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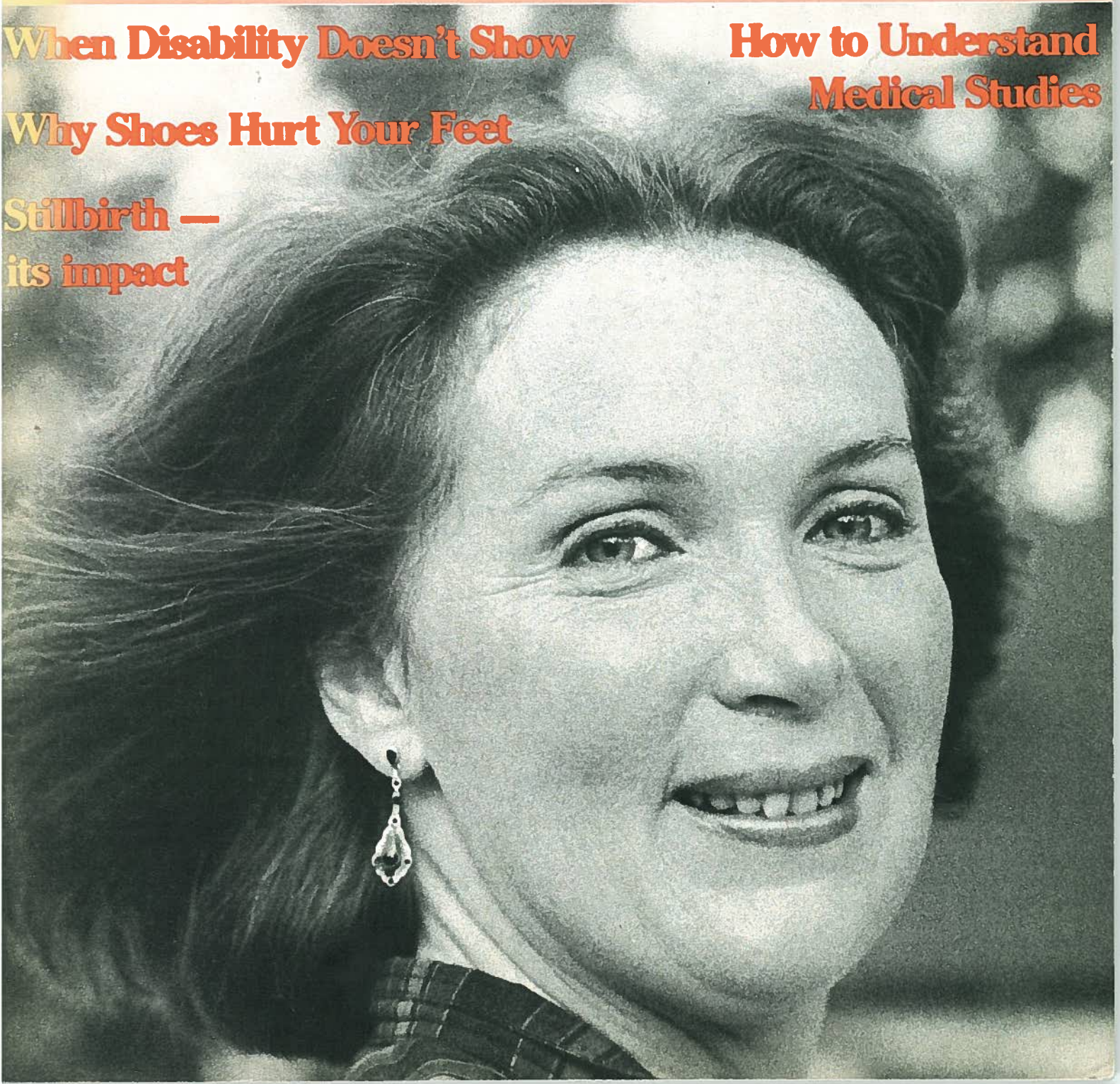
A CANADIAN WOMEN'S HEALTH QUARTERLY

