

Spring, 1985

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# Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY



*Lesbian Health Concerns*

*Teaching Medical Students to do Pelvic Exams*

*Why We Don't Use Birth Control*

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# THANK YOU . . .

To all of you who sent a donation following our request in the Winter, 1984 issue, we offer a warm and sincere thanks. Your cheques have helped our bank account; your notes have helped our hearts. We've received both small and large donations, and appreciate them equally knowing how difficult it can be to find spare cash in these tight days.

Your donations have helped. We managed to hire Connie and Heather to coordinate circulation and promotion, and the outreach programs planned are getting underway. We couldn't have done it without your support. Thanks.

## Healthsharing

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**Seeking Sisterhood**

*Healthsharing* has devoted many of its pages to exposing and analysing the sexism and misogyny inherent in our present health care system. We recognize that all women are vulnerable to sex bias in medical and scientific research. And we recognize that stereotypes and sexist assumptions prevail in a medical system that epitomizes socially prevalent sex-based hierarchies and inequalities.

Within our collective are lesbian, heterosexual and celibate women. In addition to the disadvantages we suffer within the health care system by our femaleness, significant social barriers and risks are imposed upon those of us who are lesbians because of our sexuality. The lesbians among us are more likely to have lovers denied access to us in hospital. Only some of us are able to have a partner included under our employee health plan or to benefit from family health insurance offered by the province.

As feminists, we think no woman should have to hide parts of her life, especially parts which are fundamental to her being and quality of life - whom she chooses for a lover and partner, for instance. In the same way that all women have fought for pride as paid workers, in being mothers, in being outspoken, so too have women fought to gain pride as sexual people.

For heterosexual women, sexual pride and satisfaction may be relatively public; for lesbians, such pride often rests within a smaller community. Heterosexual women must join lesbians in seeking public pride in the sexuality of *all* women. Personal joy, pride and satisfaction are immensely strengthened when mirrored in the public world - all of us need to see our reflections publicly, with acceptance and validation.

Today's lack of public acceptance for lesbianism affects more than just personal and emotional well-being. It can affect health in its broadest sense. And because of heterosexism and homophobia within the health care system, we know very little about the ways in which health is different for lesbian, celibate and heterosexual women.

Just as women refused maleness as a standard for medical research and health care delivery, we need to move beyond the assumption that all women are heterosexual. Any number of health issues may affect lesbians differently from heterosexually-active women, just as they may affect celibate women differently from either. We don't yet know. The prevailing assumption that all women are heterosexual and sexually active has meant that very little research has been conducted into how health matters *might* differ for lesbians. The prevalence and transmission of sexually transmitted diseases may be different because of sexual practices. Stress effects of living in an anti-homosexual world could compound ill health for lesbians. The choice of motherhood and limited access to artificial insemination services within a health system that supports traditional life styles is also a growing concern for lesbians.

But lesbian-centred research is just one of the changes required. Given current fear of and anger towards lesbians and homosexual men, lesbian-centred research cannot yet be free of bias. Women who volunteer as subjects in lesbian health studies are likely those women who are self-identified and probably out as lesbians. These women may not be representative of the general lesbian community, many of whom do not have the emotional and economic support and freedom to allow them to come out, even to their own health care worker.

Robin Barnett explores coming out in her article in this issue of *Healthsharing*. Coming out carries with it great risks. Outright abuse, inaccurate and stereotypic assumptions, avoidance, and breach of confidence are some of the responses which a lesbian might fear from her health care worker, not to mention the stress and anger of being confronted once again with the assumption of heterosexuality.

In a heterosexist and homophobic society, the notion of lesbian health care may strike one as almost a contradiction in terms. But not all health care practitioners are subject to such pervasive negative attitudes. Much work and struggle is being done, both from within and outside the system, to eradicate the anti-homosexual bias of our health care. Whatever our sexuality, this struggle is critical for us as feminists. Struggles against sexism and misogyny are meaningless unless they are carried on in conjunction with struggles against other forms of oppression - racism, classism, homophobia and heterosexism.

Elizabeth Allemang  
Amyra Braha  
Connie Clement

Connie Guberman  
Diana Majury

Lisa McCaskell  
Heather Ramsay

## Selling Calcium

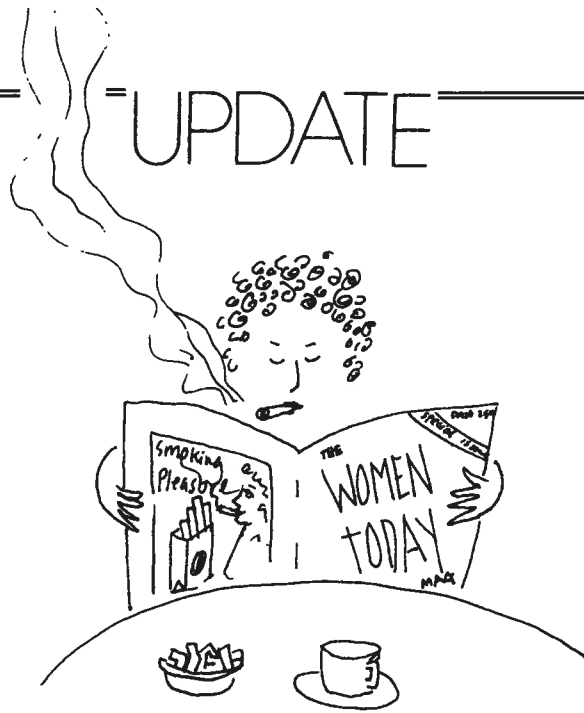
VICTORIA—Last fall, University of Victoria Extension presented a lecture on osteoporosis. I was quite surprised to see that the \$7.50 fee included dinner and I had visions of an entirely white meal. However lasagna and salad were the menu offerings; the real calcium pitch came later. The lecture was sold-out - a first in my experience of attending women's health events. The audience was overwhelmingly female and the average age seemed to be 50 and older.

Two guest speakers were introduced: Dr. Valerie Walker from the University of British Columbia, who specializes in research on osteoporosis, and a representative from the OSTOP Society of B.C., a self-help group for those people who have osteoporosis or want advice or support. A peculiar format ensued with a video tape of Walker talking about osteoporosis being played while she sat before us. The video was not properly edited so it was often ineffective. At the end of the tape, Walker answered questions, and the representative from OSTOP spoke briefly about her group.

The presentation was underwritten by Sandoz Canada Inc. a firm that makes, among other things, calcium supplements. While there was little outward mention of Sandoz, each participant received a conference packet complete with a Sandoz note pad, pencil, and a series of articles about osteoporosis, half of which mentioned Sandoz in some way.

Osteoporosis has recently received much needed media coverage and if the evening in Victoria is any indication, many women want information about it. The OSTOP Society of B.C. works in association with the Osteoporosis Society of Canada. The British Columbia branch address is P.O. Box 35646, Station E, Vancouver V6M 4G9.

Susan Moger



## Recognizing Alternative Families

MADISON, Wis.—Madison is one of a number of American cities considering passing an "alternative family rights ordinance." The impetus behind the ordinance came from a lesbian couple who were denied a family membership to the YMCA. In the interim, the couple has launched a lawsuit against the YMCA based on discrimination on the basis of sexual orientation, prohibited under Madison's equal opportunity ordinance.

The purpose of the alternative family rights ordinance would be to recognize the many diverse, committed relationships between individuals. The ordinance would grant to those relationships some of the social and economic privileges presently accorded the nuclear family. The benefits which would be available to alternative families would include family health insurance, family memberships at health clubs, bereavement leave, hospital visitation and authorization of emergency medical care.

The definition of alternative family under consideration is "two or more adults involved in a mutually supportive relationship who are registered publicly as 'domestic partners' in order to be considered, under municipal or-

dinance, as a family along with their dependent children." Although the ordinance would clearly benefit gay and lesbian couples, it is not restricted to homosexuals. The application of the ordinance to two or more adults recognizes other types of alternative families, including partners living together for economic and emotional support, heterosexual lovers, people with disabilities and their live-in attendants and extended families.

Although limited, opposition to the ordinance was vehemently expressed at public hearings on the issue. Ironically, the primary objections are that the ordinance is anti-family and that it will somehow erode the traditional family.

The Madison business community, although not present at the public hearings, apparently also has concerns which render them unable to support the ordinance. The issue for local business is the possibility of increased costs of employee health insurance plans and lost revenues for health clubs. However, the data compiled for the task force looking into the ordinance indicates that increases in costs would amount to less than eight-tenths of one per cent.

## Smoking Stats Ignored

More women, particularly young women, are smoking cigarettes these days. This is a surprising fact, considering the wealth of information on the subject, however current cancer statistics show an increase in smoking related cancers, particularly lung cancer in women.

Yet a group of researchers with the American Council on Science and Health have found that this major health problem is passed over, or worse yet, considered a taboo subject by most prominent women's magazines.

It was found that even magazines that had regular health columns rarely ran articles on cigarette smoking, despite the alarming risks that women smokers face such as lung cancer, possibility of spontaneous abortion, delivery of premature and low birth-weight infants, and neonatal death.

As cigarette advertising can generate hundreds of millions of dollars of revenue annually, it seems to be considered more lucrative to run the ads than to run articles covering the potentially harmful effects of cigarette smoking.

More worrisome still is the fact that women rely on those magazines as sources of accurate health information. The American Council on Science and Health has responded to this by publishing their findings to make women aware of this gap in the coverage of health topics and of the need to publicize in other ways the health hazards inherent in smoking.

Ellie O'Regan

Alternative family rights ordinances present a significant challenge to the heterosexism and homophobia so prevalent in North American Society. By itself, an ordinance cannot change attitudes, but it does provide a positive basis for discussion.

Diana Majury

## Deflecting Law Suits with Goodwill Advertising

TORONTO — In January, 1985 A.H. Robins Canada undertook a major advertising campaign suggesting that women still wearing Dalkon shields - or any other inert intrauterine device inserted in the early to mid 1970s - "call your doctor for an appointment."

The advertising campaign follows in the wake of literally thousands of financial claims for damages filed by women who suffered pelvic infections or infertility linked with wearing a Dalkon. Although the Dalkon Shield was withdrawn from Canadian and U.S. markets in 1974 after it was linked to 16 deaths, Dalkon Shields were vigorously sold for several years prior to 1974.

The advertising campaign falls far short of the international recall demanded by several women's health organizations. The ads currently running in newspapers, magazines and on radio and television across Canada, fail to mention the dangers of Dalkon Shields.

Dr. Constantine, Medical Director of A.H. Robbins Canada, agreed the campaign was not a recall. He called the campaign "a service" to the women who may still be wearing devices, but admitted that "the legal nightmare in the U.S. may have something to do with it 'the campaign'."

"Enough is enough," he said, "There are lawyers in the U.S. who have specialized in suing Robins. They've even offered seminars for \$100 to other lawyers."

Robins went ahead with the ad campaign - as far short of a recall as it falls - with minimal encouragement from Health and Welfare Canada. Following a similar ad campaign in the U.S., Robins head office sent a letter to the Canadian Embassy and numerous other embassies on Oct. 29, 1984. The Canadian government, while commending Robins' intention, felt the federal government had little ability to accept their offer to run a similar cam-

paign in Canada. Jean Sattar, Information Officer at Health and Welfare, stated that because health is a provincial matter the federal government has "no jurisdiction;" Robins "would have to arrange re-financing with the provinces." The federal government then passed the buck by writing the provinces. As of the last week of January, only Manitoba had responded. Robins went ahead without provincial input.

The Robins offer to pick up financial costs for removal of devices not covered by local health plans, may encourage women without health insurance, illegal immigrants and women whose doctors extra bill to have old IUDs removed. It's a small step forward.

## Clinics Alive & Well

MONTREAL—Two clinics that provide services to women in Montreal are being squeezed by expansion of the provincial CLSC health and social services network. CLSC (Centre Local des Services Communautaires) has the mandate to coordinate all medical and social services in its region.

The Head and Hands Youth Clinic in Notre Dame de Grace, a suburb of Montreal, has operated independently for more than 15 years providing model service to meet needs of teenagers. This past year it had to rally considerable community support to ensure that plans for a proposed CLSC in the neighbourhood won't threaten its existence.

