women's Health Centre: Regina Healthsharing Incorporated (RHI) continues to come closer to its goal of establishing a women's health centre in Regina. Provincial funding has been granted to allow planners to turn their dream into a reality. A proposal, to be completed by June, 1982, is in the process of being developed and written.

Amidst the turmoil of working towards meeting the proposal deadline, RHI has also been spreading its wings and growing both in membership and as an organization. To this end, the membership has recently ratified a joining of the Regina programme Women In Need (WIN) with RHI. The liaison is one of mutual sharing where WIN inherits a Board of Directors and RHI adopts a pilot project. WIN features a special ongoing two week course entitled: "Get Your Act Together" where low income single parent women have their needs met through counselling, legal aid, emotional and advocacy support. This union affords both groups exciting possibilities for the future.

ALBERTA — Ellen Seaman

Nurses Forced Back: The big news from Alberta this month is Bill 11, the *Health Services Continuation Act.* Aimed at ending a nurses' strike that was shutting down most of the province's hospitals, the bill contains some of the most repressive anti-labour measures enacted in this country. Under its provisions, the union itself was forced to order its members back to work.

Penalties for disregarding the Act include decertification of the union and large fines. And more — union officers or representatives found guilty would be prohibited from working in *any* capacity with *any* union until the Act expires in December 1983. Full service has now been

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restored at Alberta hospitals and little attention is being paid to the nurses' complaints about poor working conditions. The strike was not for more money but for improvements in such areas as unpaid maternity leave, shift rotation and guaranteed hours for part-time workers. It is expected that this bill, passed with one day's debate, will serve as a prototype for other labour disputes.

BRITISH COLUMBIA

VANCOUVER — Beth Hutchinson

Women and Health Conference: One hundred and fifty women from communities throughout central B.C. gathered in Prince George on March 27 and 28 for a Women and Health conference. There were workshops on Native Health Care, the Health Care Industry, Depression, Contraception, Home Births, X-rays, Psychic Healing, Herbal Medicine and more. It was an exciting conference because of the issues discussed and because many women who live miles apart were able to gather.

Abortion Action: A coalition of groups from the women's, labour and pro-choice movements, as well as political, community and church groups, are working together to plan a weekend of pro-choice (on abortion) activities. Plans for the weekend include rallies, speeches and marches in many different centers throughout B.C. The demonstrations are being planned to voice opposition to the Borowski challenge before the Supreme Court. Borowski contends that a fetus is a person from the time of conception and that abortion is murder.

The implications of this legal challenge to women's lives are drastic — safe, local and inexpensive abortion will not be available to any of us. Once again, only the wealthy will have access to abortion. This would bring about what lack of legal abortion has always brought about — illegal and unsafe abortions, costing many women their health and lives.

The strongest and best defense against the Borowski challenge us the mobilization of massive and continuing support for women's right to choose.

Midwifery Legislation Drive: Support for a midwifery system is growing in B.C. as we continue to experience dissatisfaction with standard obstetrical practice. The Midwifery Association of B.C. and the Midwifery Taskforce are organizing to convince the powers-that-be of the necessity of change. The Association and the Taskforce are presently working on draft legislation in this area and are drawing up a curriculum for a local school fo midwifery. Anyone interested in supporting these efforts can do so by writing to the Ministry of Health (Victoria), to express dissatisfaction with the present system and provide reasons for preferring a midwifery system.

10th Anniversary of the VWHC: The Vancouver Women's Health Collective celebrated its 10th anniversary this spring with a party on April 3 and with plans and commitment to more work toward changing our lives, health care system and society.

Happy Anniversary from Healthsharing — 10 years — you are an inspiration to us all!

VICTORIA — Susan Moger

Cervical Cap Study: Two years ago Mary Conley, a physician in Victoria, began importing cervical caps from England and offering them to her patients. After fitting close to 400 women, Dr. Conley affirms that the caps are popular, especially among older women. However, it has become apparent that some women have stopped using the cervical caps only one or two months after receiving them. In order to find out more about this situation, Dr. Conley is working on a study, the results of which will be mentioned in a future report.

Centre Continues Despite Withdrawal of Funds: The Coalition of B.C. Rape Crisis Centres is no longer receiving funding from the B.C. government. The issue at stake was access to confidential client information. The story of how and why this happened is too complicated to report in this format. The following is instead a report on the Victoria centre and how it is coping one month after its funding ceased. The three staff members are continuing to work, without pay. The crisis line continues to be staffed on a 24-hour basis, but the office is now open three days a week rather than five. The centre is receiving money from the public and is trying to establish a large bank of sustaining contributors, people who will give a specified amount of money each month. A proposal for funding for the centre is presently before the city.