When Disability Doesn't Show

**How to Understand
Medical Studies**

Why Shoes Hurt Your Feet

**Stillbirth —
its impact**



INSIDE

Vol 8:4

September, 1987

Collective Members

Amyra Braha, Connie Clement, Susan Elliott, Deborah Feinstadt, Alice Grange, Connie Guberman, Diana Majury, Lisa McCaskell

Administration

Connie Clement, Katie Pellizzari

Advertising

Alice Grange

Circulation/Promotion

Heather Allin, Mary Margaret Crapper, Deborah Feinstadt, Theresa Wright, Sharon Klein, Lynn Goldblatt

Copy Editing/Proofing

Elizabeth Allemang, Susan Elliott

Design/Production

Alice Grange (coordinator), collective members, Heather Allin, Elizabeth Amer, Pam Bristol, Jill Cameron, Mary Margaret Crapper, Barbara Muirhead, Heather Ramsay, Ida Wellwood, Theresa Wright

Editorial

Connie Clement (coordinator), collective members, Frumie Diamond, Bonnie Lafave

Typesetting

Lynne Fernie/Type A

Printing

Delta Web Graphics

Cover Photograph by

Katherine Mann-Buchanan

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COLLECTIVE NOTES



Heather Allin

top row: Amyra Braha, Deborah Feinstadt, Susan Elliot and Lisa McCaskell.
bottom row: Connie Guberman, Alice Grange, Connie Clement and Diana Majury.

We hope you have had as good a summer as we have! This issue includes more personal stories than our usual format — we like it and hope you do. Rather than tell you our stories, here is a photograph so you can see what this group of women really looks like.

the members of Women Healthsharing

LETTERS

Dignity and reverence

What a pleasure it was to read *Celia's Blessingway* (Summer, 1987)! How lucky this young woman is to be surrounded by people who appreciate the importance of this great event in every woman's life! We can all benefit from the type of creative ritual described by Judi Pustil. Just think how we would truly prosper if every human passage were treated with the dignity and reverence it deserves!

Thank you for sharing your story, Judi.

*Lucy Watroba
Hamilton, Ont.*

Healthy environments

D'Arcy McKillop Farlow's article on the Epp Report (*Achieving Health For All*, Summer 1987) cuts quickly through the rhetoric to the fundamental question: can and will the government address the environmental and social causes of ill health?

We don't know the final answer to that question, but we do know that the Health Minister's recent actions indicate a willingness. His officials have hired our company to carry out a wide-ranging review of "healthy environments," and to recommend research priorities.

Our focus is on the following questions:

- What kind of environment is healthy for Canadians?
- What kind of environment is not healthy for Canadians?
- How do we create a

healthier environment for Canadians?

We intend to challenge old assumptions, and we are not afraid to identify the real issues crisply and clearly. We are also consciously trying to avoid sexism, homophobia, racism, ageism, prejudice against people who are ill, and other bias, in this study. We will need help from your readership in doing all of these things.

Anyone who is interested in contributing ideas or literature references relevant to this topic is invited to get in touch with us as soon as possible. Call us at the Sunnyhill Research Centre, 416-294-3531 (local to Toronto phones) and refer to the 'healthy environment study.' Or write to us at R.R. #1, Goodwood, Ontario, Canada L0C 1A0.

If you wish a copy of the final report please leave your full address.

Barbara J. Small

Bruce M. Small

Goodwood, Ont.

Dilantin dangerous

For the last year I have been researching a commonly used drug, Dilantin. This anticonvulsant has been marketed in Canada since 1938.

According to the medical literature, Dilantin (Phenytoin, Diphenylhydantoin) is the most widely used drug for epilepsy. It is prescribed widely for migraine headaches, anxiety, behaviour problems, central nervous

system symptoms and heart ailments. When taken by pregnant women it can cause 'fetal hydantoin syndrome' (FHS). This syndrome is characterized by a variety of major and minor abnormalities consisting mainly of craniofacial anomalies (e.g. cleft lip/palate, impaired hearing); heart defects; central nervous system abnormalities; limb and skeletal malformations; mild to moderate retardation; developmental delay and intellectual impairment.

