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COLLECTIVE NOTES

AN UNHEALTHY BUSINESS

The avaricious power of the multinational drug companies is hitting home on a number of fronts these days. In our Newsfront section, you will read of Merrell Pharmaceutical's swift move to remove their hot seller, Bendectin, from the market within a week of an American law suit against the company concluding in the plaintiff's favour. In an open letter to doctors, a representative of the company spoke of the company's reluctance to cease production of the drug because of "the continuing ill-informed opinion and attack coming from outside the proper medical and scientific arena."

By this he means people like us who are trying to challenge that power by informing the public of the dangers of improperly tested drugs. What this drug company rep doesn't tell the doctors in his letter is that most of the studies which attempt to show the drug is safe were funded by Merrell. Similarly, the Smiths, whom you will read about in Maureen McEvoy's article on DES, were paid to do their research by Eli Lily, the company which manufactured the drug.

But this is not news. The heads of large pharmaceutical companies, the researchers hired to test the drugs, and the so-called government regulatory bodies expected to monitor these studies have long been bedfellows, however strange.

At a recent conference on Women and Pharmaceuticals in Québec (see Regional Reports), attended by one of our collective members, participants discussed the link between the activities of drug companies in Canada and in the developing world. A number of cases were cited of drugs long ago banned in Western countries which are still being heavily prescribed in Third World countries, often at exorbitant prices. As one conference participant asked, "Why are the side effects of drugs considered less serious for people of the Third World than the West?" Because of poorly monitored drug provision laws in some countries, multinational drug companies are allowed to abuse millions of unhealthy victims. Their massive profits are made at massive cost.

The horror stories which drug company executives attempt to suppress are endless. From a friend doing union work with workers at a pharmaceutical plant in Ontario, we are told of male workers who have been found to be growing breasts as a result of exposure to synthetic hormones in the plant. Drug company representatives will go to great lengths to keep stories like this from being made public. They will also spend literally billions of dollars denying their responsibility in court cases such as they have with DES in the United States. Their business is not health, it's profit.

The more we hear, the madder we get. Look for a special issue of *Healthsharing* on Women and Pharmaceuticals some time in 1984.

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NEWSFRONTS

Merrell Gives In... Reluctantly

Merrell Pharmaceuticals Ltd. of Toronto recently announced that they will stop the manufacture of Bendectin — an anti-nausea drug used in pregnancy — because of increasingly negative publicity.

According to company representative Michael Grimshaw, the decision came after two years of increasing publicity and hundreds of law suits allegating that the drug causes deformities in fetuses.

There are currently 300 lawsuits pending in the U.S. although the drug has been available for 27 years throughout the world, said Grimshaw.

He added that there is no medical evidence to support charges that the drug is unsafe and said "there are numerous studies showing it has a high safety record."

But a jury in a District of Columbia court does not agree and recently awarded $750,000 to the family of a 12-year-old girl who was born with an incompletely formed right hand, as well as missing fingers after her mother took Bendectin.

Grimshaw said the resources needed "to continue to demonstrate the high safety record of this drug" made it unprofitable for the company to manufacture it.

"The drug has been subject to unwarranted criticism. We suspect the U.S. legal system creates an environment that's conducive to these kinds of cases because the lawyers get a percentage of the awards," he added.

But according to a 1980 report in *Mother Jones* magazine, the criticism is quite justified.

Two major studies are cited that document Bendectin's association with defects such as missing hands and feet and a horrible deformity in which the brain forms outside the child's head.

Grimshaw said, however, most of the criticism is coming from "outside the medical community".

Since 1982, Merrell has made more than $1 million in sales from Bendectin in Canada, "and that hasn't been a declining figure either," said Grimshaw.

Only Watching

Media Watch, a national organization dedicated to eliminating sexrole stereotyping and pornography recently opened its first national office with a $50,000 government grant.

From its Vancouver office, Media Watch is launching a national awareness campaign to encourage women to take action when they see or hear themselves insulted by the media.

But not all Canadian feminists see this as a solution to the problem.

"This is a somewhat bureaucratic way of doing things," said NDP MP Lynn McDonald in a recent interview. "We don't just want to count porn, we want it stopped."

According to Media Watch founder Sylvia Spring, "By September we will have Media Watch representatives in every province and territory and a very visible public education campaign in place."

The organization will provide women speakers to talk about the issue, an education information kit, complaint forms, suggestions for action, and will lobby various government and industry agencies on the subject.

But McDonald says she worries that the $50,000 grant from the Secretary of State may be used as an excuse by the government not to take further action on the problem.

Spring said, however, "The role of Media Watch is to make sure that the many women who feel constantly assaulted and angered by daily bombardments of sexist materials on radio, television, and in print, will be able to voice that anger effectively and collectively."

Meanwhile, McDonald has released an informational package on pornography to more than 600 community groups and the media.

"Our present laws are woefully inadequate and are so considered by police, prosecutors, the Minister of Justice, women's organizations and child welfare associations," she said.

Under current legislation, any amount of violence can be shown in the media as long as it is not linked with sex, said McDonald. "So the woman in the meat-grinder is okay as long as she's got her clothes on."

The public's outrage against pornography is continuing to mount and according to McDonald, it is rumoured that Communications Minister Francis Fox has had to hire three people to handle complaint letters alone.

She added that people who are offended by pornography in the media can lay charges with the police and it is important to write to both Fox and Justice Minister Mark MacGuigan.

The Justice Minister is expected to introduce new legislation on this issue in the fall.

An Ottawa organization has also taken a stand against the increase of pornography in the media. Ottawa Women Fight Pornography have organized a boycott against Eaton's for their involvement with Glenn Warren Productions (the company that provides facilities for the production of First Choice Pay TV Playboy programming). So far the group has gathered more than 170 pledges from area residents.

Police Harassment

On June 20th Colleen Crosbie, a Toronto women's health activist, nurse and midwife, was picked up off the street by police and charged with procuring an abortion. If convicted, Crosbie could be charged with a possible maximum life sentence.

The charge came two weeks after the house where Crosbie lived was raided by Toronto police. The police seized a variety of literature, the gallies and mailing list for the current issue of *Bulldozer* (a twice yearly publication for prisoners), and Crosbie's birthing instruments. When picked up by police Crosbie was pressed for information about unrelated political activities and told that charges against her would be dropped if she complied.

The charge not only represents police harassment of politically active individuals but also epitomizes government interference in the private lives of women. Crosbie faces both a possible jail term and the loss of her career.

Contributions and letters of support are needed. Contributions toward legal expenses should be made payable to "David Cole in trust," 11 Prince Arthur Ave., Toronto, Ontario M5R 1B2. The preliminary hearing begins October 24, 1983 in Toronto. Telephone Marlys Edwards at (416) 964-9664 for further information.

Medical Heretic Shows Anti-Life Colours

Abortions would end in the U.S. if an assassin could sneak into a hospital and gun down three or four doctors just as they were about to perform abortions, according to an American doctor.

Mendelsohn addressed about 50 anti-choice demonstrators gathered outside Dr. Henry Morgentaler's recently opened abortion clinic. The doctor added that in Chicago there is something called a Saturday Night special — a small handgun that can be bought from a storefront. But Mendelsohn admitted that his "Chicago Solution" might not go over well in Manitoba.

Winnipeg's *Free Press* quoted Dr. Robert Mendelsohn, author of *Confessions of a Medical Heretic* and *Malepractice,* as saying, "It just occurs to me that if three or four doctors around the country got plugged, then abortions would come to an end."

Ladies for Life, a group of about 14 chiropractor's wives had invited the author-doctor to Winnipeg. Ladies for Life president Louise Desaulniers said she disagreed with Mendelsohn's remark but was sure he was "just kidding".

After a morning of radio appearances, Mendelsohn appeared at the side of anti-choice activist Joe Borowski. Mendelsohn charged that most doctors do not like normal pregnancies.

"In fact they like to do abortions," he claimed. "Doctors in general belong to the religion of modern medicine which is a religion of death... they do anything they can to prevent normal pregnancy."

The doctor also urged fellow Jews to unite against Morgentaler's abortion clinic. He added that Jews should ostracize their fellows who do not oppose abortion. "It's time we cleaned up our own house."

Herbicides on Trial

In a highly charged court case, 24 expert witnesses were recently flown to Sydney, Nova Scotia to testify about the effects of herbicide use in forestry spray programs.

Fifteen plaintiffs are suing Nova Scotia Forest Industries — one of three pulp and paper companies in the province that use the phenoxy herbicides 2,4-D and 2,4,5-T in forestry spray programs designed to eliminate competing hardwood species.

If they win, the plaintiffs hope to prevent the spray from directly affecting their property and water supplies and to set a precedent that could further restrict the use of these toxic chemicals.

Witnesses for the plaintiffs gave solid testimony, presenting a frightening picture of the threat these herbicides pose to human health.

One witness was Dr. Susan Daum, founder of the Occupational Medical Clinic, Mount Sinai Hospital and a specialist in environmental medicine. She has first hand experience in treating patients accidently sprayed in a forestry spray program, 11 years ago. Daum said the patients exhibited problems ranging from enzyme and lipid abnormalities, liver problems, delayed nerve response, and chloracne to one case of soft tissue sarcoma — a rare form of cancer.

Justice Merlin Nunn asked Daum why the effects of dioxin (TCDD, a contaminant of 2,4,5-T) were not more obvious if it was so toxic. Daum replied that if thalidomide had caused a common birth defect, it would have been very difficult to determine its source. Rare cancers like tissue sarcoma, may serve as "marker tumours" for the more common ones.

Dr. Wilbur McNulty, from the Oregon Regional Primate Research Centre, said rhesus monkeys show a high rate of spontaneous abortions after a single dose of dioxin — a contaminent in 2,4,5-T.

Although the trial ran from May 5 to June 6, the plaintiffs still need moral and financial support. For more information please contact Herbicide Fund Society, Connie Schell Treasurer, R.R.#1, South Haven, Nova Scotia B0E 3G0.

Nurse-Run Resource Centre

The first health resource centre in Canada staffed entirely by nurses has been in operation for three years at the University of Manitoba. But nurses in that province have recently come under fire from doctors who fear nurses' interest in preventive health care threatens their interests, says a recent report from the Manitoba Women's Newsmagazine, *Herizons.*

However, Dr. Helen Glass, president of the Canadian Nurses' Association says extending nurses' care outside traditional institutions such as hospitals does not interfere with doctors' jobs.

Rather than health care methods which centre around illness, nurses emphasize health and preventing illness. If they discover acute or chronic illness, clients are referred to a physician.

APOLOGY

• to Susan Hower for both forgetting her by-line and cutting her news item in half during paste-up. Susan wrote the *Newsfront* about herbicides in the June, 1983 issue.


HEALTHWISE


Evil Brew by Anne Rochon Ford

I've had a love/hate relationship with coffee since my late teens. It began with a feeling that there was something very grown up and sophisticated about languishing over a cup of it with a friend in a restaurant. There's no more discounting the effects of peer pressure with this rite of passage than there is with drinking alcohol or smoking cigarettes.