The threat of coming under the wing of a top-heavy CLSC led to extensive negotiations in both Montreal and Quebec City. The province recently guaran-

teed Head and Hands funding to continue current services, as long as no similar services appear in the community, an event which seems unlikely. With strong community support and ample evidence that Head and Hands is almost alone on the front line of youth health and social services in the city, the clinic appears to be secure for awhile yet.

Patrons of Clinique des Femmes, which has operated for a number of years as a satellite of the inner-city CLSC Metro, were distressed to hear that it would have to move. The clinic was relocated from its own cosy 4-story row house on Peel Street into the existing CLSC Metro facilities in the Guy Metro station.

Surprisingly, the move - ac-

complished in early January - has generally pleased both staff and patrons according to coordinator Sandra Golding. Although construction is not yet finished on their new space, the Clinique des Femmes will now benefit from longer hours (8 a.m. til 8 p.m.) and more available staff for all clinics. The benefits go both ways, for now the CLSC Metro has access to perinatal and gynecological services as well as a sexual assault centre.

It's hoped that the new quarters will soon have the old comfortable and personal atmosphere which - along with excellent service - has brought women from all over the island of Montreal to the clinic.

Deborah van Wyck

## Morgentaler Meets Edmonton

EDMONTON—Despite his much publicized attack by a ketchup-wielding assailant in Calgary, Dr. Henry Morgentaler's recent Alberta visit met with a decisive show of emotional and financial support.

Two major events, a fund-raising dinner and a public forum, organized by Abortion By Choice were sold out. The attendance of nearly 200 at the dinner and approximately 750 at the forum could easily have been much greater had space allowed. The events grossed \$20,000 to help meet the \$150,000 Morgentaler has incurred in legal expenses.

While Morgentaler supporters decided against pickets and demonstrations for his visit, opponents had no such qualms about public expression. Anti-choice groups carried signs that one observer described as "disturbingly right-wing and bordering on anti-semitic."

Except for an organized anti-choice demonstration outside the public forum, the hecklers were few in number although they gained a lot of media attention. One minister shouted at Morgentaler, "A woman should be put to death for having an abortion." Another

demonstrator who taunted "You don't abort Jewish babies," reflected the prevalent anti-semitic tone.

For more information about Abortion By Choice, a northern Alberta chapter of CARAL, contact: Abortion By Choice, P.O. Box 4098, Edmonton, Alberta. T6E 2A6.

Ellen Ticoll

## Pregnant Teenagers

ST. JOHN'S—A high rate of pregnancy among teenage girls forces many to leave school before graduation. A multi-agency committee has recently been established in the hope of reversing this provincial trend.

The 1984 report of the Newfoundland and Labrador School Trustees Association found teenage pregnancy was the major reason young women leave school. The report recommended the formation of a multi-agency committee; in Newfoundland's parochial school system this is something of a first.

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## Community Health Care

A meeting this spring of Community Health Representatives (CHRs) from the Nishnawbe Aski Nation which includes 21,000 people living on 42 reserves in northern Ontario, is just one part of the ongoing struggle for Indian control over Indian health. Indian and Inuit communities want a transition of control over CHR training programs from Health and Welfare to native communities.

Approximately 700 CHRs are currently employed in native communities across Canada. More than 90 per cent of CHRs are women. They receive a very brief training in maternal child health, monitoring patients on medications, health education and referral procedures and then return to work in their communities. In isolated northern communities, they are usually the only resident regular health worker but they are linked to a network of nursing stations and health centres.

CHRs find that their training has not adequately prepared them to deal with the needs of their communities.

Other problems with the CHR program as it currently exists in Canada include: a lack of opportunity for CHRs to specialize or receive continuing education in the skills they need (first aid, intravenous administration and set-up, cardiopulmonary resuscitation); a lack of recognition within the health system of the experience; and responsibility that CHRs have and carry disparate pay and benefits between communities. The training program and curriculum have also been criticized for lacking a sensitivity to native culture and tradition.

Indian and Inuit proposals seek to address all these problems by instituting native control over all aspects of defining health needs and training health workers. That the Medical Services Branch of Health and Welfare has agreed to fund a national

CHR conference sometime in 1985 suggests it recognizes the isolation and other problems CHRs face. But national conferences are not an acceptable alternative to community control over community health.

Women in communities across Canada want to define our health needs and we want real choice in health care. This kind of community participation and community control will be difficult to achieve in parts of the country where there is a strong medical and hospital monopoly over health services decision making. Such control will first be achieved in communities where there is less competition for patients, power and the health dollar.

Dianne Patychuk

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## Exercise Hazards

Calcium deficiency and the temporary interruption of menstrual periods are surfacing as parallel conditions among women athletes.

The latter condition, known as athletic amenorrhea, may be a result of high level training.

A recent study cited in *The New England Journal of Medicine* found that low estrogen levels can cause temporary interruption of menstrual flow and bone loss that female athletes may experience.

Further studies are required to examine the direct links between prolonged training and potential long-term effects on women athletes such as symptomatic osteoporosis in later life. For reasons not entirely understood, prolonged training affects female hormone levels.

An increase of daily calcium intake to supplement possible deficiency is suggested.

But with the exception of the apparent effect on the estrogen metabolism, exercise does strengthen the bone. The extent of bone softening seems to be directly related to the method, type and intensity of the exercise program.

Darlene E. Palmer

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## Focusing on Home Care

Nova Scotia is the only province in Canada without a comprehensive coordinated home care program. In addition to wanting such a program to serve older and disabled persons, advocates want nursing homes put under the jurisdiction of the Department of Health to assure better care and to curtail a growing trend toward care for a profit.

The Registered Nurses Association of Nova Scotia (RNANS), a professional association representing more than 8,000 registered nurses, is promoting a proposal as outlined in its document, *A Model for Home Care in Nova Scotia*.

The Women's Health Education Network (WHEN) sees public education as a major ingredient to effect change for home care in the province. With this in mind, WHEN organized a program co-sponsored with the Consumer Association of Canada designed as a model for a travelling roadshow for community use. The 25-minute film, *The Business of Aging*, available from the NFB, was combined with a panel of women representing RNANS, the Senior Citizen's Secretariat, Canadian Pensioners Concerned

and a Public Health Administrator working with a home care pilot project, over 65 per cent of the clients participating would have been admitted to nursing homes or hospital if the service had not been available.

For a copy of *A Model for Home Care in Nova Scotia* write to: Ms. Joan Mills, Executive Director, RNANS, 6035 Coburg Road, Halifax, N.S. B3H 1Y8.

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## Toxic Work

TORONTO — When Saskia Post, a Brampton plastics factory worker, discovered she was pregnant in 1983 she quit her job, fearing potential damage to her growing fetus.

Despite her precautions, Post's baby was born blind with severe birth defects. She believes the damage was caused by her exposure to harmful chemicals in her workplace. After extensive genetic testing the baby shows no sign of chromosomal damage. Post is currently suing her employers for damages.

Her situation is not unique. Many Canadian men and women are experiencing reproductive problems due to hazards in their workplace. The new Hamilton Workers' Occupational Health and Safety Centre is currently receiving complaints from workers ranging from inability to conceive to birth defects in children.

For further information on occupational health and safety contact Stan Gray at the Hamilton Workers' Occupational Health and Safety Centre, 1071 Barton St. East, Hamilton, Ont., (416) 547-8962.

In Toronto, a meeting has been scheduled for April 10, 1985, 7:30 p.m. at the Development Education Centre, 427 Bloor St. West, to discuss support for Saskia's case. For more information contact Debbie Field at DEC, (416) 964-6360.

Debbie Field

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## Hyster-Help

An American author who underwent a hysterectomy at 26 is currently writing a book to help other women cope with surgical menopause at an early age.

Betty Tonsing Carter who had a complete hysterectomy 10 years ago has drafted a questionnaire for women who had the same surgery before age 35. Carter's book will include a description of her surgical experience, medical data, research reports, interviews and a bibliography and list of support organizations.

If you had a partial or complete hysterectomy before you were 35 please contact Carter c/o Yoshioka, 1462 10th Ave., San Francisco, California 94122 for the questionnaire or more information.

# Examining Lesbian Health



BY ROBIN BARNETT

DRAWINGS BY MARY FIRTH

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## Healthcare and Lesbians

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The feminist health movement has highlighted the misogynist training of doctors and the anti-woman bias of much modern medicine. Women do not experience an equal relationship with doctors since knowledge has power. The high status of doctors in this society gives them power - chosen or assigned - over their patients. Nearly all women have difficulty dealing with doctors and choices about treatments. Is this situation any different

for lesbians?

Yes, the difference results from homophobia and heterosexism. Lesbians cannot forget that this society operates from a heterosexual perspective. Many lesbians are cautious about revealing their lifestyle because they never know when coming out will have negative consequences. They face discrimination in every part of society. Heterosexual relationships and the nuclear family are standards in our

society by which all are judged. Lesbians are always making decisions about whether to come out or to pass as heterosexual. Lesbians' interactions with the health care system are no different than with other parts of their lives. Lesbians are vulnerable in any given health situation because they never know what to expect, sometimes even if they have known a health worker for years. An incorrect or awkward statement made by a health worker

may be made in ignorance of a client's sexuality or it may be made from bias or fear. Going to a doctor may be more stressful for a lesbian than living with whatever ailment she has. Inadequate or hostile treatment by medical professionals may prevent lesbians from seeking care. Stories of misdiagnosis and voyeuristic health care workers abound in the lesbian community.

Heterosexism and homophobia aside, lesbians may be less likely to see health professionals simply because they are less likely to use birth control than heterosexual women. Statistics show that women consult medical professionals more than men. One of the key reasons is because of contraceptive, gynecological and reproductive concerns; and most routine gynecological screening is handled in conjunction with birth control or prenatal visits. Even sexually active heterosexual women, with good reasons for having birth control check-ups, would often rather put off seeing the doctor. For lesbians, this tendency is easier to act upon.

Current lack of knowledge about lesbian health matters and ensuing ignorance promotes and perpetuates myths about lesbians, and makes it difficult for lesbians to get accurate and thorough information about their health. Medical studies about lesbian health problems are almost nonexistent. Indeed under homosexuality - read male - the few articles mentioning lesbians mostly focus on hormonal studies and mental health, I suspect intent upon finding abnormalities with lesbians. Alternative health practices and research appear to fare no better. Moreover, health training for doctors, nurses and alternative health practitioners rarely introduces matters relevant specifically to lesbians. Generally, only when lesbians or gay men in these programs raise the issue of homosexuality does the topic get mention.

Most health workers assume that every woman is heterosexual, that sexuality means intercourse and that all women need birth control. In this context, lesbianism represents a deviation from the norm. Many lesbians tell me they dread hearing from an unfamiliar health worker, "What kind of birth control do you use?"

Different types of sexuality must be acknowledged by the health professions; assumptions cannot be made. For instance, some self-identified lesbians have sexual encounters with men, or a woman may be celibate. A suggestion I find useful is for the birth control question to be

phrased more sensitively, such as "Do you have need of birth control?" Sometimes the question should not be raised in an initial meeting with a client.

Even some health workers who try to be supportive of lesbians may make assumptions or generalizations about the sexual practices of lesbians based on limited knowledge. This could have serious repercussions. For instance, a woman I know arrived in the hospital emergency department with severe abdominal pain. Several months before she had come out to her doctor, who seemed supportive. While she was under anaesthetic her doctor told the specialist about her "gay lifestyle." The specialist ruled out pelvic inflammatory disease (PID) based on this knowledge; her normal appendix was removed. She was not asked

how long she had been a lesbian or whether she had sex with men. Later, following further consultation, she was diagnosed with PID and treated for it, and she had had to suffer the effects of major surgery for the appendectomy.

Finding a sympathetic health worker can be difficult. Lesbian information centres or feminist health centres, where available, can be valuable sources for practitioners names. Many lesbians depend on word-of-mouth referrals, but this is easiest for lesbians in contact with a lesbian community. Access is a problem, especially for rural women, who may have no choice but to depend on the available health practitioner. I know of many women in rural British Columbia who travel hours to see a sympathetic or supportive doctor.

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## Coming Out

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Women have different needs when shopping for health care workers. Some are interested in personality, some in qualifications or attitudes. Where choice is available, many lesbians seek health workers who understand the societal pressures on lesbians. Some seek lesbian health practitioners. Others choose heterosexual male workers. Given the range of choice, it is difficult to offer guidelines about how and when to come out. What works with one woman in a particular situation may not work for another woman.

