

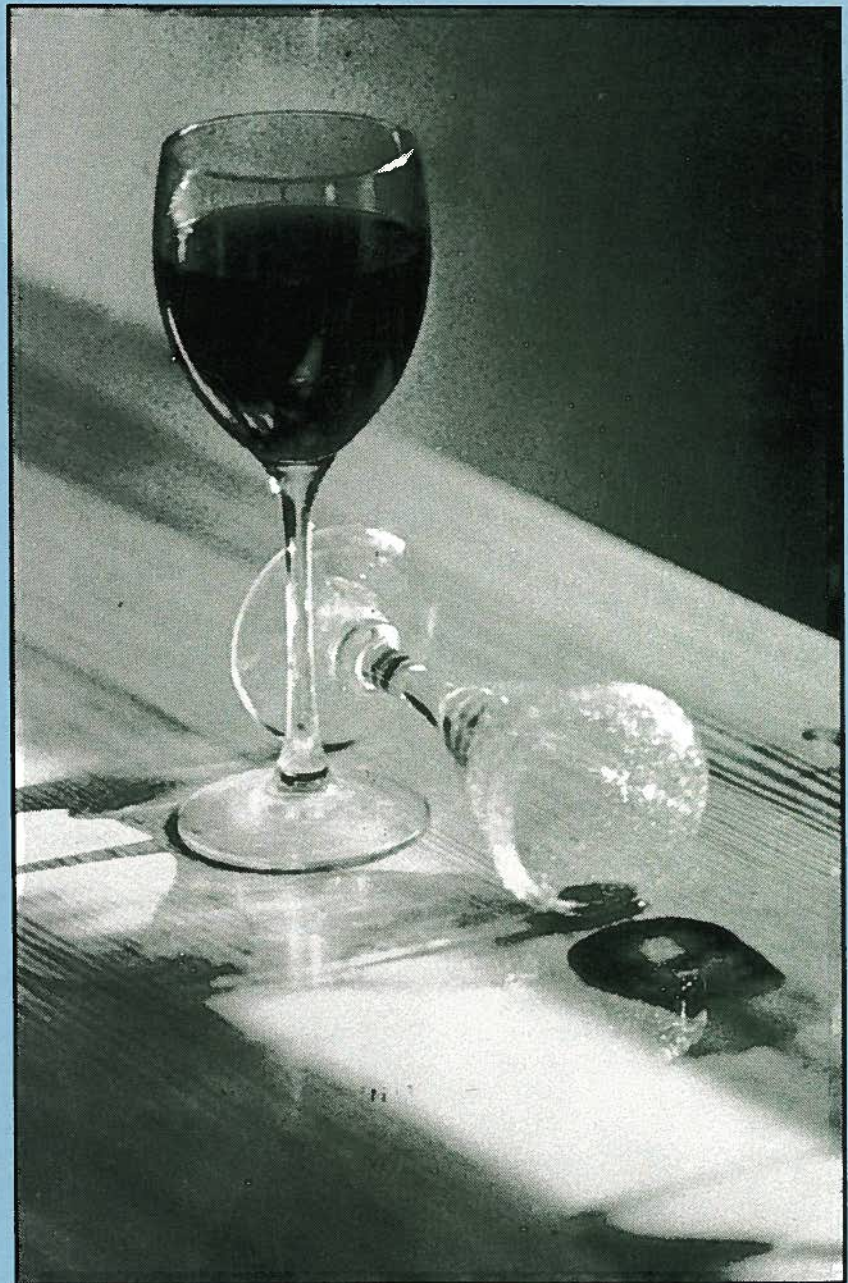
Fall, 1984

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# Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

- Why Women Drink
- Transforming Erotic Power
- Private Dental Practice



# Inside Healthsharing

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*Healthsharing*

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## Healthsharing

Published by  
Women Healthsharing



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## Cause to Celebrate

It is rare when an act of Parliament gives us in the Healthsharing collective cause to celebrate. The Canada Health Act (Bill C-3) now gives us cause.

Women in Canada are only now becoming well-versed with the ins and outs of lobbying. As a group we have not learned well enough how to function in parliamentary halls or how to focus attention on minute details of legislative wording. These actions are repetitive and plodding, and success comes in the form of paper.

The tremendous impact of the country's nurses associations and health coalitions are evident both in the passage of the Act and in the revisions to it. The present form of the Canada Health Act is due in large part to extensive lobbying by these groups. However, the realization of the conceptual changes so skillfully wrought in the Act still lie in the future and there remain a number of hurdles to the effective implementation of the Act.

One of the most encouraging aspects of the successful nurses and health coalitions' campaign is the fact that it breaks the stranglehold that doctors have held as primary lobbyists and influencers of health care legislation. With a few striking exceptions, doctors adamantly oppose the Canada Health Act. No wonder — the Act has the potential to eliminate extra-billing and to dramatically increase the number and types of deliverers of health care services under provincial health care plans.

Without the sustained work of the Canadian Nurses Association, the Act would not now include the clause "a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and *where the law of the province so permits, similar or additional services rendered by other health care practitioners.*" Without the health coalitions the Act might not include clauses that expand universality and transferability of coverage, clauses intended to insure that payment of premiums will not be a precondition for insurance. For the first time federal legislation includes means for provinces to be penalized for allowing over-billing (dollar for dollar on core insured services) and to resolve fee disputes with physicians and dentists.

While women concerned about health should applaud the influence of nurses, there is not time to sit on our laurels. By Monique Begin's own admission the Act is "very modest", much depends upon provincial implementation and effective federal enforcement.

In applauding the eloquence and strengths of the Canadian Nurses Association, Flora MacDonald, Conservative M.P. from Kingston/Thousand Islands, Ontario, stressed that "The term 'health care practitioner' ... has opened the door to reform ... but that opening is little more than a crack which will be of small use if no further action is taken by other governments."

It is difficult to determine what factors made the federal government so receptive to the arguments of the nurses and health coalitions. Certainly timing was one such factor. The act was hustled through by a health minister committed enough to medicare to take the provinces on when her government was anxious to curry favour with the general public prior to a federal election. But there were other factors at work. Perhaps the most important lesson to be learned from the Canada Health Act campaign is patience. The lobbying process is a long and arduous one, with what seem to be small gains for huge amounts of labour. The nurses associations have been writing and submitting briefs for years. The Canada Health Act is not a total victory; there were compromises and set-backs. There is still a vast amount of work to be done for the effective implementation of the Act and for the improvement of our medicare system.

We urge you to work with allies within your own provinces to find ways to influence your provincial governments. State your case, badger, plead, argue, embarrass, fight at any level you can. Some provinces offer more potential than others. The conservative governments will argue the need for low costs and simultaneously back doctor's independence, paying little heed to evidence that insuring non-physicians can reduce costs. The OMA is threatening to challenge the constitutionality of the Act.

The challenge ahead is great; the nurses and health coalitions cannot be left to fight alone. They need our active participation — our health needs our active participation.

Amyra Braha  
Betty Burcher  
Connie Clement

Diana Majury  
Lisa McCaskell

Jo-Ann Minden  
Julie Wheelwright

## Corporate Bottom Line

MINNEAPOLIS — On February 29th, 1984 Federal District Court Judge Miles W. Lord delivered remarks to senior staff of A.H. Robins Company, manufacturers of the Dalkon Shield. The Dalkon Shield, an intra-uterine device implicated in serious, and sometimes fatal, pelvic infections, was withdrawn from the market in 1977. Well over 9,000 claims for damages are currently pending against A.H. Robins Company. Excerpts of his speech follow.

"It is not enough to say, 'I did not know,' 'It was not me,'...Today as you sit here attempting once more to extricate yourselves from the legal consequences of your acts, none of you has faced up to the fact that more than 9,000 women claim they gave up part of their womanhood so that your company might prosper...

"If one poor young man were, without authority or consent, to inflict such damage upon one woman, he would be jailed for a good portion of the rest of his life. Yet your company, without warning to women, invaded their bodies by the millions and caused them injuries by the thousands. And when the time came for these women to make their claims against your company, you attacked their characters. You introduced issues that had no relationship to the fact that you had planted in the bodies of these women instruments of death, of mutilation, of disease...

"The company has not suffered, nor have you men personally. You are collectively being enriched by millions of dollars each year. There is no evidence that your company has suffered any penalty from these litigations.

"Mr. Robins, Mr. Forrest, Dr. Lunsford: You have not been rehabilitated. Under your direction your company has continued to allow women,

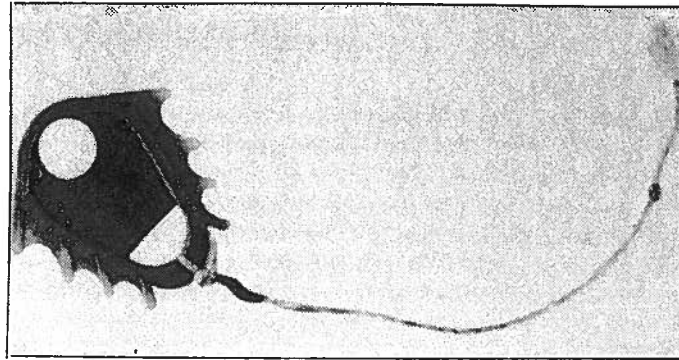


Photo: Robert Rose

tens of thousands of them, to wear this device — a deadly depth charge in their wombs, ready to explode at any time...We simply do not know how many women are still wearing these devices because your company is not willing to find out. The only conceivable reasons that you have not recalled this product are that it would hurt your balance sheet and alert women who have already been harmed that you may be liable for their injuries. You have taken the bottom line as your guiding beacon and the low road as your route. That is corporate irresponsibility at its meanest.

"If this court had the authority, I would order your company to make an effort to locate each and every woman who still wears this device and recall your product. But this court does not. I must therefore resort to moral persuasion and a personal appeal to each of you. Mr. Robins, Mr. Forrest, and Dr. Lunsford: You are the people with the power to recall. You are the corporate conscience.

"Please, in the name of humanity, lift your eyes above the bottom line. You, the men in charge, must surely have hearts and souls and consciences."

## Midwifery Coalition Born

DEBERT, N.S. — The Midwifery Coalition of Nova Scotia was formed in February, 1984 during a meeting sponsored by the Midwifery Working Group of the Women's Health Education Network (WHEN) Maternal/Child Health Committee. Joining the group as a charter member is FORM (Friends/Families Organized for the Re-establishment of Midwifery) from the Annapolis Valley and the North Shore Midwifery Coalition.

The legalization and recognition of midwifery as part of the Nova Scotia health care system is the new coalition's main goal. Public education of birth alternatives is the focus of the group's efforts.

The Maternal/Child Health committee can be contacted through the Women's Health Education Network (W.H.E.N.), Box 99, Debert, N.S. B0M 1G0.

## Sole Support Mom's Take Control

TORONTO — For 3½ months this past summer, sole support mothers in Regent Park have been engaged in a nutrition project. Regent Park is a low-income housing development of approximately 12,000 people. About 1,000 of the residents are sole support mothers, most of whom are on government assistance.

With the help of a Masters of Health Science student from the University of Toronto, a Summer Canada grant from Employment and Immigration Canada was obtained, and six students were hired. Support for the project was also received from the Department of Public Health, the Ministry of Agriculture and Food, Metro Toronto Housing Authority, the Department of Parks and Recreation, food companies, and a foundation.

The project was intended

to develop public awareness of the inadequate assistance benefits sole support mothers receive (benefits in Ontario have not kept up with inflation since 1975), and to establish a link between low income and poor nutrition. This was done through surveys administered to 109 sole support mothers in the Park. A further goal of the project was to provide opportunities for discussion of food issues and to devise practical strategies for coping with high food costs. Participatory cooking and dining evenings provided a forum for these goals, as did trips to pick-your-own farms and the organization and maintenance of a community vegetable garden. The successful garden gave the project a high profile and facilitated excellent television coverage.

The food problems expe-

rienced by sole support mothers in Regent Park are many. Lack of access to low-cost food is a major problem as there are no full service supermarkets in the area where convenience and variety stores are numerous. Insufficient financial resources for purchasing good quality, nutritious food, and a lifestyle that encourages convenience food over nutritious, balanced diets are further problems these women face.

At the time of writing, the project was half-completed and its goals yet to be evaluated. It is hoped that this is just the beginning of an ongoing attempt by a community to take some control over an increasingly impersonal environment, an environment which can and does lead to malnutrition in our own backyard.

By Jo-Ann Minden

## Off The Streets

VANCOUVER — B.C. Attorney General Brian Smith's latest solution to the problems facing Vancouver's West End is a restraining order on prostitution. In response to some 40 statements from West End residents about conditions in their neighbourhood, Smith has issued a writ naming 30 persons, mostly prostitutes, public nuisances. He has asked the B.C. Supreme Court for an injunction to give police authority to crack down on the people named in the writ.

Smith's application restricts those named from many activities, particularly the buying and selling of sexual services. It also places restrictions on such activities as loitering, littering,

screaming and swearing within the boundaries of the West End.

On June 1, 1984, shortly after Smith announced his intentions, demonstrators took to the West End streets in an attempt to draw the public's attention to the situation and its implications. Feminists and other radical groups are worried about the vague nature of the proposed injunction. They are concerned that prostitutes are once again taking the rap for the chaotic conditions of Vancouver's most densely populated area. They are also concerned that inappropriate legal measures are being taken to deal with the long standing social problems stemming from

street prostitution.

Street prostitution, especially juvenile prostitution, is increasing and it is a concern to many people. Lack of suitable employment and severe cut-backs in social services are driving more and more young people into the streets.

Smith's action could set a precedent in which there would be little to stop police from labeling any one of us a public nuisance and picking us up for being a little rowdy one night while walking home from a downtown bar.