I don't know that anyone actually *likes* the stuff the first time they drink it, usually pouring in three or four teaspoons of sugar to make it palatable. Somehow we *grow* to like it, especially when we learn as students or as shift-workers of one type or another that we can count on it to get us through the night.

Once we've been initiated to coffee, many of us have a hard time giving it up. The addictive agent in coffee, caffeine, is in every sense a drug, complete with marked effects on the central nervous system and noticeable withdrawal symptoms. How many of us have tried to wean ourselves off coffee only to have found that we became terribly drowsy and lethargic, perhaps even came down with a headache?

Although caffeine is also found in tea, cola drinks and chocolate, its concentration is highest in coffee — from 50 to 175 mg per cup depending on the type of coffee and the way it is prepared. The undesirable effects of caffeine on the body vary from one person to the next, depending on the extent of habitual caffeine consumption. If you consume coffee sporadically or infrequently, you are more likely to feel the effects of caffeine more intensely. These include heartburn, gastric disturbances, irregular heartbeats, a general increase in metabolism as well as a rise in body temperature and blood pressure. Part of the temporary "lift" you get from caffeine comes from the sudden rise in the body's blood sugar levels. This in turn forces the pancreas to work harder in order to return the blood sugar levels to normal. The overall effect on your body of all this overwork can be a general fatigue which often sets in 2 to 3 hours after consuming coffee. At this point a true caffeine addict will reach for another cup of coffee and set the whole process in motion again. The result is one very tired pancreas and central nervous system.

Caffeine consumption seems to produce many contradictory effects on the body. For example, the Migraine Foundation of Canada indicates that a small percentage of daily migraine sufferers find caffeine *triggers* their headaches. Others have found caffeine effective in *relieving* a migraine if taken in the first stages of an attack. Similarly, although caffeine consumption increases urinary output, retention of fluids in the body is also reported. Women suffering from pre-menstrual water retention are encouraged to remove any caffeine-containing substances from their diet. And finally, caffeine used for weight reduction can have the exact opposite of the desired effect.











Many people trying to lose weight rely on the speedy effect of caffeine to curb their appetite. If taken in the form of coffee, however, gastric acids and intestinal secretions resulting from the drink can produce contractions in the stomach which lead to feelings of hunger.

Some coffee drinkers think they're doing themselves a favour by switching to de-caffeinated coffee. Don't be so sure. The main process by which caffeine is removed from the young green coffee beans involves using a highly potent solvent known as trichloroethylene which has been shown to cause liver cancer in mice when used in high doses. (Look for coffee decaffeinated with plain water.)

There are a number of reasons why women in particular should heed warnings against caffeine consumption. The effect of caffeine on estrogen and progesterone production is still being studied, but oral contraceptives have been found to inhibit the body's ability to normally eliminate caffeine. Women taking oral contraceptives should be aware that caffeine will build up in their systems more readily than in those of non-users.

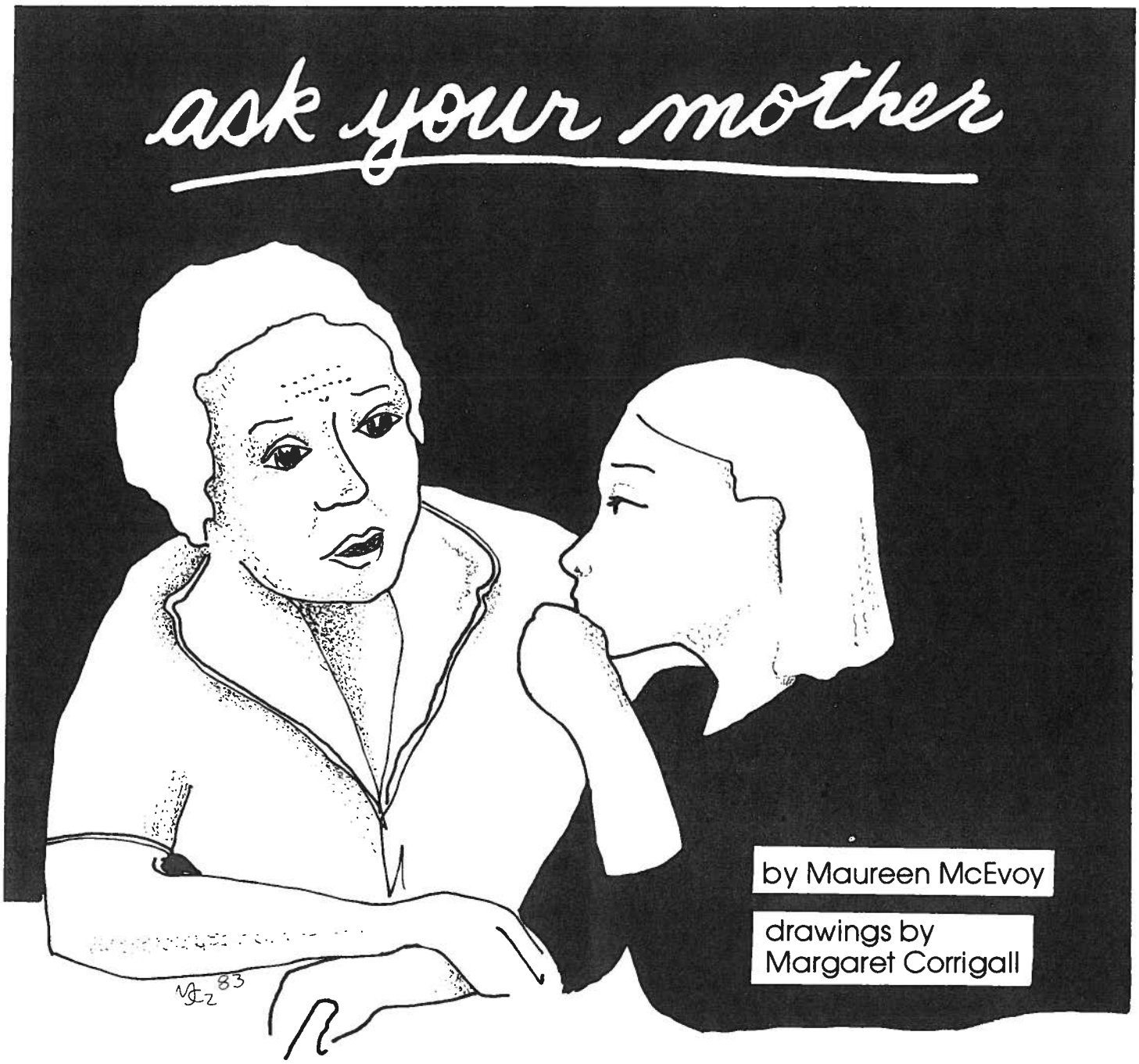
Many women report the presence of breast tenderness and benign fibrocystic lumps just prior to the onset of their menstrual periods. Caffeine may be the culprit yet again. Coffee, tea, chocolate and cola are part of a family of chemicals known as methylxanthines. American research has found that methylxanthines help the growth of cystic breast lumps. If you do find tender breast lumps which have proven to be benign but re-occur monthly, try removing caffeine-containing substances from your diet. You may be sensitive to methylxanthines.

Because caffeine has been found to cross the placenta in pregnant women, concern has been expressed about the effects of the substance on the fetus. Extensive caffeine consumption has been shown to lead to an increased incidence of spontaneous abortions, still births, breech deliveries and respiratory problems at birth. The Ontario Addiction Research Foundation suggest that, ideally, "bags of coffee would be required to bear a label warning pregnant women to consume no more than a small fraction of a cup each day."

In spite of all these intimidating facts, many of us continue to want to relax over a cup of coffee with a friend or to enjoy it with our morning paper. Perhaps if we can change our thinking about caffeine, and begin to see it for what it really is — a powerful drug to which we can and do become very easily addicted — we will be better able to break the habit and learn to find pleasures in herbal teas and coffee substitutes.

Anne Rochon Ford is a member of Women Healthsharing and of the Toronto Women's Health Network.

ask your mother



by Maureen McEvoy

drawings by Margaret Corrigall

Less than two years ago, Harriet Simand had never heard of diethylstilbestrol (pronounced die-ethel-still-best-rawl), more commonly known as DES. Then, a routine physical examination revealed she had a rare cancer of the vagina, a cancer associated with the drug. A week later, she was in a California hospital undergoing a total hysterectomy, lymph-adenctomy and removal of the vaginal walls. She was 21. Today, she is the president of DES-Action Canada, a self-help group committed to educating the public about DES.

Hailed as a wonder drug in the Forties, DES was given to thousands of North American women, and to women all over the world, to prevent miscarriage. The stories Harriet tells about DES fill one with wonder. Not wonder about the marvels of modern science and medicine, but wonder at how the public health system could heavily prescribe a carcinogenic drug. The DES story has all the ingredients of a soap opera: generosity, greed, ignorance, arrogance, hindsight, tunnel vision, aggressiveness and pain.

DES has had a number of harmful effects on the daughters and sons of some of the women who took it. Besides the cancer, which is relatively rare, DES daughters may face structural abnormalities in the reproductive organs, infertility, ectopic pregnancies, miscarriages and premature births. DES sons may encounter structural changes in reproductive organs and sterility. DES mothers may be at increased risk for breast cancer. No one really knows if more effects will surface as the DES children age. As one researcher put it, "the human experiment of DES is going on in Canada right now."

The story of DES began as a gift to the world. In 1938, in England, Sir Charles Dodd developed the first synthetic estrogen and did not patent it. The medical community welcomed the discovery. Synthetic estrogen was cheap and could be administered orally because, unlike natural estrogen, it was not destroyed by gastric juices. Within a few months of the discovery, DES — virtually untested for safety or efficacy — was on the market.

In 1946 a husband and wife team from Boston, George and Olive Smith, published an article in the American Journal of Obstetrics and Gynecology suggesting that DES could help prevent spontaneous abortions.

Scientific research was not as sophisticated back then as it is today, but even then some doctors questioned the validity of the Smiths' report.

Dr. William Dieckman of Chicago reported that the control group in the Smiths' study had not been given a placebo, a usual practice. The Smiths' claim that DES was beneficial could have resulted from the extra attention given to the women taking DES.

Dieckman returned to Chicago to carry out his own research. He presented his findings in 1953. He had developed a double blind study, meaning that neither the doctor nor the patient knew who received the drug and who received the placebo. His results: twice as many of the DES mothers had miscarriages and DES babies were slightly smaller. Inexplicably this bad news did not affect the prescribing rate of DES. The Smiths responded by publishing another paper contending that DES could make a "normal pregnancy more normal". The combination of the Smiths' continued endorsement, and aggressive marketing by pharmaceutical companies ensured that DES was prescribed for the next 18 years.

The same journal that published Dieckman's study in 1953 carried an ad in 1957 proselytizing the use of desPLEX (one of DES's many trade names)... to prevent abortion, miscarriage and premature labour... recommended for routine prophylaxis in ALL pregnancies (ad's emphasis).