I feel the issue of coming out to professionals is complex and variable. A woman should not feel compelled to come out; the decision is personal. I find it depends on a woman's rapport with her health worker, and how she assesses her own health needs and risks. It may also depend on a woman's willingness to raise issues with her health worker and their ability to build a relationship of trust and respect. A woman told me of her conversation with her male doctor regarding artificial insemination. He was uncomfortable with the idea and tried to talk her out of it, ostensibly concerned about his own legal liability. She had known him for several years and he was aware of her lesbianism. She did not accept his recommendations, and she continued to pursue the possibility of artificial insemination. After several more visits he was helpful and working with her.

I urge a woman who chooses to come

out to clarify with her health care worker what information is to be documented and the future use of information in order to ensure security. Notation is especially important in the case of emergency medical care and hospitalization where hospital staff have access to a woman's medical records. Despite a public commitment to confidentiality among the medical and health professions, in my experience many health workers talk among themselves about clients' medical problems and personal lives.

Lesbian identification - verbal or documented - can have serious delayed consequences. I can envision a horrible scenario: a woman's sexual orientation is noted in her medical chart; years later her medical records are subpoenaed by the courts in a child custody case in which she is hiding her lesbianism; she loses custody of her children. I do know of one case where information about a woman's lesbianism was passed from a sympathetic worker to one who was openly hostile and verbally abusive to the woman.

There is sometimes a fine line between when it seems crucial to the treatment of a medical problem to come out and when it might be peripheral. For example, problems of contagious diseases put partners at risk and lesbians may need to request information about transmission. But what about conditions such as cancer that do not depend on a woman's sexual orientation? It may not be worthwhile for a woman to come out in these circumstances.



# Health Concerns

There are lesbians who believe that lesbians are healthier than heterosexual women and that they do not require routine medical care. I believe routine medical care is just as important for lesbian women as for heterosexual women, although it is not clear from the literature what the particular lesbian health needs and concerns are. The few articles written about physical health such as "Lesbian Healthcare" by Francine Hornstein and "Self-Health for Lesbian Women" by the Emma Goldman Clinic for Women in Iowa, tend to focus on vaginal health and artificial insemination. There is speculation in the medical and lay literature about other health issues affecting lesbians. Questions are beginning to be posed about hypertension, menopause, emotional health, substance abuse, motherhood choices, and breast and vaginal health. It is difficult to define areas of concern for a broad range of women who come from diverse social, racial and ethnic backgrounds. There is a danger that lesbians may be even more likely to be stereotyped on the basis of sexual preference.

Within the last year several groups in the United States undertook studies to define lesbian health issues. The National Lesbian/Gay Health Education Foundation in Washington received a grant from Ms. Foundation to carry out a national lesbian health needs survey. The Lyon-Martin clinic in San Francisco began investigations into the incidence and nature of genital tract infections among lesbians. Both these studies will attempt to examine economic, cultural and racial factors. These studies conducted by gay and lesbian lay organizations may provide some very useful information.

Some lesbians have expressed to me a fear that the search for lesbian health issues may be used to stereotype lesbians. For example, a higher incidence of alcoholism among lesbians is reported in the medical literature. Statistics I have seen in *Lesbian Health Matters* and the *Sourcebook on Lesbian/Gay Health Care* estimate one in three lesbians is alcoholic. This information has been cited as evidence of the unhealthy lifestyle of lesbians and used to argue the negative repercussions of lesbianism. The bar culture is often identified as *the* problem. There is no recognition of the discrimination lesbians face and their need for a distinct culture, a culture that inevitably has both negative and positive aspects

like any other culture. Alcoholism is a general problem in our society. It may or may not be any more prevalent among lesbians than within society as a whole. And if alcoholism is more prevalent among lesbians, we don't yet have a handle on why.

## Gynecological and Breast Health Concerns

Because so little is known about lesbian health issues, it is difficult to make suggestions about routine health care. Regular check-ups for breast and vaginal health are important for all women. Breast and vaginal self-help information is available from the Vancouver Women's Health Collective for lesbians who cannot afford medical coverage or who do not have access to supportive health care. I hope lesbian self-help groups and publicity about the value of regular health care will provide useful strategies for encouraging lesbians to seek information. The self-help approach, like the feminist health movement, stresses health wellness and prevention.

Breast self-examination is crucial for all women. It is meant to familiarize women with their own breasts so that they will notice any changes. Lesbians without children may have a higher incidence of breast cancer because medical statistics

indicate a higher risk for breast cancer among childless women. Fear of finding lumps and cultural stigmas against touching ourselves are two common obstacles keeping women from performing this exam. While health workers can perform the exam, a woman is more familiar with her own breasts; most women find lumps themselves. I suggest lesbians do this simple examination with a partner or close friend, or in the context of a self-help group.

A lesbian with breast cancer may suffer the same physical and psychological effects of mastectomy as heterosexual women, but she may additionally face the heterosexist assumptions of both hospitals and mastectomy recovery programs. Like many women, lesbians may face internal struggles about their appearance and wholeness following a mastectomy. However, these concerns are not discussed in a lesbian context.

Our society ignores the effects of mastectomy. From the moment a woman wakes up from her operation effort is made to pretend she is ok. In an attempt to be compassionate and reassuring, nurses often enquire about a woman's boyfriend or husband, in order to open a discussion to help her find ways to feel sure she is still feminine and appealing. Mastectomy recovery programs. fre-



quently staffed by volunteers who have had mastectomies, tend to focus on the ease of regaining one's appearance by use of prostheses and assuming a normal lifestyle; these volunteers likewise often ask questions about boyfriends and husbands.

Regular screening for abnormal cervical cells, done by Pap tests, may be something lesbians relegate to heterosexual women. Many women receive this test when they visit health workers for birth control check-ups. Warnings about the risks for abnormal smears in health literature and practice focus on heterosexual activity. However, two studies, "Failure to Identify Venereal Disease in a Lesbian Population" and "Factors Influencing Lesbian Gynecological Care," suggest that the incidence of abnormal pap smears among lesbians is comparable to that among heterosexual women. Nevertheless, these studies report lesbians only get pap smears on an average of every 20 months rather than yearly.

Unlike breast self-exam, women need trained health workers to administer Pap tests. Self-help groups, lesbian clinics and access to sympathetic workers are ways I see to encourage lesbians to seek this test. Pap tests can be combined with cervical self-exam, either in a self-help group or in a worker's office. The condition of the cervix can be an indication of vaginal health.

According to the literature I have reviewed, lesbians actually get less vaginal infections than heterosexual women, though some problems such as gardnerella, chlamydia (both bacterial infections) and herpes seem to be increasing among lesbians. Medical guidelines for healthy sex rarely address lesbian sexuality. Organisms can be passed between women in a number of ways. Information about sexually transmitted diseases can be sought from women's health centres.

The percentage of hysterectomy among women over 60 years of age seems to be increasing in North America; estimates range from 25 per cent in a Canadian publication, *A Friend Indeed*, to 50 per cent in *Malepractice* by Robert Mendelsohn. A recent news report appearing in the *Vancouver Sun* cites total hysterectomy as the most common operation in the United States. There are numerous gynecological problems which are treated by hysterectomy including PID, fibroid tumours and endometriosis (a condition where the lining of the uterus grows outside the uterus).

I have met many lesbians under 30 years of age who have had hysterecto-

mies for any of these conditions. Lesbians without children, an estimated 70 per cent of lesbians according to a letter to the editor appearing in the December 1984 issue of *Ms.*, may have a higher incidence of endometriosis because of a higher risk reported for women without children. Susanne Morgan in *Coping With A Hysterectomy* speculates hysterectomy may hit particularly hard at lesbians; and women who do not want children may be offered the operation sooner than women who do want children. Lesbians who do not want children may accept the operation because they are not told of the possible side effects of the surgery, that the loss of the uterus and ovaries may affect their general state of health and sexuality. There are numerous studies which document hysterectomy overuse among poor women and women of colour, some of whom may be lesbian.

Lesbian health care and needs are being increasingly discussed and investigated. A growing number of medical studies are being published, and more and more literature about health care written by lesbians is becoming available. Some recent articles reported in *Lesbian Health Matters* address health care workers specifically in order to increase their understanding of lesbian health concerns. Other articles urge gay men and lesbians to come out. Advocacy work is also being done throughout North America to introduce lesbian health

issues and sexuality into health care training programs. And I believe the International Lesbian/Gay Health Conference held in New York last summer provided the first forum for the discussion of lesbian health matters on a North American scale.

The increase in research, discussion and advocacy is intended to heighten the awareness of lesbian health issues both among lesbians and medical professionals and within the general population. Lesbians may then begin to feel more comfortable seeking health care, and the health care they receive may be improved. Lesbians within health care training programs may also begin to find it easier to come out to classmates and instructors.

I believe we will hear more about lesbian health care need and issues over the next few years. Think how reassuring it would be for lesbians if a book or pamphlet concerning lesbian health were available among all the other health literature lying around health care offices.

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*Robin Barnett is a member of the Vancouver Women's Health Collective. Her other writings include A Feminist Approach to Pap Tests and Understanding Vaginal Health. She attended the International Lesbian/Gay Health Conference held in New York in June, 1984.*

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### Resources on Lesbian Health

*Sourcebook on Lesbian/Gay Health Care*  
National Gay Health Education  
Foundation, Inc.,  
P.O.Box 784, New York, NY 10108

*Lesbians in Midlife: Menopause,  
Hysterectomy and Sexuality*  
presentation by Susanne Morgan  
P.O. Box 6534, Ithaca, N.Y. 14851

*Lesbian Health Matters*  
Santa Cruz Women's Health Center  
250 Locust Street, Santa Cruz, CA 95060

*Self-Health for Lesbian Women*  
Paula Klein and Suzanne Vilmain  
Emma Goldman Clinic for Women  
715 Dodge, Iowa City, Iowa 52240

*Self-Insemination*  
Feminist Self-Insemination Group  
Box 3, Sisterwrite, 190, Upper Street,  
London N 1

*Publications for lesbian and gay medical  
students*  
American Medical Student Association  
1910 Association Drive, Reston, Virginia  
22091

"Failure to Identify Venereal Disease in a  
Lesbian Population"  
P.Robertson, M.D. & J. Schachter, M.D.  
*Sexually Transmitted Diseases*,  
April-June 1981

"Factors Influencing Lesbian Gynecologic  
Care: A Preliminary Study"  
S. Johnson, M.D. et. al.  
*American Journal of Obstetrics and  
Gynecology* May 1, 1981

"Lesbian Health Issues"  
K. Degen & H.J. Waitkevicz  
*British Journal of Sexual Medicine*  
May, 1982, pp. 40-54.

*PMS, Menopause, Breast, Health and  
Vaginal & Cervical Health,  
Self-Help Packets,*  
Vancouver Women's Health Collective  
888 Burrard St., Vancouver, B.C.  
V6Z 1X9

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\* This resource list pertains to this article and is not intended as a complete list on lesbian health issues.

# **NOT** THE OLDEST PROFESSION

## **Two Women Talk About their Experiences as Professional Patients**

*During the mid-1970s, when the women's health movement was on the rise and its impact was being felt throughout an increasing range of health services, a number of medical schools began using live models for pelvic examination teaching. So-called professional patients were hired to help teach medical students.*

*In several locations in the United States feminists became involved in teaching in these early programs but eventually pulled out because they were unable to succeed at affecting any fundamental changes.*

*The Women's Community Health Centre, Inc. in Boston developed a seven point contract intended to ensure their role as active teachers and organizers with local hospitals. Even so, they were unable to play the feminist role they had hoped the contract would ensure. When they left the program they encouraged other women to not participate in pelvic teaching programs. (Women & Health, July/August, 1976.) In at least one instance, another women's health centre withdrew from a similar arrangement with a medical school and then set up an independent teaching program run out of their own offices that students could take part in on their own time. In this setting, with a program organized and offered by feminists, "the rapport experienced by the program participants and the [feminist teaching] nurses had been astounding. ... The result was an exploration with students of such topics as sexuality, abortion, contraception and ambivalent feelings regarding their roles." (Sage-Femme, Winter, 1978)*

*In 1979, the University of Toronto Medical School began a program adapted from American medical school models. By using professional patients to teach, it aimed to "make students more competent in their performance of pelvic examinations ... and to improve the quality of 'well woman examination'". But as the following interview shows, there can be a big difference between "professional patients" and respected teachers.*

*Wendy Barrett and Michele Dore, both feminists with backgrounds in women's health and sexuality, began working as professional patients at the University of Toronto Medical School in 1979 and 1980 respectively. Although the program continues today, they describe the program as it was during the two years they participated as professional patients there. This interview, conducted by collective members Lisa McCaskell and Amyra Braha last summer, explores Michele and Wendy's dissatisfaction with the program.*

Let's start by describing what the professional patient program is. Was the program a new idea when you got involved in it?

