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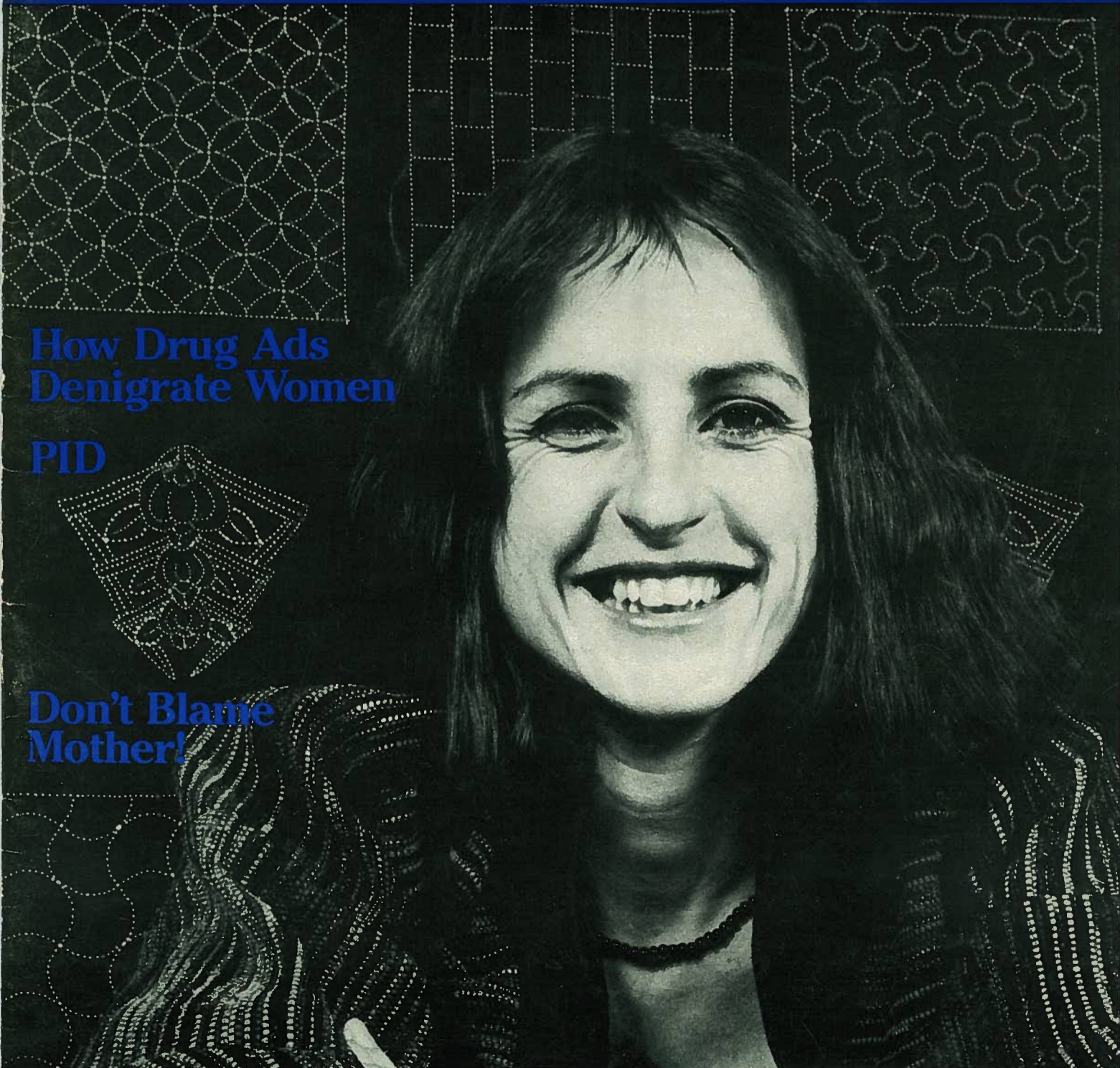
Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

How Drug Ads
Denigrate Women

PID

Don't Blame
Mother!



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Healthsharing

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COLLECTIVE NOTES

Picture a woman

Women's roles *are* changing, however slowly. Yet the images of women — on television, in magazines, in the newspaper — continue to reflect a narrow and rigid definition of what is seen to be female in Canadian society. There are a few new twists, for instance, the super woman image: the woman who manages a successful career, takes care of her home and family *and* looks stunningly glamorous, all at the same time and without difficulty. But in general, changes in media representations of women continue to be painfully slow to change. Sometimes it even feels like we are moving backwards.

Advertising is, of course, a major purveyor of images and has a huge influence on how society sees women. Advertising is a powerful tool for social control and the reinforcement of traditional values. In advertising women tend to reflect one of two general stereotypes: We are seen as either incompetent and difficult or as sex objects who are unnaturally and unattainably "beautiful."

"In Poor Health," a feature article in this issue of *Healthsharing*, examines the stereotypes of women in the pharmaceutical ads found in medical journals. Here the doctor is the buyer; the doctor is being sold something to help make women better, to fix them up. Not surprisingly then, the women in these advertisements conform to the incompetent stereotype. We find women portrayed as unable to cope, non-compliant, a nuisance to others and controlled by their biology. And they are homogeneous — one pill fits all. These ads sell not only the product. The cumulative effect of their images can diminish doctors' view and treatment of women patients.

The medical journal ads are in strong contrast to lifestyle ads in the mainstream media which are directed at women themselves or their male ad-

mirers. Lifestyle ads tend to rely upon a sexualized stereotype of women, projecting an artificial and unattainable standard called female beauty. Such ads create a self-fulfilling prophecy of failure: Women are blamed for failing to use the "right" make-up, vitamins or fabric softener, or for not being diligent about the Jane Fonda workout or the current fad diet. Nowhere in these ads do we see the uniqueness and diversity of women, women as inherently beautiful, instead of made beautiful.

Only one of the women in the pharmaceutical ads examined in "In Poor Health" fulfills the beautiful woman stereotype; and she is on hormones. A second woman fails to measure up; her make-up isn't quite sufficient; she is portrayed as stupid. An old woman is seen as muddle-headed and unable to cope; she clearly needs help. Then there is the dreaded nag, usually portrayed as some poor man's wife or mother. In this ad we see her as a belligerent bus passenger harassing the male driver! Still another woman is sad and regretful, another worried and tense. We see a woman who has tried too hard; she is wearing so much make-up you can see her wrinkles. Her problem is age. Here again, the real beauty, pain and diversity of women is missing; we are left only with stereotypes.

At *Healthsharing*, we struggle to present women in their diversity and to avoid the stereotypes. But it isn't always easy. As an issue-oriented magazine, *Healthsharing* publishes drawings and photographs which illustrate women's health problems. We believe our visual images of women are positive and realistic. We're proud of the quality of the artists' work we've been able to share with you. Yet we recognize the validity and importance of the letter from Pat Johnston (Letters) who criticizes *Healthsharing* for its ten-

dency to focus on women as victims. It is true. We document the experience of women as victims of bad medical practice, of dangerous drugs, of environments polluted for profit, of inept bureaucracies, of sexism and misogyny. These important articles present a picture which is all too real, but it is not the whole story.

We want to publish another kind of article as well, one which illuminates the health-related aspects of women as creators, women triumphant and powerful, women as joyous lovers, mothers and daughters.

Many readers have written requesting our writer's guidelines. We encourage you to challenge yourselves and us — find and write positive women's health stories. We are not looking for "How I Lost 100 Pounds and Found Love" and we won't stop publishing articles about critical health issues, such as "PID: The Silent Epidemic" in this issue. But we are seeking to change the balance of our content.

Let us work together to change the stereotyped images of women in media. Along with Carol Fennell (Letters), let's use Media Watch; let's use consumer and political pressure to change the prevailing negative and destructive images of women. As women we want to see ourselves portrayed as we see ourselves — positive, strong and diverse, as beautiful, as women.

Elizabeth Amer, Amyra Braha, Connie Clement, Connie Guberman, Barbara Lamb, Diana Majury, Lisa McCaskell, Heather Ramsay



Katherine Mann-Buchanan

UPDATE

Depo provera approval unknown

CANADA (!) — Organizations across Canada have joined the Canadian Coalition on Depo Provera to urge the federal government not to approve the injectible hormone at this time (see Healthsharing, Winter 1985 and Fall 1982).

On November 22, women in Nova Scotia, Montreal, Ottawa, Toronto, Winnipeg and Vancouver held press conferences; women in many other cities undertook local media blitzes. By mid-December over 60 organizations had joined the rapidly formed coalition. On December 18, five members of the coalition met with Health Minister Jake Epp to discuss concerns.

The Coalition called on Epp to release all documents in government files relating to Depo Provera and to establish a public participation method to assess the safety and danger of Depo Provera. Further, the coalition representatives urged Epp to use the example of Depo Provera to examine loopholes in drug legislation and the overall procedures for drug approval in Canada.

As *Healthsharing* goes to press, we are awaiting the release of a report to department staff by the federal Advisory Committee on Female Reproductive Physiology. Last September,

in a report on oral contraceptives, this committee was highly favourable to Depo Provera use and is thought to have already submitted some form of written recommendation of approval. Hence, it will be interesting to see whether the forthcoming report (clearly intended for public release) differs in its recommendations.

The coalition continues to urge women and organizations to inform the government of their concern about this drug. A background paper reviewing some of the medical concerns was distributed to women's groups across the country. Both a postcard and a letter to Jake Epp are being distributed by women's groups to their members.

To contact activists in your part of the country, telephone a feminist health-group, consumer organization, the YWCA or National Action Committee (both these last organizations have mailed information to their members about Depo Provera). To contact or join the Canadian Coalition on Depo Provera, write c/o Women's Health Interaction at 58 Arthur St., Ottawa, Ont. K1R 7B9 (613) 563-4801.

CONNIE CLEMENT

Sterilization common

LONDON — Sterilization is outranking the pill as the contraceptive of choice in Canada, according to researchers at the University of Western Ontario. The study, published in the September '85 issue of *Family Planning Perspectives*, includes the first estimates of Canadian contraceptive use since 1968.

The study, based on telephone sampling nationally, included 5,315 women. It assessed both current contraceptive use and which methods women had ever used. The greatest factor affecting type of method used, according to T.R. Balakrishnan, a professor in sociology and the principal investigator, is marital status. "Generally, if women are single they use the pill, no matter what age. If women are married they shift to sterilization fairly early," he told *Healthsharing*.

Among married women (3283), 73 per cent use a method of birth control and of those 73 per cent, 59 per cent use either female or male sterilization. Among never-married women (1430), 57 per cent use a method of birth control and of these 57 per cent, 71 per cent use oral contraceptives. Oral contraceptive use among married women has dropped from 43 per cent in 1968 to only 15 per cent in this study.

Of the total population in the study, only 9.1 per cent use condoms, 8.3 per cent use IUDs, and 6.6 per cent use diaphragm, spermicides, withdrawal or various forms of rhythm.

Balakrishnan says the demographic breakdown according to age, marital status and geographic location is comparable to Canadian statistics.

The Canadian Coalition on Depo Provera

- Over 70 feminist, consumer and health groups have joined the Canadian Coalition to inform Canadians about potential dangers and inadequate research on Depo Provera, an injectible hormone, and to lobby the government not to approve its use as a contraceptive.

- The coalition needs your donations to cover costs of informational mailings, telephone calls, media releases, meetings with government.

- Send your donation now to the Canadian Coalition on Depo Provera, c/o 58 Arthur St., Ottawa, Ontario K1R 7B9. Make cheques payable to Women's Health Interaction. For more information, write to this address or telephone (613) 563-4801.

Electroshock findings rejected

TORONTO — The Ontario Coalition to Stop Electroshock rejected the findings of a provincial government-appointed study group's report on the dangers of electroconvulsive therapy (ECT). The report, published in December, 1985, "whitewashes and covers up" the dangers of ECT say coalition members.

ECT, first used approximately 40 years ago, is a form of treatment involving the passage of electrical currents through the brain. The currents induce seizures and destroy brain cells. "There is no acknowledgement of that horror in the report," stated Don Weitz, according to a report in *The Globe and Mail*.