It seems ludicrous now, but the American Food and Drug Administration did not require a drug to be tested for effectiveness. In Canada the situation was similar — new drug laws, particularly official screening tests, didn't exist. Testing the effects of a new drug on developing fetuses wasn't introduced until 1962, a legacy of the thalidomide tragedy.

No one really knows how many women took DES for either high risk or routine pregancies. In the States the estimates range from three to six million women.

in Canada

the estimates fluctuate wildly, probably because no one has ever attempted to research the use in Canada. The Canadian Medical Association won't even hazard a guess. Dr. Richard Graham of Health and Welfare's Bureau of Human Prescription Drugs guesses that maybe 20 Canadian physicians prescribed the drug. A spokesperson for Health Minister Monique Begin estimates between 25,000 and 50,000 women took the drug. Dr. Alex Ferenczy, a pathologist at Montreal's Jewish General Hospital and a board member of DES Action Canada, guesses that the use of the drug in Ontario and Quebec was almost as prevalent as in Boston (the home of the Smiths). Ferenczy acknowledges little is known about Western and Atlantic Canada.

"I'd say the use in Canada can be traced to the number of obstetricians and gynecologists who went to the States for training," he said. "Probably 80 per cent of U.S. trained doctors used the drug."

The highest estimate of use in Canada comes from Dr. Arthur Herbst, a leading researcher in the DES field. Herbst, an obstetrician at Massachusetts General Hospital, was invited to speak at the recent annual conference of the Quebec Association of Gynecologists and Obstetricians. Even the most cynical might wonder if Herbst's invitation was related to the storm of publicity generated by DES Action Canada in the last year.

Working from the latest number of reported cancers in Quebec (five), Herbst suggested that there were 100,000 exposed mothers in Quebec alone.

Herbst is difficult to discredit. He, along with two other doctors, made the link between DES and the appearance of a rare vaginal cancer.

By 1971 eight young women aged 15-22, in Boston, where the Smiths had done their research, had developed a rare form of cancer called clear-cell adenocarcinoma.

Eight cancers might not seem like much but, up until 1971, only three cases of clear-cell adenocarcinoma in young women had been reported in all the world's medical literature.

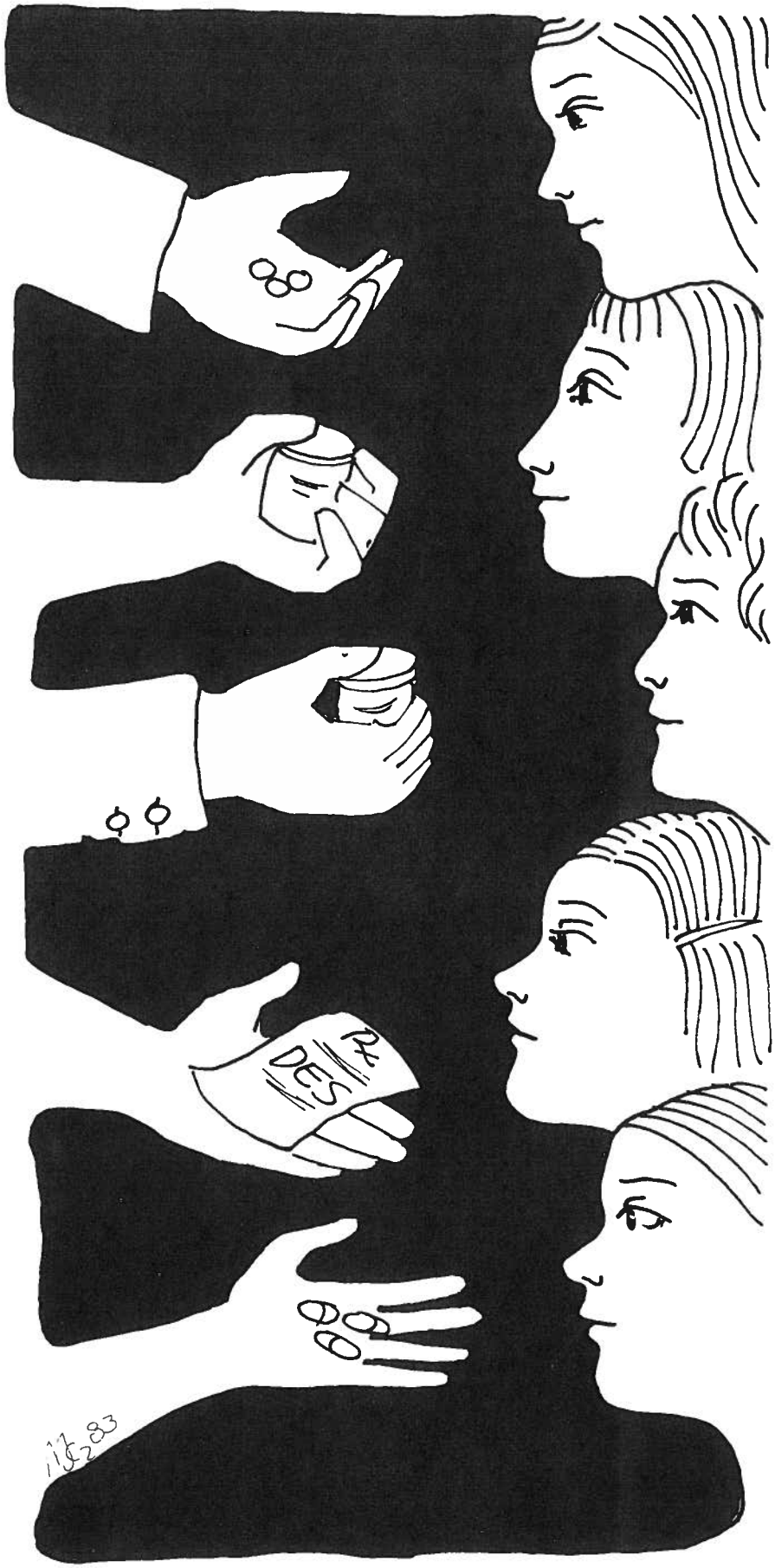
Herbst and company donned their sleuthing gear. Douches, tampons, contraceptive pills and sexual activity were ruled out. "Finally," they reported, "one of the mothers made an intuitive guess that the cause might be the DES she was given during pregnancy." Bingo. Seven of the eight young women had been exposed to DES in utero (in the womb).

Herbst's findings were widely reported. Then, almost two decades after DES was marketed, the drug was contraindicated in Canada and the United States. Contraindicated means DES was not taken off the market but was no longer recommended for use in pregnancy. However, doctors were still free to prescribe it.

Herbst went a step further. Most of the current knowledge about DES related cancer has come from the registry of DES daughters he established. For example, review of the cases revealed that the risk of cancer was lower than previously feared (the usual estimate is between 1 in 1,000 and 1 in 10,000); the incidence of cancer rises sharply after age 14, peaks at 19, and falls; and risk is greater for DES daughters who were exposed early in pregnancy.

What is not known is what effects, if any, will face DES daughters as they age, particularly when they reach menopause. Before the onslaught of DES related clear-cell adenocarcinoma, the most frequent of this form of cancer developed in menopausal women. It is quite possible a "second peak" of adenocarcinoma is around the corner.

Judith Smith (not her real name) is a 32 year old federal civil servant in Ottawa.



In May of 1978 she was diagnosed as a DES daughter. She'd never heard of DES before. Neither had her mother. Her family doctor referred her to a gynecologist with experience in DES because he noticed Judith had a hooded cervix (abnormal ridges of tissue around the cervix), commonly found in DES daughters.

"The gynecologist said I must have been exposed to DES. The drug names meant nothing to my mother," Judith says.

Nevertheless they attempted to check. Her mother's doctor was no longer alive, his records lost. It is not uncommon for DES exposed people to run into dead ends when trying to locate medical records. Often the records of pregnancy are twenty or more years old. Doctors have retired or changed practices. Pharmacies claim they do not keep records that far back. And a rather suspicious number of floods and fires have occurred in offices of doctors suspected of dispensing the drug.

A lecture which Harriet Simand gave in Ottawa provided the missing clue for Judith. Many women took vitamin pills that were coated with DES.

Judith asked her mother, who remembered she had been given a Vitamin E pill. The doctor had told her it would help her have a better pregnancy.

Judith also wanted to call her mother because the lecture revealed that DES mothers may face an increased risk of breast cancer.

"We started out of initial dual concern. Then came her inevitable guilt. I have no hard feelings against her and she came to accept that."

"She believes that without the drug she wouldn't have had me," she said. "Whether it's right or wrong, I let her keep thinking that."

Judith was plagued by a heavy vaginal discharge throughout her teens and early twenties. It was from adenosis. Another DES related change, adenosis means glandular cells, which are not normally present in the vagina, have developed. These cells are not cancerous but they do secrete mucus, their normal function — and are often mistaken as a vaginal infection. For reasons unknown, the adenosis often disappears as women reach the age of 30.

"It was such a relief to hear that other women have this secretion. If it is a reasonably common affliction then I'm not totally weird or abnormal.

"I have this ostrich like tendency when dealing with problems. I had such a lot of anxiety about this secretion. I used to think it was because of masturbation or heavy petting."

While Judith does believe she is past the high risk period to develop clear-cell adenocarcinoma, she is very worried about fertility and conception.

She has good reason to worry. Difficulty in conceiving and carrying a pregnancy to term are the most common problems DES daughters face.

Cathy Lawson has known she was a DES daughter since she was 12.

"Mom took me to the doctor for a check-up. She didn't tell me why. The doctor was the one who delivered me. He talked to me for the first half hour before the exam. I was just this wide-eyed little kid." Now 25 and a nursing student in Ottawa, she remembers that period vividly. Her mother had twigged to DES through a women's magazine article. Cathy was given a clean bill of health at 12 but through her twenties she experienced breakthrough bleeding and painful periods.

"They tell you that if you have abnormal bleeding you should get it checked out. Every time I would say DES, they would go ohh. Then they'd say 'it's ok, don't worry. Let's wait another month'.

"In retrospect I don't think they knew anything about DES."

Finally she was referred to the same gynecologist as Judith, who gave her the DES screening exam.

The DES exam is similar to a regular gynecological exam. The vagina and cervix are examined and palpitated. In addition to a regular Pap smear, a separate smear is taken from the circumference of the vagina. Next the area is usually swabbed with iodine. Normal tissue stains reddish-brown, adenosis tissue does not — hence the name clear-cell adenocarcinoma. A colposcope, an instrument like a magnifying glass, is used to inspect the vagina and cervical walls. In Cathy's case the doctor also took a biopsy which proved benign. Because the procedure took place in a teaching hospital, a number of residents were also present.

"The whole thing of checking to see if you have cancer is emotional. These extra people didn't help. I was offended they didn't ask me first."

Cathy refused to undergo further tests to determine the shape of her uterus. Usually the uterus is in the shape of a pear. A misshapen uterus, usually in the shape of a narrow T, is another side effect among DES daughters. The T-shaped uterus makes conception more difficult. Cathy and her spouse hope to start a family next summer.

"I would be very upset, even outraged, if I couldn't have children because of this. I might even consider a lawsuit then."