MICHELE: I believe the program here was modeled on a program in Winnipeg and a couple of places in the States, where women - awake, alive, functioning, smart, intelligent women - who are comfortable with their bodies, especially with their reproductive parts, could have some input into training medical students to do pelvic examinations and breast exams. We thought at the time that this was a really good opportunity to be able to have some influence on the attitudes of future doctors.

WENDY: I and a couple of other women I knew who got involved in the program had been working in alternative health services for a long time. We had worked with a lot of issues that relate to gynecology and women's reproductive health. As feminists who worked in women's health we wanted to have some kind of input and effect on the medical training of doctors. Because they get so much propaganda about women and who we are, it's extremely important that they hear from women during their training about what we need, what we want and how we feel. They need to learn how we want to be treated, how we want to be talked to and how we want to talk back.

Describe the program - how many hours a day did you work, how many students did you see, what was your role?

WENDY: We usually worked all morning, about three hours. We were usually introduced to about six students, and then saw them individually along with the teaching doctor in the doctor's office. We were supposed to be given half an hour per student, but if one of the other women didn't show up we would have to take on the extra students. There were 20 to 25 women working as professional patients. Even so, we sometimes saw ten students. That's ten internals in one morning - it was ridiculous.

MICHELE: You'd have one and you weren't even half way through and someone would knock on the door and say, "Your time's up." And it wasn't just internals we were doing. We were doing rectals and breast exams.

Anyone can learn to do an internal. What's important is the attitude with which you do it, the comfort level you give the woman, how you talk to her, when you tell her to undress and the language that you use. So for me, in doing the program, that was my agenda, to teach those kinds of things. I wanted to

stress the need for everyday as well as scientific language. I wanted to talk about respect given to women and her role as an active participant in any medical exchange, to tell medical students that each woman is an expert about her own body.

I was getting paid to do the internal. So we had our work cut out for us trying to cover all that in the 20 minutes given us to teach the physical techniques of the examinations.

WENDY: I did feel I had some control over what I would let them do. If I felt okay that day I might let them do a rectal, but if I had just gotten my period no way was I going to get a rectal.

Would you describe a bi-manual examination?

MICHELE: It's when you insert two fingers, usually of your right hand, into the vagina. Then with your left hand you feel for the ovaries and uterus. The thing with the bi-manual is that most people, when they first start, don't know what they're feeling. So it takes quite a few times to be able to get a good feel. Some of these students didn't feel successful unless they could feel your ovaries; they would not stop.

How well trained were the women, the patient teachers?

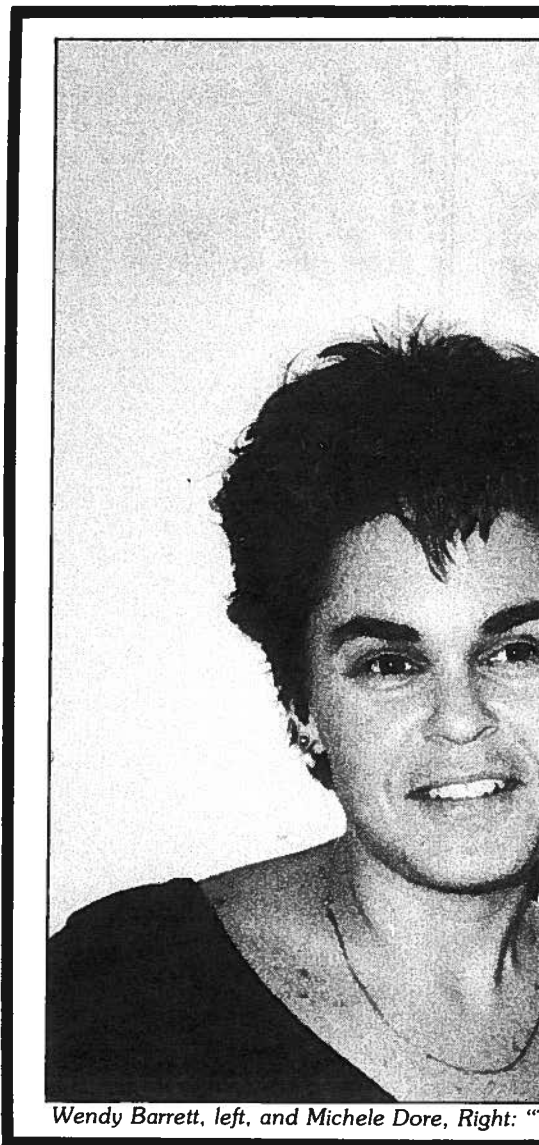
MICHELE: The doctors would demonstrate the examinations when we started and then we would all take a turn on each other - that was the training! We had an advantage because we were working in clinics and understood female anatomy. There were quite a few women who did not have the same amount of skill. You really need to know a lot in order to be able to teach it, but most women do not understand their internal structures, their vagina and cervix and all of that stuff. Many of these women were no different. As far as I know, they'd take anybody into the program.

How much were you paid to be in the program?

MICHELE: We were getting \$30 an hour. We both thought in the beginning it was such good money. And then when we started thinking about it and what we were doing, it should have been much better money.

WENDY: I don't think the medical students were told we were getting paid for our work. Sometimes they would come in and say, "Well, how come you're doing this?" and when I would tell them I was getting paid they were quite surprised.

How well prepared were the students? Did you do all the teaching or were they taught in some way before seeing you?



Wendy Barrett, left, and Michele Dore, Right: "I

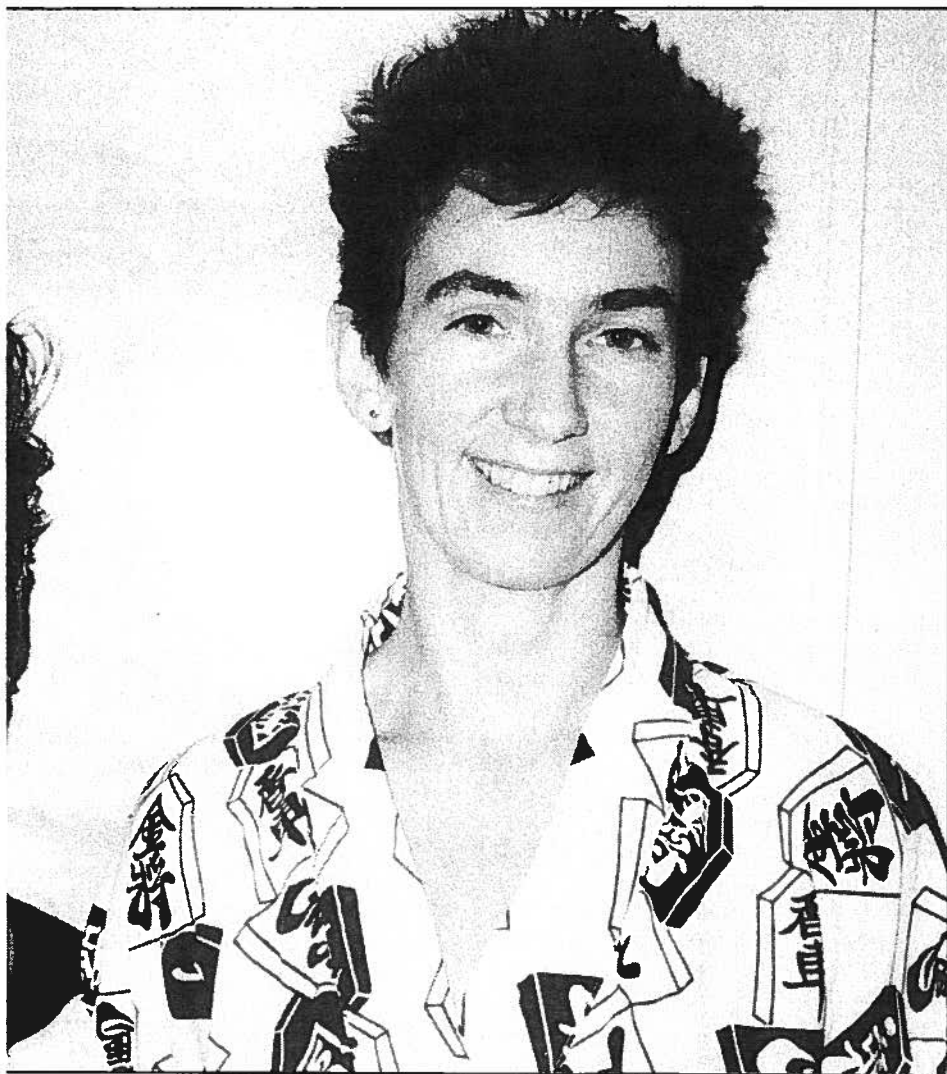
WENDY: They had studied gynecology and about women's reproductive organs the night before in a book. Or they might have practised with the Gynny doll. Gynny is a stuffed manikin who has reproductive parts. Gynny is only half a body, from the waist. It's like beanbag with ovaries, a uterus and a rectum.

MICHELE: It typifies the inhuman, fragmented presentation of women that happens in pornography.

WENDY: Sometimes they were shown a film, which was really clinical and old. It didn't seem especially consistent from hospital to hospital. Traditionally, medical students often learned to do internals on women who were anesthetized or who couldn't speak English. Some medical schools still do that. And, of course, some students and teaching doctors find it easier.

How do you think the students felt about you?

WENDY: I think most of the men had



program valued our bodies, but never our skills or knowledge."

very mixed feelings about who we were, what we were doing and why we were doing it. Some of them were extremely nervous, and some of them were very cocksure. Some guys couldn't speak to us because they felt so nervous and so ashamed. There were guys who couldn't thank us enough. They were so grateful. They realized that nothing else could reproduce what we were doing. Others thought we were sluts. I can just imagine the discussion they were having at lunch hour - whose crotch looked like what and what this woman acted like and what she felt like and all the cracks and insinuations. I'm sure they discussed it.

I'm sure a lot of them had never had sex before. We would ask them if they knew where the clitoris is and they wouldn't have a clue, but were afraid of looking like jerks. Or maybe they'd had sex, but they'd never seen a woman's crotch. Many of the male students would

have seen women's genitals only in the context of sex: either in pornography or with women they'd had sex with, if they'd looked. Most of the medical students had gone right through high school into medical school; they'd done nothing else except go to school.

I felt much more comfortable with the men who were embarrassed. At least they showed their feelings. But it seemed that a lot of times, we would get our periods on days that we were having internals. It would be the second day of your period so you had to deal with that too.

MICHELE: You see this is interesting, you know the way they set things up in the rules. They didn't want you to come to the program, at least they assumed you didn't want to come, and you assumed they didn't want you to come if you had your period. Whereas Wendy and I always went whether we had our periods or not because that's reality, that's life.

WENDY: They're going to be examining women with their periods all the time.

There were a few men I remember who were married. They'd been married for two or three years and some of them had a child. They were better. They were much more respectful; they were more mature. Sometimes they had practised on their wives.

MICHELE: And also, they were more up front about feeling embarrassed.

WENDY: They took their time and were more sensitive, generally speaking. But 95% of the medical students had gone right through school.

Some of the women were better. Most of them knew what an internal examination was and I found them to be more sensitive than the men.

MICHELE: They really felt for you in terms of being naked in front of all those people.

A lot of students were not really interested in gynecology at all. They were going to go into internal medicine or another specialty and didn't see the point of putting their hand up someone's crotch. They were going into something totally unrelated and this was just something they had to do.

*What was the response you got from the teaching doctors and the hospital staff?*

WENDY: Some of them were okay, but some of them didn't like the idea of the program. The doctors were not very supportive toward us and didn't ask us for any input or how we wanted to handle things.