A conservative, commonly accepted incidence of major congenital abnormalities in the newborn exposed to Dilantin is at least 11 per cent plus another 33 per cent with development delay and intellectual impairment. Compare this to the 2 per cent general population rate for congenital defects. One study found that only 28 per cent of exposed fetuses could be considered normal.

Women must call on Health & Welfare Canada to make laws and regulations which govern safety of drugs (passed in 1951) retroactive. The excuse which Health & Welfare gives of not having enough money to monitor 'old' drugs is not valid, as pharmaceutical companies could be expected to contribute if they wish to sell their products in Canada. In 1983, several Wall Street analysts estimated that Parke-Davis makes up to \$100 million a year on Dilantin, making it their best selling product.

I would appreciate it if you could inform people of the dangers to women of child-bearing age and the exposed fetus. I would like to hear from others with children affected by Dilantin, Thalidomide, Bendectin, etc.

*Stephanie Ledingham
Ottawa, Ont.*

(Send letters c/o C. Clement at Women Healthsharing)

Achieving Health well integrated

I was delighted to see a review of *Achieving Health For All* in the summer issue. As a fitness professional, I can see my own work as fitting into the Health Promotion Framework, and it's gratifying to see the holistic, integrated approach that the framework takes.

I agree with many of D'arcy McKillop Farlow's statements (e.g. women and tranquilizers, the empowering effects of women's health networks and services), but I disagree with her statement that the report "pushes people to assume impossible levels of individual responsibility without recognizing that they have decreasing control over the environment in which they live." At a recent address to the International Congress of Health, Physical Education and Recreation, Ian Shugart, senior policy advisor to Jake Epp, said:

"While Canada can be justly proud of [previous health promotion] initiatives, our changing understanding of health has also made us realize that there are some major problems with a health promotion approach that focuses almost exclusively on individual lifestyle change.

"Exclusive focus on lifestyle change can lead to a tendency to 'blame the victim' for health behaviours that are largely a result of environmental and cultural circumstances.

I believe, as does Farlow, that the Epp Report "does offer value." It is the result of the concentrated efforts of many individuals. It is a breath of fresh air in a health promotion "culture" that persists in the "eat right and exercise" recipe for a healthy life.

*Cathy Beaumont
Toronto, Ont.*

UPDATE

Alberta cutbacks

On May 19th, the Conservative government in Alberta announced the removal of what it calls "non-medically" required services from the Health Care Insurance Plan, effective August 1, 1987. The long list of cuts includes the deinsuring of contraceptive and premarital counselling, tubal ligations and vasectomies, IUD insertion, and eye care for anyone over 18 and under 65. In addition, benefits for physical services are reduced. The Minister of Hospitals and Medical Care, Marvin Moore, says the prime reason for removing these services is that a few physicians were "abusing" the Alberta Health Care Insurance Plan in their billing for these services. No proof has accompanied these serious allegations. In removing these services, the Getty government has punished the users of medicare for alleged misconduct of some doctors.

The far reaching effects of these cuts cannot be overestimated. \$2.1 million that the Alberta Health care Insurance Plan paid on behalf of women for reproductive services has been arbitrarily cut. The adolescent pregnancy rate in Alberta is an alarming 36.8 per cent higher than the overall Canadian rate. Alberta also has the highest rate in Canada of teenage hospitalization for pelvic

inflammatory disease and ectopic pregnancy, indicating that sexually transmitted diseases are an urgent problem.

A further indication of the disturbing "cut back trend" in Alberta, especially cuts affecting women, was the Conservative government's decision in June not to give \$200,000 in emergency funding to two shelters for battered women. The Alberta government is creating a two-tiered health system which will result in enormous social and economic costs to society. Once again, those less able to pay and most needful of services have been unfairly burdened.

In response to the cutbacks, the Alberta Coalition For Universal Health Care, a new and growing coalition of diverse groups, has formed. In addition to demanding that the government of Alberta reverse the cutbacks, the coalition seeks to mobilize Albertans to become involved in policy decisions affecting health care. Long-term strategies have been planned to ensure continuation of universal cost effective health care in Alberta. For more information about the coalition, please contact Chris Hunter, (403) 263-1550, local 336.