Cathy has a younger brother who is also DES exposed. It didn't occur to anyone to wonder what the effects of DES would be on the sons until 1975.

Dr. Marluce Bibbo and others at the University of Chicago found that DES sons had a number of health problems. While they couldn't find evidence of a direct link between DES and testicular cancer, they did find that more DES sons had undescended testicles. Such men face a risk 35 times greater than the general population for testicular cancer.

There was more. DES sons had abnormally small testes and penises. As a group they had more sperm abnormalities which may, or may not, reduce fertility.

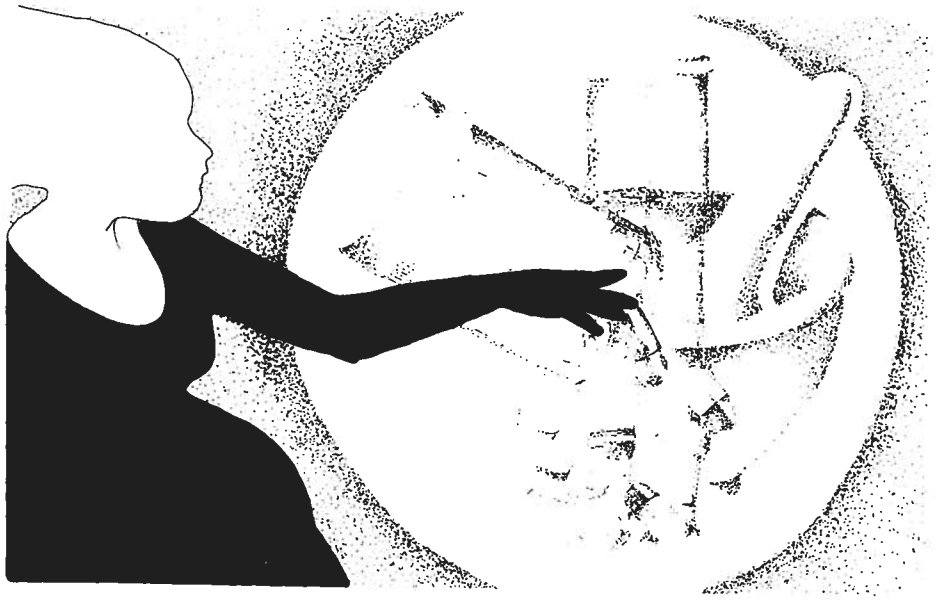
In one study four times as many DES sons had benign epididymal cysts. The epididymis is a collecting structure on the back of each testicle where sperm are stored.

Finding DES sons to interview for this article proved difficult. Men may be generally more reluctant to talk about their reproductive organs. If we think the amount of information in the public sphere about DES daughters is limited, information about DES sons is downright sparse. Generally, regular self-examination of the testicles and annual check-ups are recommended.

Headquarters of DES Action Canada was originally located on a quiet, tree-lined street in the west end of Montreal, in the Simands' basement to be precise. It was a small room, filled with boxes of posters, pamphlets and press clippings. They have since found a new space.

It is from this small space that the Simands and their corps of volunteers have sent out a blitz of telephone calls and letters, trying to raise some awareness of the DES problem. They have had some impact. Almost every contact for this story knew of the Simands, if only as "that lady from Montreal."

Harriet asked her mother, Shirley, to help her organize a DES action group in Canada after they attended a DES conference in Boston last October. It was the first time either of them had spoken with daughters and mothers coping with the devastation of adenocarcinoma and other DES-related problems. More than 35 DES action groups exist in the States. Currently the only Canadian group is in Montreal although organizing efforts are underway in Toronto, Ottawa, Vancouver and Thunder Bay (see box).



Since the first priority was funding, they applied to Health and Welfare. And they waited. Then, on November 20, 1982 the Montreal *Gazette* ran a front page story. That was a Saturday. On Tuesday, Health and Welfare granted them $20,000 for a five month pilot project to provide education in Montreal through posters and pamphlets.

Harriet embarked on a one woman press campaign. The Quebec media lapped it up.

Letters arrived too, from all parts of Canada, from large cities and small towns. "We started to get suspicious. If DES had worked its way to the Northwest Territories, it had probably worked its way everywhere else." To date, DES Action Canada has logged more than 3,000 phone calls.

In the twelve years since DES was contraindicated, Health Minister Monique Begin has issued only one press release to the general public. Health and Welfare is now considering preparing an insert in the family allowance cheques. Emphasis is on the word considering. As these cheques are mailed to families with children under 18, the information could possibly miss those born between 1941 and 1965, unless the recipients are young parents.

It took at least a dozen calls within the maze of Health and Welfare to hear the deparment's position on DES. This quote from Graham of the Department's Bureau of Human Prescription Drugs, sums up the attitude: "The information is that the department's special committee on reproductive physiology feels that, for the moment, all that needs to be done has been done."

There are lots of things Harriet would like Health and Welfare to instigate: to undertake a national public education campaign through advertising; to establish a registry for DES exposed people similar to American registries; to support an information centre for doctors and to tighten new drug laws.

Help from other sources is scarce.

In the mid-seventies, Dr. John Bennett, director of professional services with the Canadian Medical Association, was busy getting the word of the contraindication out to physicians. He prepared articles for medical journals, issued press releases and appeared on radio and TV. The CMA also recommended doctors search through their files to recall patients who had been prescribed DES. He won't say if that recommendation was ever followed. Harriet has yet to meet a woman who was recalled.

Bennett concedes that every piece of DES publicity brings more patients to the doctors' attention. That doesn't mean his association plans to do any more publicity work.

The idea of a registry and information centre baffles him. "I suppose it would have been very good at the time but the highest risk age group is shrinking and in a few years it will be gone." Not quite. American researchers estimate that fully half of the people who are exposed to DES are unaware of that exposure and thus, receiving no special monitoring. And, as said before, no one knows what may happen when the DES population ages.

purpose of the American registries is to monitor DES exposed people and to notify them as new information is released.

Bennett does not say how DES exposed Canadians, known or unknown, will be protected and monitored although he agrees that they should be.

Alex Ferenczy, the pathologist at Montreal's Jewish General Hospital, wants to establish an information centre for doctors. "Doctors need to be kept current." The centre could also train doctors in the protocol of treatment and also act as a registry and document prevalent use. Currently the only data collection about DES is being conducted by the Simands. Ferenczy is not aware of any Canadian research into DES.

Ferenczy estimates establishing such a centre would cost $50,000. A proposal for funding was forwarded to the Canadian Cancer Society.

Dr. Robert Macbeth, executive vice-president of the Society, hadn't read the proposal. Even if he had he doubts the Society would fund it.

Early detection brings the highest rate of survival. Early detection hinges on public education. Public education costs money.

In less than two years Harriet has catapulted from an anonymous young woman attending university to the central figure in a barrage of publicity, not all of it gentle. Despite all this Harriet remains remarkably unruffled. "Of course sometimes I'd get mad; sometimes I'd laugh," Harriet says. "You get used to it. Nothing surprises me any more."

"I don't fit the image of the cancer victim. They expect me to sit around contemplating life all the time."

She's found that the best approach is to calmly and rationally explain the problem, what she wants and that she's prepared to go to the press. "If you scream and yell, you'll be dismissed as hysterical."

Ironically the sales of DES in the United States actually rose by four per cent following the FDA ban in 1971. The drug remained on the market and although doctors were informed of Herbst's findings, they were free to continue prescribing it. Harriet knows a Montreal woman who was prescribed DES for her pregnancy in 1974.

A study in the Forties had indicated that estrogens given to pregnant rabbits early in gestation "will prevent implementation or produce abortion and during later stages it leads to death of the fetus." Well, in the early Seventies, the drug that had been marketed to prevent miscarriages was repackaged as a post-coital contraceptive.

Known as the "morning after pill", DES was given to women who believed they might become pregnant after unprotected intercourse. Although the FDA initially approved the drug for this use and then withdrew its support, DES was never approved as a morning after pill in Canada. Graham says the drug was never cleared and no company ever asked for approval. But it was used.

"Our special committee condemned the use of this drug as a morning after pill," Graham said. "If the drug didn't work (i.e. the woman was pregnant) then we have a new generation of DES exposed. The committee made a strong suggestion about approaching a hospital therapeutic abortion committee in the event of failure."

Relying on anecdotal evidence, the CMA's John Bennett thinks morning after use has fallen off.

"I remember I got into trouble several years ago for saying that buckets of it were being used in universities. DES was fairly widely used then. I don't think there is the same kind of use."

The drug companies didn't despair because another use had been developed — this time as supplement to cattle feed to stimulate growth. For once, Canada was ahead and banned the use of DES in livestock in 1973. The U.S. followed suit in 1980.

Still another use was as a lactation suppressant for new mothers who didn't wish to breastfeed. This application was never officially approved either.

Current approved use is for the treatment of breast and prostate cancer, although it is also being used as estrogen replacement therapy for menopausal women.

Several people listening to Harriet's lecture in Ottawa were boggled by this litany of use and abuse.

"Many people think the drug companies are acting in all our best interests. Health and Welfare might like to rely on the drug companies for appropriate studies, but I'm a bit more suspicious," Harriet says.

Harriet and her mother realized a year ago that no one else was going to tackle the problem of DES in Canada, so they might as well start now. Renewal of the Health and Welfare grant that allows them to organize across Canada has given them an enormous task. There is so much that needs to be done.

They have pamphlets and posters they would be delighted to give away. A film about the Simands and DES is currently in production by Studio D of the National Film Board.

The last word goes to Shirley Simand. "I get so frustrated at these doctors sticking together. They recall Fords and Chryslers when there's a defect don't they? Why won't they recall patients so we can prevent more pain?"

Maureen McEvoy is a freelance journalist who lives in Ottawa. Her paid employment is with Studio D at the National Film Board.

DES Action Canada

Millions of women have already suffered the consequences of inadequate testing of drugs. And yet we would probably be right if we predicted that there are other DES and Thalidomide-type stories down the road. What can be done to prevent more tragedies of this nature? The initiative seems to have to come from us, the citizens, the victims of the drug company and government blunders.

DES Action is part of the history of consumer advocacy groups working to expose the harm that has been done to so many by poorly-tested drugs. In addition, DES Action hopes to make those who don't already know it aware of the fact that they might have been exposed to a drug which could cause them harm. More than half of those who have been exposed to DES do not know it.

DES Action groups began forming in the United States as early as 1975 to help respond to the unmet, and often unrecognized, needs of the DES-exposed people. With strong indications that the drug was prescribed just as heavily in many parts of Canada as it was in the United States, DES Action/Canada formed in Montréal in 1982.

As **Healthsharing** goes to print, DES Action groups are forming in a number of cities across Canada. Like their American counterparts, the groups' goals are:

1. To identify all persons exposed to DES and to ensure that appropriate referral and follow-up care is available to them.
2. To provide resources to educate consumers and healthcare professionals about DES and the unique care needed by DES-exposed people.
3. To ensure the recognition of the need for further research relating to DES exposure.