The teaching doctors called the medical students "Doctor so and so" and they called us by our first names which always really bugged me. They wouldn't even introduce us by our last names. Obviously we were supposed to be ashamed of what we were doing. The message was you wouldn't want someone to know your last name, someone might start calling you with obscene phone calls or that kind of thing. It's because of this whole thing confusing sex and morals.

MICHELE: Some of the doctors seemed to resent the fact that we had no formal medical training and were doing this kind of teaching. Yet we were skilled. We were experts and we were teachers.

WENDY: Usually when we got to the hospital the first person we would see would be a nurse. We'd tell her who we were and what we were there for; she'd tell us where to sit and where to wait for the students. It wasn't a very warm response.

And that's really the only contact we had with the nurses unless we had our

period that day and were bleeding, or we ran out of gloves or needed more speculums. Basically, I got the feeling they just wanted to leave us alone.

I'm sure no one ever sat down with the nurses and said, "Okay, these are the women who are coming today and this is what they are doing. This is why they're doing it, and this is why we in the hospital teaching program feel it's very important." *How did your friends respond to your being involved in the program?*

WENDY: Some of my friends didn't say anything at all, so who knows what they were thinking. Most people would say, "I don't know how you can go through that." I think my friends who were working in the same field as me understood a bit more.

I think some friends actually felt like I was prostituting myself. When I first started the program, I didn't feel like that at all, but by the end, that was how I felt...like I was working on the street.

MICHELE: At the beginning I felt like I had a lot of power, a lot of control. For me, it is a powerful thing to be able to take my clothes off in front of half a dozen medical students and teach. I would like to have continued to feel that way, but by the end I felt fucked over: I felt used.

The biggest feeling for us should have been a feeling that we had respect. We have a skill that not a lot of people, and not a lot of women have. We didn't end up feeling like that.

We started realizing how this program was tied up with sexuality. We both started feeling like we were in the same position as prostitutes, and then we started saying, "Yeah, we are. We are." We're doing exactly the same thing. We're being paid. It's just a little more legitimate because it's down on paper somewhere; we're getting a cheque from the University of Toronto.

We were selling our bodies for a service. And we were skilled at what we were doing. And part of this confusion had to do with sex. I mean, we were doing sex education at the same time as we were doing all this other stuff. You know, it's not just technical stuff; it's emotional stuff and it's stuff around sexuality. The program valued our bodies, but never our skills or knowledge.

*Did the program change while you were involved so that you played a more active teaching role? Were you able to increase the respect given you?*

MICHELE: During the program there was never a meeting where all the teaching doctors would come together and meet the women who were going to

be doing the teaching. There was no joint brainstorming and planning. We had no input into that and some of us - not all the women - requested and wanted to have input into planning. Our last year, when both of us were getting really fed up, we were saying quite clearly that we wanted changes made.

In this kind of program, the women need to ventilate and you need support, and we wanted to build that into the program. But again, that would have meant giving more credibility, more support and more power to the women doing the program. We were the ones taking our clothes off; no one else was doing it.

One of the things we wanted was to meet the medical students with our clothes on, face to face, and sit and talk with them before we undressed. We wanted to meet them with the teachers out of the room. These guys were always standing over the students like hawks and watching every move they made and listening to every word that came out of their mouths.

We proposed sessions with all the medical students where two of us at a time would have an hour and a half, or two hours, to talk about how nervous they were, to acknowledge that nervousness is a perfectly normal way to feel. We wanted to talk about attitudinal stuff, values, the things women want. We wanted to explain to them why we were doing the program, to give the program more legitimacy.

They tried to create some kind of mechanism for complaints, but they never brought us into planning. I stayed with the program for so long because I thought I was actually getting somewhere.

*How do you think the other women felt about the program? Was your desire for fundamental changes in the program unusual or did the other women want the same things?*

MICHELE: It was sometimes hard to know. The other thing we wanted, Wendy and I, was to have the women who were doing this stuff work in teams, because it could have been so much more effective. We could have done a much better job and had a lot more support. We started saying a lot of things about our own personal feelings and how it felt to go through that experience. We wanted all the women to have a voice and say, "This was my experience. These are the doctors I like; these are the ones I don't, and this is why. He did this to me; he did that to me. I would like to do this in future."

WENDY: Many of the women didn't open up their mouths as much as Michele and I. They were a bit hesitant to make recommendations and criticisms. The power of doctors is too great. But once suggestions were made, nearly all those women felt changes would be a really good idea.

*In spite of your frustrations with it, you stayed three or four years - that's a long time. Why did you finally leave the program?*

MICHELE: I joined the program because I wanted to have some kind of impact and control, some input into the teaching of medical students so they would have better attitudes and views toward women and gynecology. What we were really saying in the end is we want more power and control in this program. We wanted to have input. We're women. We know what would work best. We know what has to be changed. We want to tell you how to improve this program.

The teaching doctors who ran the program wouldn't accept this.

WENDY: Even if changes had been made, it was such a drop in the bucket. One day or one morning with us, or twenty minutes with us, was not going to have a big impact on doctors' attitudes towards women and doing internals. Without other changes in medical training, it just isn't enough.

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*Wendy Barrett lives in Toronto. She works at Huntley Youth Services with women and children who have been sexually abused.*

*Michele Dore is a single parent living in Toronto. She is currently working with issues of violence against women and children, and with the Lesbian Speakers Bureau.*

*Amyra Braha is a Women Healthsharing collective member who is presently studying book publishing at Centennial College in Scarborough. Lisa McCaskell, also a collective member, is in the journalism program at Ryerson Polytechnical Institute in Toronto.*

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*We would like to encourage readers to share any experiences you have had with similar programs. Let us know if you've had negative experiences similar to Wendy and Michele, if there are teaching programs you feel are positively structured, or if, as a medical student, you valued or tried to improve such a program. What's happening in medical schools - and nursing schools - today?*

# THE BIRTH CONTROL GAP

by  
**Dianne  
Kinnon**

drawings  
by  
**Ruth  
Jones**

"The Birth Control Gap" will appear as a chapter in **The Healthsharing Book: Resources for Canadian Women** (Kathleen McDonnell and Marianna Valverde, eds., The Women's Press, Toronto, forthcoming). The book, to be released in May, 1985, was prepared under the auspices of Women Healthsharing with funding from Health Promotion Directorate, Health and Welfare Canada. The book's large format incorporates thematic chapters about health issues and annotated listings of Canadian books, pamphlets, audio-visual resources and organizations pertinent to women's health.

Permission for advance printing of this chapter was granted by The Women's Press. For ordering information about **The Healthsharing Book**, and other Women's Press titles, contact the Press at 16 Baldwin St., Toronto M5L 1L2. Tentative price is \$9.95. Orders will be handled by the University of Toronto Press.

Contemporary women are now entering the second generation of modern, technological contraception. Since the Pill and the IUD ushered in a new era of contraceptive options, we have been introduced to contraceptive foam, suppositories and sponges, sympto-thermal birth control and now, awaiting us on the horizon, are hormonal rings, injections and implants. Only the condom, diaphragm, cervical cap and the rhythm method remain in popular use from before this technological revolution in birth control. And while these tried-and-true methods are far from having gone the way of the dinosaur, they are no longer treated as serious options by large numbers of women. Younger women, particularly, share an almost universal distaste at the very thought of using barrier methods. They are also put off by the idea of the IUD, and, while they may exhibit an interest in the science of sympto-thermal fertility awareness, they can't imagine using it for birth control themselves.

As most birth control counsellors will testify, the Pill has first billing among teenaged women long before they walk in the front door of the clinic. The vast majority begin their thirty year odyssey of controlling their reproduction by using it.

On what basis are women making contraceptive decisions, and why? Is it just a matter of choosing "the best method for you, one that fits your lifestyle," a favourite phrase of clinicians and birth control counsellors? Have we won the contraceptive battle, because we now

have the choices our grandmothers couldn't imagine? Or are these "choices" something of an illusion? How far have we really come in our struggle to control our fertility?

The medical reality is that contraceptive methods as a whole are shamefully inadequate. Many pose real health hazards to women who use them, and none is totally effective. Contraceptive "choice" is really a matter of selecting the least attractive option, and usually means changing methods several times throughout the reproductive years. Moreover, women have not really won control of our choices in birth control. Contraceptive research is still in the hands of male doctors, by and large, and reflects their biases and assumptions of what kind of contraception is best.

Perhaps an even more important aspect of reproductive choice is *how* we use the existing technology. Our ideas about our bodies, and the choices we make in our relationships have profound effects on the birth control we use. The result for women is often that we cheat ourselves in order to please our partners or fulfill some unrealistic sexual expectation of our men.

Use of barrier methods such as condoms, the diaphragm and foam is a good example. Any contraceptive that must be used just before or at the time of sexual intercourse is considered undesirable by many couples. Barrier methods, most say, interfere with the sex act and make sexual encounters less spontaneous and therefore less pleasurable. This attitude is

rooted partly in the expectations of the sex act. Sex has been given an exalted position in our relationships, and we are willing to go to great lengths to achieve what we see as better, even perfect, sex.

Some women in new relationships don't like to bother their partners with birth control and some men do not consider it their responsibility to inquire or offer assistance. Virtually everyone who uses barrier methods has taken chances with them - not using condoms "just this once" to preserve an intimate moment, going ahead with sex even if the diaphragm has been left at home. Even in the most liberated of relationships, many women still put a high priority on the romance of a relationship, and often this means taking responsibility for using a non-intrusive birth control method.

Natural family planning, or symptothermal birth control, which can be a highly effective and medically safe method, is used by few couples because of the high degree of commitment and co-operation necessary. Some men flatly refuse to even consider it because it involves a week of planned abstinence from intercourse (not necessarily from other forms of love-making) each month. In fact, though many of us are not conscious of it, the sex act still largely revolves around male pleasure. For example, though barriers are not used because they supposedly detract from lovemaking, barrier methods do not affect female sexual response, and some actually enhance it. The extra lubrication of contraceptive foam is very helpful for a dry or semi-aroused vagina. Condoms may enhance a woman's pleasure by slowing down her partner's orgasm until she is fully aroused and also capable of orgasm. Use of a

diaphragm or cervical cap has no effect on physical sexual response of men or women - neither can feel it - and their intrusion into the pre-coital encounter probably affects women less than men, since women seem more able to sustain a level of arousal. So often our rejection of barrier methods is a protection of our traditional expectations of male pleasure.

Is spontaneity in sex more important to men or women? Certainly *planning* is of more crucial benefit to women, if unwanted pregnancy is to be avoided. Whether through preference or necessity, women have been the holders of the key and, more often than we know or want to admit, the planners of supposedly spontaneous sex! We should ask ourselves to what lengths we will go to maintain this illusion of spontaneity. On a very crude level, some men believe their women should always be sexually available, and there are some women who want to stay readily available, in order to hold on to their boyfriends. But is natural sex so important a value to men and women that it should be the deciding factor in birth control?

Women's difficulty in consciously planning pleasurable sex is tied to another deciding factor in contraceptive choice. The double-bind thinking that punishes strong, self-positive sexual women and rewards shamed, passive women is still with us. A dominant message in pornography, advertising and party jokes still equates women's sexuality with promiscuity and evil, while male sexuality is filled with images of power and dominance. The old ideas of the dirtiness of sex and our bodies "down there" die slowly. An amazing number of women, young and old, have difficulty thinking

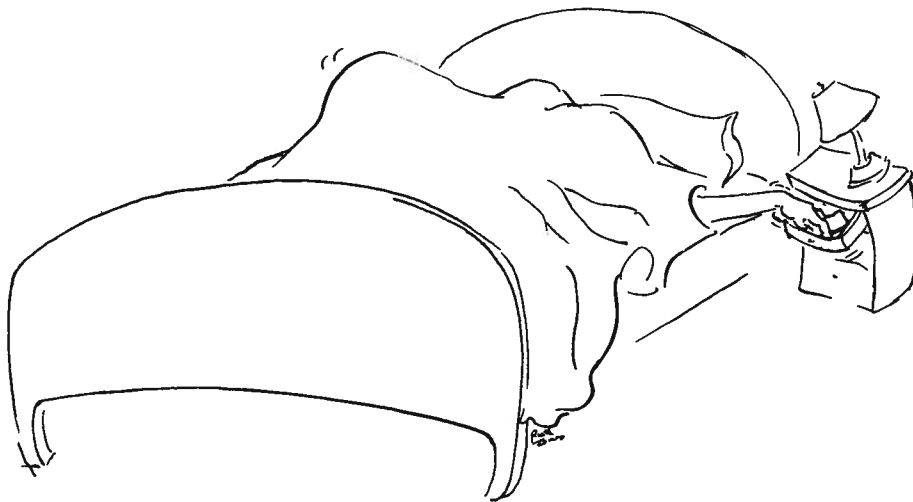
about, looking at or touching their own genitals. For example, though many women have an academic interest in fertility awareness, the thought of actually examining their own vaginal mucus is abhorrent. Many women cannot use the diaphragm, cervical cap or sponges for the same reason. Some women are also turned off by the idea of an IUD in their uterus; others can accept it because a doctor is inserting it.