JOAN HOLLENBERG

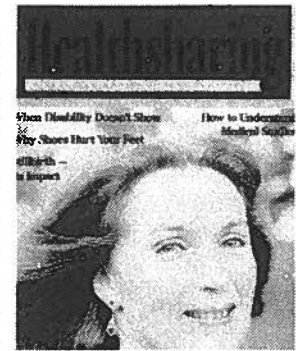
Rural women's health

Women Today of Huron County will soon receive a \$13,500 grant from the Ontario Ministry of Health to produce a video and support material for a project dealing with health promotion for rural women. Earlier this year another provincial government agency, the Women's Directorate, agreed to provide \$15,000 toward the \$28,500 project.

The video and accompanying materials are meant to assist other rural women's organizations in developing mutual aid support groups as a means of promoting women's health. The video will portray the variety of groups that Women Today has been able to establish as part of its Women Being Well Project, also funded by the Health Promotion Directorate. Over 100 women meet regularly in various groups associated with the project.

Making the announcement on behalf of Health Minister Murray Elston, Jack Rieddell, MPP for Huron-Middlesex, said the provincial government is very supportive of this project because it increases community awareness of women's health issues and enables women to take responsibility for their own health. He said, "Women Today is a well recognized group that helps rural women to learn to help themselves."

VALERIE BOLTON



About Our Cover Photo...

Lorraine Fry is photographed here by Katherine Mann-Buchanan, one of her many long-time sisters on Toronto Island. Lorraine is a community legal worker, working with immigrant blue collar workers who have suffered injuries, disease or other trauma in the workplace.

Apology

Our apologies to readers and to authors Mary Breen and Janis Wood Catano. We goofed while laying out *Can She Read It? Readability and Literacy in Health Education* (Summer, 1987). A box entitled 'How to Write for People with Low Literacy Skills' was cut by half through an editorial-design confusion. Because the *meaning* was changed significantly, we have agreed to reprint the box in its entirety.

You will find the box on page 16 in this issue. We encourage you, if photocopying small quantities, to be sure to add this page to the summer article. [To reprint, we request you obtain permission first.] Women Healthsharing and the authors have copies of the full article in a new layout, should it be useful to you.

Our apologies to Paul Schwartz whose photo credit for page 6 of the Summer 1987 issue was inadvertently deleted.



Elizabeth Mueller, a former Dalkon Shield user fielding questions from the press outside A.H. Robbins Canadian headquarters.

A Toronto demonstration and a press conference in Vancouver, held on July 21st, marked the date that U.S. bankruptcy courts finalized corporate reorganization plans for A.H. Robbins, makers of the Dalkon Shield intrauterine device. Over 300,000 women have filed claims against the company for damages resulting from wearing Dalkon Shields. Dalkon Shield Action Canada can be reached c/o the Vancouver Women's Health Collective, 888 Burrard St., Vancouver, B.C. V6Z 1X9.

Health reviews underway

Several government advisory health panels in Quebec and Ontario are expected to make recommendations in the fall.

In Quebec, the Rochon Commission, which has been reviewing health issues for two years, released preliminary documents in May. Although the report, available in French only, made no recommendations, its general tone implied recommendations anticipated in a final report to be completed September, 1987. The report has focused on defining glaring social and geographic inequalities in access to health and health care.

The problem is not simply inadequate distribution of services and personnel. The

report backs statistical trends from the federal government and shows that life expectancy at birth in poorer parts of Montreal is 13 years less than in richer sections. For the Inuit of northern Quebec, life expectancy is half the Canadian average.

In Ontario, the Evans Committee reported in late June and the Spasoff Committee is expected to report later this year. Although the need for two similar committees has been questioned, the Health Review Panel, chaired by Dr. John Evans, has examined availability and usage of services; the committee chaired by Dr. Robert Spasoff is focusing on determinants of health quality. Spasoff intends

Immigrant women's conference

In May, 1987 the Vancouver Society of Immigrant Women sponsored its first conference. Titled *Immigrant Women's Well-being*, the conference attracted over 100 participants from a wide range of immigrant groups as well as interested health and social workers. The opening keynote address was followed by three panel discussions in the morning — one on personal experiences of immigrant women, another on coping with stress, and the third on self-image and self-esteem.