YOUR HELP IS NEEDED! Though you may not personally have been affected by DES there will be and have been other such drugs which may affect your life or the lives of those close to you.

Contact the group nearest to you if you have any volunteer time to spare. If there is not a DES Action group near you, the Montréal office can provide you or your groups with the necessary information, pamphlets, posters and booklets to get a DES Action group going in your area.

Also, a slide-tape show on DES, produced in the States is available for group showings through the Montréal, Toronto and Vancouver groups. Contact the one nearest you if you would like to arrange a showing:

DES Action/Canada
c/o Harriet Simand
Snowdon P.O. Box 233
Montréal, Quebec
H3X 3T4
tel: 514-482-3204

DES Action/Toronto
c/o Anne Rochon Ford
P.O. Box 1004
Postal Station A
Toronto, Ontario
M5W 1G5

DES Action/Vancouver
c/o Barbara Mintzes
Vancouver Women's Health Collective
1501 West Broadway
Vancouver, B.C.
V6J 1W6
tel: 604-736-6232

Groups are also underway in Ottawa, Winnipeg, Thunder Bay, Calgary and St. John's. To contact these groups, write or phone the Montréal office and they will put you in touch. Volunteers are needed in these cities.

by Harriet Simand and Anne Rochon Ford

HELP FOR PREMENSTRUAL SYNDROME

by Karen Walker • drawings by Adrienne Alison

Carol Williams (not her real name) is a thirty-three-year-old woman with two children. Every couple of weeks she experiences what she calls her "reality change." Her husband, Bob, describes her change from a warm, loving woman to one who is raging with anger. Carol also describes feeling depressed and tearful, experiencing bloating in her abdomen, tender breasts and, just before her period, migraine-like headaches. Once her period comes, these symptoms go away and she feels herself once again, but she is left with feelings of guilt about her behaviour before her period. During the fourteen days of her "symptoms," she is able to control her behaviour fairly well at work, as she does not want to jeopardize a possible promotion; she worries that her family consequently receives more of the results of her irritability. She fears that she might abuse her children or alienate her husband.

She approached her family physician who, after hearing her symptoms, prescribed a diuretic to relieve the water retention, and offered her a prescription of an anti-depressant which she was hesitant to take. He described her problem as premenstrual tension and told her that there was nothing physically wrong with her. She left the doctor's office feeling that there was not much help for her. She used the diuretic and did experience some relief from the breast tenderness and abdominal bloating, but her emotional symptoms, if anything, became worse. Her depression about her situation increased and occasionally, she had thoughts of suicide. She began to feel she was losing control and feared she was having a nervous breakdown.

Carol has premenstrual syndrome or PMS. It is estimated that as many as 40% of all women experience this syndrome to some degree, and approximately 5% may have symptoms as severe as those described by Carol.

PMS is characterized by the presence of a variety of symptoms between ovulation and early menstruation. The definition of PMS depends more on the timing of the symptoms than on the type of symptoms. The symptoms are varied and may involve all systems of the body. Sometimes, family and friends notice the emotional symptoms, and see their link to the menstrual cycle before the sufferer does. She may be more aware of the physical changes.

The symptoms include:

Emotional: depression, tearfulness, anxiety or panic attacks, tension, irritability, anger or violent outbursts, difficulty in concentrating, mood swings, feelings of being unable to cope, lethargy, suspiciousness;

Nervous System: headaches, migraines, sleep disorders, forgetfulness, confusion, epileptic seizures, dizziness, fainting, clumsiness, accidents;

Skin: acne, oily skin, boils, herpes, rashes;

Respiratory: asthma, sinusitis, sore throat, hoarseness;

Bones and Muscles: backache, muscle cramping, joint pain;
Circulation: heart pounding, swelling of feet, ankles, fingers;
styes, swelling of the surface lining of the eye (noticed with contact lenses not fitting), redness or irritation, glaucoma;
Urinary: cystitis (bladder infection) urethritis (soreness of the urethra), less frequent urination;
Gastro-Intestinal: food cravings particularly for sweets or salt, craving for alcohol, intolerance for alcohol, abdominal cramping, abdominal bloating, constipation, gas, weight gain, sores in mouth;
Breast: swelling and tenderness;
Sexuality: increase in libido.

The symptoms vary considerably from woman to woman and sometimes from one month to another in the same woman. Some women have only one symptom; more commonly, they have several.

Premenstrual syndrome may start at puberty with the onset of menstruation. It may increase in severity following the use of birth control pills, a pregnancy, a period of amenorrhea (lack of period), sterilization, hysterectomy, or a period of severe stress. Painless menstruation is often a feature of PMS, since PMS is often the result of progesterone deficiency and painful periods are more often the result of an estrogen deficiency. It is also common for those with PMS to have had pregnancies associated with threatened miscarriage, toxemia, and postpartum depression.

The sex drive may be increased or, if feeling depressed, it may be decreased. Because of the food cravings and resulting food binges, many women have experienced weight gains. It is often, though not always, resolved by menopause.

Experts do not agree on the exact causes of the syndrome. Most theories suggest a hormonal imbalance and some researchers feel that there is not likely a single cause. The cause could lie in the ovaries, the pituitary gland or the hypothalamus gland.

Dr. Katharina Dalton, who has been treating PMS in England for over 30 years, feels that a deficiency of progesterone causes the symptoms. Other theories include an excess of estrogen, a deficiency of prolactin, a deficiency of endorphins, low blood sugar, a vitamin B6 deficiency, a magnesium or potassium deficiency, or an excess of prostaglandins.

As mentioned earlier, Dr. Dalton has been treating women with moderate to severe PMS for over 30 years. However, until recently, no comparable help has been available in North America.

Many women, like Carol, have gone to their family doctor and perhaps to a gynecologist or psychiatrist. Sometimes, the relationship to the menstrual cycle has been missed completely. Treatments tried have included diuretics, tranquilizers, anti-depressants, psycho-therapy, oral contraceptives, progestagens (like Provera), analgesics, anti-prostaglandins, estrogen, D and C, laparotomy, thyroid pills, hysterectomy, electric shock treatment, Lithium and lobotomy. Some of these treatments may have alleviated some of the symptoms. However, other treatments such as oral contraceptives, progestagens and hysterectomy may actually cause a worsening of symptoms.

Many women have also felt that their premenstrual syndrome, defined as "premenstrual tension," is emotional in nature, rather than having a physiological basis. Unfortunately, for some this has meant they have tried to hide their symptoms. Consequently, support from family and friends has often been lacking. In general, most women with PMS have felt invalidated in their experience, which adds to their problems with coping.

Now, in the U.S.A. and Canada, clinics have started to open to offer treatment for PMS. Also, self-help groups have formed and referral services are being initiated. Women need to assess the available programs and treatment to make informed choices about them.

In general, because the etiology is not completely understood, no *one* treatment provides *the* answer. Some self-help approaches work for some women and not for others.

Diet and Lifestyle Changes

The importance of a wholesome and well-balanced diet and regular excercise cannot be over-emphasized in the treatment of PMS.

The symptoms of variations in blood sugar levels (or hypoglycemia) are exhaustion, depression, insomnia, irritability, headaches, dizziness, muscle pains and cold hands and feet. Most of these symptoms can also be symptoms of PMS. Their occurrence in PMS reflects that the blood sugar level may drop too rapidly or to too low a level. This may cause food cravings for sweets and caffeine and possibly alcohol.

Women who have these symptoms may find some relief from the following suggestions:

- Avoid simple sugars and simple carbohydrates and instead focus on foods that are used more slowly in the body and result in a more even blood sugar level. Such foods would include proteins and complex carbohydrates such as fish, poultry, dairy products, whole grains, nuts and seeds.
- Avoid caffeine (see *Healthwise* in this issue).
- Have frequent small meals daily instead of three large meals, so that no more than three hours goes by between snacks. Particularly important is breakfast and a bedtime snack because of the fast overnight.

Many women may feel that they retain fluid premenstrually. Some women crave salt. Some women actually gain weight, but for those who feel swelling in their ankles, fingers, breasts, abdomen and eyes, they could be experiencing a relocation of their body fluids. Fluid in the tissues causes pressure on nearby organs and muscles which can cause the discomfort which many women speak of.

For those who gain weight, there may be help in drinking plenty of water (6 to 8 glasses daily) and reducing salt intake in the symptom time.

If a woman has been taking diuretics for her PMS, potassium rich foods or potassium supplements are essential since diuretics deplete the body's reserves of this important mineral. Fatigue, abdominal bloating, muscular weakness, twitching and tremors are common symptoms of low potassium levels. Foods that are rich in potassium include sunflower seeds, wheat germ, almonds, raisins, parsley, peanuts, dates, figs, avocados, yams, bananas and green vegetables.

Many women experience some relief of the symptoms of bloating, headaches, food cravings and depression with the use of Vitamin B6. There is some suggestion that Vitamin B6

may enhance the body's natural production of progesterone.

Women who experience premenstrual muscle cramping may find relief from raspberry leaf tea or calcium. Women with PMS generally have low magnesium levels. This causes nervous tension, mood swings, abdominal bloating and breast tenderness. Magnesium is present in leafy green vegetables, nuts and whole grains. If supplementing, magnesium needs to be taken in a 1:2 ratio with calcium for proper absorption.

In addition to potassium depletion, zinc levels can also be disturbed by taking diuretics. Zinc deficiency is common in many women and particularly women wearing copper IUDs. This mineral is involved in the metabolism of proteins and carbohydrates. Good sources of zinc include liver, mushrooms, milk, eggs, red meat and seafoods.

Some women have found relief from premenstrual breast tenderness by taking Vitamin E.

Exercise is also important and can do much to relieve the symptoms of PMS, particularly tension that is associated with the other symptoms. Exercise will help to relocate excess fluid from the tissues back to the bloodstream. Exercise will also encourage the release of beta-endorphins, the chemicals responsible for an increased feeling of well-being, much needed by many women premenstrually.

Women with PMS should exercise regularly, and the form of exercise chosen should be one that can be maintained throughout the time of the symptoms. Yoga or relaxation techniques can be helpful, but some women indicate that they need a more vigorous form of exercise when they are experiencing severe symptoms. The type of exercise is not as important as having a daily routine that can be maintained.

Stress will make the symptoms of PMS worse. Where possible, women may try to plan their activities to reduce stress during their premenstrual phase. Taking time daily to relax and nurture oneself is important. If possible, a soak in a hot tub, babysitter relief from active children, keeping a daily journal, listening to music, meditating, and daily orgasm can all be helpful.

The formation of peer support groups can provide valuable support and information for women who suffer from PMS. Because PMS is just being recognized, there is a need for professional and public education. Women need to have their experience validated and to receive support from family, friends, and co-workers.

The most important diagnostic tool for the woman who feels she has PMS is her own charting of her menstrual cycle and of the symptoms she experiences throughout. The simpler the system, the better.

Most clinics which deal with PMS or simply teach fertility awareness have charting materials. Women may also wish to keep a daily diary of their symptoms and their severity. Recording food intake and activities of "bad days" may also help a woman gain insight into the factors which trigger or contribute to her problems. More self-awareness can also help her plan for and deal more constructively with her symptom time.