The reality for many women is that their sexual encounters are still filled with such embarrassment and ill-ease that a frank discussion of sexual pleasure, much less contraception, is still not possible. For teenaged women, the problem is even more acute. Most cannot countenance the idea of going to a family doctor to be fitted for a diaphragm to be carried around in their purse, because this assertive action belies everything they have learned about what makes a woman sexually desirable.

Male attitudes toward contraception are also an important factor. The idea that virility is tied to fertility is an important factor in many men's rejection of vasectomy as contraception. Condoms, too, have an age-old reputation for being less masculine.

The issue of safety of various birth control methods has affected patterns of contraceptive use. There has been a significant rise in the use of barrier methods over the last five years, as more and more women become concerned about the safety of the Pill and the IUD. Many of these women have in fact almost used up their "Pill years" (10-15 years of use before the age of 35) before switching to other methods. The Pill is still the overwhelming choice among young (15-25) contraceptive users. Much of the conflicting opinion about certain health risks of the Pill is no longer in doubt. We don't just suspect that the Pill carries a higher risk of heart attack, stroke, breast cancer and cervical cancer; the research is conclusive enough to be widely accepted even in the medical community, which historically has been strongly pro-Pill. Yet millions of women undertake these risks in order to prevent conception.

Recorded side-effects of the oral contraceptive number in the hundreds. Almost every woman experiences some common unintended effects: intermittent bleeding, headaches, depression, weight gain and increased vaginal infections. They are the price women pay for the effectiveness and ease of using the Pill. Young women are subjecting themselves to these so-called nuisance effects in the



Is spontaneity in sex  
more important to men or women?





## Are these "choices" something of an illusion?

short run and are gambling on serious consequences in the long run. The payoff is another invisible means of contraception and a few extra percentage points of protection over most other methods.

IUDs appear to offer the perfect promise of invisible contraception. Once inserted, a woman's only responsibility, theoretically, is to periodically check the string to see that it is in place. In reality, many women endure very long, painful periods, recurrent infections and the threat of pelvic inflammatory disease. No wonder Germaine Greer and other women have begun to ask "Is sex worth it?"

Despite all this the mystique of no-muss, no-fuss contraception dies hard, and women still gravitate to the Pill and the IUD despite the risks. An important reason is that many of them are not realistically informed about risks or of all options. You can't make a real choice when one option is heavily weighted by your doctor, the expert, and the other choices are discounted. Some doctors pooh-pooh other methods, or know nothing about them, such as symptothermal or cervical caps. Medical advertising is also heavily pro-Pill. Oral contraceptives are marketed as the modern woman's answer to contraception. Advertising of the Pill and the IUD encourages removal of contraception from the sexual act and from "down there," and plays on our ambivalence toward our own sexuality.

Why do women choose methods that privatize and separate contraception from sex, giving them more individual control in preventing unwanted pregnancy but also leaving them with the total burden? Because, in today's world, this is preferable to having to convince their lovers to get involved. Most of us do not

yet have the kind of relationships with men that allow us to make contraceptive decisions on grounds of mutual choice and preference. As long as we are economically and emotionally dependent on men, we will continue to compromise our contraceptive decisions instead of striving for mutual respect, equal relationships and pride in our sexual selves.

A better contraceptive world is not hard to imagine. But it will not depend entirely or even mainly on the development of new technologies. More crucial is a change in sexual attitudes on the part of both men and women, as well as a change in women's role in society. Both are essential to real reproductive freedom for all women. When women reject squeamishness about "down there" and teach their daughters pride in their bodies, ideas about sexuality will begin to change radically.

Imagine, for instance, a world where sexual activity is not focussed on vaginal penetration. Sex in this new society wouldn't mean intercourse as it does now, but a wide spectrum of sexual activities leading to mutual orgasms. This change would be an improvement in women's sex lives. The majority of female orgasms come not from vaginal penetration but from other kinds of stimulation, so variety in sexual expression would make sex better for many women. Freedom from intercourse would open up whole new vistas of sexual pleasuring, or as one visionary man put it, learning to "make love with my whole body." Natural family planning would not be the burden that some find it now since a week of protected intercourse or no intercourse at all would not be unusual. Condoms and foam would be less of a

hassle, since they would only need to be used occasionally.

Outercourse, or non-penetration sex, is on its way in. It will not happen until we teach young people and adults that self-masturbation, mutual masturbation, oral sex, etc. are good expressions of sexuality. For men, it would mean a major, but positive change in orientation. Perhaps a freedom from the need for penetration by men is necessary for the acceptance of the condom, for instance. Once men can let go of the idea that their sexual identity is centred on the tips of their penises, encasing them may be possible. When heterosexual men start to accept condoms as being in their own best interest, we truly have some hope for use of the only present male contraceptive; more importantly, we will have brought about a change in attitude.

We must continue to press for more research, higher safety standards and more effective birth control. The priority must be less intrusive, less medically controlled contraception so that reproductive care is more self-directed and holistic. Access to all methods by all women who want them is a necessity, and abortion must continue to be available as a backup. The more difficult part of our struggle will be to exorcize the internal oppression that prevents us from making positive sexual decisions. Only then will women develop the power to challenge social expectations and the medical status quo.

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*Dianne Kinnon has been involved in women's health activities in a variety of capacities. Currently she offers workshops on both pornography and human sexuality. She recently resigned as the director of Planned Parenthood of Ottawa.*

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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.*

## Surviving DES

by Margaret Lee Braun

The network was formed because of a feeling by those of us who have had DES-related cancer that our unique concerns were not being addressed - by the medical establishment, the media, or even lay organizations like DES Action. However, as a group, we were not without blame for this lack of attention. We were not talking about ourselves or sharing our perspective about DES cancer.

Consider the case of DES Action. A main impetus for its formation was fear that the rare form of vaginal cancer that began to show up in the DES-exposed in the early '70s would become epidemic. It did not. It has become apparent that other terrible injuries, usually affecting childbearing ability, are more likely to result from DES-exposure. But the cancer remains the most dreaded possibility.

Yet many people involved with DES Action, through no fault of their own, have never met someone who has had this cancer. Few can know, beyond their darkest suspicions, how the cancer actually affects a woman's life.

There is little general information published about it. In the case of vaginal cancer it is a disease that reaffirms the natural privacy we feel about our genitals. It is not an easy experience to talk about. And it is an extremely rare cancer. Prior to 1971 only three cases of this type of cancer were recorded in all of western medical literature. Today we may read an article citing the incidence and treatment of this cancer, facts whose underlying meaning is left to the imagination. Is it realized that for the "case-history" her cancer is not the end of a story - but just the beginning?

For this type of cancer victim there are few knowledgeable people to turn to for support. The medical professionals who are treating her may maintain a clinical distance. The medical staff, often near her age, may be in awe of her problems or inexperienced in dealing with her con-

cerns. In the midst of physical and emotional trauma the patient may find it easiest to hide her own confused feelings from her family and friends to protect them from the truth of how she feels.

Turning to the media to learn about her own feelings through others' experiences, she finds no true life stories quite like her own. She is not at all sure how she should feel about this sudden upheaval in her life. She knows she feels alone and different. But society has no guidelines for coping with this unprecedented circumstance.

What are the issues a DES "cancer daughter" faces? What has happened to her after the immediate trauma of cancer? Where is she and what has she been doing over the years?

By all appearances she has dropped out of sight and is living happily ever after. By my own, and many other's experience I know differently. In some cases she has dropped out of sight but it is because she has been healing herself - actively, and, out of necessity, with the concentration, and sometimes privacy, that the healing process requires. And until recently she has been healing herself alone.

In 1971 I had this cancer. I was nineteen years old and had never heard the word DES. When I did hear it it was all mixed up with the words carcinoma, tumour, vagina, bladder, lymphnodes, hysterectomy, sterility, anesthesia, surgery...words I had never paid much attention to before.

Twelve years later I still tremble at the memory of that innocent girl. Twelve years later I am sometimes so sick of the phrase DES and DES Daughter that I wish I'd never heard them. But the words have become a part of my everyday vocabulary because I have learned to accept my history - it is always with me. In fact, twelve years later, I am still healing.

After the treatment for the cancer I was left to deal with the physical recovery on my own - the excruciating pain of the removal of the vagina, the burning rawness from the skin graft taken to form a new vagina, the pain from surgery cutting through my abdomen and pubis, the radical hysterectomy that cut out my uterus, fallopian tubes, an ovary, and too many lymph nodes; the catheter that remained in my bladder for months, the torment of having to wear a plastic mold

(or vaginal prosthesis) around which the new vagina, hopefully, would shape itself.

As the physical healing progressed, far more dangerous injuries revealed themselves. I was horrified by what had happened to me. I was embarrassed by its intensity and intimacy. The most private parts of my body had been brutally attacked and wounded, and I dreaded telling anyone. I wished I'd had some kind of visible cancer, of the elbow or nose. Something I could point to and comment on. Instead of a cancer of the vagina - the very image of which brought up the most primitive terror, in myself, and others.

In short I felt like a freak.

At no other time in history had women survived such assault to live with the results of this disease. I had cancer because of medical ignorance. I lived because of medical technology. But I was a reluctant and inexperienced survivor.

"They cut out my vagina," I would whisper to myself over and over again. Shocked, yet needing to get closer to it; to constantly, privately acknowledge it.

How would that shortened, new, raw vagina ever work? Should I just let it close up and forget about men? Why did it always hurt so much? And why, every time I had intercourse did my own private hell of memories and fears leave me curled up in a ball, crying hysterically with a hurt that wouldn't go away?

I felt damaged. I felt unacceptable. I felt I was not a woman. Women have babies. Women have vaginas. Women have hormones that work. I felt confused and very alone.

I wrote to my doctor suggesting he put his DES Cancer patients in touch with each other. Quite awhile later he gave my name to one of his patients who was recuperating from surgery. She wrote me. I wrote back. She was young and positive and full of interests. We exchanged a couple of letters, then she stopped writing. Later I was notified that she had died. We never got far enough in our correspondence to talk about our feelings about DES, about cancer, or our own bodies.

Over time my questions and fears were faced. It has always been hard work, and also a matter of psychological survival. Through changing life experiences and a strong wish to heal myself, a new sense of

myself slowly established itself and grew more confident.

Eight years after my surgery I met, through DES Action, a fellow survivor. Then another, and another. Wonder of wonders, I was *not* alone. The value of being able to express the array of emotions and worries about our common experience was immeasurable. I felt a whole new stage of healing begin.

Since the network began last year approximately thirty women have contacted us. This is the largest record of those who've had this cancer outside of the medical establishment. This means that already we have a working hotline to alert each other about potential health problems, health care, legislative action and information sources. And many women in the network have been able to meet or correspond with others with similar concerns.

The women I have met through the network have been an inspiration to me. We come from many different backgrounds and have many different stories to tell, many of them more tragic than

mine. We have all coped with a tremendous range of emotions about our circumstances - from shock, grief, anger, and self-pity to the acceptance that has helped us to go on with our lives in as healthy a way as possible.

What I think we'll see in the next few years is a willingness among us to elucidate or bear witness to our DES history. The inner strengths once needed to heal ourselves personally will now be used to reveal ourselves as the survivors we are.

And if a survivor gains any hard-won wisdom from her experience my wish is this: That our suffering from DES will keep us alert enough to go beyond the appearances of our everyday lives to examine the consequences of our actions.