In all, women were eager to share their experiences and to learn from one another. The panel on coping with stress touched on many factors that come into play when women are faced with stress including eating behavior, and drug and alcohol use.

To close the morning Rosemary Brown, former British Columbia MLA, gave a moving speech about low self-

esteem as well as some interesting and entertaining pointers on how to establish self-confidence in a new culture and new surroundings.

Participants returned in the afternoon to a choice of five workshops. In the smaller groups women really got to talk more about topics such as family violence, problems of adjustment, and decision-making. Many emphasized how much they were breaking from traditional roles and about the fear and satisfaction that brings. Women left the conference wanting more time and more discussion.

Women brought proud traditions from many corners of the world. This was a wonderful experience for Vancouver whose fast growing immigrant population is having a strong and positive impact on the city.

MAGGIE THOMPSON

to produce a list of health care goals for Ontario and recommendations of how to achieve the stated goals. Preliminary papers from this committee note the importance of individual and community empowerment as well as the need for affirmative action for disadvantaged groups. A third committee, a Select Committee on Health, will hold public hearings on the commercialization of health and social concerns such as child care and long term care of the elderly.

The Evan's Committee report gave general endorsement to the concept of patient's rights. It called for the creation of comprehensive community clinics and health

service organizations as alternatives to fee-for-service medicine. It recommended the establishment of a health council with mixed membership to take over provincial health planning and policy creation. This panel recognized that health needs of rural, northern and female Ontarians are not being adequately met now.

The extent of consumer input invited by these committees is encouraging. The committees seem to recognize that lay people can be experts when it comes to our bodies and our health. The women's health movement has significant experience and leadership to contribute.

DIANNE PATYCHUK

B.C. custody of fetus

A frightening precedent has been set, a precedent that reminds us of the painful, degrading and sexist scenarios described by Margaret Atwood in her novel *The Handmaid's Tale*. For the first time in British Columbia the Ministry of Social Services and Housing has apprehended an unborn child — legally known as a fetus.

The case involves a woman who arrived at Grace Hospital, a Vancouver maternity hospital, to give birth. Details about the case have not been

made public, but by all accounts the woman would not give her consent for a cesarean section to be performed. On the basis of her non-cooperation the Ministry moved to apprehend the unborn child.

The legal status of this case has not yet been determined. Two hearings so far have been adjourned. Already however, in B.C. antiwoman and antichoice activists are applauding the ministry's decision. A medical ethicist from the University of Victoria

has stated that the ministry should have the authority to apprehend fetuses from 20 weeks of gestation on.

The Women's Legal Education Action Fund (LEAF) is in the process of intervening in the case as a friend of the court. Their application will be heard on June 29th and the apprehension case itself will be heard the week beginning July 13th.

If deemed legal, this apprehension will become the second of its kind in Canada. The first was in Belleville,

Ontario, where in April this year Judge Kirkland granted a fetus legal status. This case involved a street woman who was behaving erratically. Rather than dealing with her mental health, an action was brought by the Children's Aid Society of Belleville to apprehend the fetus. In his ruling Kirkland made an order that the woman could be forced to have a medical examination to see if the fetus is healthy!

MAGGIE THOMPSON

B.C. government imposes new fees

The British Columbia government has done away with hospital user fees. However, they'll be making up the difference by imposing new user fees on patients of chiropractors, massage therapists, physiotherapists, podiatrists and naturopaths. As of July 1, 1987, patients who choose alternatives to the conventional medical system will pay the first \$5 of the government regulated fees.

Ironically, Dr. Don Nixdorf, the Executive Director of the Chiropractic Association of British Columbia feels that the hardest hit may not be the patients themselves.

"Although for some people even a \$1 increase would represent a tremendous amount," he says, "there are exemptions to cover many individuals." The practitioners themselves will be financially squeezed, says Nixdorf.

"In B.C., non-medical health care practitioners can either opt-in or opt-out of the provincial health care scheme," explains one

massage therapist.