The committee was given the task of assessing the use of ECT two years ago amid growing concern that the treatment was being abused. Although the report acknowledged that ECT can have "an adverse functional effect on memory" and admitted that there are risks associated with ECT, it focused on the need to weigh

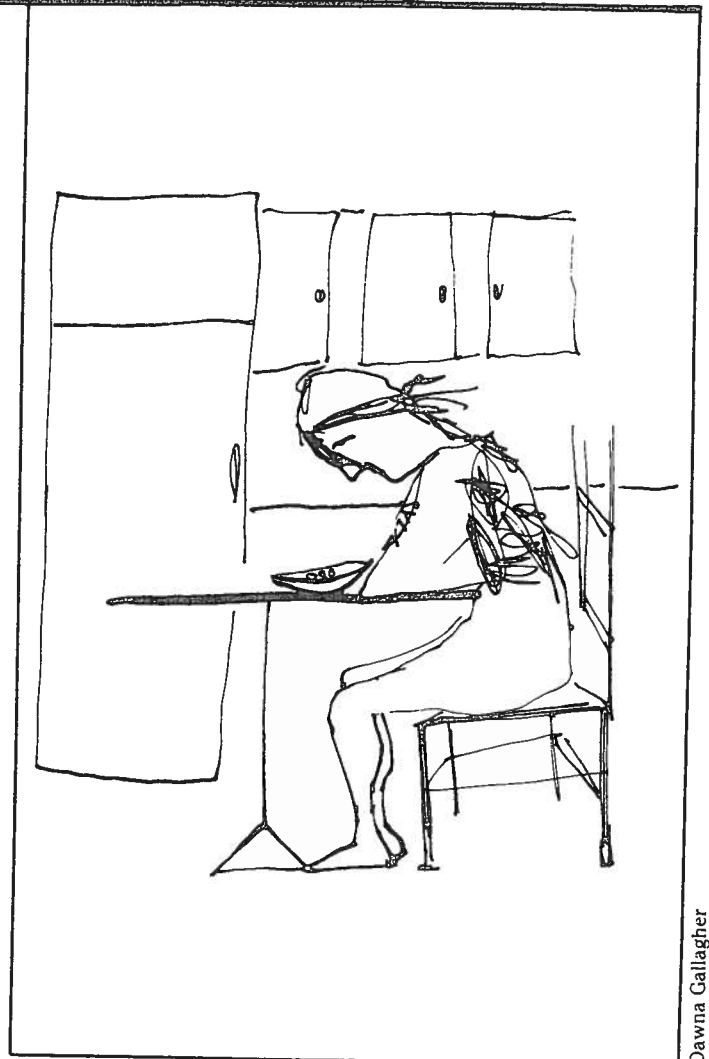
risks and benefits in each individual case.

According to Dr. Bonnie Burstow, who spoke with Healthsharing about the report, the committee was asked to explore ECT administration to look for both age and sex bias. Several submissions presented to the committee addressed these concerns. Even so, the report fails to mention either concern.

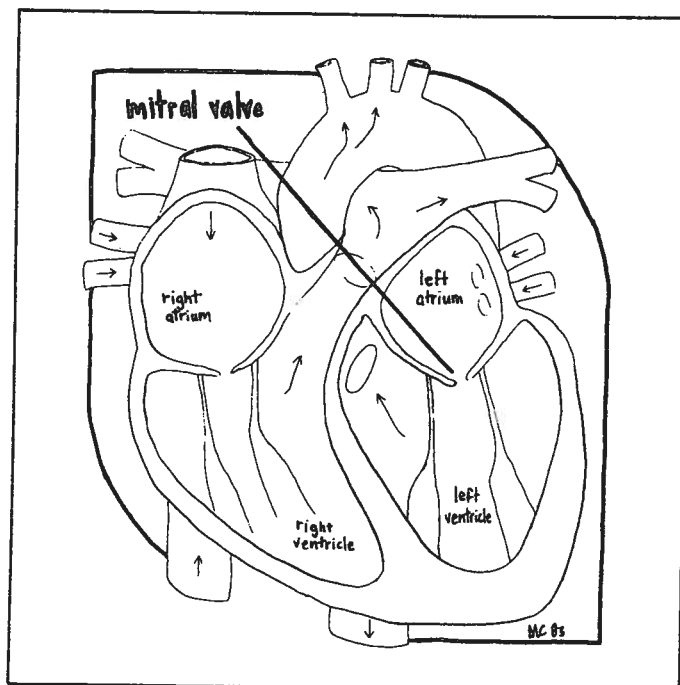
A 1984 report on ECT use in Toronto, released by that city's Department of Public Health, found that twice as many women as men receive ECT. According to Burstow, the ratio in some other provinces is even worse. "Shock is very much a feminist issue and we need to address it," she says.

The Ontario Coalition to Stop Electroshock is seeking a meeting with the Minister of Health. Several demonstrations have been organized and more activities are planned for the near future.

DEBORAH FEINSTADT



Dawna Gallagher



Mitral valve prolapse

NEW ORLEANS — The mitral valve of the heart consists of two connective tissue leaflets that can lose their resiliency and stretch, causing a murmur or clicking sound which can be heard with the help of a stethoscope. Called mitral valve prolapse, this condition affects from six to 21 per cent of the general population and is more common in women. It is usually benign, but in all cases there is an increased susceptibility to infection of the valve (endocarditis) which can lead to further potentially dangerous heart problems (See *Healthsharing*, Spring 1983).

At the Omega Institute, a New Orleans fertility research and treatment centre,

71 women undergoing gynecologic treatment were also given a cardiac examination. Of these women, 96 per cent had mitral valve prolapse. Although the study scale is too small to extrapolate, it suggests a highly significant association of the condition with various pelvic and Fallopian tube diseases. Because of the risk of endocarditis, Dr. Joseph Bellina, director of the Omega Institute, suggests women having gynecological surgery should be examined for mitral valve prolapse so that preventative antibiotic coverage can be administered.

SUSAN ELLIOTT

Dalkon fiasco continues

WINNIPEG — The Women's Health Clinic in Winnipeg is taking A.H. Robins, a large U.S.-based multinational pharmaceutical company, to court. The case stems from U.S. bankruptcy courts establishing a deadline for all claims against Robins in relation to the Dalkon Shield, an intrauterine device associated with severe infection and complications (see *Healthsharing*, Winter 1985 and Summer 1981).

Represented by Manitoba Legal Aid and Robert Manchester, a Vermont lawyer, they are charging that in requiring Robins to mount an advertising campaign in the U.S. while using any form of announcement in other countries, the court imposed a discriminatory process. They will request the courts to require a full-scale advertising campaign in Canada. The court-action will also seek an extension of the deadline now set at April 31, 1986 (this is already an extension from December 31, 1985). The deadline extensions will be based on the premise of inadequate notice to Canadian women. Currently other organizations in Canada, Britain and Australia are being approached to join the legal action.

Throughout January, following media coverage, women's health groups have been contacted by many women who have used Dalkon Shields. Women who experienced gynecological or fertility problems related to the IUD should act *now* to file a claim against the company. Legal advice can be of assistance in obtaining medical records and in assessing the extent of a possible claim. Unfortunately, few Canadian lawyers are experienced in U.S. product-liability litigation. Legal Aid offices can help with

medical records; U.S. lawyers experienced in Dalkon Shield issues can work with Canadian lawyers.

Sybil Shainwald, a board member and legal advisor for the National Women's Health Network (U.S.) is one of several lawyers who has been undertaking Dalkon cases for several years. "It's important that Canadian women know that U.S. lawyers will handle these cases on a contingency basis — it won't cost them up-front. We have nurses who can help assess medical charts." Shainwald and Manchester are both part of a group of over two dozen lawyers who have formed a 'claimants committee' to track cases. This committee is fighting to extend the deadline and to ensure a fair settlement process.



In establishing the claims deadline U.S. courts required A.H. Robins to establish a simple claims process. To this end, a box number has been established (Dalkon Shield, Box 444, Richmond, Virginia, 23203, U.S.A.). The company is encouraging women to write directly to this address without the assistance of a lawyer. Shainwald is worried that if lots of women write directly to the box number, there will be no way to know the total number of claims or to determine the overlap between lawyers' records and those of the company, making it harder to argue for improvements in the existing claims mechanisms.

If women do write directly to the box number, their letters should be cryptic — don't tell your story. Letters should be sent registered, return-receipt requested. A questionnaire, which must be completed by June 30, 1986, will be sent back. Women's health groups in Canada have the names of a few U.S. lawyers with good reputations, and we suggest you stick with these if seeking U.S. legal help.

CONNIE CLEMENT

Timothy William Post

In our summer 1985 issue, *Healthsharing* published the story of Saskia Post and her infant son, Timothy, ("Taking Action" by Ruth St. Amand). It was a personal story of the effect of health hazards in the workplace. In January Timothy died at the age of 2 1/2. *Healthsharing* women send their sympathy and encouragement to his mother.

Disadvantaged health



Rachel Burger/CPF

WASHINGTON, D.C. — A U.S. government report substantiates what most people of colour have known for years. The report of the Task Force on Black and Minority Health, a taskforce of the Health and Human Services Department, indicates that 60,000 "excess deaths" occur in the U.S. each year among minority Americans. The statistical disparity occurred in the following categories of disease and mortality: cancer, cardiovascular disease and stroke, chemical dependency, diabetes, infant deaths, homicide, suicide and accidents.

While not intended to do so, the statistics in the report lend credence to charges made by consumer health groups and Black activist organizations

that minorities receive sub-standard health services in many parts of the U.S., and suffer harm due to poor working and housing conditions.

No similar report has been done for Canada as a whole. However, several provincial-area studies have found similar discrepancies in Canadian health status, especially when comparing native and non-native health parameters.

According to an item in the November, 1985, "Women & Health Roundtable Report," the U.S. Health & Human Services Department has announced that it is establishing a new office with a \$3 million budget in this fiscal year to implement recommendations contained in the report.

Urinary infections can be reduced

LOS ANGELES — Recurring urinary tract infections (UTIs) are a familiar problem to many women. There are a number of health habits and behaviours that are commonly thought to contribute to the spread of the infective agent (usually *E. coli* bacteria).

Two researchers from UCLA's School of Public Health have recently published the results of a study that attempted to evaluate the statistical association between UTIs and various risk factors such as diet, clothing and urination habits. Women who were experiencing their first infection (primary UTI) and women who were having a recurrence (secondary UTI) were questioned about their habits during the preceding four weeks. Two habits showed a strong association with both primary and secondary UTI: using tampons and drinking soft drinks. Inserting or removing tampons might spread bacteria from the vagina to the urethral opening and in addition, the inserted tampon might press against the urethra inhibiting complete emptying of the bladder. Soft drinks increase urine pH which might facilitate bacterial growth. This is in contrast to cranberry juice and vitamin C which decrease urine pH and are both often recommended for UTI relief and prevention.

Surprisingly, according to a report published in the November issue of the *American Journal of Public Health*, wearing pantyhose had only a slight positive association with UTI which may reflect the trend toward lighter hose with cotton linings. Urinating before sexual intercourse was moderately associated with UTI; urinating within 15 minutes after sexual intercourse had a negative

(preventive) association.

Women are often advised to urinate both before and immediately after sex to avoid pressure on the bladder during intercourse and to wash out any bacteria that may have come into contact with the urethra. Wearing tight jeans which can irritate the urethra was also strongly associated with primary UTI.

A number of other factors such as drinking coffee, alcohol, eating spicy foods, taking bubble baths, using sanitary napkins and hesitating to excuse oneself to urinate were also analysed but the results were inconclusive. Many individual habits had only a small association with UTI but several of these habits together might substantially increase the risk of infection especially if the compounding effects of frequent sexual intercourse and diaphragm use (both previously known to increase the risk of UTI) are added.

Although limited by the complexity of the interaction between various habits, this study does confirm that a number of potential causes of UTI are practices that women can control.

SUSAN ELLIOTT

Apologies

We apologize to staff at the Health Promotion Directorate, Health & Welfare Canada. The Directorate provided financial assistance for the development and distribution of the "Rural Feminism" article in *Healthsharing*, Winter 1985.

Maureen Moore

P I D

The Silent Epidemic

It's been six years since Judy began to have bouts of illness and pelvic pain that mystified her family doctor. During that period she and her husband tried unsuccessfully to conceive. Finally, their doctor sent them to a specialist who discovered Judy's tubes were blocked, preventing the union of egg and sperm. Only surgery could correct the problem. During the operation doctors removed the ovary and tube on one side; these were found deeply buried in scar tissue. However, Judy's dreams of having children were destroyed a few weeks later. An ultrasound image of her abdomen revealed an abscess draped over her remaining tube. Antibiotic treatment cured the abscess but the infection had closed the tube again. Judy's doctor told her she had chronic pelvic inflammatory disease and further attempts to open her tube would also end in failure. Judy says, "The agony, grief and guilt that I've experienced over the past years knowing I will never carry a child, has pushed me over the edge more than once. It's something I have to live with, and try to work out, day by day; I don't think I will ever get over it completely. Like my PID, these feelings only go into remission."

Pelvic inflammatory disease (PID) is epidemic in Canada and much of the world. In 1982 140,000 Canadian women were treated for the disease. (This figure is extrapolated from Health and Welfare Canada records of PID treated in hospital.) Numbers are increasing rapidly. If the present trend continues, by the year 2000 one out of every four North American women will have PID, estimates Dr. Willard

Cates of the Centre for Disease Control. Rates are highest for young women but women of all ages are at risk.

Despite these terrifying figures there is deep silence on this disease. Few women know it exists. PID is the name for infection that strikes a woman's reproductive organs: her uterus, tubes, ovaries, and the broad ligament that supports these structures. Infection causes inflammation of delicate tissues; thus the name pelvic inflammatory disease. Sometimes the infection spreads to the woman's bowel, liver, or the lining of her pelvic cavity. The body protects itself by forming sticky scar tissue called adhesions that bind and distort the pelvic architecture, gluing the uterus, for example, to the bowel. This scarring can occur inside the tubes, blocking them. This is what happened to Judy. PID can also cause abscesses that might burst, leading to peritonitis.