With the current political climate in B.C., this possibility seems anything but far-fetched.

by Lorna Zaback

## Repeat Abortions Not Irresponsible

MONTREAL — Attitudes toward women having a second, a third, or even a fourth, abortion are often punitive. Even staff in clinics providing abortion counselling can slip into stereotyping 'repeat aborters' as irresponsible.

Research published in the March/April *Family Planning Perspectives* persuasively argues the inaccuracy of such stereotypes. The study, carried out at Montreal General Hospital in the late 1970's by a team of medical and psychology faculty, found no difference on measures of psycho-

logical adjustment or attitudes about sexuality among women seeking first or repeat abortions.

The women having repeat abortions, approximately one-fifth of the 580 women interviewed, were older, less likely to be married, more tolerant of legal abortion, and had intercourse more frequently. Contrary to expectations of some, women seeking repeat abortions were slightly more likely to have been using contraceptives at the time they became pregnant.

The researchers found that

the two groups of women had more similarities than differences. They concluded "that a large number of women who are sexually active and who use imperfect birth control techniques can be expected to have repeat abortions. The challenge rests in communicating these findings to those who work with abortion patients, so they may counsel these women with more confidence, knowing that repeat abortion is due more to a probability of pregnancy than to psychological problems."

## Peer Counselling Successful

AUGUSTA, GA — Peers influence all of us. Especially among adolescents, when distrust of the other is often high, peers are an important source of information. Accordingly, a study reported in *Pediatrics* (February, 1984) examined the comparative influence of peer versus nurse birth control counsellors by analyzing teen compliance with oral contra-

ceptives.

While compliance itself is a controversial issue, and only a partial measure of counselling adequacy, the study findings are interesting. The clients counselled by a peer had significantly better follow-up use of the pill than those teens counselled by an adult nurse. This was so irrespective of other factors such as fre-

quency of sexual intercourse, number partners, worry about pregnancy or hopelessness about the future.

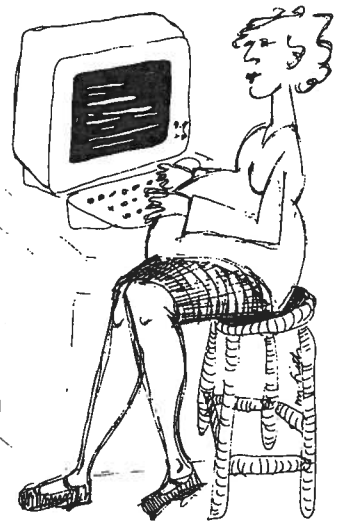
Even being unable to generalize the conclusions because of the tiny study size (57 teen women between 14 and 19), the study does support a possible positive and supportive role for lay adolescent health counsellors.

## Work and Pregnancy

A recent study has confirmed what many women already know — working outside the home does not affect pregnancy and its outcome.

Reporting in the *Journal of Occupational Medicine*, authors Marion Marbury and her associates found that when comparing a large group of working women to housewives, working in itself was not a risk factor. Taking into account pertinent variables which can affect labour and neonatal outcome, a few significant correlations were found including an increased risk of prolonged gestational age among primiparous women and an increased risk of fetal distress in women having a third child who leave the work force before the ninth month. There was no evidence to account for these findings.

The authors do raise questions for further investigation. They will be examining specific work categories to determine if particular occupations, especially stressful ones, carry an increased risk. Their study does not address the possible risks of household products to housewives or whether voluntarily leaving work before the ninth month is beneficial. The latter question could help provide guidelines for determining maternity benefits.



# A Foot In The Door

After two long years of public discussion and speech-making, the Canada Health Act (CHA) was finally passed in April 1984, amid much media hoopla. The physician associations and the provincial governments were horrified, but popular politics won the day. Citizens organizations and progressive professional organizations formed a temporary alliance with the federal political parties and the Act was passed with a minimum of delay.

Was it worth the effort?

Some say no! The legislative changes won were, at best, very modest. The CHA essentially confirms the status quo, i.e. curative medical services. An important opportunity for evolving a health care system that includes illness prevention strategies and de-emphasizes institutional care was lost.

Others say yes! The CHA represents a victory for popular politics. For the first time in many years, broad-based coalitions of consumers, trade unions and professional associations organized and worked co-operatively to lobby for major social policy change. Their experience was generally positive as people learned that politics can be fun, and they were spurred on by success. Their collective struggle provides a valuable model to build upon for future negotiations of the 1977 *Federal-Provincial Fiscal Arrangements and Established Programmes Financing Act* (EPF).

## What Is New?

The CHA replaces two earlier federal statutes, the 1957 *Hospital Insurance and Diagnostic Services Act* and the 1966-67 *Medical Care Act* (jointly known as Medicare), which together guaranteed publicly-insured hospital and physician treatment and care

to all Canadians. The Act modifies the provincially provided services recognized for full transfer of federal payments. It does not change the basis for calculating the amount of federal transfer authorized under the EPF.

The EPF regulates health services. It provides block-funding to the provinces and territories through tax-point and cash transfers based on a complex formula involving the total provincial population and the growth of the GNP. Financial penalties for non-compliance with the programme criteria are deducted from the cash transfer. Tax-point transfer — the major source of federal funding — is not mentioned in non-compliance regulation, limiting the federal government's ability to monetarily control provincial extra-billing and user charges.

New features appearing in the legislation are:

- A preamble defining "health" as mental and physical wellness and "health care" as all activities that "promote physical and mental health and protect against disease," including "collective action against social, environmental and occupational causes of disease." Although this is a step in the right direction, the remainder of the Act completely overlooks mental health services, as well as social, environmental and occupational health risks and preventative strategies. Thus, the Act implicitly recognizes curative medical interventions as the only health strategies worthy of government funding.

- A new category of acceptable health provider — the "health care practitioner". These are practitioners who are "lawfully entitled under the law of a province to provide health services." The federal government will cost-share in the services of those practitioners whom the provinces

allow to provide insured health services. Nursing, chiropractic and other non-medical services are not automatically covered under this legislative change; however a significant financial barrier to insuring these services is removed.

- A higher standard of "universal coverage." Provincial insurance plans must now cover 100 per cent of "insured persons" on uniform terms without financial barrier, a 5 per cent increase from the previous 95 per cent. Insured persons are defined as provincial residents except those persons, such as the RCMP and the Armed Forces members, who are covered under separate legislation. This change, while undermining the health premium philosophy, does not ban premiums or any other health care tax levied by a province; the choice of taxation method is a provincial prerogative. It does mean that no person can be denied access to insured physician and hospital treatment because of an unpaid premium.

- Mandatory penalties for non-compliance according to criteria outlined in the Act. In previous legislation, all penalties for non-compliance were discretionary and involved the withholding of the full federal contribution. The CHA implies that each non-compliance condition has an unspecified financial value which may be withheld in the case of proven non-compliance. The withholding of funds requires the federal government to levy a mandatory dollar-for-dollar penalty against the provinces that permit physician extra-billing and unauthorized hospital user fees. These penalties are levied only against the cash transfer, and although the withholding is authorized as of July 19, 1984, the funds are to be retained in a special account for three years and returned to a province that subsequently bans extra-billing and user fees.



Unfortunately it is the provincial insurance plan, not the federal government, that now defines "authorized" user fees. Chronic care changes or per diems levied after a 60-day stay are not penalized.

## What Is Missing?

As previously mentioned, the CHA ignores mental health services and strategies to combat social, environmental and occupational health risks. Also lacking in the Act are a sense of national leadership, long-range planning and prevention strategies. Although community-based and home care services were expected to have been included in the first series of negotiations, the federal Liberals stated it was too "risky to expose the health care system to wider reform." These shortcomings should be addressed in the 1985 renegotiation of the EPF.

The Canada Health Act may be considered a temporary measure and not a potential saviour of the health system. It facilitates marginal improvements, but is lacking in a much needed structural change.

by Michèle Harding

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For more information about the conference and registration forms, please write or phone NDP Outreach, Room 216, North Wing, Legislative Assembly Building, Queen's Park, Toronto M7A 1A2 (416) 965-3700.

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## OSTEOPOROSIS

by Viviane Caplan

**Painful Urination**

Painful urination could be due to excessive use of soap in the genital area. Avoiding the use of soap has been found to be a simple, effective and safe way to eliminate some kinds of painful urination. In cases where bacteria is not the cause of this problem, try washing with water only, using soap only once or twice a week.

**Pill Popping**

Tips on how to swallow pills:

1. drink plenty of water
2. stand rather than sit
3. take a sip of water first to lubricate the throat
4. tilt head back for pills
5. tilt head forward for capsules
6. follow with a glass of water

**Support for Physically Abused Women**

Kay Brownfield, a Registered Massage Therapist, would like to contact physically abused women who want to re-establish a healthy attitude towards touching, both giving and receiving. Kay has several years experience with massage and psychotherapy. She is interested in finding women who care to discuss this program, participate in it, or support it with funding. Call the Aurora Natural Health Centre in Toronto, (416) 365-0674.

**Artificial Insemination**

Women who have used artificial insemination, either in or outside clinical settings, and who would be willing to be interviewed — please write to Rona Achilles, 147 Wheeler Avenue, Toronto, Ont., M4L 3V5, or call (416) 694-1745.

Osteoporosis is a major public health problem, affecting about one-quarter of the female population over the age of 60. Osteoporosis is the reason that many older women break their hips if they fall. The cost of acute care of these hip fractures runs into the millions of dollars and it has been estimated that 12 to 20 per cent of elderly patients die within six months after such fractures. In addition this syndrome results in a loss of height, dowager's hump and chronic back pain; it is a major cause of limited activity in postmenopausal women.

The word 'osteoporosis' comes from the Greek words 'osteon' which means bone and 'poros' which means passage. It reflects the fact that the bone has become thinner and more porous. Why does this happen? Factors important in the development of osteoporosis include genetics, nutritional factors, bone changes in aging, sex hormone deficiency, hormonal imbalance, lack of exercise, smoking and drinking coffee and alcohol. The person most likely to have osteoporosis is a sedentary, post-menopausal white woman with a diet deficient in calcium.

Whites have a much higher incidence of osteoporosis than do blacks, which has been attributed to a greater bone mass in black populations. Inuit women also have a high incidence of osteoporosis. One of the important factors that lead to osteoporosis is the decrease in sex hormones that occurs at menopause. Just how estrogen deficiency leads to a loss of bone mass is not understood. Nutritional factors which have been implicated in causing osteoporosis include low calcium intake, high protein intake, vitamin D deficiency, deficiency of fluoride and possibly excess phosphorus in the diet.

Recommended consumption is about 800 mg. of calcium per day. Women with osteoporosis have been shown to consume less than 500 mg. per day, compared to the up to 1000 mg. of calcium some researchers suggest middle-aged women may need per day to compensate for poorer calcium absorption with increasing age. Diets high in protein, common in North America, cause increased urinary calcium excretion. The North American diet is also high in phosphorus, which was once thought to lead to poor calcium balance. Recent experimental evidence which showed no deleterious effects in normal menopausal women, however, leaves the role of phosphorus in doubt. Elderly people often do not drink enough milk or get exposed to enough sunlight. This can lead to a vitamin D deficiency which itself causes poor calcium absorption. Fluoride is also important in bone formation and the incidence of osteoporosis is reported to be reduced in areas where the drinking water is fluoridated.

Current medical treatment of osteoporosis includes hormone therapy, calcium and vitamin D supplementation and fluoride therapy when necessary. Hormone therapy appropriately involves the use of estrogen and progestin since combined hormone treatment reduces the estrogen-related risk of uterine cancer. Usually a combination of therapies are used. Exercise programmes, especially weight-bearing exercises, have been shown to be beneficial.

At the moment we do not have precise techniques for measuring the severity of osteoporosis or how it responds to treatment. This makes it difficult to suggest methods of prevention and treatment. What is clear is that women can benefit from exercising and making sure they have adequate calcium and vitamin D in their diet, throughout their entire life-cycle. Some foods high in calcium are green leafy vegetables, dairy products, tofu and canned salmon. We now know that calcium loss begins as early as age 25 so prevention is necessary over a long period of time.

*Viviane Caplan is an instructor in the Department of Food, Nutrition, Consumer and Family Studies at Ryerson Polytechnical Institute in Toronto.*



# Why Women Drink

by Linda Rasmussen

Illustration by Pat Foote-Jones

*All of the personal statements in this article are taken from interviews with women from an Edmonton self-help group, a chapter of Women for Sobriety. Founded in the U.S.A. by Jean Kirkpatrick, its structure is similar to Alcoholics Anonymous but its programme focuses on concerns important to women, particularly self-esteem. The names of the women have been changed.*

In the pages of popular women's magazines, successful, independent women hoist glasses of sherry, liqueur, vodka and wine, proclaiming that women are now liberated enough to drink. A proliferation of white, light and sweet alcoholic drinks, 'suited to women's taste buds', has flooded the market. Alcohol companies, taking note of the tobacco industry's highly successful "You've Come a Long Way, Baby!" pitch are selling their product to women as another symbol of liberation. And women are buying it.

Women today, especially young women, are almost as likely to drink as men; the number drinking has increased approximately 70 per cent since the 1940's, compared to an

increase of only 19 per cent for men. While women appear to have achieved a 'new equality' in the realm of social drinking, they have also left themselves vulnerable to a problem previously considered a man's disease — alcoholism.

Women have no special biological protection against alcoholism. To the contrary, alcohol appears to have a much more adverse effect on women's health than men's. Alcoholic women have a mortality rate three to seven times greater than women in the general population. Women are more prone to some alcohol-related diseases, such as cirrhosis, which develops in women after a shorter history of drinking and at a lower level of consumption than men. Women are also more likely than men to die from medical conditions related to alcohol abuse.