Prior to April of this year, regardless of what an opted-out practitioner charged per treatment, the patient was reimbursed \$11. On April 1, that amount was increased to \$14. But as of July 1, the imposition of the user fee reduced it to \$9. So while the government is paying less, the patient is paying more, the opted-out practitioner is receiving exactly the same amount, and the opted-in practitioner is receiving a \$3 increase.

Nixdorf believes that the administrative costs of collecting the user fee may eat up the \$3 increase that opted-in practitioners receive, leaving them no better off than they were prior to the April 1 increase. Theoretically, this could entice more practitioners to opt-out — which ultimately will force patients to pay much more than the new \$5 user fee.

LYNNE MELCOMBE

Winnipeg clinic active

The Women's Health Clinic in Winnipeg hosted its sixth annual series of self help workshops. This year's theme was Your Emotional Well-Being. Eleven workshops were presented. Some of the topics were women and spirituality, sexuality, super woman syndrome and aging. Pam Snowdone, workshop coordinator, reports that nearly all evaluations were very positive.

Menopause workshops are offered every three months. The current one day format, with enrollment of up to 20 women, includes information about life cycles, development and physiology, nutrition, estrogen replacement and psychosocial issues. The clinic

is considering adjusting the format in response to evaluations that indicate a need for more discussion of materials presented and more sharing of personal experiences.

A recent premenstrual syndrome support group was our first dedicated to couples for coping with PMS together. The women's partners, all men, asked for an ongoing support group for partners of women who experience PMS.

The clinic continues its activities in four major areas: delivery of direct medical services, counselling, education programs and advocacy.

SANDRA GESSLER



Smokefree

Teaches Women to Quit Smoking

Phyllis Marie Jensen, R.N., PhD.

183 Munro Street, Toronto, Ontario M4M 2B8

(416) 465-1323

Planned Parenthood Newfoundland/Labrador

Planned Parenthood in Newfoundland and Labrador is celebrating its 15th anniversary this year. The last 15 years have been rewarding and demanding. There has been no lack of ideas or energy, but there has often been uncertainty as to the financial future of the clinic. Planned Parenthood Newfoundland/Labrador is the only provincial association in Canada which has operated services without government funding since 1980. The staff and volunteers have had to be creative and committed to raise the approximately \$100,000 operating budget each year.

Some of the money comes from fundraising events such as the annual auction, or in past years, the annual Pre-Regatta Crabfest. Other money comes from donations and fees charged for clinic

services such as pregnancy testing and renting baby car seats.

Clinic coordinator, Wendy Williams says that the reason for Planned Parenthood's continued success is that there is community support and a demand for the services the clinic provides. This support is made concrete by the fact that women and men in the community have given money to keep the clinic open and many have donated time and energy to staff the clinic.

Each day, approximately 30 people visit the clinic, and many more telephone for information and counselling. Staff consists of a paid clinic coordinator/nurse, part-time nurse and job shared secretary/bookeeper and 11 volunteers.

The clinic offers pregnancy testing and counselling on a walk in basis, three physician

clinics weekly, and sexual counselling one afternoon a week. Prenatal classes are held for single women, and support groups are held for infertile couples, menopausal women and women with premenstrual syndrome. A speaker's bureau gives talks and workshops. Planned Parenthood Newfoundland/Labrador has published 11 original booklets: *The Teen Man's Sexual Survival Manual*, *In Touch — for Teen Women about Sex, Facing the Change* (a workshop manual on menopause), *Infertility Facts and Feelings*, and *Infertility Treatments and Choices* (Adoption, Artificial Insemination, Directory of Services, Fertility Awareness, In vitro Fertilization, and Nonparenthood).

With the continued support of the community, Planned Parenthood Newfoundland/Labrador looks forward to another 15 years of community service.

DEBBIE REDFERN

Women in prisons

In April of this year, The Elizabeth Fry Society of Saskatchewan began to provide a series of workshops on women's health concerns to the inmates of Pine Grove Correctional Centre for Women near Prince Albert. The project, funded by Health and Welfare Canada, started with a needs assessment. The workshops and information sessions, run primarily by outside agencies, have been designed to meet identified needs.