What pills do we take now despite our experience with DES? What do we eat, drink, smoke, breathe or expose ourselves to now despite our experience with DES? What do we contribute to or participate in that our society continues to pretend we can get away with no adverse consequences?

Our own bodies keep us from ever forgetting the lessons of DES. Yet I think we all recognize that working with DES goes beyond personal healing. It is a responsibility each of us has to each other and to society to remind ourselves of what we must not forget.

*Any women exposed to DES may contact DES Action: C.P. 233, Snowden Post Office, Montreal, Que. H3X 3T4. For women who have had cancer of the vagina or cervix due to DES exposure in utero, the DES Cancer Network can be contacted at: P.O. Box 10185, Rochester, N.Y. 14610.*

*Margaret Lee Braun is the national coordinator of DES Cancer Network. She lives in Rochester, New York.*

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## Our Bodies, Ourselves Reborn

Reviewed by Connie Clement

**The New Our Bodies, Ourselves: A Book By and For Women, The Boston Women's Health Collective, Simon and Schuster, Inc., New York, 1984, \$18.95 paper, \$29.95 cloth, 647 pages.**

Go to any discussion about women's health or women's bodies and you will find women who started their explorations by reading *Our Bodies, Ourselves*. First published as a small, newsprint book in 1970, *Our Bodies, Ourselves* has remained the uncontested textbook of women's health activism. One commercial edition and then another were joined on our bookshelves by countless other women's health books. Like a slightly tired, bedraggled friend it became dog-eared from use and just a bit more out of date each year. Yet, year after year it was *Our Bodies, Ourselves* that I reached onto the shelf for looking for a particular reference, some bit of forgotten information, a simple wording to explain some disease or a remembered salient quote.

Through the years I have worked in women's health various people have been my teachers, my guides, my mothers...and none more so than members of the Boston Women's Health Book Collective. Both for me individually and for Women Healthsharing as a collective, the Boston collective has always

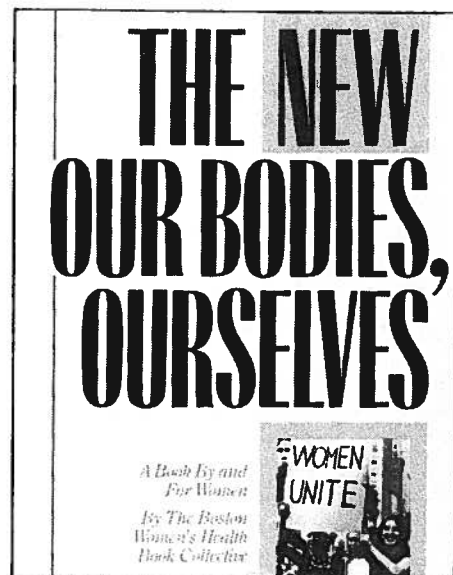
responded with whatever it was we sought. And so, we have waited with anticipation for the new edition since its first rumours several years ago, and through draft chapters to the finished bound book in hand.

*The New Our Bodies, Ourselves* is at once the same well-loved book reborn and a new book. The most noticeable change - the one everyone has commented upon - is its huge size. The 650 over-sized pages reflect not just increasing knowledge and age of the authors, but their place in a larger, stronger and more aware women's health movement. Just as the movement has broadened far beyond gynecological and reproductive concerns, beyond disease and medicine, *The New Our Bodies, Ourselves* includes more personal healing, more alternative health care and a wider range of issues.

The new sections are numerous. Proudly displayed on the back cover, the new material includes chapters on body image; alcohol; mood-altering drugs and smoking; health and healing; psychotherapy; environmental and occupational health; violence against women; new reproductive technologies; women growing older; and developing an international awareness.

The book retains a mixture of women's personal voices and experiences and medical/health information which will allow women to increase control over health and health care. The book still exudes the belief that we can be our own best experts about our bodies.

The lives of more women are incorporated within the pages of the new edition. The chapter entitled *Women Grow-*



*ing Older* replaces the old menopause chapter found in the 1976 edition - eureka, women live beyond menopause! The new chapter, imbued with the words of older women take the reader right up to a brief exploration of controlling one's own death. Voices and concerns of lesbians, women with physical disabilities and women of colour are integrated throughout the text. A separate chapter continues to present specific issues for lesbians, but the chapter no longer stands alone; it is grouped with a similar chapter of women loving men and a general chapter about sexuality.

The concerns touched upon make the book of greater value for more readers. Key issues of recent concern are there: infertility, DES, occupational hazards, new reproductive technologies. The



resource sections at the end of each chapter are expanded; they refer to a wealth of more specific readings.

All that said, the book is just too big. It overwhelms. It is too long and too large to be an intimate friend, to allow the kind of sit-down-and-absorb reading which gave such value to the earlier editions. It has become, more than before, a reference work - a book you turn to for specific information rather than for generalized insight and perspective.

The loss of the book as an intimate is also a direct result of our changing movement. As a California health activist commented recently after an evening of non-stop health talk, the women's movement now encompasses so many issues and so many women that the intimacy of the early 1970s movement is behind us. Ironically the network frays as the impact of feminism is felt across society.

Although *The New Our Bodies, Ourselves* contains a chapter entitled *Developing an International Awareness*, Canada is essentially missing from the book. Except for a resource mention of *Healthsharing*, you'll be disappointed to find that the U.S. network extends to the Third World without reaching north of the border.

The women's movement has always offered special moments, insights and close friends; *The New Our Bodies, Ourselves* offered me several gifts - a poem for a close friend, a quote for an upcoming workshop, some pages for general distribution, and an insight into a new friendship. It will offer you something of equal value.

Buy the book. Give it to your daughter, a colleague, a neighbour - it will be as well received and as well-loved as it has always been. *And give it to yourself.* Make your own links with the book; read the sections with greatest meaning for you. Enjoy.

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Connie Clement is a member of Women Healthsharing. She works as a family planning administrator for the City of Toronto.

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## Demystifying Cancer by Linda Rosenbaum

**Afraid to Ask: A Book About Cancer**, Judylyne Fine, Kids Can Press, 1984, \$19.95 hardcover, \$12.95 paper.

*Afraid to Ask: A Book About Cancer* is a book badly needed. Every year 9,400 Canadian women get breast cancer; 3,700 will die. Thousands more will be diagnosed with cancer of the cervix or endometrium. Now that smoking is on the rise among women, we can expect thousands more to develop lung cancer as well. Though this book was specifically written for teenagers to help them understand what may be happening to them, their family or friends, it offers all of us the answers to questions about cancer we're not only afraid to ask, but doctors are often unwilling to answer.

There are no answers yet to some of our questions. But in an attempt to avoid the pain or anger existing answers may elicit, doctors sometimes choose to take the easy way out. They want protection from a personal encounter they may not have time to face and are often not trained or willing to face. Luckily, *Afraid to Ask* can step in where our doctors leave off.

The first chapter of *Afraid to Ask* explains what cancer is. Judylyne Fine makes complex cellular biology and biochemistry not only comprehensible, but interesting. Yet it is when Fine writes about who gets cancer and why, and what the prognosis may be, that she really starts to penetrate the technical fog that the medical profession has generated. For those in need of specific information or immediate answers about their own cancer or that of their friends or family, the book is a reliable source. There are explanatory chapters on all types of cancers, sensitive interviews with patients, families and health professionals, and in-depth discussions on prevention and treatment.

Fine chooses not to take the easy way out. She includes a chapter on dying to help those of us who must face the loss of someone we love or to come to grips with our own death. Fine admits it was the most difficult chapter to write. She still wonders whether she achieved the fine but difficult balance between facing reality

and offering hope. She still cries when she reads the chapter today.

Fine lets readers know that their fear, anger, pain, sadness or hurt are appropriate responses to having cancer, and are shared by others. The chapter on breast cancer honestly discusses the real fear of many women that they will no longer be sexually attractive after surgery. Instead of dodging the issue of poo-pooing the notion, Fine acknowledges the sometimes awful truth: "Some relationships do break up because of breast cancer, although others do not." She then gives recommendations on where to go or who to talk to for further information or counselling.

# Afraid to Ask

A Book About Cancer



Judylyne Fine

*Afraid to Ask: A Book About Cancer*, is not a discussion on the politics or big business of cancer, though it does emphasize that more money should be going toward preventive education rather than finding a cure. It is not a book for people who want theory or analysis. But if we are to have control or power over our lives, whether in sickness or in health, Fine knows we must first start with knowledge.

*Afraid to Ask* gives us the facts. What we then do about them is up to us.

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Linda Rosenbaum is a health promoter with the Toronto Department of Public Health and is a freelance writer.

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# LETTERS

How can we encourage you, our readers, to write to us, and to other readers, more often?

In person women ask members of the collective about some article or another, readers comment on a concern or a disagreement with some thought or statistic shared in the magazine, but rarely do women write us with these kinds of concerns.

Oh, we get mail - don't get us wrong. We get lots of it. Women telling us how much the magazine means to them, women who've just discovered the magazine, women starting a new health collective or organizing a conference who want some help, women seeking a specific reference ... and all these letters mean a lot to us, but they aren't addressed to other readers.

In working on Healthsharing we have hoped that at least some articles would initiate discussion and debate, and that some of the debate would be situated between the covers of this magazine. Thus far, this has happened very little. We've had no more debate in writing about the special issue on midwifery and abortion - which we know was contentious - than about basic information articles.

We urge you to consider writing letters. When the content of the magazine pleases you, prods you, angers you, do something about it: write us. Write each other c/o Healthsharing.

## Population and Politics

I have just finished reading Anne Marie Smart's article *Population and Politics* (Winter, 1984). I commend her on a well-written, informative report, and commiserate with her on the frustration she felt, and I imagine still feels, concerning this conference.

I am continually astounded at how organizations, groups and conferences which are created out of a desire for change and growth, so frequently founder and retreat back to the safety of the status quo. I am also frustrated by the lack of strong, clear-sighted chairpersonship; to wit, why did none of the leaders of the conference call an end to the politicking that occurred and refocus attention on the concern of the conference: population?

I also enjoyed Ruth Jones' drawings, especially the one depicting how few women attended the conference. I noticed that only the women in the drawing had their eyes open; this appeared, to me, to be a metaphor for the world in general.

This was my first issue of *Healthsharing*, which we just started receiving at work. I look forward to future issues. Thank you for a fine magazine; it is evident how much hard work goes into creating it.

Jennifer L. Smith  
Toronto, Ontario

## Not an Easy Choice

Many feminists working in the pro-choice movement found Ms. McDonnell's book *Not An Easy Choice* to be informative and thought-provoking. It raises a lot of hard questions for feminists, and could be the catalyst for productive feminist debate about the fundamental right of reproductive control.

However, many of us also have very serious reservations and disagreements with some of the aspects of this book, none of which were addressed in the book review by Ellen Monk (Winter, 1984). It is important that these criticisms be made. McDonnell argues that the pro-choice movement is at a standstill (a premise with which many would disagree) because the movement is too one-dimensional. She says that if the movement is to remain relevant, we must attract support from a wider cross-section of people by taking moral stands on a wide range of reproductive issues. I feel that the portrayal of the pro-choice movement as one-dimensional is totally unwarranted. Most of us involved in the struggle are actively involved in a wide range of feminist concerns. McDonnell suggests that we should compete with the moral guardian status of the anti-choicers by expanding our efforts into other less contentious areas where we might ally with those same anti-choicers. This "if you can't beat 'em, join 'em" attitude is defeatist. As feminists, shouldn't we rather continue to educate society about the essential and fundamental morality of the pro-choice position? We should emphasize that our position is a moral one, and not a selfish one as the anti-choicers would paint it.

McDonnell urges that we "let in" the foetus as an entity with competing rights, and that no woman should have an abortion except for serious reasons. This position is condescending and self-righteous. No woman has an abortion frivolously. We should of course offer our support in helping a woman to come to a decision but we have no right to admonish women to make sure

their reasons for choosing to terminate a pregnancy are valid. McDonnell also says that we

must allow our sisters to grieve their abortions. Of course we should, to the extent that we experience grief. But I feel compelled to state that in the 10 years existence of CARAL (Canadian Abortion Rights Action League), most women from whom we hear express great relief, not grief, at being able to choose to terminate an unwanted pregnancy.