The Victorian belief that alcoholism was a sign of moral failure gave way in the 1930's to the concept of alcoholism as a disease. Recently, this medical model has been judged too restrictive to explain the great diversity of problems in the alcoholic population. Many researchers now believe that problem drinking must also be seen as a behav-

ioral problem with the person using alcohol to adapt to the particular stresses in her life.

---

*"I did it to overcome a big inferiority complex. Also to overcome the stress of being a single parent. I was raising three kids, I was in quite a high pressure job. Drinking kind of eased it, kind of blotted everything out." (Sandra)*

---

This is not to suggest that a certain stressful life event will 'cause' alcoholism. The once popular belief that women's problem drinking was precipitated by a personal crisis is now in doubt. This idea may have arisen from the female alcoholic's need to justify her drinking in order to reduce the stigma she felt surrounded female alcoholism.

The reason why a particular woman reaches for an alcoholic drink may be the most revealing sign of all. Alcohol is the ubiquitous social lubricant in today's society. For most people it is an acceptable and pleasant way to celebrate or to add to the enjoyment of a meal or time with friends. The occasion, not the drinking, is the focus for

the majority of drinkers. However, for some, the effects of alcohol take on an overriding importance. Many people may, on occasion, use an alcoholic drink to help them relax, to forget a negative experience or to deal with a particularly stressful event; but for the person with a drinking problem these become the primary reasons for drinking.

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*"I lived alone, I was divorced. I never drank socially — it was strictly to deal with the depression and loneliness. It was never used to have a good time."* (Joyce)

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Linda Beckman of the Department of Psychiatry, School of Medicine, UCLA, has done extensive research on women and alcoholism, focusing on women's motivations to drink. She believes that what are perceived as reasons for drinking and what are felt to be its consequences determine a person's actions. She had identified three main reasons for drinking — 'social' (to celebrate a special occasion or to be friendly), 'escapist' (to relieve tension, depression or loneliness) and 'powerlessness-inadequacy' (to overcome feelings of lack of control or inadequacy). Comparing alcoholic men and women, she found that men were more likely to drink for escapist reasons, while women drank to overcome feelings of powerlessness.

"Many of the women clients I see are confused about their role in society. Women 'fall between the cracks' as they often attempt to live in both worlds," says Caroline Mossman, a counsellor at a treatment programme run by the Alberta Alcoholism and Drug Abuse Commission. "Some use alcohol as a way of coping with the understandable stresses. The power, for them, appears to lie with everyone — husbands, employers, children — except themselves."

Beckman discovered that alcoholic women drank for different reasons than non-alcoholic women. For alcoholic women, the primary motivators to drink were to avoid unpleasant feelings, including feelings of powerlessness and inadequacy. They were likely to use alcohol as their major method for coping with unpleasant feelings. Non-alcoholic women, on the other hand, identified 'sociability' as their reason for drinking.

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*"With the alcohol I felt confidence, — believing in myself, feeling good, just feeling I had a lot power. I could do anything, I could talk to anybody. Without the alcohol, I was nothing more or less."* (Pat)

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Beckman's study of heavy and normal female drinkers of college-age indicated a very similar pattern between young heavy drinkers and adult alcoholics. She also cites one longitudinal study which found that women who use alcohol as a method of coping with stress in early adulthood are more likely to develop drinking problems in middle-age. This did not hold true for men.

While alcoholics in general are known to have low self-esteem, Beckman found that women alcoholics have even lower self-esteem than male alcoholics. Beckman discovered that women alcoholics believe that drinking "made them feel more adequate, built self-confidence, relieved anxieties, reduced worries and loneliness, and increased feelings of power and control." She founds that a majority of alcoholic women also felt that alcohol was sexually facilitating, helping them deal with sexual problems. It is unclear, however, whether these beliefs are due to defensive rationalization, selective memory or real differences between alcoholic and non-alcoholic women. She suggests that if the drinker believes that she feels powerless before she drinks and, subsequently, feels more powerful after she has had a drink, these perceptions will lead to a problem-drinking pattern if left unchallenged.

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*"I began to drink an awfully long time ago and I continued to drink because I felt trapped. My mother and my husband thought I could do anything but I didn't have self-confidence. I felt that I couldn't do things as well as I wanted to. I was striving for perfection. When I was drinking, I felt I could do anything. I think that was one of the reasons I kept drinking. It seemed like I was reaching it but it was false. Inside I was fearful I couldn't do it."* (Margaret)

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Beckman's studies, as well as others, indicate that it is extremely important to look at issues of self-esteem and self-concept in order to understand

alcoholism, particularly in women. There is not necessarily a causal relationship but, for low-esteem women, the misuse of alcohol can lead to a further erosion of self-esteem.

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*"It's self-perpetuating. It just creates more loneliness, more stress, more lack of self-confidence. You drink more to get over that, to the point where you've developed a full-fledged alcohol problem and you really don't have much left."* (Sandra)

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Alcoholic women appear to feel less socially competent and more anxious than non-alcoholic women. They also tend to see themselves as less effective in being able to reach their goals or change themselves. One recent study found that, while both alcoholic and non-alcoholic women accepted the idea of being self-responsible, expressive and assertive, alcoholic women saw themselves as further removed from their ideal.

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*"Women are great self-blammers. They blame themselves for everything that happens. I blamed myself for not being a good wife, therefore my husband was an alcoholic. We blame ourselves inwardly and it takes away from our confidence."* (Margaret)

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Alcoholic women seen in treatment appear to have developed a self-image based upon their relationship with others, particularly their sexual relationships. They exhibit traits associated with the traditional female role — dependence, passivity and learned helplessness. Treatment programmes have found that recovery from alcoholism for women is dependent on developing a healthy balance of independence and dependence, learning to be self-reliant and self-responsible, and acquiring a comfortable identity as a woman.

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*"The problems still come up but, now that I'm sober, I'm learning to deal with them. At first, I used the Women for Sobriety programme constantly, at least once an hour. Now it's maybe once every three or four days. You stop placing demands on yourself and begin accepting yourself just as you are. You are going to make mistakes; you don't have to be perfect."* (Sandra)

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Research is now suggesting that there is no such things as a 'typical alcoholic woman'. Past stereotypes of lower-class, bar-hopping, promiscuous luses or middle-class suburban housewives sipping sherry behind lace curtains have been dispelled. A woman with a drinking problem can come from any social and economic background, be any age, and have an elementary school education or a Ph.D.

Women, however, do appear to be at greater risk because of certain personal or background characteristics. Not every woman with one or more of these characteristics will become an alcoholic but research studies indicate that the possibility appears to increase for such women.

Women who work outside the home are two to three times more likely to develop problems with alcohol. The reasons for this are varied and, for the most part, speculative. It is difficult to determine whether a working woman's excessive drinking is due to increased opportunities to drink, to the stress of her work or to the extra demands of a job added to the home responsibilities which most women carry. Alcohol problems for working women do appear to be related to the number of children at home and to lower status jobs. Women with children generally report higher distress levels, and traditional 'women's jobs' (like clerical, retail sales and service work) have been identified as the most stressful types of employment.

However, working inside the home does not protect women from drug problems, and often only changes the type of drug abused. Housewives are much more likely to use minor tranquilizers and to abstain from alcohol, suggesting that women choose the drug that may be most available or acceptable to them.

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*"I've always felt insecure. I've got a good job and I don't know why I have it. I felt I had to work ten times harder. It was always good to come home and have a few drinks to unwind."* (Sandra)

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Being without a partner is a fairly significant factor in alcohol abuse for both women and men. Current studies suggest that women under 35 may be more vulnerable to problem drinking following a separation or divorce. As well, alcoholic women tend to have

more marital problems and more multiple marriages than alcoholic men.

One large study found that nearly half of the husbands of alcoholic women were heavy drinkers themselves. These husbands tend not to object to their wives' drinking and may even encourage it. The wives of male alcoholics, on the other hand, were likely to act as a positive force in interrupting their husbands' drinking problem.

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*"My husband comes from a family of alcoholics but he didn't have the problem. I had the problem. He didn't deal with it when he was growing up, he just shut if off. He did the same with me. He coped by just blocking it all away."* (Pat)

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Children of alcoholics have a greater chance of becoming alcoholics themselves. Female alcoholics appear to be even more likely than male alcoholics to have had an alcoholic parent, especially the father. Whether this familial tendency is due to heredity or learning (or the interaction of both) is still open to question.

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*"I think I was escaping reality, family problems. I was a very shy person. The more I needed to meet people, the more I needed to drink. Coming from an alcoholic family didn't help much I guess. I was probably reacting to my father's drinking because, at the time when I really needed him, he was never around."* (Denise)

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Women with drinking problems are also more likely to have experienced a more emotionally disruptive and unhappy family life as a child than either non-alcoholic females or alcoholic males.

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*"It's something that's common to all of us — there are alcoholics in all our families. My dad was, I married one, and one, maybe two, of my kids have a problem."* (Sandra)

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Only recently has being the victim of incest or rape been identified as a major factor in the development of alcoholism in women. Some addiction treatment programs report as many as 45 to 70 per cent of their clients have been sexually abused. This should alert addiction and sexual abuse counsellors to be on the lookout for this connection in their clients.

"I am repeatedly appalled at the incidence of sexual abuse among the women I see. I always encourage women to discuss their sexuality and often, even during an initial interview, painful, long-submerged stories of sexual abuse come pouring out," AADAC's Mossman says. "It is important that women clients have access to a female counsellor with whom to share such intimate feelings."

As well, lesbians appear to have an increased risk of developing drinking problems. This is possibly due to the increased stresses they may experience or to a lifestyle which may be more alcohol-oriented.

No one of these characteristics have proven particularly effective in predicting which women will eventually have problems with alcohol. For individual women, interaction of several different social, cultural, genetic and environmental factors is responsible. Marian Sandmaier, who interviewed a wide cross-section of alcoholic women for her book *The Invisible Alcoholic: Women and Alcohol Abuse in America*, cautions that the kinds of stresses precipitating alcohol and drug abuse in women are far more complex than those being promoted by the popular media.

While social drinking is now acceptable female behavior, heavy drinking is not. People are still more uncomfortable with drunkenness in women than men, probably because such behavior is out-of-sync with our concept of "being a lady." Attitudes like these create barriers to reaching the woman who has a problem with alcohol.

Even when a woman is referred to a counsellor for assistance she is much more likely to be identified as having a personality or family problem than a drinking problem. While she may be having other difficulties, the problem drinking is often overlooked. Everyone, including the woman, may be more comfortable labelling her sick than alcoholic. This may explain why so many alcoholic women end up with prescriptions for minor tranquilizers.

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*"I was kind of becoming aware of my drinking problem but I really didn't know what to do about it. I tried to stop on my own and couldn't. Then my mother told me off. She said that she was afraid for her grandson, afraid that I would harm him. She hurt me so bad that I was ready to kill myself. But she scared me and it got me thinking. So I called my brother who had been through a programme and I said 'What do I do?'"* (Pat)

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The traditional belief that an alcoholic has to reach 'rock bottom' before he or she can be helped is no longer considered valid. The sooner a person realizes she has a problem, the better the prognosis for recovery. Family, friends, employer, doctor — all can play a role in breaking through the denial process and can assist the woman in getting help. As well, organizations which are assisting women in crises (sexual assault centers, battered

women's shelters, counselling centres) can identify and assist women with drug problems since, as some researchers suspect, women may be more likely to come to these centres than to a drug abuse programme.

Over the last decade, it has become clear that alcoholic women benefit from treatment programmes and self-help groups, such as Women for Sobriety, which recognize the unique problems women face. Rather than having society's view of women reinforced, successful programmes help women arrive at new conclusions about themselves ... that they are competent, powerful and lovable women.

According to Mossman, "power is often a matter of perception." She therefore does a lot of consciousness-raising with clients, both women and men, encouraging them to recognize the power they do possess. "When a woman begins to recognize her rights to some basic needs, there is often a marked change in her use of alcohol."

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*"Before, it was...something goes wrong, have a drink...something goes good, have a drink...something goes mediocre, have a drink. Now you have to start thinking, 'Something bad happened, what am I going to do about it?' I am realizing I can cope with these things."* (Sandra)

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The Edmonton women interviewed are:

Joyce — 45, secretarial bookkeeper, divorced

Sandra — 39, office manager, divorced, three teenage children

Margaret — 63, retired teacher, grandmother

Denise — 35, works outside the home, married, four children

Pat — 29, hairdresser, married, one child

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Linda Rasmussen has worked as an educator and consultant in the area of family planning and addictions for the past six years. This article and a short pamphlet on women and addictions were written under the auspices of the Provincial Women's Committee of the Alberta Alcoholism and Drug Abuse Commission.

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# Transforming Erotic Power

by Mariana Valverde

drawings by Nancy Walker

In our society sex is always gendered sex. Traditionally, people have thought that one's sexuality was determined by one's biological sex: but the very real differences between male and female experience of, and ideas about, sex have to do not so much with chromosomes as with our socially created gender roles. It is only when we see sexuality as a dynamic and profoundly human (as opposed to animal) aspect of life that we will create the possibility for changing sexual behaviour as well as sexual attitudes.

Male experts have presented sexuality as the 'fun' part of reproduction, the carrot used by Mother Nature to get us to reproduce. Sexual behaviour was judged according to its relation to reproduction — and reproductive roles

were used to justify social roles. Sexual behaviour was supposed to fit neatly into reproduction (and reproduction itself was seen very narrowly, as woman's exclusive calling). Homosexuality was thus an aberration, for it broke the chains with which sex had been confined. Women's sexual potential was examined only from the point of view of traditional motherhood, and men's sexual potential was reduced to conquest and impregnation.