Two years ago a fifteen year old Vancouver woman died of PID. In Canada deaths are rare due to the availability of government supported health care. Where this is not the case women die. In the United States 900 women die of PID each year. While many women recover completely from the disease, others suffer from a spectrum of health problems. After one attack of PID a woman has a 15 per cent chance of becoming infertile; this rises to 75 per cent after three bouts of the disease. The PID epidemic is also responsible for the rise in ectopic pregnancies in Canada. A woman who's had PID has a tenfold increase in risk of ectopic pregnancy. Such preg-

nancies are life-threatening and emergency surgery is required to remove the fetus and, in some cases, the tube as well, thus reducing the chance of future pregnancy. Statistics show that 75 per cent of women who get PID have not had a child previously.

In addition, 20 per cent of women who get PID develop chronic pelvic pain. This pain can be intractable and disabling. Sometimes PID becomes a chronic or recurrent health problem and the infection never seems to go away. Even women who recover completely from PID remember it as a frightening and discouraging illness in which recovery is often measured in weeks or months.

Researchers have identified several causes of PID. The most common cause is sexually transmitted disease (STD); however even some women who've had PID were never told of this connection. "I had a very prim and proper doctor," Sue, a PID sufferer, says ruefully. "His attitude was — nice girls don't get VD."

Nothing could be further from the truth. During sexual intercourse partners share genital tract bacteria. If these bacteria include STD's such as chlamydia, gonorrhoea, or mycoplasma, a woman is likely to contract a disease that might progress to PID. According to Dr. Bill Bowie, a Canadian STD expert, about 50 to 60 per cent of PID in Canada is caused by chlamydia, a disease in which bacteria spend part of their lifetimes inside human cells which later burst. Chlamydia causes tremendous tissue damage; women with chlamydial PID are twice as likely to be infertile as those

with gonococcal PID. Untreated, chlamydia can persist for at least 10 to 15 years; therefore chlamydia can be brought into a relationship and cause problems later on. Men can carry and transmit chlamydia without having any symptoms. Even women can have unnoticed cervical chlamydia.

Mycoplasma causes 10 to 15 per cent of PID according to Dr. Bowie; yet tests for mycoplasma remain almost entirely unavailable to Canadians. They are not routinely performed even in the case of women who have PID.

Gonorrhea tests are part of every general practitioner's repertoire; however many people with gonorrhea have chlamydia too and the penicillin that treats most gonorrhea has no effect on chlamydia which responds to tetracycline drugs. Incomplete STD tests and treatment are dangerous.

Ironically, during the Second World War men were taught STD was something "decent" men got from "bad" women. Condoms were thought to protect men, not women. This view reflects the deep ignorance of the true consequences of STD in women. In contrast, the effects of STD in men are usually minor. Men sometimes develop painful urethritis. STD-linked infertility in men is rare. Yet the female sex partners of men with either gonococcal or nongonococcal urethritis (NGU) are at risk for PID.

PID is primarily a heterosexual disease. Sperm carry bacteria past the mucous barrier of the cervix into the uterus and tubes. Even though only certain bacteria are classed as sexually transmitted, in reality all genital bacteria are passed back and forth during sex. Modern microphotographic techniques reveal bacteria attached to sperm in the ejaculate of infected men. These bacterial hitchhikers, no problem for men, can cause or contribute to PID in women. Debi Milligan, who wrote the section on PID in *The New Our Bodies, Ourselves*, told me she had PID for five years. She went to 16 different doctors before she found a New York fertility specialist who took swabs from her husband's urethra and cultured his ejaculate. Numerous bacteria were found. When she and her husband were treated with identical antibiotics effective against the range of bacteria found in both partners, Debi was cured; she did have to undergo surgery at the same time to remove an

abscess and scarring that resulted from five years of untreated infection. Antibiotics alone cured her symptomless husband.

Although the medical literature is unanimous on the subject of the need to test and treat the male partners of women with PID, this doesn't always occur. Part of the reason for this is that men are usually referred to other doctors, particularly urologists, who are oriented primarily to disease in the male. Sometimes they class bacteria that contribute to PID in women as "normal flora" for men since these bacteria don't cause problems in the male genital tract. Yet according to Dr. David Eschenbach, a Seattle researcher, ejaculate should be completely free of bacteria.

It's disturbing that if the man undergoes testing it's common for culturing of the ejaculate to be omitted entirely. Some researchers think that men will not be willing to supply a sample of ejaculate, so a test that might identify bacteria causing disease in women is not even suggested.

A further cause of PID is IUD use. From three to nine per cent of IUD users get the disease. The tails of IUDs act as wicks that allow bacteria into the normally sterile uterus. Often these bacteria are normal inhabitants of the vagina; once they pass beyond the cervical mucous barrier they can cause PID. Recent medical articles advise doctors not to give an IUD to any woman who has not completed her

family. This implies, quite wrongly, that PID is an acceptable risk for women who don't intend to have children. A 1972 study by Dr. Eschenbach estimated that 110,000 American women got PID as a result of using IUDs in that year alone. Statistics indicate many of these women still suffer from the long term effects of PID — infertility, chronic pain, and recurrent infection. At one time the IUD was thought to be the ideal contraceptive for adolescents; now we know it to be the worst.

Medical procedures in which instruments are passed through the cervix into the uterus can lead to PID as well by allowing vaginal and cervical bacteria access to the uterus. In a Swedish study 12 per cent of PID cases were preceded by a medical procedure that opened the cervix. These include D & Cs (minor operations in which the uterus is scraped), menstrual extraction, therapeutic abortion, hysterosalpingography (a fertility test in which dye is injected into a woman's tubes), internal fetal monitoring, and endometrial biopsy. A woman may be able to lower her risk of PID by being tested and treated for STD before undergoing such procedures.

One reason such tests are not always performed is the mistaken belief that only certain women get PID. A general practitioner told me she was taught in medical school that only women who were, in the words of her teacher, "practically prostitutes" ever got PID.

Possible Indicators of PID

- infertility
- miscarriage
- stillbirth

The following symptoms may indicate PID if the bacteria have spread upwards:

- a cervix that bleeds easily (this might be noticed as bleeding after intercourse)
- frequent need to urinate
- pain with urination
- an abnormal Pap test
- abnormal vaginal discharge
- eye infections or pneumonia in the newborn
- enlarged cervix

Note: Few women experience *all* the above symptoms. Any symptom should be checked out with a doctor even if a woman has only one of the above possible indications of a health problem. It's common for women with PID to have only one symptom and for that to be subtle.

PID Symptoms

- lower abdominal pain, intermittent or constant
- pain with ovulation or intercourse
- increased menstrual cramps
- fatigue
- fever
- chills
- nausea
- "flu-like" feeling
- abnormal vaginal discharge

The identification of women with PID with prostitutes expresses the prejudice some doctors still feel. In the medical literature some researchers refer to women with PID as promiscuous. This suggests women with PID are to blame for getting sick. While it's true that a woman who has sex with only one man during her life greatly reduces her chance of getting PID, this is only the case if the man has never had sex with another woman before or after or during their relationship. By this definition "promiscuous" is an inclusive category indeed!

Women are also predisposed to PID any time the cervix is open, during menstruation, ovulation, and after miscarriage or childbirth. Forceful douching may increase a woman's risk if bacteria are pushed into the uterus. DES daughters are at higher risk for PID than other women. Few women are in a position to be without any risk of developing PID.

PID is an underdiagnosed disease. Blood tests that measure infection in the body are frequently inaccurate in the case of PID. In fact only 16 per cent of all cases of PID fit the classic "text-book" description of the disease. PID often has surprisingly mild symptoms even though the reproductive system is being destroyed. Seattle research shows little correlation between the severity of symptoms and pelvic damage. Anne is a married woman who has had only one sex partner. She did not fulfill the stereotype of the "promiscuous" PID victim. Neither were her symptoms dramatic. For six years she suffered from intermittent pelvic pain and occasional abnormal bleeding. Finally, exploratory surgery revealed massive damage due to PID. Anne underwent microsurgery to restore her fertility and at the same time doctors cut the nerves to her reproductive organs in an attempt to alleviate her

pain. The operation was not successful. The pain persists and she hasn't been able to conceive; because of the nerve surgery she has lost much of her sexual sensation.

Any delay in diagnosis is serious in the case of PID. When a woman gets treatment within two days of the onset of symptoms chances of cure are much higher than those of a woman whose treatment isn't begun for a week.

In Sweden even the slightest symptoms of PID are taken seriously according to Dr. Sweet of the University of California Medical School who says that women in Sweden generally receive more diagnoses for PID than North American women. The city of Lund in Sweden is the centre of world research on PID. Since 1960 data on this disease have been gathered by doctors at University Hospital's gynecology clinic, the only such clinic in the city. A woman in whom PID is suspected is asked to undergo immediate laparoscopy, a surgical procedure in which a "scope" allows doctors to view the reproductive organs. If PID is diagnosed samples for culture are taken from the tubes. The results of these cultures may be crucial in adjusting the antibiotic treatment that's begun immediately. In addition the meticulous record keeping provides the world with the most complete information about PID we have so far. In fact, the North American figures on the long term consequences of PID are extrapolations from the Swedish statistics. We have not been doing studies to establish such records of our own.

The most effective treatment for PID is intravenous therapy with more than one antibiotic. This must be given in hospital. In Canada only one in eight women with PID is treated this way. Most are sent home with oral antibiotics. According to Dr. Sweet this practice lessens the possibility of cure; even

with state of the art treatment many women with PID do not regain their health. Research has not established highly effective treatment. Dr. Sweet says no one would tolerate such a high treatment failure with other diseases.

This raises the question: why has so little research been done on PID? Medical literature in the United States relates PID to socioeconomic level. In the past PID was seen as a disease primarily associated with poverty and race. Early articles suggested that the sexual habits of black women put them at risk for PID; little research interest was sparked by their affliction. STD related problems had been solved for men. Gonorrhoea and syphilis, diseases that previously attracted a great deal of research and attention, could be cured by one shot of penicillin. Diseases of affluence, such as heart disease and cancer, captured the medical imagination. The health of black women did not.

Almost unnoticed at first, the PID rate began to rise. In the United States this can be traced entirely to an increase in PID in white women. Doctors were surprised when middle class white women with PID began turning up in their offices.

In the late 1960s a trickle of articles appeared questioning the safety of IUDs; gradually the evidence implicating IUDs became stronger as documentation was gathered. To counter this a great deal of money and advertising skill was expended in a successful effort to assure doctors that IUDs were safe, and that in view of world overpopulation they were needed. At the same time sexual customs were changing in North America, resulting in an increase in the numbers of sex partners people were likely to have in a lifetime. In general it was still thought that most PID was due to gonorrhoea. Even though Swedish researchers were telling the world about the role of chlamydia and the technology for sampling and culturing the bacteria was available, North American investigators didn't begin to use the Swedish techniques until about five years ago. Only then did they become aware of the importance of chlamydia.

Today much of the research money tagged for PID has been diverted to AIDS. There is no major PID research in Canada. At a recent Vancouver conference on sexually transmitted

disease there was not one paper given on PID although there was a talk on nongonoccal urethritis, a much less serious male illness. Sweden, a country that leads the world in its attention to women's rights, remains unchallenged as the world centre of PID research.

Men have not yet been educated about their role in causing the disease, and the ethical responsibility of a man whose relationship with a woman results in her infertility or disability remains unexamined. IUDs, although much less popular than before, continue to be inserted. Despite the fact that sexually transmitted disease is a major health problem, women, the group at highest risk, are unaware of its prevalence.

The prevention of STD and PID is partly the responsibility of provincial governments. However, only in Ontario and Saskatchewan is chlamydia a notifiable disease. A disease with this classification requires health workers to notify and treat all partners of a person with the illness. Before a province can make chlamydia a notifiable disease it must spend money on programs providing free testing and treatment. Most Canadian provinces have chosen to save money at the expense of women's health. Yet even in monetary terms this is false economy. PID and its consequences cost upwards of \$114,000,000 in Canada each year according to Health and Welfare Canada.

One can't help wondering if there would be such silence about an illness if it affected 140,000 young Canadian men each year and could render them infertile or in chronic pain, especially if one of the treatments was major surgery on the reproductive organs — surgery that might include castration.

Another reason we don't hear more about PID is the shame many women with the disease feel. This is comparable to the emotions triggered by unmarried pregnancy in the 1950s. A situation that can happen to almost any woman is somehow seen as evidence of a moral lapse in a particular woman. Even those whose PID did not result from sexually transmitted disease are reluctant to go public about infertility or disability. The isolation brought about by suffering and illness allows it to continue. Very few PID victims know they are part of an epidemic.

This summer women took an important step toward change. The Canadian PID Society was founded by women, most of whom have PID, to offer support and information. Sue Laing, a member of the society, is one of those who is ending the silence on PID. This is her story.

It was early 1970 when Sue had the first attack of the abdominal pain that signalled an end to her life as an able-bodied, healthy woman. Over the next five years the pain worsened. She had fevers and swollen glands.