At the moment, the centre's primary concerns are: assuring the public that the centre is still operating, figuring out how to keep the office functioning without being able to pay salaries, bringing more women into the collective and working on fundraising.

While the cutoff of funding was no real surprise to those women working in the coalition, it has been difficult adjusting to the reality of it. The government has called upon other groups to apply for funding to provide a similar service. So far no money has been granted. Feminist groups have resolved to support the coalition and not apply for the money. *Healthsharing* readers can give their support to rape crisis centres belonging to the B.C. Coalition by: sending money, spreading the word around the country and writing to the centre to voice concern and support. This will help the centre workers feel less alone: The Victoria Rape/Assault Centre, 1947 Cook St., Victoria, B.C. V8T 3T8.

Letters

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

Anti-rape Centres: The Funding Crisis in B.C.

The B.C. government terminated funding for the Coalition of B.C. Rape Centres in February of this year. For Northwest Women Against Rape, operating in Terrace, B.C. (a northern community of 10,000 people) this decision by the government has had many consequences, the most significant of which is a heightened consciousness among members as to the power of government and/or corporation funding to co-opt feminism.

Since International Women's Year (1975), when it was politic for governments to fund the women's movement, we have seen a slow, and in my opinion, intentional erosion of the support of governments of women's organizations. Diminishing dollars is evidence of a co-optation process, whereby groups develop a dependency on initial funding, which comes with few strings attached only to later find themselves in the position of selling themselves and their politics down the river or being out on the street.

Governments fund rape centres not only because of their need to keep up appearances, but because they originally believed that rape centres would function *within* the criminal justice system and increase the number of convictions of rapists. This would in turn validate the criminal justice system itself. What the government was not prepared for, was feminist ideology and practice which evolved an analysis of sexism, including in it criticism of the government and the criminal justice system. The goal of feminist rape centres is to stop rape, not to convict rapists.

This contradiction between the government's intentions and that of feminist anti-rape workers has brought down upon us a series of events. The U.S. government ceased funding feminist rape centres and they totally integrated rape services into the social service structures of the government. The Quebec government after terminating the funding of the anti-rape movement, offered funding to social service groups. And in B.C. over the issue of social service evaluation, the government abruptly terminated the funding of the Coalition only to now be offering those dollars to other groups in B.C. Only if women's groups present a conservative platform of reform will the government express delight in providing dollars.

During discussions about an appropriate evaluation of service model, the provincial government introduced a demand requiring access to our confidential files about the women who phone the lines. The government offered us no rationale as to why they needed this information to assess our service and could not offer real assurances that the information would be kept strictly confidential.

The issue of confidentiality is indisputedly at the core of the operation of rape centres. The trust built between women in the communities and the rape centre workers rests solely on the assurances we give women that what they say to us does not go any further. The safety of women who call us often rests on our maintaining confidentiality. To violate the trust built between ourselves and the women in the communities we work in is what the government demanded of us. The government put the Coalition of B.C. Rape Centres in the position of having to choose between government funding and feminist principles.

Since the termination of our funding, protests have been launched, and despite massive support by women's organizations, trade unions, and other groups, the Socred government, in the midst of a series of cutbacks, has successfully weathered the confrontation — or so it would appear.

Meanwhile, we are continuing to work towards ending violence against women. The 24-hour phone lines in Terrace, Nanaimo, Victoria, Vancouver, Prince George, Powell River and Duncan continue to be answered. Our public education programmes are being carried out. And, as we struggle to adapt to the changes imposed by the government's action, we have begun to develop ways and means to ensure our survival as feminist anti-rape centres well into the future.

Maureen Bostock
Northwest Women Against Rape
Terrace, B.C.

Edmonton Women's Health Action Network Disbands

EWHAN decided some time ago to disband. We just weren't making a go of it in terms of getting our basic direction figured out and finally we just weren't productive any more and saw no hope of becoming productive.

However, (and now the better part) we did have some money in the kitty when this decision was made and after some rumination on our part we have decided how to disburse it. So enclosed please find a cheque for $100.00 as a token of our esteem for your magazine.

Keep working as we eagerly await each issue!

Ellen Seaman for EWHAN
Edmonton, Atla.

LaLeche League

"Unsolicited Advice" by Kathleen McDonnell (Vol. 3, No. 1) was wonderful! I am pregnant and can relate . . . over Christmas, my mother-in-law was full of helpful advice for me (walk four miles a day, rest, stay in hospital as long as you can, don't have visitors once you're at home, etc.) most of which I didn't agree with. I do, however, have a piece of advice for pregnant women — check in with the local LaLeche League for support.

Beth Ann Albright-Peakall
Ottawa, Ontario

Too Organic?