This impoverished view of human erotic potential was — and still is — characterized by the view of sex as a *thing*, like a hormone or a bodily fluid. Doctors and politicians alike speak of sexual desire as something tangible that can either be hidden from view, controlled by regulations, or else be

allowed to flow freely through the social landscape. But sexuality is not a thing. It's a process, a constantly changing relation, a constellation of feelings, ideas, desires and physical experiences. It has no centre, no 'essence', no beginning and no end, and no orderly set of static categories can possibly encompass it.

This does not mean, however, that sexuality is something mystical about which we cannot speak. It does not mean that our intellect has to be switched off as we enter the realm of the erotic. We must avoid intellectualizing our desires and longings — but we must also avoid the passive-mystical approach, which does not seek to understand and hence cannot help us to change or grow.

If sexuality is a process, then we must use a form of reasoning that is suited to understanding relations in motion. We have to use a dialectical approach, which sees reality not as a collection of separate facts but as an interconnected family of contradictions. In this way we will be able to grasp the basic framework underlying erotic play, and to understand the 'laws of motion' of our desire, without having to kill and dissect it first. We will also be able to see ourselves as products of history and social conditioning, and as active human beings with some possibilities to change ourselves.

If eroticism is a relation, not a thing, how can we describe it? We can begin to describe it by examining not so much one individual or another, but rather what happens between them. When someone is in a sexual or erotic

relation to someone else, what is that like?

The sexual urge has a lot to do with the urge to both know someone and be known by them, in the deeper sense of 'to know.' We all need to be autonomous human beings, and to be acknowledged as independent and powerful; we want to be the one who is loved. But we have an equally strong need to give up our human power, to surrender it to a stronger being who will 'take' us and, for a while, relieve us of the tremendous responsibility of making choices. The need to assert our sexual power and overwhelm someone is perpetually shifting, giving way to the deep longing to be engulfed, to be overpowered and yet protected.

The two poles of the dialectic can manifest themselves as lover and be-

loved, active and passive, protector and protected — and, most commonly, as male and female, with all the social baggage that implies. The dialectic has the potential to reconcile the opposites, and to achieve a new level of mutual recognition that is all the stronger for having emerged out of the tug of war and the exchange. But this rarely happens in reality, especially if the two people involved are of different genders. Among gay people, the erotic play cannot just happen automatically: even if the two people end up in static roles, they have first to decide who is going to play what role. Among heterosexuals, the dialectic tends to be of the non-productive, static sort.

### **Eroticizing Power... And Powerlessness**

In our rigidly gendered society, erotic interactions tend to follow a pattern which does not allow the lover to ever become the beloved, or the protector to seek protection. Men are cast automatically into the 'strong' role, and women are, without a struggle, put in the role of the one who is taken, the one who surrenders. It is clear that the male role links power to eroticism; and the images of male eroticism directed at women are as diverse as the varieties of male power. The violent dark stranger of Harlequin romances is erotic in a dangerous way, while the Young Doctors in Love are erotic in a nice suburban way. The rock star and the football player have distinct sex appeal, depending on the social meaning of their roles. But the one common denominator is that power contributes to a man's sex appeal.

Women are not supposed to exercise any active power. We are not supposed to initiate sexual play, and indeed are not granted the right to put a complete stop to the erotic initiative of the male. But we do have a very indirect and limited form of erotic power: the power of surrender.

To make surrender into a form of power, we have to make it count. We have to hold out, play hard to get, extend the courtship and postpone sex. In this way we exercise an indirect and rather passive form of power over the aggressor, a kind of power that is usually referred to as 'feminine wiles.'

Surrender is our peculiarly feminine power; it's also our particularly feminine eroticism. The guardedness of the



Graphic by Nancy Walker and Robert Minden

hunted has to be covered in a sexual gloss, as does the strength of the hunter.

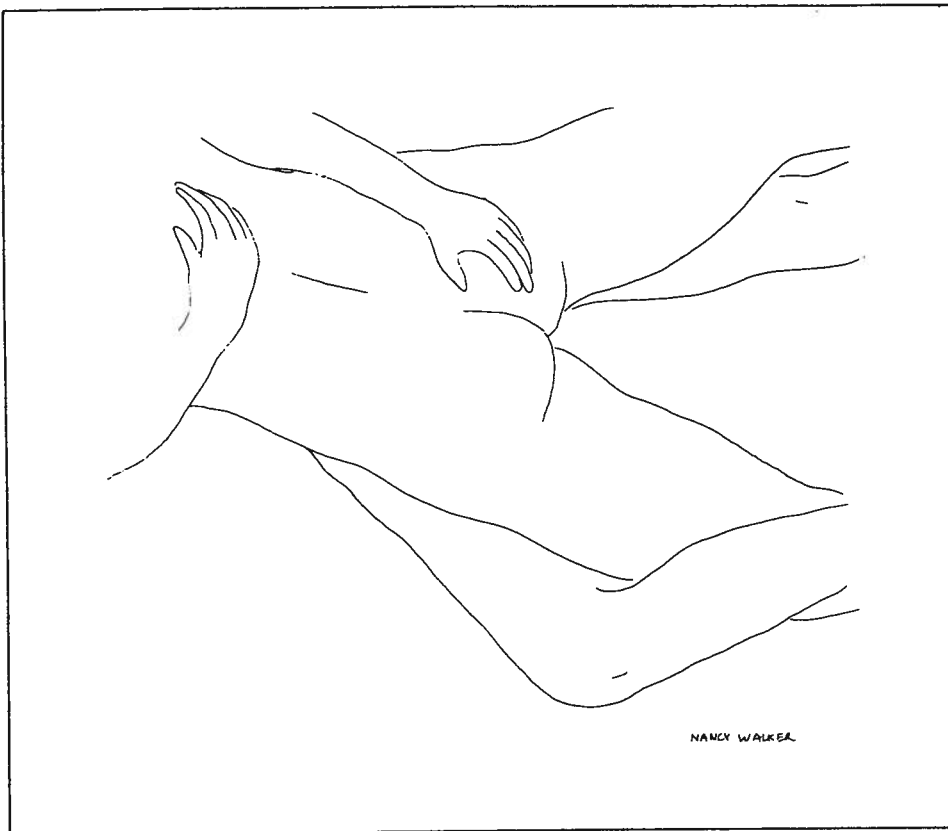
Hence, anything that prolongs the hunt — while holding out the promise of eventual surrender — will be part of the 'feminine wiles' that make up traditional feminine eroticism. Outright direct nakedness is not very erotic, because it puts an abrupt end to the hunt: nudist beaches are not especially sexy places. But the plunging neckline, the skirt with the long slit...ah, there the dialectic of postponement and fulfilment can be played out.

## Can Equality Be Erotic?

Many feminists have pointed out that the eroticization of male power, e.g. in pornography, helps to prop up patriarchy, by making it sexy. And so many feminists have come to the conclusion that we have to purify sexuality and eliminate all power from erotic interplay. I think this is very wrong, however. In my view, it is not power itself which is inherently bad, but rather the way in which power gets used by one gender against another, and by one individual against another. In our society, economic power gets used by one class against another; but we cannot abolish power itself. What we have to do is change economic relations so that economic power rests in the collectivity and cannot be used by one person or group against another. Similarly, erotic power has come to mean rape and violence against women. But are we being realistic when we envisage a feminist society in which there is no erotic power, no lust, and everything is enveloped in the soft mists of tenderness? Come on!

Where there is strong eroticism, there is power. The point is that we have to change gender relations so that one person's power isn't another person's humiliation; we have to make sure that everyone can be both the lover and the beloved, the protector and the protected, the one who takes and the one who surrenders. This will involve social change, not just an improvement in attitudes. How could a heterosexual woman freely give in to her desire to be overwhelmed, in a society in which women are raped every hour?

We have to equalize and collectivize power; and then we will be free to really play, to really explore the possibil-



ities of the dialectic of desire. As long as there are strictly defined gender roles, women will not be able to be aggressive — and we won't even be free to be passive, because following a script is not really freedom.

We should not be thinking about abolishing sexual power, but rather about subverting it, transforming it, so that we are more in control of the dialectic, more free to make choices and changes, rather than fall routinely into prescribed scripts. Erotic power has to be detached from patriarchal relations; it has to be used to eroticize equality rather than inequality.

## Gendered Sex Appeal

In our society, the gender scripts we are given dictate not only our behaviour but our perception of what is sexy. Control over nature and power over other people are elements that make males erotic. But do these kinds of direct power make women sexy? Not at all; on the contrary, women who gain access to these kinds of power are perceived as losing their eroticism. Men assume that rich women are rich instead of being adorable, and dismiss them as bitches that have nothing going for them other than their dollars.

(Remember the sex-crazed millionaire lady that Groucho Marx pretends to woo in film after film?) If a woman has lots of money, or is something exalted like the Governor General, she will immediately be desexualized in the public mind. Sports heroines with gorgeous bodies seem to leave young men's hearts remarkably unmoved: they're just too strong, too powerful, to content in their own bodies. Their status does not depend on being attractive to men, but on winning games. Their sense of their bodies is thus relatively independent of the male gaze. This is what makes them 'butch' in male eyes.

If independence is butch, dependence is adorable. If direct power (a strong backhand in tennis, a powerful political position) is seen as de-sexing women, then are there any forms of power with feminine sex appeal? Or is feminine eroticism equal to complete helplessness?

Utter lack of power is in fact not very sexy, even in traditional terms. The inflatable doll may have her uses in the masculine scheme of things, but the sexiest females are those who have some spark to them, those who fight back just enough. It is the Marilyn Monroes, Greta Garbos and Bette Midlers which are most successful at generat-

ing feminine eroticism, and they are by no means wimps. Dolly Parton may bleach her hair and exaggerate her breasts, but there is no doubt that she's got a mind and a body, and that men would have to overcome some obstacles if they wanted to 'take her.

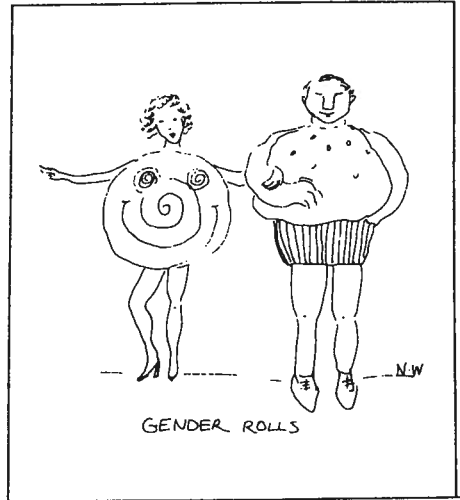
In fact, the spunkier the woman, the more satisfying the hunt. If she shows some resistance, the surrender will be more of an event. We may dismiss this as not a form of power at all, since it hinges on knowing just when to give in and how long to hold out, knowing exactly the difference between sexy bitchiness and masculine rudeness. But it is a form of power, and women have been exercising it for longer than we might care to admit. It is indirect and unassertive, and often it doesn't work to protect the woman from frontal assault, but it is power nevertheless.

One of the main problems with this sort of feminine erotic power is that it is necessarily expressed in double messages and ambiguous signals. So much so, that it is easy for women using it to lose sight of what they really wanted in the first place, or even to never know what they wanted. Since women are supposed to exercise their erotic power only in response to male initiative, sometimes we lose our ability to say to ourselves, "I want this guy, or this woman, and now." And even when being pursued by a would-be lover, we have trouble distinguishing between the inherent attractiveness of the candidate and the thrill of the hunt itself. We can of course tell if someone repels us; but, short of absolute disgust, there are many situations in which we give in to someone who might be more or less adequate but who, if the truth be told, does not really turn us on all that much. But it is perfectly understandable that we confuse ourselves in this manner, since the feminine approach to erotic encounters is so shrouded in mystery and mixed messages.

## Femininity As Deception

The difference that gender makes in the development of one's eroticism is clearly seen in 'typical' images of sexy women and men, as seen in *Playboy* and *Playgirl*. In these images, the facial expression is extremely important; it is by no means just an appendage of the genitals. If we examine the expression of women, we see that women are either smiling in an inviting way or,

more commonly, giving the reader a coy sidelong glance. Women rarely look directly into the camera. The camera — the male glance — looks at them, pursues them, and they merely indicate their willingness to continue the hunt. The men, on the other hand, usually face the camera directly, and always have an 'honest guy' sort of look. Direct eye-to-eye contact is sexy in men, apparently, but not in women.



This suggests that straightforwardness is ok in men, and is indeed part of being sexual; whereas for women eroticism consists of coyness and game-playing. Something is being said through these pictures about the role of truth-telling in the formation of male, as opposed to female, eroticism. For males, sex is related to truth, whereas for women, sex is the terrain of deception. For instance, the use of make-up — combined with expressions such as 'I have to put my face on' — implies that erotic interaction with men must necessarily be, for women, a school of deception, an alchemist's workshop where we learn to make our bodies appear as other than what they are, where we learn that we must never speak our own desire clearly but rather manipulate the manifestations of male desire so as to obtain something of what we want.

The feminist poet and thinker Adrienne Rich has explored a related problem in her brilliant essay, *Women and Honour: Notes on Lying*. In it she points out that traditionally men have had to be 'as good as their word' in their dealings with other men. Business and warfare alike are governed by a code of male honour in which being a proper male is equated to telling the truth. By contrast, women's words are

traditionally seen as ambiguous and potentially deceitful. A man's word is worth something, but the phrase 'a woman's word' does not even make sense in our language. This does not mean, Rich points out, that women are totally outside the realm of honour (any more than they are outside the realm of power in sexuality). Women can still be honourable — but not by speaking the truth. Woman's honour consists of a silent and bodily loyalty to one man. Woman's honour is merely chastity, a passive and purely physical condition, not even an act or deed. Male honour, on the other hand, is both active and verbal, i.e. both physical and rational.