Her general practitioner told her he couldn't find anything wrong with her. One day she couldn't stand up. This time her doctor discovered an abdominal mass he said might be cancer. Sue agreed to surgery. When she awakened from the operation the surgeon told her he'd removed her uterus, tubes, and half her left ovary. The diagnosis? Pelvic Inflammatory disease. Sue left the hospital grieving for the loss of her ability to have a child but relieved she didn't have cancer. She had no idea some women never recover from pelvic inflammatory disease.

A year later the pain was worse than before her hysterectomy. Desperate, over the next four years she underwent three more major abdominal operations in which the last bits of her ovaries were removed along with scar tissue that obstructed her bowel.

Unable to work since 1980, Sue lives on disability pension today. Doctors prescribe medication that only takes the edge off her pain. She still feels

sick. Recently an ultrasound image of her pelvis showed a collection of fluid, perhaps caught in scar tissue. This restricted urine flow; her left kidney, filled with toxic waste, began to enlarge. It took antibiotic treatment to reduce pelvic swelling. Despite estrogen treatment Sue developed osteoporosis from hormone loss; at 39 her bones are those of an elderly woman. Though her health is poor, she continues to do as much as she can. Last summer she tended her vegetable garden by lying on her side inching along the rows.

Sue hopes that by telling of her experience with PID other women will learn more about an illness that is potentially devastating. She hopes the PID epidemic will be stopped. Speaking of the diagnosis and treatment of her illness, Sue says, "I think they should do better."

Maureen Moore is a Vancouver writer and the president of the Canadian PID Society. (The opinions expressed in her article are not necessarily those of the Canadian PID Society.)

How to Prevent PID

- Get tested for STD
- Ensure that your male sex partner gets tested for STD
- Ask your male sex partner to arrange to have his ejaculate tested for bacteria
- Use barrier methods of birth control, particularly condoms
- Don't douche forcefully
- Learn about STD and PID
- Share your information with other people
- Write to the Federal Minister of Health and Welfare, Jake Epp, asking him to encourage research on PID. Send a carbon to your provincial health minister
- Write to the health minister in your province asking that chlamydia be made a notifiable disease if you live in a province other than Ontario and Saskatchewan

Calcium for Runners

Results of a California Study of 17 female long-distance runners has concluded that women exercising to the point where menstrual periods cease face a loss of bone mass and more frequent fractures. Runners who are affected by amenorrhea (lack of periods) should take a calcium supplement of 1500 milligrams a day. (*Self-Care*, Sept.-Oct. 1985)

Bitten by the Frost

Out in the cold? Well, if your skin whitens and becomes numb, with sharp stinging and itchiness, you probably have a mild case of frost bite. Your toes, fingers, ears, cheeks, nose and neck are the most vulnerable areas and need to be well protected in the cold. If you develop frost bite, head for indoor heat or shelter as quickly as possible. Put your frost-bitten hand under your arm pit or next to your abdomen or wrap it in a loose dressing. A frozen ear or cheek can be warmed with a hand; but do not rub or massage or immerse in water. And take better care next time — once bitten, you're at greater risk for future frost bite. (U. of T. *Health News*, Dec. 1985).

Pilonidal Cysts

The pilonidal cyst is located around the tail bone and is caused by an ingrown hair and follicle which blocks sweat glands continuing to secrete sebum and other fluids. For treatment, antibiotics and sitz baths may work if the cyst is small and doesn't constantly recur. Surgery to remove the cyst wall may be necessary if it is chronic and recurrent.

I am interested in other people's experiences with this common problem. The doctors I have seen have all recommended surgery and I am particularly interested in other treatment and/or cures which people have found effective: Ellen Reynolds, 196 Carlton Street, Toronto, Ontario M5A 2K8.

Request to Readers

Dear *Healthsharing* readers:

We are interested in establishing a pan-Canadian media contact list. We are sure that many of you have extensive knowledge in various health fields. We hope that you may be willing to speak with local and national media about health issues of concern to women.

Throughout the past few years members of Women Healthsharing have intermittently contacted and responded to media requests for information. Most of these requests are from Toronto-area media, but many have been from national media with Toronto offices.

During the last few months — with both the Depo Provera and the Dalkon Shield crises — Connie Clement, one of our collective members, has done more media work than usual. Because the Depo Provera campaign was planned (in three weeks, but still planned!), a number of women's health groups were able to share the media work. Even so, because she undertook some of the national media work many calls came in from across Canada. In some cases, Connie referred reporters to a local group or individual; in other cases, she didn't know a local person to handle the request.

We'd like to encourage you to share media work and media profile. While we all know that media finds it convenient to focus on stars, Connie doesn't want to be a star and neither do we as a group. We'd rather show media and Canadians as a whole how many feminist health activists there are!

If you are interested in responding to media requests, send us your name, address and telephone numbers. Tell us about yourself — a resume which lists paid and volunteer experience in feminism and health would be great. Tell us the issues you feel competent to speak about (and please don't exaggerate — we decline more media queries than we accept at Women Healthsharing because we strongly believe that if someone else is more qualified — or simply that we are not qualified — we shouldn't speak). Send us references if you can; anyone we might know or whose work speaks for itself would be best. If you've already done some media work, tell us about it or enclose examples of coverage. Tell us if you prefer newspapers, radio or television — some are more comfortable or skilled in one medium than in others.

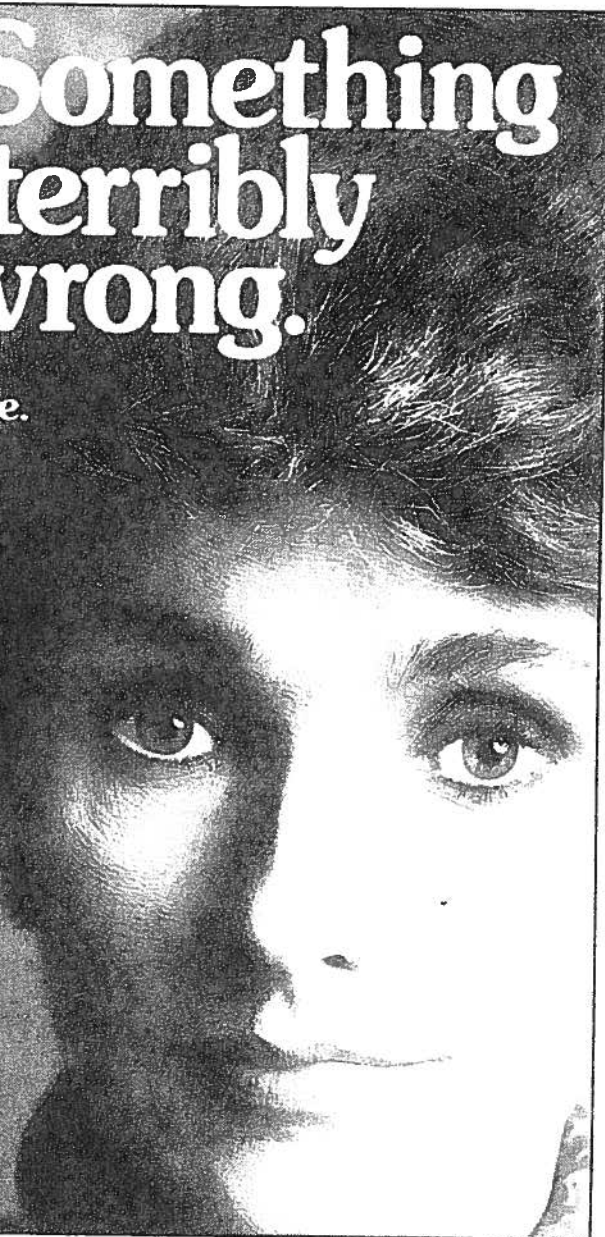
We want to foster good relations between the feminist health movement and Canada's journalists and media producers. The better our relations, the more and better the coverage.

Developing a comprehensive media contact and referral system is a major project — just the type of thing that would be suitable for a pan-Canadian women's health clearing house. We do *not* have the woman power or funds to do this to perfection, but we can promise to play a part in encouraging Canada's Toronto-based national media to quote and feature more non-Toronto women. You send us information about yourselves and we'll try to send you media contacts.

The Healthsharing Collective

Anne Rochon Ford

In Poor Health



**Something
is terribly
wrong.**

The menopause.

Is it right for a woman to suffer needlessly with hot flashes, sweats and sleepless nights? Is it right for her to be fatigued so often?

Is it right to allow estrogens to become depleted through the menopausal years, and to let this depletion cause problems when the clinical symptoms of this estrogen deficiency can be treated?

Is it right that a woman be denied the chance for an improved quality of life when millions of other women around the world have been helped with estrogen replacement therapy?

Natural estrogens...for the treatment of estrogen deficiency.

PREMARIN
gives her back something she's lost.

"If she could cope, she wouldn't have called."

"When women outlive their ovaries ..."

"When compliance is an issue with your female patient ..."

It's pretty hard to ignore advertising slogans like these. And yet most of us never see them. They appear in medical journals seen almost exclusively by doctors. They are the advertisements pharmaceutical companies use to advertise their products. They are not really available for the scrutiny of the lay public and understandably so, since the lay public are not the targets of these ads.

Many medical journals, from which doctors get a good deal of their updated medical information, are heavily supported by the pharmaceutical companies which advertise in them. While many of these journals are subscribed to by doctors, some are sent free and unsolicited to the doctors by the companies which subsidize them.

The advertisements placed in these journals by pharmaceutical companies are advertising products for one of the wealthiest industries in North America today. (Figures vary, but the pharmaceutical industry is consistently ranked in the top four most profitable industries.) Pharmaceutical companies have one aim — to sell their product. To achieve this, they invest millions of dollars annually in slick advertisements which sometimes run three or four pages an ad. These lace the journals doctors rely on for new information. Estimates of around

\$3,000 per doctor per year are spent by the pharmaceutical industry in Canada to convince doctors to buy their products.

In their glossy attempts to appeal to doctors, the advertisements frequently contain images of women which perpetuate long-standing negative stereotypes. Enough research has been done on the influence which advertising has on its viewers for us to know that doctors are affected by these negative images. The most well-intentioned doctors cannot help being influenced, in whatever subtle way, by the myths and stereotypes portrayed in these ads.

Ivan Illich and Thomas Szasz are among a number of social thinkers who have stated that doctors serve as agents of social control or "social gatekeepers." If we accept this theory, we should then ask how much of what doctors learn or have reinforced about women in this advertising contributes to their "gatekeeper role"? Elissa Mosher, an observer of the pharmaceutical ads, has noted:

"The suggestion is that women should be medically managed with mood-altering drugs when adapting to changes in their lives . . . The "empty-nest syndrome" and the "irritable post-menopausal woman" are advertising creations developed in timely response to women's conflicts and search for identity and fulfillment in our society.

It is important to bear in mind who the pharmaceutical companies are trying to appeal to in these ads. It is not you or me, the potential consumers of these products; it is the doctor who will choose to write that prescription. This fact raises interesting questions about why doctors choose to prescribe drugs so readily for women. The late Ruth Cooperstock of the Addiction Research Foundation found through a study of a Canadian population that women are more likely than men to receive a prescription for mood-altering drugs by a ratio of 2 to 1 and that that increases with age. She further found that symptoms presented by a woman — "My neck is always tense" — were more likely to elicit from a doctor the response of a drug prescription. The same symptoms presented by a man were more likely to result in the doctor sending him for lab tests or x-rays.

A few years ago, in some research I



he
is suffering
from
estrogen
deficiency

carried out for the federal Department of Health and Welfare, I looked at the image of women in the advertising pages of six Canadian and American medical journals between 1966 and 1983. The ads used women either to advertise a drug product specific to women (such as birth control pills or estrogen replacement therapy) or to highlight the use of a drug for women, even though the drug may have been indicated for both men and women (for example, tranquilizers). I found that a series of images of women appeared consistently; I have broken these down into a few themes:

Women can't cope

References to coping or the inability to cope are very prevalent in the ads

dealing with women, often in highlighted copy, as in "If she could cope, she wouldn't have called." Emphasis is on the woman's powerlessness, an effective device in the promotion of drug products. It is a particularly popular theme in the advertisements dealing with drugs for menopausal symptoms. The menopause is referred to in one ad as a time when women simply "are beside themselves."

The inability-to-cope theme is one that we will likely be seeing more of in years to come as increasing numbers of women attempt to juggle both families and careers outside of the home. The theme has been used most flagrantly, however, in ads for drugs for the elderly. One ad speaks volumes: "She doesn't know if she's coming or going" is the type of comment one



she
is the
reason
why

Behind... suffering...
 when symptoms point to
 estrogen deficiency, prescribe
premarin Ayerst
 the original conjugated estrogen

might overhear spoken by family members in semi-hushed tones, but the idea of using it in an advertisement, complete with trick photography, is in dubious taste. This ad, from a fairly recent medical journal, is, sadly, quite typical of ads for drugs for the elderly, in which a figure (more often female than male) is portrayed as hopeless, pathetic and simply unable to cope anymore.