Progesterone

A physician may recommend Progesterone therapy for the woman whose

symptoms are very severe when lifestyle and diet changes do not provide enough relief. Dalton has been treating women with moderate to severe symptoms for the past thirty years. Dalton, progesterone's best salesperson, feels that if the correct diagnosis is Premenstrual Syndrome, the woman will experience dramatic relief by using progesterone suppositories either vaginally or rectally. She views women with PMS, whatever the cause, as having a progesterone deficiency.

The dosage of the progesterone administered varies considerably with the individual and depends upon the severity of the symptoms, the age at which symptoms began, number of pregnancies, if any, etc. Each woman learns to regulate her dosage with the aid of her physician. The need to continue the progesterone also varies. All women will be able to reduce the dosage over time; women with less severe symptoms may be able to discontinue use of progesterone and be relatively symptom-free after several months of treatment. Often women become symptom-free after menopause. Symptoms also tend to disappear during pregnancy.

Dr. Dalton, based upon her own clinical experience and studies, states that there are no contraindications to the long term use of progesterone nor any long term side effects. She also claims no negative interactions with drugs. She points out that the levels of progesterone that are usually attained by the therapy are less than those which normally occur during pregnancy. It is thus not possible to overdose in her opinion.

Some of the possible short-term side effects include lengthening or shortening of the menstrual cycle and spotting premenstrually. Some women describe a restless energy and may have some difficulty sleeping. Occasionally, menstrual cramps may occur but not severely.

In the United States, there has been considerable controversy over the use of progesterone. The Federal Drug Administration (F.D.A.) did not approve the use of progesterone for PMS initially. The cautions provided by the F.D.A. have linked progesterone to progestagens. The latter have been loosely called "progesterone," but are chemically different from the real thing. **Note that there is an important difference between progesterone and progestagens.** The progestagens tend to cause the body to produce even *less* progesterone, which is why women with PMS often have side effects with birth control pills containing progestagens, and their symptoms are worsened.

Progestagens have been implicated in thrombophlebitis, coma, or paralysis resulting from blood clots in the brain. Liver dysfunction has also been observed. They are contraindicated during pregnancy because of an increase in birth defects. The progestagens are undergoing further study regarding risks and benefits.

These concerns about progestagens have caused concern about progesterone. Although Dr. Dalton is confident about progesterone's safety, others feel there have not been enough controlled studies done. More study will take time, however, so the question of safety will remain unanswered for some time. In the meantime, the Health Protection Branch of the Department of Health and Welfare should be encouraged to carry out such an investigation.

In the interim, we do know that progesterone seems to alleviate PMS symptoms and women with severe symptoms are desperate for relief. As with any treatment, it is the woman who must weigh the risks and benefits of the use of progesterone and it should be as informed a decision as possible.

This whole issue was a difficult one for me personally as I considered being employed at a centre where progesterone would be an aspect of the treatment program for women with PMS. I had deep concerns about the possible risks of using progesterone. Learning the differences between progesterone and progestagens has helped alleviate these concerns for me. It has also become clear to me that some women need more than the nutrition and lifestyle changes, and I want to trust their ability to make an informed decision about treatment.

PMS as a Feminist Issue

PMS is creating problems for some of us as feminists. There is real concern that it will be used against women . . . yet another excuse used to prevent women from working in certain professions or from promotions to positions of authority. On the other hand, as women, we recognize that some of us do have difficulties premenstrually. It is important not to generalize from the difficulties experienced by some to draw conclusions about all women. But to deny or ignore the existence of PMS means many women will not receive the acceptance, understanding, and perhaps treatment that they need and deserve.

In particular some feminists have expressed concerns about the legal aspects of PMS. There has been considerable media attention paid to the use of PMS in England as a legal defense. The potential for violent or criminal acts can be a part of PMS but it is not common (and criminal behaviour is still considerably lower in women than in men).

It is important to recognize that very few women with PMS lose control, although many may fear the loss of control when premenstrual.

Perhaps as women, we need to become more open about our menstrual cycles and less defensive about our femaleness. Creative energies are part of the premenstrual time. We do not know how PMS would be expressed if women were empowered and comfortable in expressing anger and ambition. The physiological changes would still occur, but the nature of the symptoms might be quite different.

Karen Walker has experience in psychiatric nursing education. She has been involved in childbirth education and consumer advocacy. Currently, she is employed at the Premenstrual Syndrome Centre in Mississauga, Ontario.

Resources Available:

- *Self-Help for Premenstrual Syndrome* by Michelle Harrison, Matrix Press, Cambridge, Mass., 1983.
- *"An Owner's Manual"* (for self-charting), by Dianne McGibbon, MD., Box 675, Station U, Toronto, Ontario M8Z 5Y9
- *PMS Information and Referral Service* Box 363, Station L, Toronto, Ontario M6E 4Z3 (416-653-5027)
- *PMS Support*, 18 Wildplace, Barrie, Ontario L4N 4W7
- *PMS Support and Self-Help Group*, Willowdale, Ontario (416-445-6638, after 4 pm).
- *Premenstrual Syndrome Centre*, 1077 North Service Road, Applewood Village Plaza, Mississauga, Ontario L4Y 1A6 (416-273-7770).

Psychiatry and Social Control

Work and Madness: The Rise of Community Psychiatry, *Diana Ralph, Black Rose Books, 1983, $12.95*

Reviewed by Julie Wheelwright

Is your work driving you crazy? If you are a blue or pink collar worker, according to Diana Ralph in her recently released book *Work and Madness,* the answer is probably yes.

Ralph documents the rise of community psychiatry as a method of social control over workers in Western countries. She argues that the shift away from individual clinics to mass public mental health treatment, the expanded definition of mental illness, the replacement of long-term hospital care with cheaper, more accessible therapy and "preventative consultation", have been made in the interests of capitalism.

She presents a very believable argument. Ralph begins by outlining theories of why community psychiatry blossomed after the second world war. She dismisses the idea that government was motivated by benevolence or that the mental health lobbyists finally got their message through to the legislators.

Instead, she argues that, as corporations and businesses began to feel the pressure to increase their productivity, they demanded more of their workers. As men and women were forced to work in increasingly dehumanizing jobs, under dangerous conditions, with ever simplified tasks, their mental health took the toll.

Business and government responded to this by pumping funds into community psychiatry — its main task to " 'help' workers and their dependents adjust to increasingly alienated, degraded and pressured conditions, in order to prevent labour unrest."

In its own interest, government expanded its role in regulating labour as corporations pressured their workers to increase productivity through speed-up methods or automation.

"Even when they do not actively resist, workers break down emotionally (and physically) under the pressure and exhibit a variety of 'behaviours' which fill production goals," says Ralph. "Much of the behaviour associated with either organized resistance or individual breakdown is now defined as 'mental illness'."

Thus community psychiatry exists to increase workers' tolerance for ever more alienated and pressured work and reduces their resistance to alienating situations. Rather than recognizing that there are faults in the system, workers are made to feel that they are 'insane'.

To illustrate this point, Ralph cites an example from the 1950s when the Medical Director of U.S. Steel diagnosed as signs of mental illness, the following complaints by workers: "At one time four people came to me in the course of two days, all from one section, each requesting a change of job for medical reasons. One said he couldn't stand the noise on his job; it was making him tense and nervous and he couldn't sleep at night. Another said the job was too heavy; at the end of the day his back and legs were aching. Two of them said the odors of solvents on the job were making them nauseated; they couldn't eat their dinner at night."

Ralph puts it simply when she says, "environmental pressure explains madness far better than any theory of individual flaws."

But her theory breaks down in her examination of domestic problems. She says that the meaninglessness and damage to self-respect of this work spills over into the workers' private lives affecting their families. This spillover of tension is reflected in rising rates of, among other things, family violence.

This ignores the fact that wife-battering or child-abuse, or incest, are not problems confined to the working classes. It also implies that given better working conditions, these problems would disappear, an analysis that ignores the sexist institutions in our society that encourage these abuses.

Ralph also fails to adequately explain why housewives have been the greatest victims of mood-altering drug therapy if they are not subject to the increasingly debilitating working conditions she describes. She does not explain why there has been such a dramatic increase in drug abuse by housewives in recent years, if women have always lived and worked under these conditions.

The book is extensively researched with numerous footnotes and an extensive bibliography and the theory, believable. Ralph ends by urging the labour movement to address the problem of community psychiatry.

"In order to fight oppressive conditions and change things, we need our wits about us. We need to feel what is dangerously stressful, and we also need to feel the anxiety, aggression, and anger which give us the incentive to fight those conditions. Rather than 'letting off steam' individually in counselling, we need to let it erupt in collective action."

Julie Wheelwright is a free-lance writer who recently moved from Vancouver to Toronto. She has been a regular contributor to Kinesis.

Graphic by Pat Foote-Jones

In Fear and Loathing

A History of Women's Bodies, *Edward Shorter, Fitzhenry & Whiteside, Toronto, 1982. $33.50*

Reviewed by Elizabeth Allemang

I choked my way through this infuriating book because I feel compelled to publicize its worthlessness. This is not a history of women's bodies; rather it is a collection of gruesome tales of women's defective bodies vividly recounted by a man who obviously fears and despises women. I suspect that these "misadventures in childbirth, abortion, and various diseases" originate more in Edward Shorter's mind than in historical reality. Certainly women suffered (and continue to suffer) brutal treatment in many aspects of their lives. Our pain is real — however, Shorter, a professor of history and women's studies at the University of Toronto, manipulates and misrepresents history for his own ends. He seeks to prove that women's oppression arose from their own physical inadequacies.

Shorter's analysis of women's oppression is simplistic and unconvincing. He argues that the real source of women's oppression was the "terrible historical burden of their own ill-health" which was exacerbated by the poor, often brutal health care they received. He elaborates this argument through a discussion of women's birth experience, physical differences between men and women, and women's perception of sex, focusing on European material from the eighteenth to the twentieth centuries. He claims that the victimization of women by their own ill-health was eradicated by dramatic advances in medical care and technology in the 1930s. Women thereby attained physical equality with men, creating a "physical platform for the launching of feminism".

Obviously, the source of women's oppression is more complex than poor health and insensitive health care. Even healthy women are oppressed! Shorter neglects to acknowledge the continuing victimization of women by the male dominated medical establishment. Rather he views obstetrics and gynecology as women's allies in the struggle against oppression.

The simplicity of Shorter's analysis is further revealed in his description of feminism. He defines feminism as "women having the same sense of personal autonomy as men". This is a very limited definition. It focuses on the personal without elaborating the social, economic, political or sexual roots of women's oppression and their implications for feminism. It is not surprising that feminism for Shorter depends on men — male doctors and male support — for its preconditions. Equally predictable is Shorter's discomfort with the present women's movement with its focus on self-help and its questioning of the underlying assumptions of our male-dominated culture.