Rich's insight is borne out by the images of soft porn: the men appear to be 'as good as their word', and to have a no-nonsense approach to sex. The *Playgirl* models don't look as though they would turn away from a woman and claim to have a headache. The women models, by contrast, never ask a direct question through their stance or their glances. Their bodies are often twisted in unnatural poses, which, apart from making them physically vulnerable, also suggest women's traditional ambiguity. The body gives a contradictory or at best ambiguous message: the body is turned toward the camera and appears receptive to a sexual encounter, but the head is turned away in denial. As represented in these pictures, women are deceitful not only in their words but in their very bodies. Their bodies lie and pretend, while at the same time exciting the male viewer: in a word, they tease.

Men are being constantly told that women's bodies are there to tease them. Women don't have legs to walk with, but only to display or not display them to the male glance. And since women never ask for pleasure directly, never speak their desire, then the male viewer can always assume that a firm 'no' conceals a hidden 'yes'. If men don't hear women saying "I want this" loudly and clearly, they're going to have difficulty hearing us when we say no. They have been trained to never take women at their word. Because of the complexity and indirectness of the language of female sexuality, a man can be 'honestly' convinced that a woman is really saying white when she says black.

Why does female sexual desire have to cloak itself in this complicated array of veils? Why can't the *Playboy*



bunnies look straight at the male camera and say, "Hey you hunk, I want you?" The best way to answer this is to look at what would happen if women gave up all the subterfuges of femininity. The result would be that the erotic game would stop being erotic and would suddenly become ridiculous. If the male were put in the role of the hunted, he would look foolish, un-male, and definitely unsexy. The woman who assumed the role of hunter would become ridiculous as well; she would be a 'slut' or a 'nympho'. A woman who looks at men up and down is not a real woman. She is perceived as a whore, and as deserving all the contempt that is heaped on her.

The amazing amount of contempt that whores have traditionally received is a good indication of the amazing amount of fear lurking in the hearts of men. Why are they so afraid of being looked at? After all, when they stare at women, they claim it's done out of healthy interest. And if women stared at men, they wouldn't be very likely to follow it up by rape. So what's so scary?

What is scary is that when they are being looked at they are vulnerable. They can be evaluated, judged, compared to other men, and perhaps ridiculed for their flaws. Even worse, women might take a close look at their sexual equipment and pronounce it inadequate. That is probably the ultimate fear, the worst nightmare, the source of most male anxiety. In order to avoid such judgements, they have to avoid being in any situation that might lead to vulnerability. They define the roles from the beginning, and make sure that the sexual gaze, in bed or out of it, is directed from male to female. The female gaze does not look directly: we women avert our eyes, and acknowledge the other's gaze without looking directly back. This even happens among lesbians; two lesbians can be horny as hell and about to jump in the sack, but they'll conscientiously avoid staring at the desired body. We women might respond, and respond passionately; but we do not counter-attack.

## Power In Sexuality

The problem with the dialectic of sex is not that it involves power, but rather that the very entrails of power have

gotten so incredibly distorted in our patriarchal, capitalist society that it is almost impossible to imagine a sexual power that is neither sexist nor competitive. But sexual attraction will always involve power, and lust will not disappear if the inequality between the sexes disappears.

What we can hope for, and work for, is a world in which sexual play is not hopelessly handicapped from the start by being mired in the stereotypes of masculinity and femininity. What we can work for is a culture in which the dialectic of eroticism is freed from the bonds of social power, and the roles that lovers assume in their play are not dictated by their gender and class. When a man is being aggressive with a woman in the bedroom, it's hard to imagine that this has nothing to do with the power that the man automatically has over women as a group, and so his bedroom aggressiveness can very easily slide into outright chauvinism, if it isn't that from the start.

This should not lead us to the incorrect conclusion that all sexual aggressiveness is inherently male, and that the desire to fuck your lover hard is necessarily related to male hostility. When power is shared and exchanged, it becomes the opposite of domination. It becomes the dynamic and sexually exciting road to creating a new kind of equality, one which is not boring or static.

As women, we reject the violence and inequality which have characterized heterosexuality as an institution (and which have also crept into homosexual relationships). But we will not be doing ourselves any favour if we shy away from anything stronger than caresses and kisses, and insist that feminist sex is all sweetness and light, and that men fuck but women make love. We have to reclaim fucking. We have to admit that, yes, sometimes we just want to be physically overwhelmed by the body of a lover, by the strength of her whole being: and in this surrender we are not put down or powerless, because we have freely chosen to open up to someone who is an equal and who is equally vulnerable. And we know that, if at times we want to be taken, at other times we feel a passionate and all-encompassing desire to take her, to fill her, to grasp her hard, to break down barriers and dissolve the tidy phrases into a powerful wave. We

know that there is in us a lust which is pushing to get through, a lust that can fill all of our senses, a lust that is both rough like a rope and sweet as mother's milk. We can fuck and make love at the same time.

Erotic power is dangerous today because rape exists, and because women are merely survivors, not full and active human beings. Erotic power is tyrannical today because even those of us who do not sleep with men are deeply marked by all the attempts made to make us feminine. Erotic power is oppressive to women today because one's sex determines what kind and quantity of power one will have in the erotic games. Erotic power is today entangled with domination and with the economic scarcity that mark not just the marketplace of commodities but also the marketplace of sexual partners. Erotic power is oppressive today to all those who do not fit the stereotype of what is beautiful.

But it is possible to imagine a different world. And it is to some extent possible to free up some of our suppressed desires, and — in those rare occasions when we are safe, with someone we genuinely trust — to explore our longings. Lesbians are in an especially crucial position to experiment and to create, for we are not quite so handicapped in our relationships, both partners belonging to the same oppressed gender. Nevertheless, whether or not we can begin to let our erotic relations lose their rigidity, we can all begin to imagine what we would need in order to allow our sexuality to be a source of change and growth, a source of shared power and mutual acknowledgement, instead of a source of anxiety and stagnation.

It is possible to imagine a desire that does not destroy, a lust that is joyful and creative instead of demeaning, an erotic power that does not reinforce patriarchy but rather subverts it. It is possible to break the chains that tie power to gender and to oppression, and to free it so that we can use it to create a truly human eroticism.

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*Mariana Valverde is a Toronto writer and teacher. Her book, Sex, Power and Porn, will be published by The Women's Press in 1985.*

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# Failure of Free Enterprise: Private Dental Practice

by Deanna Geddo

illustrations by Margaret Corrigan

I practise one of the most unpopular professions: dentistry. For seventeen years I have dreaded the moment when someone asks me what I do for a living. That is usually the end of a good time and the beginning of hostile looks and tales of horror from everybody around me. A recent survey of a hundred of my patients in Toronto confirms my impression that most people are terrified of dentists. More than one-half of the men and over two-thirds of the women answered "yes" to the question "Are you nervous about going to the dentist?" Of the persons who said "no", at least fifteen proved to be extremely nervous once under treatment — a total of seventy-nine percent were fearful.

Moreover, my constant interaction with colleagues both in the private and academic fields makes it plain to me that preoccupations about finances and legal responsibility dominate dentists' criteria for diagnosis and treatment plans to the detriment of scientific or humanist considerations. When visiting one of the teaching hospitals in the city, for example, I was horrified to learn that a young woman was condemned to lose all her teeth because her dentist thought it "too risky" to attempt a conservative solution. The risk was not that her health would be jeopardized, but that the dentist would be sued for malpractice if the treatment failed. Oral health is the result of a successful collaboration between dentist and patient, but the positive outcome of the treatment is defeated from the start if the two people involved cannot trust each other's intentions. I am convinced that health concerns and business concerns are fundamentally contradictory and

incompatible and that a new approach to the practice of dentistry has to be created. A look at the psychological, political, and technical aspects of this very complex profession will point out clearly the basic conflict that must be resolved in order to improve the present state of affairs.

Undoubtedly, the deepest layer of the tangle is the psychological one since it lies at the bottom of human motivation. Although Sigmund Freud's psychoanalytic theories have had many detractors throughout the years, almost no one denies the existence of the unconscious, the presence of the past, regressed or not, at every moment of a person's life, and the tremendous influence of the developmental stages (oral, anal, and phallic) of infantile sexuality in adult life. Dentists operate in the site of the first and most irrational of these erotogenic stages: the mouth. They place their patients horizontally and, most frequently as a team composed of a male dentist and a female assistant, administer to them from above. This recreates a very primal scene, that of the parents leaning over the baby's crib and, perhaps, introducing objects (i.e. pacifier, bottle, fingers) into its mouth.

Upon the invasion of such a private, intimate area during the dental treatment, a plethora of confusing feelings are awakened. Warm, pleasurable sensations coexist with acute fear and rage belonging to that early period. Both categories of emotion are repressed by the patient's adult, moral self. Her/his "censorship" cannot allow erotic feelings to surge in the clinical environment. Angry feelings can, however, surface in the form of valid accusations:

"he touched the nerve and made me hit the ceiling", "he cut my lip", "he charged me a lot of money", "he didn't explain anything." This situation converts a potentially caring relationship into one of adversity and subjective perceptions of reality often distort the actual facts.

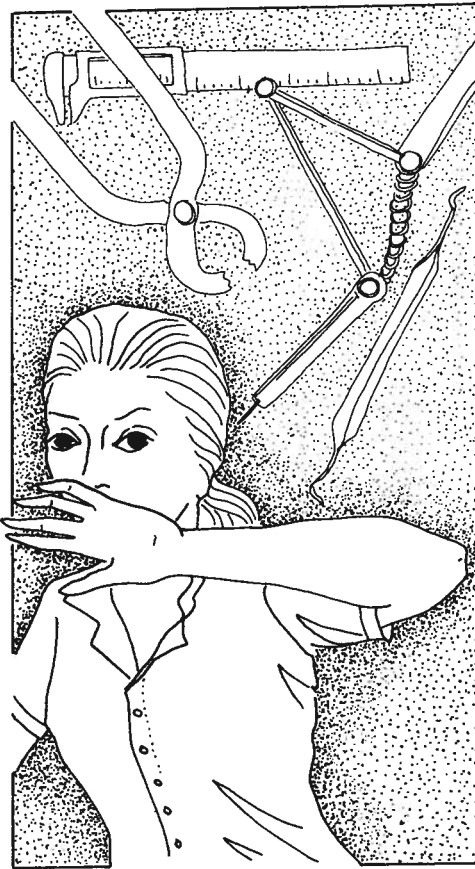
A study done in Ontario in 1978 by A.M. Hunt, et al., *A study of Dental Manpower Systems in Relation to Oral Health Status*, reveals that most people believe that their dentists are not interested in them and that they, in fact, forget about their patients completely once the treatment is finished. But, a series of case histories compiled by R.S. Gilbert in J.S. Landa's *The Dynamics of Psychosomatic Dentistry* illustrates the ways in which patients place unreasonable expectations on their dentists, not unlike children turning to their parent for rescue in a situation of distress. Feelings of being "rejected" or "abandoned" appear frequently whenever a patient has to be referred to another professional for specific treatments or the dentist goes away on holidays. One patient who had a cavity diagnosed while her dentist was absent refused to let the associate practitioner fill the tooth, so as to "punish" her doctor by developing an abscess. Her words were: "I hope you never go away again, as you can see what happened to me when you did."

Gilbert points out that "the dental situation seems to provoke in patients anxieties, irrational attitudes ... out of proportion to the reality of the treatment required." My own experience confirmed this observation multiple times. One woman, for example, was

raped by her uncle at the age of 11. The same afternoon her mother took her to the dentist who "yanked out" (sic) her teeth without anaesthetic. This patient associated the two episodes as similarly brutal and bloody violations, and had never had sexual intercourse or dental treatment since that time. She became a nun and was literally "brought" to me at the age of 43 for a consultation. Careful decoding of the horrors in her past allowed her to slowly start accepting treatment and to regain her sexuality and her trust in dentists. She has left the convent, built a career as a massage therapist, taken a lover, and is now living, in her own words, "a full and happy life."

Gilbert also says dentists themselves "may counter-react to the patient in a manner which is irrational and unrelated to the real therapeutic requirements of the patient." A dentist suffering from general guilt will feel threatened by a patient's pain and take her/his complaints personally. She/he may then get angry and possibly make an erroneous decision about treatment. The dentist's abnormal reactions may be the product of a negative self-image as suggested by a study on dentist-patient relationships done by E.L. Quarantely in 1961 and published in *Psychology and Dentistry* by Ayer and Hirschman. Of the 160 "student-dentists" interviewed, only 10 per cent thought that the public image of dentists was positive. The great majority of them believed that their patients saw them as "individuals who hurt people while doing mechanical work for which they charge too much." The author goes as far as to imply that this negative image is sometimes so intolerable that certain dentists "sublimate" it, making their "evilness" a source of pride as in the case of professional thieves.

According to Quarantely, many dentists blame their patients for the negative aspects of their reputation. They say, for example, that pain is either imagined by the patients or caused by the "atrocious" condition of their mouths. To the accusation of having only mechanical skills, dentists respond by blaming people's ignorance for viewing them as little more than garage mechanics, and they emphasize the broad scope of their studies. The same explanation is used to justify the high fees, namely, that training as a dentist is so difficult and costly that the fees charged are actually comparatively



lower than a physician's. Dentists feel that they are in the same professional category as physicians, and they are very hurt by the fact that most people see the doctor in the prestigious occupation of saving lives while they perceive the dentist as someone who only fills teeth for money. However, another study done by N.D. Richards and Lois K. Cohen, *Social Sciences and Dentistry: A Critical Biography*, in 1971 did show that 19 per cent of high school students choose dentistry because of its financial rewards and only seven per cent because they wanted to help people.