Doctor Knows Best

Again, we need to keep in mind that these ads are geared toward doctors, not toward the general public. Doubtless, pharmaceutical advertisers have recognized the increasing need to tell doctors that they're OK, in spite of increasing attacks on their profes-

sion. Positive reinforcement, seen in one ad for Premarin (a drug used for estrogen replacement therapy) shows a woman in distress. It reads, "When she can't manage, you can," reassuring doctors of their powerful and important role in society and of how much their patients truly need *them*. The tactic is simple: tell someone they're terrific often enough, and they'll probably buy your product!

Many ads are geared at appealing to "the expert" in the doctor, convincingly reinforced by short, clipped sentences, as in another ad for Premarin which reads: "You're the expert ... Think of all you know ... You know who should and who should not receive estrogens ... You're the only expert who can help ... You know your patient ... her history ... her

family ... her expectations ... her concerns ... her real needs." It's hard not to imagine that the positive reinforcement in the previous ad is not a direct response to a growing self-help movement within health care. The implication behind "You're the only expert who can help" seems to be, "So don't listen to what your patient heard from another health care giver, such as a chiropractor or naturopath, or what she might know herself about her needs for estrogen or not." This theme is also illustrated in an ad for birth control which states "The local high school expert on birth control says that the Pill makes you fat ... She is often the primary source of information for her friends and her influence could lead to pill drop-out ... Teenagers appear to be obtaining their information on oral contraceptives from the wrong sources."

Another ad for a medication for premenstrual and menstrual problems goes overboard in reassuring doctors that they are the experts in the business of women's health care. We learn in this ad that if a woman is not consulting the doctor because she has premenstrual tension, it is because she is "indulging in a kind of conspiracy of silence, deliberately telling almost anyone but you (the doctor)." We are told that such patients are "cloaking" their "valid problems" behind a "feminine mystique" (exact words). In 1966, the year this ad appeared, premenstrual tension was quite routinely dismissed as "all in your head." The paranoia displayed in this ad copy is remarkable! In light of the text, the time at which the ad appeared is noteworthy — a few years after the appearance of Betty Friedan's *Feminine Mystique* and the gradual emergence of consciousness-raising groups.

Women are dumb

This theme in the ads doesn't appear to target a particular age group but, rather, crosses all of them. Often the graphic illustration accompanying the ad conveys the message that women are dumb more than the actual ad text. One of the most effective ways to illustrate that women are dumb is to treat them like children. "You're looking at a patient who needs an hematonic — chances are 1 out of 3 that she won't take it!" The smaller print reads "Many

patients fail to comply with the prescribed hematinic dosage regimen. In pregnant women, non-compliance has been as high as 1 out of 3." Words like "comply" and "co-operation" appear in the text as easily as they might in a manual for training animals.

One ad for vitamin supplements refers to forgetful elderly patients, using an elderly woman in the ad. The text is worded in such a way — powerful, one-line statements spaced apart — as to elicit a nod of recognition from any doctor about how dumb and forgetful his female patients are (particularly the elderly). It causes one to wonder if ads making this kind of appeal might be creating a self-fulfilling prophecy and causing doctors to *look* for behaviour in patients which may or may not be there.

Women can be a real nuisance to others

When we see how frequently ads with this theme appear, we can't help but wonder just who these drugs are for — the woman being prescribed them or her long-suffering family she has imposed her moods and crankiness upon? Another ad for Premarin, depicting an anxiety-ridden woman in the foreground and her family members looking puzzlingly at her from the background, reads: "Almost any tranquilizer might calm her down, but at her age, estrogen may be what she really needs." Again the idea is that she has been a bother to her family because of menopausal symptoms, but you can help her family by giving her *drugs*.

In the ads, she might not only be a nuisance to her family but to other members of the community. The language in this particular ad is clearly aimed at trying to make the doctor empathize not with the woman and her problem, but with the poor, long-suffering bus driver who has put up with her. We're told in the ad text that "she makes life miserable for everyone she comes in contact with." Including, of course, the doctor.

Women are complainers, the advertising says, and the more that idea can be enhanced in the ads, the more convincing is the advertiser's argument for the drug which will, of course, help to silence them. About the mother who comes into the office with a colicky

baby, one advertiser asks "How often will they be back with the same complaint?" In a study conducted by Cooperstock, the stereotype which doctors have of women as complainers revealed itself clearly. In her study, 68 physicians (general practitioners) were asked to describe a typical complaintive patient (to whom they had prescribed mood-modifying drugs). There was no reference to the gender of the person in the question. In their response, 4 per cent of the physicians spontaneously mentioned men as particularly complaintive, 24 per cent didn't mention either sex, and 72 per cent referred spontaneously to female patients.

One ad shows Cooperstock's observations in practice. The copy begins by referring to genderless "patients over 50," and before we know it, the hypothetical case has become a "her."

A woman's biology is her destiny

If we are to take pharmaceutical advertising as any kind of a reflection of reality, one of the worst things about aging for women is the menopause, signalling the end of the reproductive years. The implication here is that this is also the end of her useful years.

Menopause is referred to as the time "when women outlive their ovaries" and as a simple state of "ovarian failure." Language packs a strong punch in this ad text. Failure has strong connotations and implies that they *should* be continuing to function but are not. In fact, it isn't a case of failure at all. The female human ovaries are *supposed* to stop functioning at a certain point in a woman's life cycle. It is tempting to imagine the outrage from the medical community if we were to suggest in advertising that "men outlive their testicles or their prostate" (which, eventually, they do, but this is not a fact given much attention).

So much are the reproductive years valued in our society that their end can trigger "depression with moderate anxiety" as one ad states, while another speaks of using estrogen replacement therapy "for the emotional symptoms of the menopause related to estrogen deficiency." In addition, heterosexuality, marriage and mother-

hood are assumed in the ads, and any disruption of those states is cause for alarm — and drugs.

Women are a homogeneous group

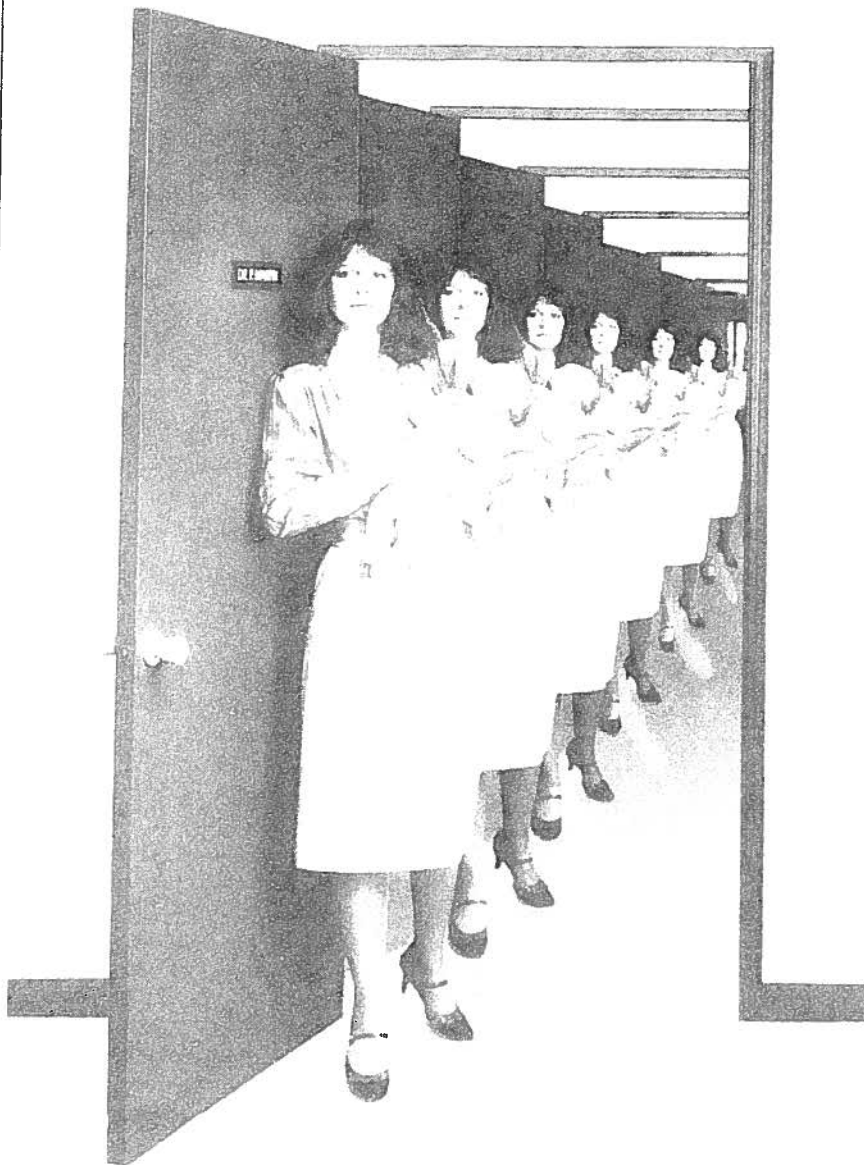
It could be argued that this assumption is true in the depiction of women in most forms of advertising, not just pharmaceutical. It is a theme which is cleverly illustrated by a photograph of a woman and a reference to "her" in the text. In a 1981 ad for an oral contraceptive, the assumption of a universal experience with first sexual encounters is evident in the copy: "her comfort and appearance is particularly important to her." Again, the copy is really more concerned about the doctor than about the woman herself. The advertisers suggest that the pill "should not cause unnecessary problems such as break-through bleeding, weight gain or acne which could jeopardize compliance." And again to reinforce the doctor's control over the patient, they are reminded in the ad, "You want to be sure she stays on her pill . . ."

Pharmaceutical company executives have also found it useful to adopt a language of pseudo-liberation by co-opting the language of the women's movement. The "You've come a long way, baby" cigarette campaign was part of the same trend. One ad for an antibacterial drug, asks whether this particular drug "discriminates in favour of women." The full-page visual for this ad is of three long-haired jean-clad young women, trying to convey to doctors that they (the advertisers) are with the times.

Another ad for Premarin tries to appeal to a sense of justice in doctors. It asks whether they don't think that it's a woman's "right" to be prescribed estrogen replacement therapy and thereby be entitled to "her own special quality of life." The ad copy tries to lead the doctor into believing that we have to accept that women have certain rights nowadays, and we owe it to them to be able to exercise their right to take this drug. In contrast with this attempt at showing women as having certain "rights", the copy writer relies on dated euphemisms like "the change of life" in referring to menopause.

When I have spoken with medical personnel about some of the images I

cramping... fussiness... regurgitation



How often
will they be back with
the same complaint?

have come across in pharmaceutical advertising, they reminded me that things really *are* improving — aren't they? — and that those horrible ads were from back in the sixties. It is true that the worst of the worst, the ads which provoke more of a laugh than a sense of anger, are found in journals from the sixties and seventies. The advertisers have had to clean up their acts to some extent, but in trying to do that, they have simply become slicker in their presentation. One notable improvement is that women doctors are appearing in the ads with greater frequency, and women in nontraditional occupations are being portrayed. But there is still a need for improvement. The gratuitous use of attractive women to sell products is as prevalent today in pharmaceutical advertising as it is in most trade advertising. The depiction of elderly women is often questionable, but is probably as much a reflection of how our society feels about the elderly as of how it feels about women.

Perhaps a more important question is whether it is ethical at all to advertise drugs. In the late 1970s, the Consumer Association of Canada made valiant attempts to have all drug advertising to doctors banned. Although they were not successful in their attempts, a closer examination of how women are depicted in the advertising should provide enough incentive for some of us to pick up the torch.

Anne Rochon Ford is the Resource Coordinator of Women's Health Care Programs at Women's College Hospital in Toronto. She is on the Board of Directors for DES Action/Canada.



Susan Penfold

Don't Blame Mother!

Theories in psychiatry, including those about mother blaming, come and go. Some theories rapidly gain ascendancy and hold everybody's attention, others fizzle out. Why does this happen?

Historical data suggest that underlying political and economic forces shape childrearing theories and determine whether or not they are popular. These data show that societal, political and economic pressures affect attitudes in the family.

In a recent paper on mother blaming, Paula Caplan and Ian Hall-McCorquodale describe their evaluation of 125 journal articles in nine journals, including the American and Canadian journals of psychiatry. The cause of psychiatric disorders was the focus of these articles. Caplan and McCorquodale hypothesize that any changes found in mother blaming attitudes might be related to the impact of the women's movement over the last 15 years. They hoped to see less evidence of it in the clinical literature. They examined articles for the years 1970, when the movement re-emerged, 1976 and 1982. They devised a method of scoring such items as how often mothers were mentioned, how often fathers were mentioned, how much the discussion focused on mothers' backgrounds and personality problems, and what part mothers were seen to play in their children's problems. They wanted to identify the philosophy underlying these articles. They found that two-thirds of the scored items were related to mother blaming regardless of the author's gender or the year of publication.