Shorter's narrow perspective is complemented by vague concepts, inadequate historical evidence, inconsistencies and generalizations. He assumes, for example, that women lacked personal autonomy in the past — during a period he vaguely terms "traditional society". He implies that in the past men were anti-women and that today most men are pro-equality, and that the women's movement is a product of the twentieth century.

He claims his thesis is to present women's own perceptions of their bodies, yet he relies principally on doctors' accounts and proverbs for his evidence. In addition, his portrayal of traditional midwives as pernicious and interventionist is without documentation.

I am most angered by the section of the book which deals with the "history of the birth experience". Over half of the book is devoted to this theme. Shorter focuses on the "dangers of reproduction", and he justifies the current alarming increase of interventions in the birth process as necessary because the "natural birth often produces a damaged infant". In return for surrendering their personal autonomy, Shorter promises that "women today receive pink, brisk babies. Nobody dies. And birth is valued as a basic part of womanhood". The rituals which surround birth in our culture are far from celebratory. Many women find childbirth an alienating, often frightening experience.

This book represents a summation of Shorter's undergraduate course on the history of women's health. The prospect that it might provide the basis of other history courses is terrifying. I suspect that it would be appealing to many students because of its simplicity and its hip language.

The history of women's health and healthcare remains incomplete. A well researched, well argued historical account of women's bodies is yet to be written. This is an outrageous book at an outrageous price.

Elizabeth Allemang recently graduated from the University of Toronto with a degree in history and women's studies. She is also the Office Manager at Healthsharing and hopes to be a midwife someday.

REGIONAL REPORTS

NOVA SCOTIA — Susan Hower

Midwives Case: Midwives Donna Carpenter, Sharleen MacLellan, and Linda Wheeldon, charged with criminal negligence causing bodily harm, reported for their preliminary inquiry on June 2nd. They asked for an adjournment to allow both the defence lawyers and the Crown sufficient time to review and prepare medical reports on the baby girl, Dara, born January 18, 1983 in Halifax. The medical records from the hospital were received less than one week prior to the inquiry. The new inquiry date is October 26.

The midwives express gratitude to all people who have helped and continue to support their personal but very public struggle. They encourage everyone concerned to participate in the political process that will guarantee the rights of parents in childbirth.

Fundraising efforts continue to support their legal defence. Families and Friends Organized for the Reestablishment of Midwifery (FORM) is one local group working for the women. APSAC-Nova Scotia continues to manage the national defence fund with a goal of $25,000: APSAC, 19 Fairmont Road, Halifax, N.S. B3N 1H5 (902) 479-2969.

Punishing the Unwed Teen Mother: In spite of vigorous and widespread opposition, the N.S. legislature amended the Family Benefits Act making unwed teenage mothers ineligible for assistance as of September, 1983 unless "extraordinary and compelling circumstances are present . . ."

In a public meeting, Edmund Morris, Minister of Social Services, made the following points in support of the proposed legislation: "the need to strike a balance between public responsibility and private responsibility; morality is a consideration . . . abortion is not the only alternative to teen unmarried women."

An ad hoc committee was formed to lead opposition to the new legislation. In record time thousands of signatures were submitted to the Minister on a petition and many briefs were presented to the Law Amendments Committee.

One small victory for the unwed teen mother in the new legislation is the right of appeal which was not originally present. And those who drew together to oppose the bill have a coalition which will direct efforts to convince government to provide alternatives for unwed teen moms, including comprehensive preventative and support services.

ONTARIO

TORONTO — OCAC

Raid on Toronto Clinic: A police raid on Dr. Henry Morgentaler's Toronto abortion clinic on July 7, 1983, has resulted in criminal charges against three doctors. Drs. Morgentaler, Scott and Smolling face charges of conspiring to procure miscarriages; Drs. Scott and Smolling face additional charges of procuring miscarriages.

The subsequent bail hearing signalled an initial success in this on-going fight for abortion reform. The doctors were freed on bail without having to acquiesce to the Crown's demand that they keep the clinic closed until the completion of their trial. The decision by the presiding judge not to impose these conditions has led the Crown to appeal the judgement.

The outcome of the Winnipeg and Toronto court cases and the continued political pressure being exerted by Coalitions based in these cities will determine our right to reproductive choice and the continued operation of the two clinics. Donations are needed to ensure the success of both the legal and political fights. A national legal defence fund is being administered by the Canadian Abortion Rights Action League, while the Ontario Coalition for Abortion Clinics (OCAC) requires to money to continue its political fight to keep the Toronto clinic open. Please address all donations and enquiries to:

Pro Choice Defence Fund
Box 935, Station Q
Toronto, Ontario
M4T 2P1
(416) 961-1507

Ontario Coalition for
Abortion Clinics
Box 753, Station F
Toronto, Ontario
M5S 2Z1
(416) 532-8193

Karen Walker

Birth Centre: The Toronto Birth Centre Committee, a group of parents and professionals, has been working since 1979 to develop a funding proposal for a free-standing Birth Centre for Toronto which would serve as a demonstration project. The Centre will provide education and care for pregnancy, birth, and newborn/parent adjustment. These efforts toward a freestanding Centre are a statement for more alternatives for women in childbirth.

In order for our proposal to be reviewed by National Health Research Development Program of Health and Welfare Canada, the Ontario Ministry of Health must indicate that if the proposal proves itself, they will provide support for its continuation. We need your help to persuade the Minister of Health to support our application so that the Birth Centre proposal can be evaluated. So far petition signatures and a meeting with our Committee have not been enough to convince the Minister to produce such a letter. Send your letters of support to: The Hon. Keith Norton, Minister of Health, Hepburn Block, Queen's Park, Toronto, M7A 2C4. If possible, please copy your letter to the Toronto Birth Centre Committee, c/o CPEA of Toronto, 33 Price Street, Toronto M4W 1Z2. Thank you for any support you can give us!

OTTAWA

Women and Pharmaceuticals Workshop: From June 24 to 26, some 35 people from across Canada participated in a Workshop on Women and Pharmaceuticals, held in Aylmer, Quebec. The Workshop was organised by INTER PARES, a Canadian international development organisation based in Ottawa.

The Workshop discussed women as consumers and victims of drugs in Canada and in the Third World.

Four main activities were proposed as a result of the Workshop:

1. To explore the possibility of forming a coalition in Canada which would be linked to Health Action International (HAI) which is based in Malaysia. HAI is a coalition of some 50 groups.
2. To start DES action committees in Ottawa, Toronto, Vancouver, St. John's and Thunder Bay following the leadership of the Montreal DES action committee.
3. To investigate the possibility of organising a conference or event in conjunction with the annual meeting of the International Organisation of Consumer Unions (IOCU) to be held in Ottawa in June, 1984.
4. To have the Great Canadian Theatre Company, who were represented at the Workshop, undertake a play on women and pharmaceuticals.

The workshop report will be available from: Karen Seabrooke, Inter Pares, 209 Pretoria Ave., Ottawa, Ontario K1S 1X1. Tel.: (613) 563-4801

MANITOBA

Lissa Donner

Morgentaler Clinic Staff Charged: Nine staff members of the Morgentaler Clinic in Winnipeg have been charged with conspiracy to procure an illegal abortion. Three of the staff face the additional charge of procuring an illegal abortion. The charges were laid as the result of two police raids made on the Clinic which opened in late April. During both raids the police harassed patients. In the first raid, a therapeutic abortion was interrupted and had to be completed by another physician at a nearby hospital. In the second raid, police broke down a washroom door in order to question a patient who had locked herself inside.

Conspiracy charges are extremely serious. The maximum sentence is the same as for the offence itself — life imprisonment for an illegal abortion. What's more, the conspiracy charge does not necessarily allow for a direct challenge to the abortion law (Section 251 of the Criminal Code). Some are speculating that the conspiracy charges were laid as the only way to include charges against Dr. Morgentaler who had not performed any abortions at the Winnipeg Clinic. The nine charged include physicians, nurses and counsellors.

The Coalition for Reproductive Choice has begun a conspirators' petitioning campaign. If the nine charged are guilty of conspiring to improve women's health, then so are all of us who are active around the issue of reproductive choice. Write to Premier Howard Pawley, Legislative Buiding, Winnipeg, to express your anger at the government's action in allowing such charges to be laid.

DEFENCE FUNDS ARE URGENTLY NEEDED. SEND YOUR DONATION TO CLINIC DEFENCE FUND, COALITION FOR REPRODUCTIVE CHOICE, P.O. BOX 51, STATION L, WINNIPEG, MANITOBA.

SASKATCHEWAN Regina Healthsharing Inc.

Tokenism Rejected: The womens' health centre, the objective of Regina Healthsharing for the past three years, has had to be put aside for a temporary period. In April, despite an intensive lobbying campaign by Regina Healthsharing, the Health Department turned down a reduced proposal for an $88,000 program.

Later that month, Healthsharing returned to the Saskatchewan Health Department $4,150 which had been given to the Board of Directors to reprint a revised version of the Women's Service Directory. The Board felt it was a token amount which would hardly cover the number of copies required. The extensive revision made necessary by the numerous government cutbacks in women's health and social services, plus the usual corrections, would have required two months of volunteer labour.

Right to Abortion on Trial: In May, the reproductive rights issue continued to dominate Regina with the Borowski challenge to the therapeutic abortion law. Borowski's lawyer was given special permission by the judge to call nine expert witnesses; the Federal Government, in defending a woman's limited right to therapeutic abortion, called no witnesses. Almost all of the witnesses called were men and one court watcher said she felt like she was viewing a Greek drama where the fate of womankind was being determined by an all male cast.

BRITISH COLUMBIA

VICTORIA

Susan Moger

Red Hot Verdict: The trial has come and gone. Red Hot Video was found guilty of possessing obscene material for the purpose of distribution and was ordered to pay $100 for each of three charges. Teresa Sankey, a member of Women Against Pornography was at the trial almost every day. She compared the experience to sitting through a rape trial — the same frustration and anger. She commented on the irony of the situation that while it was women who pressured the government and the Attorney General to lay charges so that Red Hot could be brought to trial, women were largely ignored at the trial. This was particularly evident when it came to the discussion of community standards. Women's groups could have contributed relevant and helpful information, yet no woman's group was asked to give testimony. Teresa points out that the final decision was made on the basis of the sexual explicitness of the acts in the three video tapes; broader concerns about the impact of pornography were not addressed.

An interesting aside to the trial is the fact that the Crown's office chose to bring in a woman lawyer from the lower mainland to prosecute the case. There are no women Crown Attorneys in Victoria. However, the imported female Crown did not appear to have any particular knowledge or previous experience with the issues in question. One cannot help but wonder about the strategy and political significance of the move.

According to Teresa, "the trial showed the inadequacies of the justice system in addressing the concerns of women." She feels that there is more satisfaction to be gained from being involved in grass-roots activism.

Women Against Pornography is writing a critique of the trial and the decision. It is available from them at Box 2365, Sidney, B.C.

Red Hot is in the process of preparing an appeal of the trial decision; meanwhile it is business as usual.