Certainly many CARAL members disagree with McDonnell when she advocates that feminists challenge the power of the medical profession in abortion. She argues rather naively that most illegal abortions were safe and harmless prior to the change in the law, and that the abortion procedure could be returned to "wise women" using folk methods, including herbalism and even magic. There will be women who prefer to have abortions performed by "wise women," but this should not be a priority item in our struggle for abortion rights. The majority of women want abortion to be recognized as an essential aspect of health care, covered by health insurance and provided by medically trained health care providers. McDonnell goes on to recommend that feminist and pro-choice activists should question the medical approach to free-standing abortion clinics, and suggests that they should be termed "reproductive health centres" to further de-medicalize them. Both of these suggestions are very unwelcome to those of us actively struggling to support Dr. Morgentaler and his clinics. No matter what one may think of the political acceptability of a private clinic run by a doctor, the political reality is that this is today the focus of the pro-choice struggle. McDonnell's exhortations to "reclaim abortion" is not only unrealistic but it undermines the pro-choice struggle, at a time when we need solidarity more than ever.

Finally, we at CARAL are extremely distressed at how McDonnell maligned one of our Honorary Directors by taking

**CHANGES ON THE HOME FRONT...** In December, 1984 our staff grew: Connie Guberman, a member of the Women's Press Collective, and Heather Ramsay, a member of the Rites collective joined us. They are sharing the position of promotion/circulation co-ordinator. The office is much livelier and healthier already (we've acquired spring water!) Welcome.

Elizabeth Allemang, our managing editor, who's been on staff 2 1/2 years, is resigning from her job March 1st. She's staying on as a collective member, so we're glad to say it's not good-bye. She'll be apprenticing with the Toronto Midwives' Collective, so any Toronto readers planning births keep us in mind ... maybe we'll get into the referral business eventually after all!

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his writings out of context and by actually misquoting him. Dr. Wendell Watters is as passionate an advocate of women's right to choose as one could hope to find. Those who read accounts of his testimony at the recent trial of Drs. Scott, Morgentaler and Smoling will know that he gave compelling testimony about the failings of the present hospital committee system, and laws that represent what he calls the enslavement of women by men. In *Not An Easy Choice*, McDonnell discusses the influence that doctors have had on worldwide liberalization of abortion laws (pp. 96-97). She characterizes their support for increased access to abortion as based on support for population control efforts, rather than a commitment to freedom of choice. Watters is described as a good representative of this point of view. In her efforts to substantiate this allegation McDonnell refers to Watters' book *Compulsory Parenthood* and writes, "His main aim, in a global sense, in arguing for abortion reform is not to increase reproductive options, but to restrict the

reproductive freedom of those who, in his words, 'procreate blindly and indiscriminately.'" In the section of his book from which McDonnell purports to quote, Watters actually writes: "The present century is witness to the creation of a new human value, that of reproductive responsibility. In a variety of ways society is slowly coming to acknowledge an obligation to assist couples who are trying to procreate wisely, rather than blindly and indiscriminately. When that help is withheld from sexually active couples either, preconceptively or post-conceptively, such a society favours parenthood by compulsion."

We hope that McDonnell will offer her apologies to Watters for this misrepresentation.  
*Norma Scarborough*  
*Toronto, Ont.*

**APOLOGY. . .**  
**To Nancy Walker for excerpting one frame from her cartoon *Woman's Movement* in our June, 1984 issue. We would like to share the entire comic strip with our readers.**

### Response to Incest

Sue Kaiser's brief coverage of the increase in the incidence in incest *Silence Lifting* (Winter 1984) brought to mind a thought I had when I read about this same subject in *The Globe & Mail* a couple of months ago: Women are becoming more assertive and less inclined to assume passive, powerless positions in their personal and professional lives. If incest, as well as rape, are activities motivated by people who want power over powerless others, do you think that because women are becoming

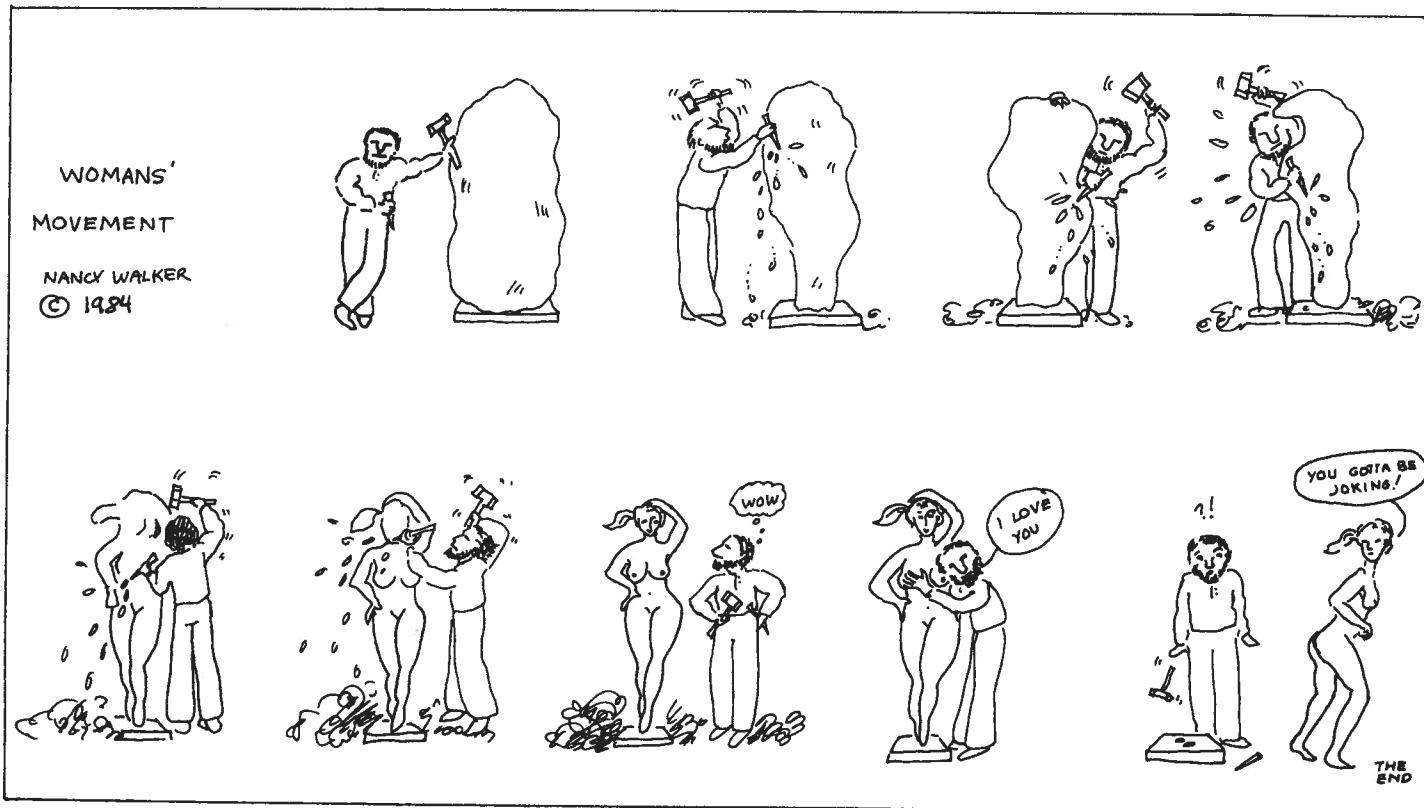
more powerful, some men are turning to children (who are usually powerless by virtue of youth and smaller stature) to satisfy their needs to be masters in sexual encounters?

Regarding Frumie Diamond's coverage of *Safe Sterilization*, I am wondering why physicians have not considered injecting methylcyanoacrylate into the vas deferens of men? Are men intuitively suspicious of such barbarism directed against their gonads?

*Mary Margaret Steckle, R.N.*  
*Toronto, Ont.*

### Our Shared Loss

Ruth Cooperstock, known to many for her probing and far-sighted work on addictions and tranquilizer abuse among women, died on January 31st. Her honesty and commitment to improve the quality of human life were evident equally in her friendships and in her research and writing. Up until the moment of her death she stayed herself - using her cancer as an opportunity to grow, to learn about herself, to share what she learned about chronic illness with others. Her passing is a great loss to the women's health movement.



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# RESOURCES & EVENTS

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## StatsCan Profile on Women's Health

*Canadian women: profile on their health* is a recently released Statistics Canada report prepared by Louise Lapierre examining the health of Canadian women and comparing it to that of Canadian men. This profile considers women's socio-economic conditions and lifestyles and will be of particular use to health educators. The report is available in French and English and may be obtained for \$6.65 (Catalogue No. 82-542E or F) from Publication Sales and Services, Statistics Canada, Ottawa, Ont. K1A 0T6 or from any of Statistics Canada's regional centres.

## Videotape on Pornography

The Pornography Project Collective is producing a series of videotapes from presentations made at the 1984 Conference on Pornography held in Kingston, Ontario. The series will deal with a number of issues such as the effects of pornography on women and men, the use of pornography as propaganda and possible strategies for change. The videotapes and supplementary literature are available on an ability-to-pay basis through Jennifer Stephen and Angela Smiles, c/o Pornography Project Collective, 51 Queen's Crescent, Kingston, Ont. K7L 3N6. (613) 547-6970.

## Contraception and Disability

*Contraceptive Choices: Tips For Counsellors* is a pamphlet for counsellors working with differently abled women. It deals with contraceptive suitability under six disability categories - developmental, psychiatric, hearing, visual, mobility and invisible disabilities (including epilepsy, diabetes, etc.).

Copies may be obtained by contacting The Birth Control and VD Information

Centre, 2828 Bathurst St., Suite 501, Toronto, Ont. M6B 3A7, (416) 789-4541.

## Women's Resource Catalogue

*The Women's Resource Catalogue* is a Secretary of State publication which lists audio-visual and printed materials of interest to women on a variety of subjects. Materials are organized under issue areas with brief descriptions of each. Health issues covered include contraception, abortion, birthing, mental health, sexuality and sports. The catalogue is available from The Women's Program, Department of the Secretary of State, Room 201, 25 St. Clair Ave. E., Toronto, Ont. M4S 1M2. (416) 966-6555.

## Bereavement Booklet

*A Beginning* is a book produced by Women's College Hospital for parents who have recently experienced the death of a child through miscarriage, stillbirth or abortion for genetic reasons. The book is available in various languages as well as in Braille and on tape. It includes a list of Bereavement Support Services/Groups and is available for \$3.00 from the Association of Volunteers, Women's College Hospital, 76 Grenville St., Toronto, Ont. M5S 1B2.

## Vancouver Addiction Centre Film

*Turnaround: A Story of Recovery* is a National Film Board production documenting a drug and alcohol treatment centre for women in Vancouver. In the 45 minute film, residents of the centre speak of pain and isolation they have experienced as women addicts as well as the growing strength and confidence they have found through treatment at the centre. *Turnaround* is available in film or video format from NFB libraries across Canada.

## Vancouver Women's Health Collective Resources

The Vancouver Women's Health Collective produces comprehensive pamphlets and kits on a wide variety of topics related to women's reproductive health. Subject headings include vaginal and cervical health, DES, birth control and fertility, menopause, abortion, menstrual cycle and breast health. For a publication list contact the Collective at 888 Burrard St., Vancouver, B.C. V6Z 1X9.

## Childbirth Videos

A videotape series - *Childbirth: From Inside Out* - covering all aspects of pregnancy and childbirth is now available, free of charge to childbirth educators across Canada. Six segments, 30 minutes in length, cover topics such as nutrition, exercise, the hospital, labor and delivery and post-natal care. The series is being distributed by the publishers of *Great Expectations* and *Today's Parent* and is available in French and English. For more information contact Iris Weverman, Promotional Consultant at Professional Publishing Associates, 45 Charles St. E. Toronto, Ont. M4Y 1S2. (416) 964-8903.

## NFB Health Resources Catalogue

*Our Bodies, Our Minds* is the National Film Board of Canada's catalogue of film, video and multi-media resources for health education.

Over 250 audiovisual productions are listed and subjects covered include addiction, death and dying, nuclear war and violence. The catalogue also includes a list of NFB film libraries across Canada from which resources may be borrowed. To obtain a free copy of the catalogue write to: Health Education Catalogue, English Marketing, National Film Board of Canada, P.O. Box 6100, Station A, Montreal, Que. H3C 3H5.