A couple of years ago, in Vancouver, I did a study of parents' perceived responsibility for the problems of children with complex developmental problems; these were children attending a child development clinic. I found the most substantial difference between the male and female parents was in attributing responsibility. Female parents were much more likely to blame themselves for their children's problems and behaviour. Male parents were much more likely to blame the female parent. There were some men who felt that they had some responsibility but they tended to view it in a different way than the women. The men were basically concerned with lack of discipline, whereas the women alluded to a more complex lack of affectional bonds and emotional relationship. The women who were blamed and who were self-blaming described a deep conviction that as wife and mother, they were responsible for the emotional health of all

other family members. Several mentioned failure to bond as the cause of the child's problem, as if something magical was meant to happen just after birth. They felt that they had been unable to bond with the child for some reason — they'd been sick or the baby had been sick, they weren't there, or they'd adopted the child; they had somehow missed out on an opportunity that couldn't be retrieved.

Beliefs about parents' influence on their children's behaviour have evolved over the last 300 years. Until the end of the Middle Ages a child was regarded as a small adult whose dress, responsibilities, recreation and habits of work didn't really differ from those of adults. Emotional bonds with parents were often diffused by wet nursing and the expectation that few children would survive beyond infancy. Kids who did survive were often sent out as apprentices or servants to other households. Alberti, a wealthy Florentine who wrote in the mid-15th century, was one of the first to acknowledge that children's early experiences contributed to their adult personality development. He emphasized the role of fathers by saying fathers should train their sons to strive for honor and fame. He thought the mother's influence had no importance except through their milk, which nourished the child. Written in the second decade of the 16th century, Thomas Moore's book *Utopia* talks about the formation of the ideal human community. He briefly discusses adult-child relationships and the treatment of children. He suggests that the people of that day thought very

little of these problems. Seventeenth century writings tended to instruct parents to chastize their children in order to tame their inherently evil characters. Bringing up children was seen as beating them if they were bad and sending them to church.

During the following 200 years recognition of the significance of love between parent and child began to emerge; this was a relatively new phenomenon. John Locke, in his writings on education, advised parents to use the child's capacity to feel fear and shame to train them and to shape their behaviour, rather like a modern day parent would do. Emile Rousseau warned that vice would be the inevitable outcome of parents inability to form affectionate ties with their children. He advised against the very widespread use of wetnurses and other substitute caretakers.

If we look into past centuries, we do not see the intense mother-child bond that has been advocated in this century. And we do not hear anyone require 24-hour mother-care in order to produce a mentally healthy child. This is a very recent, 20th century development.

At the beginning of this century professional concerns centred on the breeding of healthy stock, because of growing industrialization and the need for more workers, the loss of life of English citizens during the Boer War, and the deaths in North American wars. There was a great push to educate mothers to maintain their children's health. An ideology emerged that emphasized women's duty to bear and rear healthy children. Infant deaths and sick children were blamed on maternal ignorance and neglect. Childrearing literature emphasized the mother and the kind of health training she could provide, ignoring widespread problems of sanitation, pollution, overcrowding and poverty. World War I, with its immense loss of life, provided a further stimulus for child health and welfare policies. It became evident that not only did modern warfare consume a lot of soldiers, but victory would ultimately depend on the nation's production of healthy children.

Motherhood in the context of an intense and home-based family life, was accorded utmost importance.

Experts advocated a scientific motherhood that trained children to be neat, polite, clean, disciplined, precise and efficient. They were behaviourists, like Paul Watson, who claimed in his 1921 book *Behaviourism* that he could take any of a dozen babies at random and shape them into whatever he wanted; he could turn one into a doctor, a lawyer, a ditch-digger, a beggarman or a thief. He felt that environment was all encompassing; the baby was a lump of clay handed to you as a parent.

Imagine the responsibility presented to parents, especially mothers. There were many books that instructed parents to treat their children in a strict and rigid pattern. Fathers were told they must not hug their sons, they had to given them a gentlemanly hand-shake. How the child turned out was believed to depend on how well, how rigidly and how organized you managed to keep schedules.

Much of the ideology surrounding motherhood was temporarily suspended during World War II to allow women to maintain the labour force. Women flocked into factories taking a range of non-traditional jobs. At the end of the war a re-emergence of the traditional family structure and the need to employ returning soldiers facilitated sudden regulations barring women from many jobs and a massive appeal to maternal guilt and warnings about the dangers of maternal deprivation. The works of Bowlby, Klein and Isaacs were very much propounded on radio and in women's magazines; they emphasized that mothers needed to be with their children seven days a week, 24 hours a day. These "experts" now denounced the rigid, childrearing regime, promoted by Watson, and urged mothers to satisfy children's instinctual needs.

Theories on childrearing based on Freud's work stated that behavior and personality development were entirely dependent on the quality of the mother-child relationship during the first few years of life. While mothers were being idealized in this way, an undercurrent of blame was developing; mothers soon became scapegoats.

Idealization and blaming of mothers usually go hand in hand in the literature. On the one hand is the ideal mother who stays at home and looks after her children, the woman who is

nurturing and caring, wonderful and warm. Her opposite is the bad mother who doesn't do it right, who should be blamed for an enormous range of problems. I think these images are related to underlying cultural archetypes with roots in myths and stories about the good woman and the bad woman.

In 1943, David Levy's book *Overprotection* set the scene for treatments that focused only on mother and child. Any problems the child was attributed to pathology in the mother or to some negative interaction between mother and child. In 1948, Freida Fromm-Reichmann coined the destructive term "schizoprenic mother" — the mother thought to cause the offspring to become schizophrenic. In 1951, Bowlby's report on maternal deprivation, an influential document, concluded that mother love in infancy is as important for mental health as vitamins are for physical health. Bowlby argued that maternal deprivation caused juvenile delinquency, mental retardation, dwarfism, depression and affectional psychopathy. He charged that partial deprivation and consequent destructive effects on the child could occur when the child did not get full-time and constant attention from mom.

Writers of the 1940s through to the 1960s produced literature which we now see as mother blaming. They portray a schizophrenogenic mother as cold, aloof, domineering, critical and demanding. Parents of autistic children were viewed as causing their children's terrible affliction; often only the mother is blamed, viewed as destructive, engulfing, and totally uncaring. One of the best known for at least 15 years that autism has nothing to do with parenting is apparently due to an underlying chemical disorder or brain dysfunction. Mothers of autistic children were accused of not caring, hostility; asthmatic children were thought to be repressing a cry for help, realizing their mother's hostility. Mothers were thought to both neglect and overprotect these children. There were many similar theories during these decades.

From the mid-1960s through the mid-1970s an ideology of childrearing, particularly the idea of mothering for children's development and behavior

our were increasingly challenged. In 1964 Stella Chess wrote in *Mal de Mre* that the child's problem rests more on the imagination of a writer or a clinician than on any actual data. Many studies of this period indicate the child's experience in the first few years of life, including the mother-child relationship, are unreliable predictors of later behaviour. Studies of Korean and Greek war orphans reveal that despite the uncertainty of their lives during the war, they made good adjustments when, between the ages of five months and 10 years, they were adopted into North American homes.

The whole concept of maternal deprivation which was pushed so hard by Bowlby was questioned at this time. It was challenged by Yarrow in the 1960s and more comprehensively by Michael Rutter in his book *Maternal Deprivation Reassessed*, originally published in 1972. At the end of the 1970s it seemed to me, and to those of us who have been concerned, that mother blaming was on the wane; perhaps even laid to rest. Treatments were taking into account a host of factors like fathers, siblings, pattern of family organization and function, school, peer groups, the larger social environment, and the child's own characteristics and temperament.

While this multi-dimensional view of diagnosis and treatment has persisted in some areas, there have been some examples of the old view re-emerging — that is that what happens in a child's early relationship with the mother is all important. Vestiges of this view still haunt us. The result is mothers who feel unnecessarily guilty.

In his book *The Castrated Family*, published in 1977, Vaughan blamed many ills on liberated women; he called for a return to traditional sex roles and full-time mothering. Psychoanalytic theory was updated by Selma Fraiberg in her book *Every Child's Birthright*, also published in 1977. She claims that children are in jeopardy who don't have the full-time attention of one mothering person. Raising the spectre of maternal deprivation, her message to mothers is that each baby is entitled to and requires full-time mothering.

Theories of childrearing and parent-child relationships can be seen as the result of the gradual massing together

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of knowledge about child development and family relationships. But why do these theories wax and wane? Why do we hold that an intense mother-child relationship is the ideal, the best possible relationship for the child when other cultures have shared infant and child care? Why is this ideology temporarily suspended in time of war, as in England when nurseries and daycares were set up to enable mothers to go into the factories? How can something that is scientifically true be suspended when it's not convenient?

I propose that family patterns and practices are shaped by political and economic forces. Changes in the family may be prescribed by political leaders of the state to serve its need. In Nazi Germany, all women, married or not, were urged to have as many children as they could; Hitler promised he would personally become the godfather of every woman's seventh son. Similar pleas for more children were made in Churchill's stirring wartime speeches. In Japan in 1974 birth control pills became virtually unavailable and liberal abortion laws rescinded, partly because the birth-rate had declined and the supply of cheap labour was threatened.

In western society during 19th century industrialization, private and public spheres became more and more separate; the man went out to work and the mother stayed at home. Tasks previously performed by women at home or by the family as a whole —

making clothing, candles, soap, food preparing — were taken over by industry. As men became the sole breadwinners, women's participation in society became restricted to domesticity. At the same time, there was a growing idealization and glorification of the woman's status in the family. She became the angel of the hearth; but the glorification was accompanied by devaluation, as she was increasingly excluded from the public world.

The economist Galbraith decries the conversion of women into a class of "crypto-servants" emphasizing that the "sentimental cult of domestic virtue is the cheapest method at society's disposal of keeping women quiet without seriously considering their grievances or improving their position." Some women continued to work outside the home; they were and still continue to be marginal and temporary in the workplace, confined to segregated poorly paid jobs. To this day most women are part of a vast, reserve labour force called on in times of economic expansion or war, then urged back into the home and their vital full-time mothering duties during economic recession or when war ends.

I believe blaming mothers serves a number of purposes if you look at it in terms of the needs of the state. It gets women out of the work force, it obscures the structural sources of children's and families' difficulties by blaming individual women. People then don't look critically at poverty, terrible housing, poor schools, cutbacks, or discrimination as the source of familial problems; they don't even look at the great stresses caused by unemployment. They tend to look only at what should be done within the family itself. Mother blaming serves to preserve the traditional family structure of dominant male breadwinner and subservient wife and mother. It is clear that mother blaming often stems from cultural attitudes about women, and really has little or no scientific validity.

This article is an edited version of a speech given by Susan Penfold at the University of Toronto's Rosenstadt Lectureship in community medicine on December 5, 1985. Penfold is the chair of women's studies at Simon Fraser University in Burnaby, B.C. She has worked as a child psychiatrist at the University of British Columbia.

MY STORY, OUR STORY

Doctor Knife and the Inner Planets

Like many people I have a job, but, more important to me, when the spirit stirs I am also a writer. Recently I decided to take a year off salary and away from home. Two things were pushing me, one a family consideration; more pressingly, I had a book I wanted to start, and inviting the Muse/angel/whatever in my case always meant using the gifts my menstrual cycle brought me rather than letting them get absorbed by chores belonging to my job. At 50 I couldn't expect an indefinite flow of them; hence some urgency in taking that year whatever the difficulties.

Planning to leave in mid-June, I left my annual medical check-up until late May, whereupon a lump was discovered and I was sent to a gynecologist. Doctor Knife, a bright, friendly, efficient young woman, declared I must postpone my departure for an operation. While she meant to give me a special appointment "to discuss the procedures," I had pressed her for the earliest possible date for the operation, and found myself in the hospital before the appointment was even made. That night, sitting up in bed in a hospital nightgown and half-starved, ready for zero hour next morning, I was told that "procedures" meant a precautionary hysterectomy.

This of course was a blow. Once in the previous week I had called the doctor's office on some small point; when the nurse said "your hysterectomy," I said: "Hysterectomy nothing, she's just taking out a lump," and the nurse hadn't contradicted me; I thought no more of it. Now I told the doctor a hysterectomy didn't suit me at all: I needed my periods. She had my entire permission to open me up again the next week if she found good reason.

Doctor Knife, who presumably avoided the word "hysterectomy" at the first interview because she ex-

pected some flak, didn't seem to expect just this kind; I couldn't persuade her that wanting periods was talking about realities. The rest of the conversation stays with me only hazily. In the end, I didn't refuse permission for the hysterectomy, because I was persuaded I had no right to refuse; finally I supplicated that she leave the uterus in place if on inspection it seemed possible to leave it. Naturally Doctor Knife went ahead and did exactly what she had intended to do: a total hysterectomy. The good news that there were no signs of cancer (I had never expected any) meant that everything beyond removal of the lump had been unnecessary.

Later, on one of her hospital visits, Doctor Knife reassured me concerning my sex-life. For women not sexually active, she informed me a hysterectomy cut out any further activity, as the apparatus, once disconnected, just dried up;* however, I certainly needn't worry — just fend off lover or lovers for a few weeks. I said rather coldly that since I was as epically inactive as any patient she was likely to have, perhaps we could discontinue this subject. Her reaction surprised me. I wouldn't misrepresent it if I said this hard-headed young woman's jaw dropped, and for a moment she was genuinely taken aback. And why? Because by her own statement she had now deprived me of a future sex life, which she, as a woman with a healthy interest in sex, saw as valuable. What I valued, my right to my own cycle, I couldn't persuade Dr. Knife to even see as real.