VANCOUVER

Lorna Zaback

Farmworkers Inadequately Protected: Farmworkers in British Columbia are continuing their uphill battle for decent working conditions. Among the appalling conditions that farmworkers (70% of them women) face are: long hours, low wages, no childcare, inadequate sanitation, crowded and expensive accommodation. The most horrifying is their massive and consistent exposure to highly toxic chemical pesticides. Many of the chemicals are registered for use by the Canadian government, in spite of the fact that they have not been proven safe in tests. The outrageously high incidence of illness and even death among farmworkers exposed to these chemicals is a strong testament to their dangers.

Meanwhile, according to Karen Dean in a recent issue of *B.C. Workers' Health Newsletter,* "at a recently held convention of the B.C. Federation of Agriculture, farmers agreed to accept compulsory [workers' compensation] coverage for agriculture only if there are no health and safety regulations enforced — no inspections and no investigation of complaints. In fact, they insisted that all complaints be directed to their Federation of Agriculture for investigation." Growers are not being pressured to improve working conditions and the government seems to be actively discouraging the Workers' Compensation Board from taking any action not acceptable to farmers.

The Canadian Farmworkers' Union is angry. They are encouraging farmworkers to file anonymous complaints through their office (farmworkers risk losing their jobs if they complain openly). But even this presents problems. Often workers cannot find the time of the facilities to make a simple phone call! The CFU is attempting to keep the public informed about the situation and is rallying support. For more information contact the CFU at 4730 Imperial St., Burnaby, B.C. (604) 430-6055.

Farmwork is Canada's third most dangerous occupation. Conditions in the industry must change.

LETTERS

The letter below, by Dawna Gallagher, replies to a critique of her drawings by Frances Rooney, printed in the Spring 1982 issue of Healthsharing. *The delay in Dawna's reply is the responsibility of a Women Healthsharing collective member who neglected to send a copy of Frances' letter until it was too late for Dawna to respond in the Summer issue.*

We think that Dawna's reply is an important statement. Dawna has been a long-time contributor to Healthsharing. *We appreciate her commitment and enjoy her work and will continue to print it in the magazine.*

Because Healthsharing *is a quarterly publication, the lapse between printing the original graphics, Frances' critique and Dawna's response has been nine months. To circumvent such delays the collective has decided to share critical mail with authors immediately, in order to make same-issue response possible.*

Last Word on Graphics

I was distressed to read Frances Rooney's remarks that the graphics for her article *Lesbians in Therapy* were inappropriate. Distressed because, as an illustrator, it is important to me that my work satisfy both the art director and the writer — that it enhance, not sabotage, the article being illustrated. As a socialist and a feminist, it is important to me that I not only make a good drawing, but think about who is being oppressed and how, and ask myself whether or not my drawing provides humour and insight without continuing that oppression.

The graphics for this article were done with these considerations in mind. This does not, however, mean that the work is above criticism. It is difficult to incorporate all these considerations in an illustration, and it is not uncommon for me, or any illustrator, to "miss the mark." Usually, the work is discussed and redrawn. It is uncommon to find that this discussion is carried out in public after publication. Frances' letter showed that there wasn't sufficient communication between the writer and the magazine. It points to the need to change the process of graphic selection so that the writers are more involved. It seemed unclear in the Collective's reply to Ms. Rooney's letter what the process was. The drawings chosen were three of several which were sent. They were not all satire. And although I had not made the Art Director aware of my preferences, I was also surprised at the selection, though it is not unusual for the Art Director's and illustrator's choices to differ. Because I live in Nova Scotia, I send a variety of work and leave the final decision to the magazine or client.

Ms. Rooney's interpretations of my cartoons are ones which I had neither foreseen nor intended. My drawings are, as Ms. Rooney said, subtle: a quality of which I am quite proud. However, this characteristic makes it difficult for me to ensure that their interpretation is the same as my intent. The work illustrating the article is satire: it is not intended to be interpreted literally.

The drawing of the woman in front of the mirror. "Wondering where the dyke was you loved . . . ," was inspired by the story of the woman whose feminist therapist was not seeing her lesbian client, but was preoccupied with the dress the client wore to the session. I put her in front of the mirror to show her reflecting on the disappointment from this incident. The ink blob on her dress, which Ms. Rooney interpreted as being her period, was just a face value ink blob, which is part of my drawing style.

"Why men make you tense," was intended as a comment on the patriarchal privileges of men, their attitudes of arrogance, and their unawareness of the anger and tension this creates in women. It was not drawn with the intention of saying men make lesbians nervous.

The woman opening her raincoat was meant to be a metaphor for exposing her real self, throwing off protective layers, in this analogy shown by clothing. Her face and posture were drawn with the intention of saying, "I am gay and proud; this is the real me; I'm out of the closet." I had not considered the possible literal interpretation of her as a pervert. I can see now how this cartoon could cause that confusion and would say it doesn't work as a result. It was this cartoon which I was surprised to see printed, not because of the reading of perversion into it, but because I thought it might be too light-hearted for the painful accounts of coming out in the article.

Despite the differences in our interpretations of the drawings, it is up to you and other gay women to choose the type of images by which you wish to be represented. Like other artists, editors, and writers (gay and straight) of the women's movement, we are still searching for ways to create new images of women, ones that will be unencumbered by the oppressive models we have grown up with. It was not, I am sure, the intention of myself or the Collective to hurt other women.

It is unfortunate that *Healthsharing* chose a solution to this error which does not mend our working relationship, getting us all back on the right track. If you had approached me to redraw for the article, (although difficult to do) it would have been a more professional solution, and one which would have expressed a feminist faith in one another.

Dawna Gallagher
Halifax County, N.S.

Sexually Abused Patients' Defense Fund

We are a group of women who are six of many women who have been sexually abused by a Toronto psychiatrist (male) still practising today. In our process of contacting each other, we have become aware that this doctor has imposed this abuse on his female patients on a habitual basis for over twenty years.

Because of the humiliation and trauma this doctor has caused and is causing many women today, we feel it necessary to call to the attention of The College of Physicians and Surgeons his gross misconduct (sexual relations with patients is strictly forbidden by the medical code of ethics) and to demand the revocation of his license. Due to the skepticism with which the medical profession views women's complaints of sexual abuse by psychiatrists, we have been strongly advised by those familiar with the College's complaints procedure to engage legal counsel. Six women presenting similar fact evidence together with solid legal counsel stand a good chance of winning the case, and in so doing, of providing an example to women patients that such behavior need not be tolerated; and to their doctors, that indulgence in this practice is to put their livelihoods in serious jeopardy. Assuming we win the case, the achievement of this goal will be attained by our plan to notify the press of the doctor's name and other particulars.

To cover all foreseeable costs as the case progresses, our goal is $1000. In the name of all women who have been and continue to be sexually abused by doctors, we appeal to you for financial support of this cause. Please pass the hat at your next staff, membership, or board meeting, and make donations payable to the Sexually Abused Patients' Defense Fund, c/o Toronto Rape Crisis Centre, P.O. Box 6597, Station "A", Toronto.

Toronto, Ont.

Healthsharing,
Box 230, Station M,
Toronto, Ontario, M6S 2T3

Second Class Mail Registration No. 5327
September, 1983

RESOURCES & EVENTS

PID Booklet

A comprehensive booklet on PID (pelvic inflammatory disease) has been produced by women at the Vancouver Women's Health Collective. It is available from the collective for $2 or donation by writing c/o 1501 West Broadway, Vancouver, B.C. V6J 1W6.

Feminism in Action

CRIAW (The Canadian Research Institute for the Advancement of Women) is holding its annual conference at the Four Seasons in Vancouver from Nov. 11 to 13. The theme is Feminism in Action: New Knowledge, New Education, New Society. For further information write Dr. June Gow, Conference Co-ordinator, Dept. of History, University of British Columbia, Vancouver, B.C. V6T 1W5.

CARAL Slide Show

Members of the Toronto Chapter Collective of the Canadian Abortion Rights Action League have produced a slide show about freedom of choice. The slide show which raises issues from the pro-choice viewpoint is available nationally. In the Toronto area members of the Collective are available to facilitate discussion and to give a presentation on the issue of abortion. Contact CARAL, P.O. Box 935, Station Q, Toronto, Ontario M4T 2P1.

Women's Networks in Canada

A new 230-page handbook, *Women's Networks in Canada*, is based on papers presented at the first, and to date, only national Women's Network Conference held in Canada.

The handbook is packed with tips on how to do everything connected with establishing and perpetuating a dynamic organization — whether for career women, single parents, professionals, ecological or political causes. It covers structuring, programming, fundraising, marketing, newsletter production and more.

Co-edited by Eileen Hendry and Janet Fraser of the Vancouver Women's Health Network, *Women's Networks in Canada*, costs $6.00 and can be ordered from the Vancouver Women's Network, c/o The UBC Centre for Continuing Education, 5997 Iona Drive, Vancouver, B.C. V6T 2A4. Cheques should be made payable to the University of British Columbia.

Call for Disarmament

An international day calling for disarmament will be celebrated on October 22, 1983. In Canada the Day of Protest will focus on opposition to the Canadian manufacturing of the Cruise missile guidance system by Litton Industries and to testing of the Cruise in Canada.

Activities are being planned across the country. Watch for posters and news items, or contact local disarmament or anti-nuclear groups about events.

Global Health Reports

A new publication to facilitate the development of a global perspective on health has been launched. The project is being coordinated through Development Education Centre (DEC) in Toronto and will provide information to both health care workers and recipients of health care in both Canada and developing countries. The first Report in the series of four is focussed on Zimbabwe; the second, due out in Oct., will be about the Pacific Islands; number three will focus on Women's Health and number four — Global Ecology.

The series of four will cost $10.00 and is available from Global Health, Development Education Centre, 427 Bloor St. West, Toronto, Ont. M5S 1X7.

Women's Health Products Report

This report stems out of a Toronto Department of Public Health investigation into possible discrimination against women evidenced by the tampon-toxic shock syndrome link. The report examines health hazards of contraceptive and feminine hygiene products, menopausal and pregnancy-related nausea drugs. It includes sections about corporate testing, government monitoring and regulations, company promotion of products and the results of a small consumer survey.

The report is available for $4.00 from the Resource Centre, Main Floor, City Hall, Toronto, Ont. M5H 2N2.

Women and Therapy

A three day conference is being held in November to explore the social issues which influence women's mental health, to improve counselling effectiveness and to deepen self-awareness. This will be a major event for all who are involved with women's mental health. The conference will be held November 9, 10, 11 at the Holiday Inn (Don Valley) Toronto. For registration and information write Professional Development Associates, 3 Cameron Crescent, Toronto, Ontario M4G 1Z7.

Herbicides on Trial

The Herbicide Fund Society of Nova Scotia has published two pamphlets on their experience to stop herbicide spraying. They are entitled *Forest Herbicides on Trial: Information about Actions of Nova Scotians to Stop the Spraying of 2, 4, D and 2, 4, 5-T* and *Nova Scotia's Herbicide Case: A Court Diary*. They are available for $2.50 each or donation from Herbicide Fund Society, Public Relations Committee, RR1, Gabarus, N.S. B0J 2H0.