In the minds of their patients, then, dentists can play many roles ranging from angels to demons. They may alternately be protector figures who will cure all pain and solve the person's every problem or be evil "plumbers" who only want to make money and do not really care about anyone but themselves. Conversely, dentists may see their patients as approving individuals who legitimize their job or as ever complaining creatures who place undue pressure on them, do not even appreciate their work, and are ready to sue them for malpractice or excessive charges as soon as something goes wrong. Naturally, the judgement of

right and wrong is also highly subjective and is complicated by the presence of the dental staff. The Gilbert case histories show that patients may get angry at the dentist for something that the receptionist said to them or stop coming to the office because the hygienist scolded them for not flossing their teeth. The dental assistant, especially, can appear sometimes as a moderator and at other times as a collaborator in the dentists' role. If female, as is most often the case, she will be seen alternately as a mother-figure who comforts the patients while the dentist (the stern father, if male) is "punishing" them or as an accomplice of the "torture" that is being inflicted on them. All of these examples point to the same essential component missing in the therapeutic relationship: mutual trust.

The political (socio-financial) aspects of the present mode of dental practice do little to alleviate the feelings of distrust. Dentists are, in Marxist terms, small capitalists who run a business and have to think in terms of profit when making decision about their patients' treatment. Also, they "exploit" their staff by paying them relatively low salaries while expecting the employees to be as committed to the enterprise as the owner is. But, unlike other business persons, dentists are not allowed to advertise; therefore, so-called independent professionals are actually completely dependent on a sort of "magic" that will make people call for appointments. Many patients miss their appointments because of fear and then refuse to pay the charges for unused office time. Others leave considerable debts because of hostility towards the dentist and often boast about their travels or the purchase of a house without remembering the dental bill. Since the office expenses are enormous (53.1 per cent of the gross in 1978, according to a study by J.L. Leake, *Characteristics of Dental Earnings in Canada with Special Emphasis on Ontario*) an unpaid dental bill is not only a lack of profit but a definite loss. The insecurity created by these factors makes dentists nervous and intolerant and tempts them to overbook patients and overcharge for treatments as a protection against potential crises in the future.

Most dentists however, are busy enough to generate an income suitable for their needs. Leake's study shows that in 1978 the net average income for Canadian dentists was \$46,343. The

needs of the public, unfortunately, are not met. A paper published by D.W. Lewis under the title *Canadian Dental Manpower, Supply, Distribution, Requirements* points out that even in the highly developed province in Ontario in 1973, 234 villages and towns had no dentists. In Manitoba, in the same year, there was only one dentist for every 8,600 persons (the necessary ratio being 1:1,100 as suggested by one Canadian study). In general, dental personnel is concentrated in the most populous areas "particularly in those regions better off economically and more appealing culturally and socially." This is, according to Lewis, "the expected and acceptable pattern in what still is basically a free-enterprise market-oriented private practice system of dental care."

The effect of this maldistribution on the oral health status of the population is evident. Hunt's work reveals that in 1978 Metro Toronto, Canada's largest urban unit, had 1,461 patients per dentist and an average of 1.9 visits *per annum*. Meanwhile, Cornwall, a much smaller city, had 4,835 patients per dentist and an average of 0.9 visits. Adults of higher social class had more teeth, fewer decayed teeth, and more successful treatments. To remedy the urban-rural discrepancy, financial incentives and regulations forcing foreign or recent graduates to practise in underdeveloped areas were attempted rather unsuccessfully. However, Lewis found that a "major, significant impact on equitable distribution of services" has been obtained with experimental government-subsidized clinics that offer dental care for children and salaried positions for dentists.

Although a majority of dentists (54 per cent in Hunt's study) still feel that to be on a salary would be harmful to the quality of care, the probable truth is that they are simply afraid to lose the illusion of independence that free enterprise provides. There is no reason why the quality of care should suffer since the absurdity of contradictory concerns would automatically be eliminated in a government-supported clinic. The way matters stand now, dentists are required to be of above-average honesty to make unbiased decisions about treatments, given that the higher the quality the lower the profit will be. Therefore, it is desirable that dentists be able to go one step beyond their fear of communism and understand that the politics of dental care have

nothing to do with Soviet bureaucracy and everything to do with the health of Canadians.

**A** look at the technical (practical) aspects of dentistry will shed more light on this problem. As in a nightmare, there are several monsters in a dentist's life: the dental suppliers, the dental technicians (commercial laboratories), and the dental insurance companies, to name only a few. The suppliers operate very much like a sophisticated syndicate. Two or three big companies have the monopoly of most products and, although it is possible to find an occasional "special" on anaesthetic or impression paste through some smaller supplier, the everyday necessities have to be purchased from the companies' agents, who regularly visit dental offices and push their products at exorbitant prices. Unfortunately, most of what they sell is unavailable elsewhere and, as an added pressure, the companies will only service the equipment of their regular customers. Since dental machinery is so delicate and perishable, the threat of losing a day's work because of technical problems always hangs over the dentist's head.

Also, dentists experience a constant anxiety created by the immense amount of mistakes (some, perhaps, voluntary) that the companies make. Given that it is virtually impossible to control in detail the quantity and quality of the minuscule and expensive supplies that dentists use, they have a pervasive feeling that diamond burrs or silver amalgam capsules may be missing in each delivery.

Significant errors, however, are not the monopoly of dental suppliers. The dental technicians at commercial laboratories, who manufacture the bridges, crowns, and dentures that are placed in patients' mouths, contribute to the dentist's discomfort with their specific mistakes. No matter how careful the professional instructions (in writing, with drawings and detailed explanations), the technicians almost always manage to destroy the result of the dentist's work. Here, too, the contradiction resides in the fact that a specialty, like technical dental work, that is clearly meant for an artisan, is conducted as a business without even the ethical deterrents that, at least, most dentists have because of College regulations. The accent is on production

efficiency, and profit. Technicians are alienated from their own product, of which they touch only a fragment. They work, like factory workers, on an assembly-line. One worker does the pouring of the oral impressions; the next does the mounting of the models on an articulator; a third technician is in charge of the metal casts; a fourth looks after the porcelain veneers; and most often a fifth person will polish the final product and cheerfully grind away a perfect margin that is supposed to prevent leakage of food under a crown. In sum, the chances of obtaining poor results are increased because of the number of people involved and the fact that no one feels fully responsible for the quality of the work.

**L**ast but not least, the dental insurance companies provide their special brand of aggravation to both dentists and patients. Again, these are private enterprises whose prime concern is to make a profit, not to augment the oral health of the population. Granted, they do help alleviate the financial burden of patient in need of extensive treatment, but they also create false expectations and bitter disappointments. The most common "catches" are: "We cover 100 per cent of the treatment" (*but we follow the 1982, not the 1984, fee guide*); "We cover bridgework" (*but the missing tooth has to have been extracted while already under coverage*); "We cover everything" (*but there is \$1000 maximum per family, per year*). Patients, generally, misinterpret their coverage conditions and blame their dentists for differences between the dental bills and the insurance payments. To avoid problems, dentists spend an inordinate amount of office time investigating dental plans, writing letters to the companies on behalf of their patients, filling out insurance forms, and, worst of all, trying to find the computer code that would best apply to the oral procedure performed.

Dentistry is not an exact science nor a mechanical job as most people believe. Many more hours are spent talking to patients, listening to their fears, giving slow and painless anaesthetics, doing hypnosis, discussing the treatment, letting the patient rest, than are actually spent drilling and filling teeth. Nevertheless, insurance companies will rarely, if ever, pay for unusual time devoted to the human factor, for

psychological management of patients or for broken appointments, in spite of the inclusion of these categories in the Ontario Dental Association's fee guide. The whole therapeutic experience is reduced to arbitrary classifications based on materials employed and number of surfaces of the tooth operated on, which often results in ridiculously low fees for the time and skill invested.

Here again, dentists will be expected to possess an extraordinary degree of strength and honesty, to avoid the temptation of exaggerating the technical descriptions, and thereby obtaining a more just retribution for their work. However, because of this built-in potential to breed dishonesty, the insurance companies are always

among professionals and prime targets for stress-related diseases, drug addiction, and alcoholism. Their working conditions make it almost humanly impossible keep a clear professional judgement and a steady hand to perform a highly precise and meticulous job while making business decisions and offering emotional support to the ailing, scared people they treat. Patients have to struggle with the psychological fear of dental treatment and the natural hostility caused by its high cost, which makes them reluctant to seek help in time and prolongs the feelings of pain and fear. The present mode of dispensing dental treatment seems to be, by definition, a "no-win" situation, which harms the health of dentists and pa-

assistants could be given greater responsibility with the guidance of a dentist in the basic treatment of patients. In an experiment done in 1949 at the Forsyth Dental Infirmary, in the United States, dental hygienists were trained to prepare and fill simple cavities in the teeth of children. Unfortunately, this experiment was stopped because of violent opposition from the dental profession.

In Ontario dental assistants are little more than cleaning personnel since they are forbidden to touch the patient's mouth. Even so they could be in charge of public oral hygiene classes from which new preventative instructors may emerge and translate their knowledge into the community. Dent-



suspicious and submit dentists to humiliating questioning, sometimes reporting them to the Royal College of Dental Surgeons and prompting an investigation that, even when justified, may tarnish the reputation of practitioners and destroy their morale. But, when in trouble, dentists are unable to find solace with their employees who may not be interested or compassionate enough since their stakes are quite different from the dentist's. As for colleagues, they are generally a poor source of comfort because the free enterprise system of dental practice not only does not encourage a spirit of solidarity or union, but, as in rival businesses, creates competitive and individualistic attitudes.

**O**verwhelmed by all these pressures dentists are, not surprisingly, at the top of suicide rates

tients alike. A clear understanding of the psychological factors at play through information and open communication would help both parties to deal with their feelings more adequately.

The political and practical aspects, however, would require some drastic changes. One alternative could be to make dental care a basic right of the population and have treatment performed free of charge in pleasant offices supported by the State or, perhaps, by the Labor Unions. These offices could be built in existing community centres or church basements and become the collective achievements of each neighbourhood. Naturally, the clinic atmosphere that has such dreadful associations for most people should be changed by eliminating the white uniforms, the smell of antiseptics, and the sound of drills, not an impossible task. Hygienists and

ists and dental personnel could be paid generous but not excessive salaries and, accordingly, view themselves as instruments, not dictators, of oral health. This more equitable distribution of responsibilities and salaries may create a true team spirit that would help its members in a job that is difficult under the best of circumstances and bring into the field mostly those individuals who are genuinely compassionate and possess the healing and technical abilities required.

The result may be that, once offered the possibility of feeling safe and cared for in a nurturing environment, patients would look forward to visiting the dentist.

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*Deanna Geddo is a dentist from Argentina presently practising in Toronto.*

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# MY STORY, OUR STORY

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

## How did you do it, Virginia?

In high school I developed a passion for Virginia Woolf. I stared at her photographs, awed by her mysterious beauty, transfixed by her intense gaze. My melancholic temperament seemed transformed into something romantic when embodied in someone else.

Her complexity, originality and delving explorations into the psyche fascinated me. Her devotion to her writing was impressive, her search for the truth through art, an inspiration. Her unconventional lifestyle was especially appealing to me, a cynical teenager who celebrated rebellion and freedom. I attributed her occasions of mental instability to her precious artistic sensibility and the inordinate demands of her art. She became my heroine, my role model.

I spoke of her life and her work incessantly as I devoured novel after letter after journal after biography. My friends politely avoided me. My parents tolerated my obsession, relieved I had not chosen to emulate a drug-crazy rock star, and I cut my hair into a style resembling hers. While my bangs grew shorter, I attempted to starve myself to capture her gaunt, pensive stare. I posed around the house exuding melancholy, staring off into the distant suburban wasteland.

I discovered one aspect of her life that greatly intrigued me, but about which I remained secretive — her bisexuality. Although it seemed logical to me, a sexually confused 17 year-old who had felt passion for both men and women, I knew it was unacceptable as conversation or behaviour. So I buried my attraction to women and read about hers.

Ten years later I am still curious about Virginia Woolf's bisexuality as I continue to struggle to reconcile my own attraction to both men and women. As much as I try to shrug off the need to make a choice of lesbianism or heterosexuality, I find bisexuality a particu-

larly alienating choice; and I am doubtful of how fulfilling a choice it can be. There is widespread intolerance for bisexuality within the lesbian feminist community. I am lost about ways to explore my lesbianism in this context. And while bisexuality may be more tolerated among men, in my experience they often do not take a woman's attraction to other women terribly seriously. There is the added difficulty of meeting other bisexuals who generally do not maintain a high profile, except perhaps in the companions wanted column of most newspapers.

I am left trying to make a seemingly impossible choice. I certainly have a greater affinity for women. My life is woman-centred. I work for a feminist organization. My political work is focused on women's issues. My friends and acquaintances are almost exclusively women, and I have had women lovers. I have little in common with most men I meet. My sexual relationships with men have not been very satisfying; there are *far fewer* men than women that I find attractive. I am uncomfortable with the role I lapse into when I am with men. But do women-centredness and negativity toward men, familiar to many feminists, add up to lesbianism?

I am hesitant to personally identify as lesbian. I feel it would be dishonest. Despite a preference for women in my life, I am (occasionally) attracted to men, I have erotic fantasies about men. Can I still be lesbian?

I went to the Lesbian Sexuality Conference recently held in Toronto for answers. I hoped the conference would help me clarify my sexual confusion. I had not anticipated how profoundly my values were to be challenged. Rather than coming away from the conference confirmed in my sexual orientation, my confusion was deepened. I alternated between lesbianism and heterosexuality throughout the three days of the conference.