*Editors' note: Although "use it or you'll lose it" has been a medically-supported myth, there is no clear evidence that women "dry up." Some women use topical creams. Contrary to what this writer was told, sexual activity (alone or with a partner) is not the deciding factor in whether or not a woman experiences post-menopausal discomfort from a dry vagina.

Once out of the hospital I recovered at lightning speed, with none of the troublesome symptoms that would make hormone treatment appropriate. I'm sure many women my age, probably the majority, would be glad to get rid of both periods and menopause with such extraordinary ease. But, while I worked industriously through the year and my enthusiasm for my project in no way lessened, all I could do was pile up information in a rather random style: no shaping impulse emerged; except for the previously mentioned family involvement, it was a year in limbo. And a very unpromising start to the rest of my life.

Two kinds of concerns arise for me out of these events. First, and minor, the way circumstances and my doctor's professional assumptions combined to take away my right to assess my situation, discuss it with others, and decide for myself if I would allow so drastic an incursion into — not my body, I can't feel personal about an unused mass of tissue that never, like my stomach, sent any direct messages — but my resources, physical and mental. Doctor Knife isn't a monster — a monster would have been easy to resist. She's a conscientious member of a human profession, though no doubt biased by training and perhaps temperament in favour of efficiency (the *precautionary* hysterectomy), the concrete (the uterus is for childbearing and keeping the vagina hooked up), and professional authority (Doctor Knows Best: ultimately, Your Organs Are Really Mine). I can't blame her, granted her view of her function, for deciding on an operation that to me seemed both unnecessary and desolating; I do blame her, though, for taking so lightly my right to be in on this.

Second, and major (this problem underlies the other one), Doctor Knife and her kind don't know what the menstrual cycle is good for because

those who could talk about it don't.

Well, I can remember a friend, who no more escaped headaches, depression, and much of the rest than I did, telling me she regularly used premenstrual tension to help her finish tricky pieces of writing. She told me this because I called, with some embarrassment, to go back on my acceptance of an invitation: I wanted to keep that evening clear, and felt like a superstitious idiot when I explained why. I wasn't accustomed to discussing these matters with anyone, and I found her response strangely cheering.

You must have done something right to be rewarded as well as a curse. And if two of us in my small circle know about it, there must be lots of us among Eve's other beneficiaries. And, together, while secret knowledge of this kind is very pleasurable to the possessor, my failure to persuade Doctor Knife suggests that this particular secret has been kept too well.

My own experience is as follows. I'm a typical intuitive feeler with a jackdaw's nest of unorganized mental contents, with little self-discipline but driven by guilts and the sense of duty the doctor played on. I've never taken this inner muddle in hand (like another friend who practised meditation to learn to concentrate); it was mine, I could get along with it (just), and most months — usually premenstrually — my good angel dropped in, for anything from a flash to maybe three hours, and did something interesting with the bits. It was like the lifting of — well, not so much a veil as a fuzzy blanket that usually muffled all the outlines: a few mental objects would light up with connecting lines between them, like flying over lit roads and suburbs at night. With this improved inner vision came a burst of energy and often some phrases or verbal rhythms that would help me to get some project at least started, bridged or wound up. Meantime, for that brief spell, life simplified itself, I could manage it, the guilt, and a laborious moralism that goes with them went off to play somewhere else.

The best comparison I can give is with the charts of the old astrologers plotting the "ceaseless round/of circling planets singing on their way," as the hymnbook puts it. The changing balance of one's hormone cycle is like that of a set of inner planets whose

dance through incessantly shifting alignments brings them regularly into favourable conjunctions, raining sweet influences on the lives under their sway.

What this arrangement brought me, apart from help with writing, was a sense of well-being amounting often to a conviction that this was the real me, by contrast with which the rest of my life looked like forced imprisonment in something like Miss Havisham's cobwebby house. Within an hour or two the inner heavens would shift again, headaches and bad temper would be on their way, and my period would arrive the next day; never mind, it had brought me something, even when I did no more with those un-ordinary moments than enjoy them.

All this delicately-constituted pipeline of blessings was yanked away by the intervention of Doctor Knife. All right, I had to expect it to dry up shortly; but I assumed my friends up there would have time to arrange some other channels of communication. Good angels, please, I am still waiting; don't you see me, have I dropped out of your universe?

You certainly don't have to be a writer to experience menstrual cycle variations in creativity: what about those good days or half-days at the office, in the kitchen, at the sewing machine, when the difficult seems easy and things shine in their own light? Are there many of us who see these as side benefits of that otherwise exasperating and embarrassing female system? For most, it's likely just a dim feeling.


The reason I can put my own notes on the table with such conviction is that one year, when I had embarked on a difficult piece of writing that kept stopping dead and then restarting, I overcame a superstition about springing traps on the Muse and kept a double calendar, of my menstrual cycle and of when the writing took fresh starts, and it was overwhelmingly convincing. From some thirty-five years of writing I'm pretty sure that nearly all the days when I could clearly see my way ahead came one day before the onset of my period; a few came quite precisely halfway between onset days; and very few indeed came outside of that pattern. Like five or ten in all those years.

I've said my piece, I'm not going to send out questionnaires and mount a

campaign; but some of you might think about it, talk about it, and *tell your doctor*. Doctor Knife is an educated, responsible citizen; there are things she needs to know, and she needs us to start telling her.

This My Story, Our Story was written by a Canadian writer who chooses to remain anonymous.

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REVIEWS

A Good Read About Midwifery

Midwifery is Catching, Eleanor Barrington, NC Press, Toronto, 1985, \$9.95 paper, 184 pp.

Reviewed by Betty Burcher

Midwifery is Catching reads like a good novel — you just can't put it down. From birth stories, to midwives' musings, to descriptions of communities served by midwives, to the Canadian political reality, Barrington carries the reader through the Canadian birth maze with her delightful story-telling style.

I first read this book when I was five months pregnant. I had already chosen a midwife but I found this book useful for friends or other pregnant women who wanted to know, "just what does a midwife do and how do I find or choose one?" However, this book should not just be read by birthing parents. It makes fascinating reading for anyone interested in the current status of the midwife within the Canadian health-care system.

Canada is one of nine countries in the world which does not recognize midwifery. But midwives remain part of our history. By the 1940's, the dominance of the medical profession, with legislation supporting its monopoly on health-care paralleled by our increasing trend toward hospital births, had wiped out the tradition of community midwifery. Only in pockets in Newfoundland did midwifery survive until the late 1960's.

But during the 1970's, midwifery underwent a revival. Barrington credits the renaissance of the midwife to "radical changes of public attitudes about birth since the 1960's and to the lack of a radical response from the hospital — medical system." Three movements for social change — the

counter-culture with its values on self-sufficiency and dislike of institutional power structures, the feminist movement struggling for reproductive choices and pride in 'our bodies,' and the natural childbirth movement — all collided with the bureaucratic power of the medical and hospital institutions. Midwifery evolved as an alternative response. In 1972, the first pioneers began and by 1984 there were over 100 active midwives in Canada.

Barrington devotes a chapter, "Vocation of Vigilance," to a description of midwives and their practice. Since midwifery is not legal in Canada and consequently no teaching schools exist, midwives have taken diverse paths in their training. Some have gone outside Canada, others have undertaken apprenticeships, but all share the same dedication and passion towards labouring women and birthing.

One chapter I especially enjoyed was the description of two seemingly diverse communities served by midwives — the new age community of the Kootenay mountains in B.C. and the Old Order Mennonites in the Kitchener area of Ontario. In the Kootenays, midwifery was made necessary by the geographical isolation, a desire for self-sufficiency, and a need for births more in keeping with lifestyle beliefs. Similarly, the Old Order of Mennonites were socially isolated and had values and a lifestyle that clashed with medical technology. Granny midwives had disappeared as had doctors attending home births, so Mennonite women had to go to hospital, sometimes without prenatal care. In response, two less conservative Mennonite midwives, with training and experience overseas, began serving this community. While safety and risk may be the catchwords that the medical profession touts in opposition to midwifery, Barrington sails us through the positive

arguments, statistics and evidence that surround birth practices and midwifery. She cites the international evidence — those countries with the most impressive outcomes (i.e. the least number of infant deaths) have the most extensive midwifery services.

Yet despite the evidence, midwifery is still not legal in Canada. In her final chapters, Barrington describes the current legal status and the history of the Canadian midwifery movement. The emergence of midwifery organizations is documented, as well as the effect of the College of Physicians and Surgeons' rulings and Coroners' inquests, which were intended to curtail midwives and home births but instead have acted as catalysts to further strengthen the movement. (For example, in Ontario, a Coroner's inquest in July 1984, which was called into the hospital death of a baby born at home with midwives in attendance, became a 3½ week trial on midwifery. In the end, the major recommendation called for the legalization of midwifery.)

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The fight is not over yet. Legalization is just the beginning. There are still the questions of relationship of nurse-midwives with lay midwives, "granny" clauses, home births, remuneration from health-care programs, and medical intervention. As Barrington comments, "women-centred midwifery care represents a significant advance in the struggle for feminist self-determination. . . . The respect for infant sensibilities inherent in midwifery bodes well for our children, and therefore the future. The effects of better births will eventually reach into every social and political realm."

Betty Burcher is a former Healthsharing collective member living in Toronto. She recently gave birth with midwives as part of the team.

Questions Still to be Answered

Cardiac Arrest: A True Account of Stolen Lives

Sarah Spinks, Doubleday, Toronto, 1985, \$19.95 cloth, 230 pp.

Reviewed by Allie Lehmann

Writing a book about the baby deaths on the cardiac wards at the Hospital for Sick Children (HSC) in Toronto, Ontario is no easy task — mainly because all of the people involved have very different stories to tell. In her first book, *Cardiac Arrest*, Spinks purports to tell everyone's story but she doesn't come close. She does, however, sensationalize the parents' plight while subtly promoting her belief that murder was committed.

Cardiac Arrest is a valuable book because Spinks is a first-rate researcher. She has synthesized reams of technical data and emotionally laden fact into a slim, readable book about the dramatic deaths. With the flair of a conscientious reporter, she leads the reader through the deaths, the subsequent police investigation, Susan Nelles' arrest, the preliminary inquiry and discharge, the Dubin inquiry into the workings of the hospital, and the Samuel Grange inquiry into the whole affair.

On first reading the book is absorbing, yet upon further reflection, it's disappointing because the hard-nosed

analysis one expects from a former registered nursing assistant and labour organizer just isn't there. I found myself turning the pages (the book is chock-full of cliff hangers) anticipating a critique which never materialized.

Spinks does, for example, lambaste the police, hospital and judicial systems for their respective roles in the drama, but she is reserved in her criticism. She is much less even-handed when it comes to bombarding the reader with evidence of murder.

Spinks accepts the toxicology evidence about digoxin, notwithstanding the tremendous criticism of the data by objective scientific experts. Although she discusses the debate on toxicology which ensued at the Grange inquiry and outlines commission counsel's arguments disproving accidental overdose, she doesn't supply enough of the detail which could poke holes in the murder theory. The writing becomes a balancing act — how much weight goes to murder versus other theories — but Spinks clearly leans toward the murder theory.

She tells the parents' story well and clearly sympathizes with Nelles over the shoddy treatment she received at the hands of the police. She is much less reserved in her critique of the hospital and the judicial system. While she refers to serious communication problems pervading the HSC, the staff nurses' perspective doesn't come through. Issues facing nurses such as workload, staffing, competence and so on are not critically examined in relation to the deaths. Nor does Spinks make the connection between administrative problems and the hospital's fierce determination to prevent unionization despite repeated attempts by nurses to organize.

Spinks is also mute on the point that the long-running and expensive Grange inquiry made no recommendation to improve the workings of hospitals.

But my biggest problem with the book is one of style. In making her text readable and attractive to a large audience, she has inserted trivial details which diminish the overall quality. For example, who cares if Kathy Coulson, a former nursing supervisor, happens to don leather and ride a motorcycle? What relevance does her attire have to what happened? And the details about

Phyllis Trayner's life are even more damaging. We are told of her working class background, her isolation at the Grange inquiry compared to Nelles' affluence and popularity, and a passage also discloses that Trayner set her dining table for eight when no one was expected for dinner. Readers have told me with all seriousness that this odd behaviour infers Trayner's guilt. What nonsense, but one wonders why Spinks bothered to include it. And while she makes constant reference to Trayner's presence for all of the baby deaths, Spinks still maintains there is no direct evidence linking Trayner to the deaths. Yet these unfortunate references imply guilt by association.

Spinks' underlying theme throughout the book seems to be that health-care workers deny their emotions and repress their intuitions in favour of science and hence can't contemplate that a person may be capable of murder.