I hope your magazine will not go "too organic" and lose some of its credibility. Not that I doubt the healing qualities of the Evening Primrose flowers (Newsfronts, Vol. 3, No. 2) and *some* herbal remedies, but I'd also like to read about some of the research for women being done in conventional medicine. Perhaps an article on the "Mature Women's Clinic" at the Toronto General Hospital — a first of its kind in the country — or an interview with British author, Wendy Cooper, who travelled extensively in Europe and the U.S. interviewing doctors and women about menopausal problems.

In the Mental Health issue, how about some articles on women's "adventures" at home or while travelling . . . I echo your desire not to see the journal deal too obsessively with reproductive problems.

Jan Watkins,
Hamilton, Ontario

Saudi Reader

Thanks for a fantastic magazine. My first four issues have made the rounds in our camp here in Saudi. Our only regret is that I don't have any copies in Arabic — the Saudi women would certainly benfit from the information you provide. I'm not sure how their husbands would react, however.

Jan Roberts
Saudi Arabia

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Resources & Events

Price Up-date

Safe and Effective Birth Control Does Exist, listed in Healthsharing, winter, 1981, cannot be provided free any longer due to increased postal rates.

To obtain a copy of this broadsheet about the relative safety and hazards of various types of birth control, send $1.00 to the Vancouver Women's Health Collective, 1501 W. Broadway, Vancouver, B.C. V6J 1W6.

Toward a Non-Nuclear World — A Feminist View

Vancouver Women Against Nuclear Technology has written a 12-page booklet with the above title. It includes sections on health hazards, the link between nuclear power and weapons, the international anti-nuclear movement, alternative technology, the basics of nuclear technology and strategies.

Cost is 50¢ per single copy or 25¢ per copy when ordering 10 or more. To order write WANT, #7-1774 Grant St., Vancouver, B.C.

Adolescent Pregnancy & Native Health

The Community Task Force on Maternal and Child Health recently released a report entitled *Adolescent Pregnancy in Manitoba: Current Status, Future Alternatives.* The report explores health risks, including psycho-social problems, prevention of unintended pregnancies, pregnancy and parenting options and future strategies.

Also available is an earlier report entitled *The Manitoba Native Indian Mother & Child.* This paper outlines the maternal/obstetrical risk profile of natives, problems with professional care and some recommendations for change.

Each report costs $3.00. They are available from the Taskforce, 412 McDermot Ave., Winnipeg, Man. R3A 0A9.

Microtechnology Conference

A conference on Women and Microtechnology is being held in Ottawa from June 25-27. The conference is being sponsored by four organizations: Canadian Congress for Learning Opportunities for Women, Canadian Federation of University Women, Canadian Research Institute for the Advancement of Women and the National Action Committee on the Status of Women.

The conference objectives are to analyse issues relating to training and re-training, changing employment patterns, the automated office, health and safety, privacy and confidentiality and quality of life. Women will have the opportunity to familiarize themselves with hardware and software displayed by vendors.

For more information contact the Conference Committee, c/o Box 236, Station B, Ottawa, Ont. K1P 6C4 or telephone (613) 563-3576.

Health Facts

The Center for Medical Consumers and Health Care Information publishes *Health Facts* monthly. This newsletter alternates between a 12-page single issue format and a 4-page general topic format. It is an informative and easy to read newsletter about medical information for lay readers.

Subscriptions are $18.00 (U.S.A.) per year. To order or inquire about a sample copy write to *Health Facts* at 237 Thompson St., N.Y., N.Y., U.S.A. 10012.

Addicted Women's Self-Help Network

A Toronto area network has formed to work with addicted women and organizations about issues of relevance and concern to addicted women. Both addicted and non-addicted women are members. The Network operates a 24-hour phone line, facilitates self-help groups, coordinates support networks for individuals to participate in recovery programs and provides information to groups.

Toronto Addicted Women's Self-Help Network can be contacted at Ste. 202, P.O. Box 2213, Station "P", Toronto, Ont. M5S 2T2. Their phone is 961-7319.

Native Indian Earth Healing and Herbal Renaissance

The Ontario Herbalists Association has organized an eight day retreat (July 17-24) in the Ottawa-Pembroke area. Special guests include Norma Myers from British Columbia and Sun Bear from Washington.

Register early; only 30 over-night spaces ($275 dormitory style). $75 single day rate (includes meals). Contact Christine E. Devai, General Delivery, Jackson's Point, Ont. L0E 1L0.

Sexual Assault in Canada

This report, released by the Canadian Advisory Council on the Status of Women, looks at sexual assault from the victim's point of view. It also explores institutional reaction to sexual assault, including the role of rape crisis centres.

The report is available from the Council, Box 1541, Station B, Ottawa, Ont. K1P 5R5.