Sitting in an auditorium full of radiant women on the first evening who had come together to discuss and celebrate lesbian sexuality was exhilarating. I was surprised by the variety of the women around me; a dyke uniform was decidedly absent. The entertaining keynote address urged us to begin to

explore new ways of sexually relating that embodied pleasure and passion, respect, caring and equality. I was excited by this possibility, swept up in the enthusiasm of the audience.

The "coming out" workshop I attended the following morning was extremely useful. A series of steps were identified in many women's coming out process. I was relieved to see that one step was self-identification; this implied for me that identification was a process not an instant decision. A distinction was made between women who clearly identify as lesbian regardless of having a lesbian affair, and women who have women lovers but who do not see themselves as lesbian. I felt uncomfortable, not with this distinction, but by an implicit, if not expressed, contempt for those women who do not commit themselves to lesbianism. I was fearful to raise my confusion.

Unfortunately, the complexities of this step were not elaborated. The group was too large to accommodate everyone's needs. Coming out to family and employers took priority. In the discussion that followed I began to appreciate the implications of choosing to be lesbian; the yielding of privilege and safety saddened me.

I sensed there were other women present who were experiencing a confusion similar to mine but who, like me, remained silent. Instead many women described the certainty of their lesbianism throughout their lives and the tremendous liberation they experienced in coming out.

An announcement was made at the end of the workshop session that a coming out support group was being formed in Toronto. I was excited by the possibility of a group that would offer a supportive setting in which to explore my questions.

The "sexual techniques" workshop was equally interesting and informative. The workshop leader discussed sexual techniques comfortably and without shame. She emphasized the integral role of communication in lesbian sex and explained that the demystification of sex that accompanies communication can facilitate equality and mutuality in sexual expression. As everyone cheered in agreement, I sorrowfully acknowledged my difficulty in express-

ing sexual needs and desires, especially in a heterosexual context where sexual technique and experience seem to be highly valued, almost to the exclusion of communication.

The commitment to communication and experimentation in sexual expression voiced in our discussions was inspiring. I was left questioning whether a similar kind of sexual expression was possible in heterosexuality where the power imbalances inherent in traditional erotic roles are more deeply entrenched.

I was disappointed by a lack of direction and analysis in the "coming on" workshop. We were divided into small groups and asked to discuss successful coming on techniques. There was no critique of coming on as a desirable means of expressing sexual interest, and there was no exploration of healthy lust.

An assumption underlying the discussion and subsequent role playing in the "coming on" workshop was an equation of sex and sexuality. I find narrowly defining sexuality in this way limiting; it overlooks variation in sexual expression and lifestyle. The celibate woman who sat next to me felt excluded. I feared the emphasis on coming on for sex may have created high expectations for some women in anticipation of the dance held that evening. I approached the dance with the same trepidation I feel when I enter a heterosexual bar, fearful of harassment. I did not encounter harassment at the dance; in fact, it was a lot of fun, yet I wondered if other women felt harassed, or if any were disappointed to be going home alone.

I found myself exhausted by the end of the conference. I was no closer to answers regarding my sexual orientation. The aspect of the conference that most impressed me — an underlying commitment to exploring ways of sexually relating embodying values I cherish — is certainly not exclusive to lesbians. Nevertheless, I do feel it is more difficult for me to sustain such a vision in a heterosexual context where I feel the assumptions of traditional sex roles are more insidious and more difficult to challenge, and where support for the eroticization of equality is less apparent.

I know that if I choose to be lesbian, I want my choice to a positive step toward women, not a step away from men.

Ideally, I want to feel the freedom not to choose.★

## REVIEWS

### Unhealthy Profits

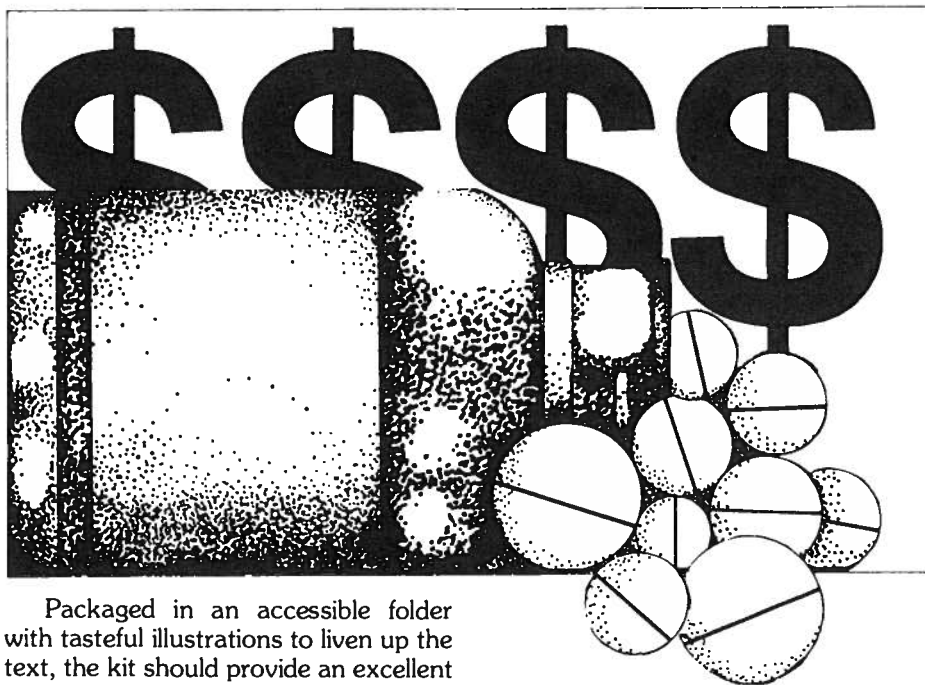
Reviewed by Anne Rochon Ford

**For Health or For Profit? The Pharmaceutical Industry in the Third World and Canada**, produced jointly by *World Inter-Action Ottawa* and *Inter Pares for the Health Action International Coalition in Canada*, 1984

How heartening it is to see that more and more questions about pharmaceutical company accountability are being raised by a skeptical Canadian public. *For Health or For Profit* is a resource kit not only for those who have begun to raise such questions (health activists, women's groups, etc.) but for those who *should* be asking the questions (health professionals, pharmacists, government decision-makers).

introduction to some of the issues surrounding the pharmaceutical industry and its impact, in particular on women in both the Third World and Canada. Through a series of single, two-sided fact sheets, we are introduced to such topics as advertising in the pharmaceutical industry, the industry's profits, dumping in the Third World, drug control in Canada, and the relationship between the pharmaceutical industry and the medical profession. The authors conclude each sheet with suggestions of possible solutions, always with an aim toward more public awareness about prescription drugs, questioning of medical control and authority, and encouraging women to develop structures which will lessen their dependence on doctors and drugs.

Some of the information in the kit is guaranteed to anger (and so it should).



Packaged in an accessible folder with tasteful illustrations to liven up the text, the kit should provide an excellent tool for discussion and an incentive for more inquiry into the wrongdoings of the pharmaceutical industry and our federal government's complicity in these wrongdoings.

The kit was produced by a group of women from *World Inter-Action Ottawa* and *Inter Pares*, also of Ottawa. In keeping with *Inter Pares'* mandate to "work for change through innovative projects in health care ... and community organization," and to increase Canadian awareness about Third World issues, the authors provide us with an

We learn, for example, that 50 per cent of drugs sold in Canada today have never passed modern tests to prove their safety or effectiveness. We learn that most drugs are prescribed by their brand name as opposed to the generic (e.g. Valium, as opposed to diazepam), thereby guaranteeing certain drug companies (the biggies) the sales of this drug, when other companies may be producing the same drug at a much lower price to the public. (A study recently conducted by *Protect Yourself*

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magazine found that prices for a given drug could vary as much as 273 per cent within the same city in Canada). The authors also note that there are visible prescribing cycles which can be directly attributed to advertising, showing that a particularly successful advertisement can directly influence doctors to prescribe a certain drug. This point might seem obvious, but let's not forget this is human health we're talking about, not floor cleaners.

If we think that advertising tactics are dubious in Canada, we are reminded that in the Third World, drug advertising is often misleading and incomplete, with side effects omitted and indications given which were long since banned in North America. Finally, we learn that large parent companies are allowed to evade taxes on their profits by selling ingredients to their subsidiaries at inflated prices. The subsidiaries are then forced to produce and price the product at a comparably inflated price, while the real profits are recouped by the parent company. This is particularly important to keep in mind in light of the fact that a number of subsidiaries of American companies are in Third World countries where consumers can ill afford the inflated prices.

After attending an Inter Pares

sponsored conference on Women and Pharmaceuticals last June, I looked forward with great anticipation to the appearance of this kit. For the most part, I am not disappointed with it. It will serve as an important consciousness-raiser for a host of different groups and individuals. The authors have wisely undertaken the task of making the link between what the industry does in Canada and the Third World. They focus largely, though not exclusively, on women, who are the main victims of the industry's blunderings and experimentation. In that it does not pretend to be anything more than an introduction to the issues, it is hard to find fault in the kit. But the kit does point to the need for more investigation into a couple of areas.

There seems to be a suspicious lack of public information in this country about the Human Drug Prescription Bureau, one branch of the Health Protection Branch (the, more or less, Canadian equivalent to the American Food and Drug Administration). The kit only begins to raise questions about this bureau which plays a tremendous role in determining what is prescribed in this country. We need to have some very basic questions answered about the safety of drugs that get onto the market here. The question of the pitiful

lack of package inserts in Canada must be addressed. What is needed is Canadian analysis equivalent to the (American) National Women's Health Network report, *How the FDA Determines the "Safety" of Drugs — Just How Safe is Safe?*

With the exception of information about problems with the Dalkon Shield and the DES tragedy, Canadian women have precious little knowledge about the pharmaceutical industry's big sellers for women: synthetic hormones and contraceptive devices. Canadian women need a lot more readable information about fertility drugs, birth control pills, the contraceptive sponge, and the many hormone replacement treatments for our supposed "deficiency states."

Let's hope that wide distribution of the kit will provoke sufficient discussion to spark the beginnings of further investigation into the pharmaceutical industry and its impact on women in Canada.

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*Anne Rochon Ford is the national field director of DES Action/Canada. She is currently working on a history of women at the University of Toronto, and is a former member of the Health-sharing collective.*

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## Drug Dumping Damages

Reviewed by Dianne Patychuk

**The Real Pushers: A Critical Analysis of the Canadian Drug Industry,** Joel Lexchin, M.D., New Star Books, forthcoming late summer 1984

In this new book, Joel Lexchin documents case after case of how the drug companies in Canada have betrayed the public trust.

The reader may not be surprised to discover that Canadian doctors are inadequately informed about the drugs they use, that unsafe drugs are not always withdrawn from the Canadian market or that every trick in the book is used by companies to hook doctors on prescribing their brands. But the frequency and continued occurrence of this is surprising.

For example, Merrell denied links

between its drug MER/29 and cataracts even when its own research had demonstrated the relationship. And long after the FDA had required Parke Davis to inform doctors that chloramphenicol not be used for minor infections because of association with a severe and fatal blood disorder, Parke Davis continued to promote the drug for this use. Canada and Central America were targets for aggressive promotion once American sales of the drug began to decline. In 1983, many years after American doctors were informed of the serious adverse reactions associated with mefenamic acid (in Canada marketed as Ponstan), a drug supposedly useful for the relief of menstrual pain, information about these effects was still not being provided to Canadian doctors.

Time after time in *The Real Pushers*, drug companies are stripped of lies, half-truths and tricks to reveal their

profit hungry core — they are in business to make a profit. What they do is, however, intimately connected with people's health.

For this reason a partnership between drug companies, government and the medical profession may make some sense; but not when it is one of government inaction and government and medical subservience to the needs of the drug industry, as has been the case in Canada. Our government has only intervened when there has been "a publicly perceived major health threat." The Canadian medical profession has repeatedly defended the right of the drug companies to be free from government intervention.

Lexchin explains that medical students and practitioners are major targets of drug company efforts and investments through gifts, trips, conferences, freebies and advertising revenue for professional journals. Medical



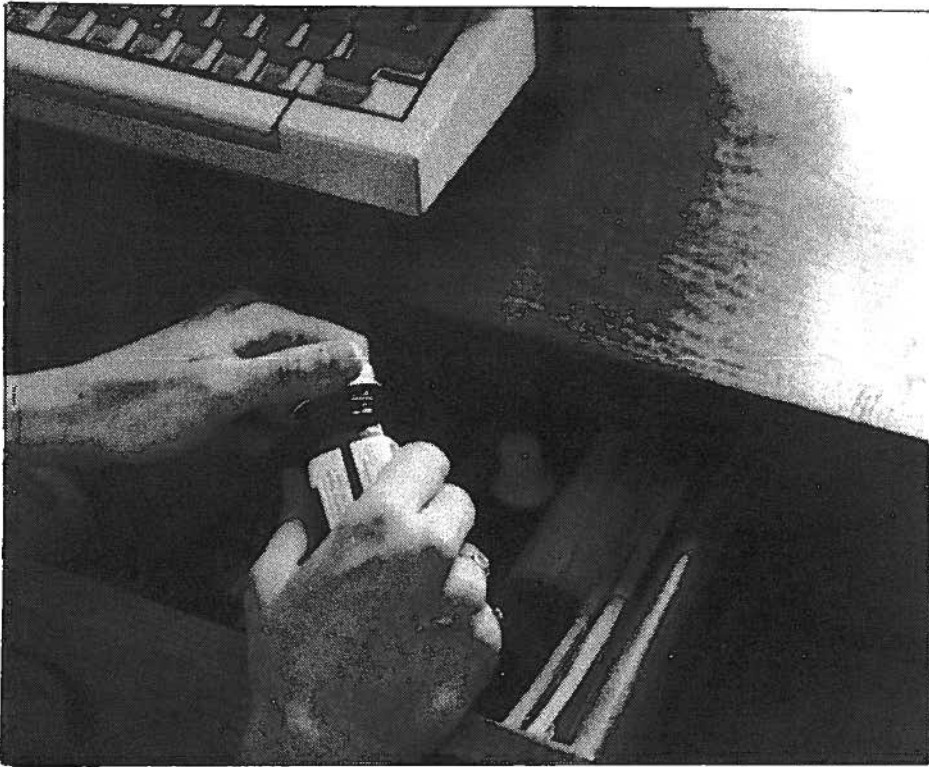


Photo: Pat Foote Jones

education also contributes by teaching illness is the result of a specific causative agent, by focusing on the individual and by trying to correct biochemical abnormalities. Medical education is biased towards the kinds of treatments that drug companies supply.