Health-care workers however, contend that a hospital rife with problems, lousy working conditions, inexperienced and insufficient staff are even more heinous to contemplate — hence it is easier to point fingers as Spinks does, than seriously and critically analyze the problem. While *Cardiac Arrest* touches on many important issues ranging from problems women face in nursing to public inquiries which violate civil liberties, the analysis never goes far enough. The book becomes frustrating to read because it seems more like a background to a news clip than an in-depth appraisal of events. Even though Spinks tried hard to sympathize with everyone, her objectivity was frayed right from the start.

Her last few pages concern the effects of the deaths on the nursing community. She maintains that nurses will likely never go 'like lambs to the slaughter' again — if only this were true. While definite gains have been made by nurses, it is almost impossible to document extensively, continuously question or assert their points of view within the rigid hospital hierarchy. Until structural changes within the system occur all the personal will in the world won't prevent nurses from being scapegoated.

When health-care workers read *Cardiac Arrest* let them be aware of

the questions Spinks hasn't addressed or answered. The definitive book on the events at HSC and their implications has yet to be written.

Allie Lehmann RN BScN was the liaison officer at the Grange inquiry for the Registered Nurses' Association of Ontario. She is currently seeking employment after the birth of her daughter.

Don't Judge a Book by its Cover

Every Woman's Health: The Complete Guide to Body and Mind
 Edited by D.S. Thompson, Doubleday, New York, 1985, \$27.95 hardcover, 823 pp.

Reviewed by Teena Marie Johns

Every year bookstores throughout North America are flooded with a variety of health-related literature. A reader makes a selection based on her own personal or professional needs, anticipating new and updated information, different perspectives on existing health issues and future plans for health care to come. At first glance, *Every Woman's Health: The Complete Guide to Body and Mind* appears to be just such a book. The table of contents strikes the reader as comprehensive and informative. Women's health seems to be approached from all perspectives; physical and emotional components appear well considered, with information on contemporary concerns of health on the job, mental and emotional health, changing roles, middle age and aging healthfully. Each of the eighteen chapters is written by a different female physician.

The book is divided into two parts. Part one, "Guide to Total Health," covers health issues such as nutrition, reproduction, sexually transmitted disease, cosmetic surgery, rape, abuse and *you*, your doctors, and the health care system. Part two is an "Encyclopedia of Health & Medical Terms" with 950 definitions and appendices on immunization guides, pharmaceutical information, health care personnel and an American Directory of Health Information.

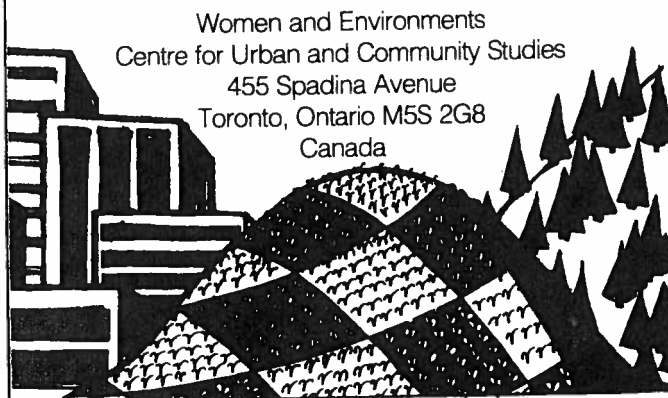
The chapters are easy to read and aim to put the reader at ease.

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Diagrams and illustrations, including 15 colour plates, substantiate much of the information. References and bibliographies are included at the end of many chapters.

But, overall, the material presented is merely general. Subjects are treated with some sensitivity and candor but clear answers to specific questions are not forthcoming. It is even difficult to say that *Every Woman's Health* might be used purely as a reference book, since it lacks clearcut, straightforward information. Current major health issues like AIDS and DES action are barely highlighted, and chlamydia and herpes, both well researched infections, are given only cursory comment.

Reference material and bibliographies are predominantly medical texts and periodicals and as such offer little in the way of accessible information. The attitudes of the contributors tend to be conventional, at times even verging on judgemental. For example, although non-traditional family roles are presented, some of the statements describing "living together" couples (as opposed to married) as rarely having relationships lasting more than ten years left me stunned.

Perhaps one of the most disconcerting aspects of *Every Woman's Health* is the overwhelming emphasis on the physician as the primary focus of health care. Prevention, responsibility for one's own health care and self-help concepts are openly discussed, as well as multidisciplinary approaches to health care. But, it is not quite enough. In the appendix "Health Care Personnel," there are 3-1/2 pages of descriptions, definitions and qualifications of physicians and a meagre few lines devoted to each of the other members of the health care team, including registered nurses, social workers, physiotherapists and psychologists to name only a few. Once again, the attitude "discuss it with your doctor" prevails.

It's hard to say who would benefit from *Every Woman's Health* — perhaps one to whom the whole notion of women's health and taking control of one's health is foreign and frightening.

Teena Marie Johns is a nurse working in community and emergency medicine

LETTERS

Changing the Victim Image

I have subscribed to *Healthsharing* for one year. I am not renewing my subscription. I am disappointed in your magazine because it's main focus seems to be on 'woman: the victim.'

While I do agree that we have been subject to many unfair situations in all aspects of our lives, I believe we are also responsible for allowing the injustices. I am not interested in reading articles that emphasize our victimization, that have a note of bitter complaint and point fingers of blame at others. I am interested in reading articles that will help me (and others) learn how to become more responsible for ourselves.

I would like to see your magazine focus more on ways in which we can learn to take control of our lives, to be strong enough and yet still soft to fight for change, to learn the balance between masculine and feminine, to take care of ourselves mentally, physically, emotionally and spiritually. There are many new and wonderful changes occurring in our society — let's hear about them and build on the positive, not the negative.
Pat Johnston
Victoria, B.C.

Shoddy Media Coverage

I was glad to read the item *BioSelf 110 Launched* by Barbara Lamb in the Update section of Winter 1985.

Very shortly after I had read what I considered a very condescending, exploitive

news article in the *Globe & Mail* about BioSelf 110, I tuned into a local CBC Halifax afternoon radio show that did a satire on this new device. It was written by men. I was absolutely shocked that these CBC men could use the topic of contraception for women as a vehicle to publicly insult and humiliate any woman who had the misfortune to be listening. In the satire women were portrayed as having *less* integrity than animals where sexuality was concerned. For example, the joke went: what happens if a woman's "BioSelf" blinks go (green) and she's in a public restaurant? She does it right there with the first waiter that appears. It went on and got worse.

The article in the *Globe & Mail* was nothing more than a promotion for this hunk of junk, going into explicit detail about taking temperature from the vagina, and so on. The article also made stupid jokes and then went on to say how fantastic the product was.

Well, that was the only so-called *news* that I read about this new product. *Healthsharing's* article was the story with the truth of the matter. The fertility awareness method of contraception will not be made very much more reliable because of this \$97 piece of plastic with a cheap computer. This method is what it is. Obviously this is a profit product, again at the expense of women. But not only are we once again exploited with ridiculously high costs, we are also insulted and publicly

humiliated with journalism that sells out its integrity in the name of sales promotion and by men who have the privilege of freedom of speech through a Canada-wide public media, who can find nothing better to say than to insult and degrade women.

I hope to see more articles like the update on "BioSelf" in *Healthsharing*. They are very, very necessary.

I should also note that I made formal complaints to CBC Halifax and the *Globe & Mail* through *Media Watch*. Of course, I received no response from the CBC or the *Globe & Mail*.

Carol Fennell
Halifax, N.S.

Infertility Explored

I am writing in response to your Fall 1985 issue on *Reproduction in a New Age*. Admittedly I read the articles with avid interest since I have had an unexplained infertility problem for twelve years. My husband and I have gone through all the routine tests currently available, have tried artificial insemination with my husband's sperm, and this past summer we were in the in vitro fertilization program here in London. We have two adopted sons so we are well accustomed to all the alternatives available for infertile couples to be parents.

Throughout these past frustrating years, I have spent countless hours trying to resolve my disappointment with our infertility. I have blamed God, my genes, my husband's sperm, our families, societal expectations — anyone or anything that seemed halfway appropriate. I have examined my motives for wanting to experience not just motherhood (which I now have), but the actual pregnancy, labour and delivery of a natural child.

As a result of all this soul searching I have decided that it

is not just our male dominated society that has placed this need for a natural child on me. I do believe there is a biological basis for this yearning. Even after reading *Test Tube Women, What Future for Motherhood?* edited by Arditti et al., I cannot agree that it is solely the patriarchal nature of our culture that has put me on this journey for pregnancy.

I find it absolutely wondrous that medical research has advanced enough to allow for in vitro fertilization programs. I do concede that more research is necessary in the male factor area and I have learned recently that there is at least some research being done currently in that area. It does concern me a great deal that the future of reproduction can go in many directions, some very negative and frightening.

With this new era in reproductive techniques, I do believe it is vital for women, fertile and infertile, to honestly assess their own needs and wishes and the basis for their choices. It is important for women to look at issues such as whether to conceive or not, and when and how; surrogate mothers; women as egg donors; IVF; women as incubators for fetuses; cloning; and artificial preselection of perfect babies of the "right" sex.

Our decision to try IVF provided yet another opportunity for my husband and me to assess where our needs lay, what we were willing to risk and why. Although the unsuccessful attempt was one of the most devastating times in our fertility quest, it has helped me to finally come to terms with my infertility. Going through that very stressful process forced me into a greater level of awareness of what I already had in my life.

Janet Mochizuki
London, Ontario

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RESOURCES & EVENTS

Midwifery in the Americas

The Midwives Association of British Columbia is sponsoring a regional conference for the International Confederation of Midwives to be held at the University of British Columbia, Vancouver, B.C. May 23 to 25, 1986. The theme is "Midwifery in the Americas" and the conference will focus on the age-old desire of women for the special care of midwives. This desire is providing the impetus for the resurgence of the modern midwife who is well-versed in modern obstetrics and in the traditional art.

For program and registration information contact: Midwifery in the Americas, 801-750 Jarvis Street, Vancouver, B.C. V6E 2A9, (604) 681-5226.

Microtechnology resources

The Participatory Research Group has produced three new resources about women and microtechnology. All the resources address health problems, isolation and deskilling as effects of microtechnology on our lives.

Who's in Control? is a 30-minute slide/tape show which portrays women caught up in the changeover to microtechnology. *Short Circuit: Women in the Automated Office* and *Short Circuit: Women on the Global Assembly Line* are the two booklets.

All are available from the Participatory Research Group, 229 College St., Toronto, Ont. M5T 1R4 (416) 977-8118. *Who's in Control?* can be rented for \$25.00 or purchased for \$150. The booklets cost

\$4.00 each; \$3.20 for 5-10 copies; \$2.50 for 11 or more copies; add 15 per cent for postage and handling. All literature orders pre-paid.

Herbal Remedies

Wise Woman Herbal for the Childbearing Year is a comprehensive and usable guide for women during their pregnancy and in the months following childbirth. The book provides women and health practitioners with reliable, natural remedies to ease pregnancy, increase energy, relieve diaper rash and colic among many other things. The author, Susan Weed, has studied herbal medicine for twenty years and conducts workshops and seminars across the U.S. and Canada.

The book is available in paperback for U.S. \$6.95 and hardcover for U.S. \$12.95 plus \$2 for postage. Make cheques payable to Ash Tree Publishing Company, P.O. Box 64, Woodstock, N.Y. 12498.

No so crazy

A new film entitled *Not Crazy Like You Think* has been produced by Jacqueline Levitin, a Quebec filmmaker. The film portrays a dozen past or present psychiatric patients. The documentary shows them talking about insanity, incarceration experiences and roles played out by themselves, family and professionals.

The film is available from DEC Films, 299 College St., Toronto, Ont. M5T 1R4 (416) 597-0524. Available in 16 mm (73 min.) or three-quarter inch video (60 min.). Rental: \$150; \$125 for community groups.

Books About the Dalkon Shield

Three books have been released during 1985 about the Dalkon Shield and the controversy surrounding this intrauterine device taken off the market in 1974 because of septic abortion and some deaths.

The best of these books is *At Any Cost: Corporate Greed, Women and the Dalkon Shield* by Morton Mintz (Pantheon, 1985). Cost for the hardcover only book is \$25.50.

Nurses and the law

A one-day seminar entitled "Nurses and the Law: Legal Implications of Nursing" will be held in Charlottetown on May 21st. Sponsored by the P.E.I. Nurses' Union, the seminar is free for members. Brochures, posters, including registration fee information, will be available in March.

Contact the P.E.I. Nurses Union, Box 1284, Charlottetown, P.E.I. C1A 7M8.

Teenage Pregnancy

A newly revised edition of "What Happens Now?" a discussion on teenage pregnancy, is now available from Second Story Women's Centre in Bridgewater. It provides information regarding alternatives for pregnant teens, health and legal advice, where to obtain help, as well as suggestions for dealing with one's emotions — all in a sensitive, easy-to-read style.

Individual copies cost \$1.50 each, plus postage and handling; bulk rates are available on request. For more information contact Second Story Women's Centre, 9 Dominion Street, Bridgewater, Nova Scotia B4V 2J6, (902) 543-1315.