Lexchin argues that reformist measures to increase competition and improve medical education are not enough: "...the real pusher is the social system responsible for the proliferation of problems, inequities and harm in the pharmaceutical field, namely capitalism." Until a new system can be brought about, he recommends reforms to fight for: independent research facilities should be established, the government should set up a crown corporation to manufacture and sell drugs, abolish patent protection, tighten up its inspection and regulation of drug company activities, and ban brand name advertising; the medical profession should require doctors to annually update their knowledge of therapeutics; and medical schools should place more emphasis on proper use of drugs and non-pharmaceutical methods of therapy.

This is a very useful book. Although some of the information is old, there

are enough recent examples to demonstrate that little has changed and that we need access to this kind of documentation. The reforms suggested are not going to come about without a good deal of public effort. His conclusions are however somewhat contradictory and limited.

After having argued that government and medicine are in partnership with the drug companies, Lexchin concludes with recommendations that increase responsibility and power of government and medical schools.

The reforms Lexchin suggests do not recognize the importance of our experience and knowledge as lay people (and as patients). He does not suggest that we play a greater role than we currently have in determining our own health and methods of treatment. Nor does he suggest who will initiate and conduct research into the development of solutions to ill-health and social dissatisfaction, or how solutions can be incorporated into government supported health care. The long history of rejection of alternative therapies, corporate social responsibility, and social costs of the industry's goals and activities will not necessarily be turned

around by increasing government and medical power.

Lexchin's optimistic conclusion that our current problems would not prevail under a different social system does not recognize the capitalist biases and priorities hidden deeply within medical knowledge, technology and practice. Medicine needs to be demystified and changed *before* it is taken into a new social system or it will not be able to support new goals. This will also entail a challenge to science — the evidence which scientific research provides and the assumptions and methodology it uses. Given the god-like authority, status and power which science and those who control it have in our society, this will be a difficult task.

The distress which drug companies cause and which government and medicine implicitly promote is an international problem and has to be fought internationally. The unsafe and ineffective drugs which western governments reject often become the primary drugs dumped on third world markets with devastating effects on third world economies and people's health. The international influence of drug companies and western capitalist medical ideology which supports it makes serious criticism and action on our part imperative, not only as people living in Canada but also as members of an international community.

No one book can cover every issue and while this book is not a complete guide to what we can or have to do, it is an excellent description of the extent and basis of the problem, and of the solutions that have been discussed on our behalf by the actors with power in the Canadian debate. It will provide invaluable assistance in our on-going efforts to challenge and evaluate medical explanations, evidence and practices.

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*Dianne Paychuk works at the Development Education Centre in Toronto and edits Global Health Reports. Her background is in nursing and sociology.*

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

## Where Do We Draw the Colour-Line?

I read with extreme sadness and anger one part of *Black Women Organize For Health* (Spring, 1984) in which Erica Mercer retells how a "white woman was asked to leave a workshop." I was angered that Mercer agreed, citing "the tradition of mistrust that exists between us."

I am of black and white heritage: my mother is half-white and half-black, my father is white, and I have two daughters from my Anglo-Saxon husband. Would Mercer have voted for my mother to leave the workshop? Or me? She might have for me and most certainly would have for my daughters who do not show any physical traces of their African ancestry.

Where do race-conscious persons (such as those at the mentioned workshop) draw the colour-line? I am proud and aware of my African roots, but I am proud and aware of my European roots as well. My black grandfather and my white grandmother would have thought it ignorant and very sad indeed that neither she, my daughters, nor myself would be allowed to learn at a black women's health conference.

The "tradition of mistrust" exists because people who are afraid to open their hearts and minds to one another are carrying it on.

Melissa Wright  
Toronto, Ont.

## Graphics Offend

We like Kate (our daughter) to look at our books and magazines, since we look at her's too — but the illustrations in the violence issue (*Healthsharing*, June, 1984) really upset her. The worst one was the lady and the scissors; since she is so visually literal, she could only see it as a picture of "hurting the lady."

Does feminist art/writing have

to use imagery like that to communicate its message? Or am I sounding like those irate house-people who write to *Time* magazine to say that they want to cancel their subscription because of all those nude people?

How and when should children learn about violence? Should caregivers try to teach them in a 'caring' and 'politically correct' way or is it our role to postpone the day of knowledge/exposure as long as possible?

I hate to be critical of such an excellent women's magazine, but her reaction is rather startling.  
Kathleen Lahey  
Windsor, Ont.

## Artist Responds

I agree that the drawing in question illustrates violence. It was meant to do so, since it was an illustration for Varda Burstyn's article about violence and women. Particularly, it illustrates a reference made by Burstyn to "the symbolized violence we are seeing in advertising." The drawing is a parody of the vile subjugation of women in advertisements. If you look closely at the drawing, you will see that the woman, who is selling a bottle of soap, is a cut-out figure. She is 'beautiful' in the pre-packaged magazine or t.v. advertisement manner, that is to say, a doll cut from a pattern, lacking individuality and real personal attraction. The strap of her Frederick's of Hollywood slip is falling from her shoulder, to evoke the role sexual titillation plays in modern advertising. The scissors are there to show that the figure of the woman has been cut from the background, although I cannot deny that I also wanted to suggest the violence against women that underlies much advertising.

The point of Burstyn's article was that we must stop "hurting the lady" as Lahey's daughter put it. Although I don't consider myself a 'feminist artist' (but rather, a feminist and an artist), I think the role of art and writing regarding feminism is, among other things, to inform and to stimulate independent thought about our position in the world, and to present our individual thoughts and feelings about the

status quo. The picture of the woman and scissors suggests the ugliness and violence in some advertising. That is its very purpose — to invite the viewer to analyse the image in terms of the real world.

How and when do we teach our children about violence must be based on our knowledge of the individual child, on the child's ability to understand our explanations and on our ability to make those explanations clear and non-frightening, obviously not an easily achieved goal considering the emphasis on pro-violent sexual imagery in the popular media. We cannot protect children forever from the horrors, and we should not paint for them a make-believe vision of a world with no ugliness. By that I'm not suggesting that we should deliberately go out of our way to show children the horrors. Perhaps when they are not ready to assimilate 'grown up' knowledge, we should wait until they are better prepared. Had I been drawing for a magazine aimed for young people I would have avoided violent images. But Lahey might have considered that the magazine is not intended to be a picture book for children but rather was an issue dealing specifically with the potentially traumatic topic of women and violence. Even the cover plainly shows the theme.

I am sad that a child was startled by the drawing; but that was after all the aim of the picture — to shock, not children, but adults.

If we all have such a reaction to violence against women (or indeed anyone) in advertising, we could begin to create an environment in which there is no chance of a child encountering such trauma.

Mary Firth  
Elora, Ont.

## Fighting Back

Your magazine regularly brings to me thought-provoking material that helps me to think about the realities of being a woman.

Since my marriage in 1979, I have been active in working against violence against women. I have supported a transition house

for battered women and worked within Women Against Sexual Assault. The challenge is always there for me to try to understand why I am choosing to work in these ways.

Part of the answer lies in the urgency and drama of the involvement. Because people are more open, or open in particular ways, during a crisis and issues are sharply focused, there is a real possibility for learning and growth. That is true for everyone involved. If violence within marriage is just the extreme end of a continuum of exploitation of women, then that clarity and opportunity to learn is precious.

There is also the magic of joining with other women to fight back, to understand and to go on. It is exciting to be part of a network of commitment that has real links across Ontario, across Canada, and throughout the world.

Your issue on violence (Summer, 1984) gave me this opportunity to think about my relationship to the struggle against sexism and about some insights, especially within *Memoirs of a Nightmare* and the interviews with the workers at Sarah's.  
Linda Reith  
Guelph, Ont.

## A New Voice

Thank you very much for *In Search of A Scapegoat* (Summer, 1984). It really puts into words the feelings and unspoken frustration that go on in my mind over the Grange Inquiry. As a nurse, I can truly appreciate what the authors are saying about the lack of political, not to mention professional, cohesion among nurses.

The potential for our voice is great but we do not seem to be able to get together and speak up on issues. Our deeply ingrained role of "doctor's handmaiden" and passive caregiver has both the nurses and the public brainwashed.

Fortunately, the education methods at nursing schools are changing to encourage new nurses to break out of this role. But, as with any change, it will take time.

Barbara Hamilton Brabin  
Weston, Ont.

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## THE MOST IMPORTANT MIDWIFERY EVENT THIS YEAR



### "C.R.E.A.T.I.N.G U.N.I.T.Y"

the second annual convention of the  
MIDWIVES ALLIANCE OF NORTH AMERICA  
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October 31 — November 4, 1984

OISE, 252 Bloor St. West, Toronto

Elizabeth Davis • Ina May Gaskin • Dr. Kloosterman  
Dorthea Lang • David Stewart

- safety and midwifery politics • workshops for health activists
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- practical workshops for midwives • resources • films and videos

### \*\*\*SPECIAL FEATURE\*\*\*

MIDWIFERY AS A WOMAN'S ISSUE

- Sheila Kitzinger • Michele Landsberg • Mary O'Brien
  - Vicki Van Wagner
- November 2, 8:00 p.m.

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# RESOURCES & EVENTS

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## Positive Menstrual Experience

*Blood is for Bleeding: The Positive Values of the Menstrual Experience* is a seven part taped documentary analysing many aspects of the menstrual experience. The tapes vary in length and are: *The Science of Bleeding* (20 mins); *Problems: Dysmenorrhoea* (55 mins); *Psychology and Psychiatry* (45 mins); *Menstruation and the Law* (30 mins); *The Terrible Silence* (30 mins); *Turning Levi-Strauss on His Head* (50 mins); *The Blessing* (75 mins).

Tapes may be purchased individually or as a set at the following prices: set of seven \$70.00 or \$10.00 per tape for individuals; set of seven \$140.00 or \$20.00 per tape for institutions. For more information contact Marlene Philip, 173 Robina Avenue, Toronto, Ont., M6C 3Y8, or phone (416) 651-3090.

## Women's Health Bibliography

An annotated bibliography of feminist books on women and mental health has been published by Boudica Books. *New Visions* by Janet Rogers lists 47 Canadian and U.S. books. Organized thematically in nine sections, it has a concise author and title index.

Available in women's bookstores or send \$2.00 postpaid to Boudica Books, P.O. Box 901, Station K, Toronto, Ont., M4P 2H2.

## DES Guide

DES Action National in the United States has published the first *Fertility and Pregnancy Guide for DES Daughters and Sons*. DES Action has combined an extensive listing of medical literature and personal interviews with DES specialists to present, in everyday

language, answers to common questions about fertility and pregnancy.

This guide, which has been reviewed for accuracy and clarity by 30 American DES physicians, sells for \$5.50 and can be ordered from DES Action/Canada, P.O. Box/C.P. 233, Montreal, Que., H3X 3T4.

## Body Image Workshop

A 10 week workshop for women on body image will be held in Toronto beginning September 24, 1984.

Women's feelings about our bodies and ourselves, the relationship between body image and personal power and other questions will be explored through sharing discussion and structured exercises in a safe, non-demanding environment.

The workshop fee is \$250.00. For further information, contact Wendy Wildfong at (416) 535-4709, or Arlene Anisman at (416) 469-2725.

## International Congress on Women's Health

The First International Congress on Women's Health Issues will be held in Halifax, Nova Scotia from October 3-5, 1984.

Thirty-two concurrent sessions will feature research and clinical papers on women's biology and mental health, preventative self-care, and economic and family issues. Canadian and American participants are eligible to receive a special convention travel fare from Air Canada. For reservations call toll free 1-800-361-7585.

Registration fee is \$200.00. The fee also covers the conference reception,

conference materials and refreshments.

For more information write to: Congress Secretariat, International Congress on Women's Health Issues, The School of Nursing, Dalhousie University, Halifax, N.S., B3H 3J5. Cheques are payable to Women's Health Issues Congress. Visa/Chargex accepted.

## Experiencing Teenage Motherhood

*Our Choice: A Tape About Teenage Mothers* is a 37 minute documentary videotape produced by The Women's Media Alliance. Made in cooperation with Jessie's, a Toronto centre for teenage mothers, this tape presents a group of teenagers describing their experiences with pregnancy, housing, the welfare system and personal relationships.

For rental or sale information contact DEC films, 427 Bloor St. W., Toronto, Ont., M5S 1X7. Telephone: (416) 964-6901.

## Immigrant Women's Health Handbook

The Immigrant Women's Centre in Toronto distributes a reproductive health handbook designed for immigrant women. These comprehensive yet easy to understand booklets include information about physiology, anatomy, contraception, pregnancy and abortion, as well as nutrition, stress and breast cancer.

The handbooks are available in English, Spanish, Portuguese, Italian and Chinese. There are plans to translate into Vietnamese and Greek.

The handbooks cost \$1.50 each. Order from the Immigrant Women's Centre, 348 College St., Toronto, Ont. M5T 1S5.