The women identified nutrition, lack of exercise and weight gain as major areas of concern. Approximately 60 per cent of the women are mothers, 80 per cent of whom are single parents, so information about pregnancy, childbirth, child development and parenting is seen as very important. Alcohol, substance abuse and sexually transmitted diseases were identified as problems by the staff nurse at Pine Grove. Sessions have been developed to concentrate on these areas as well.

The 2½-year project will be evaluated this July and again during July and August of next year, at which time the final results will be studied. Judith Tansley hopes to see the program established permanently. "We are very excited about it. It's the first comprehensive program on health in a women's correction centre in Canada, and the women here are supportive of it.

Originally designed for minimum security inmates, the program has been adapted to accommodate maximum security inmates as well. The program may reach 200-300 women in the next year.

BONNIE LAFAVE

Northwestern Ontario Network

The Northwestern Ontario Women's Health Information Network (WHIN), whose administrative office is located in Thunder Bay, has been experiencing a productive and exciting Spring.

Three summer students are producing artwork, writing articles and planning WHIN's second annual conference. The students are funded by Employment & Immigration Canada and the Ontario Women's Directorate.

The second Healthy Horizons Conference, scheduled for November 13-15, 1987 in Thunder Bay, will address the impact of technology on women's health. WHIN offers an invitation to anyone who would like to attend.

Workshops tentatively planned include infertility, Depo Provera, occupational health hazards, health as a political issue, menopause and aging, and the Superwoman syndrome.

In early May, a mini-conference, falling between the annual conferences, was held in Nipigon. An exceptional turnout of women from surrounding areas participated in well received workshops. Two similar conferences are planned for Kenora and Marathon, most likely in the autumn. The mini-conferences are a historical step in WHIN's development because ownership of the planning and finances of the events is managed by women within the communities,

thereby furthering a community-based approach. No matter how small or isolated a community is, an arm of WHIN can be established there.

Members of WHIN's board and their children met at Quetico Centre over the summer solstice on June 19-21 for an intensive self-evaluation. Personal soul-searching, creativity and commitment to future goals were central to a review of the past few years' progress and future directions. Continuing objectives include reaching communities whose residents remain isolated from health information and striving for self-sufficiency.

DEBORAH CLARKE



Navrose Contractor/Our Bodies, Ourselves

Injunction against injectible birth control

Women's groups in India and Bangladesh are involved in campaigns against hormonal contraception given by injection or implants under the skin. These products are not approved for birth control in Canada yet, and tend to be more commonly used in third world countries than in developed countries.

Women's groups in India won an injunction last winter to suspend testing of the injectible contraceptive Net-Oen (Norethisterone oenanthane). Net-Oen, a hormonal product, prevents ovulation by suppressing hypothalamic activity which initiates ovulation.

A coalition of women's groups, consumer associations and health organizations presented their government with a lengthy petition requesting the injunction as part of a major campaign against widespread use of the drug. They cited side effects such as excessive bleeding and irregular cycles. For women who do strenuous work, these problems pose particular hazards and increase risk of anemia, a major disease

among Indian women. The government agreed to suspend testing while reviewing the petition and dangers of the drug.

More recently women in India are engaged in a court action to stop testing of Norplant, an implant left under the skin for five years. In this case, the women have chosen a tactic of focusing on test standards, citing that the drug trials fail to meet international standards. They are calling on their government to suspend trials until research methods can be improved to a point that women are not put in danger by taking part in testing.

In Bangladesh Norplants and Depo Provera, another injectible hormone, are officially still in clinical trials but sold in quantities too great to be for trials only. Bangladesh women argue that so-called incentives offered to women are, in reality, often a coercive form of obtaining a woman's consent.

DIANNE PATYCHUK

Ultra-absorbent diapers

If the ecological hazards, the extreme flammability and the prohibitive cost of disposable diapers aren't enough to convince many parents to diaper their babies in "keepables," the health threats associated with the new super-absorbent diapers might be.

Recent articles in *The Wall Street Journal* and *Mothering Magazine* point out that the polyacrylate crystals responsible for the diapers' trimness and superabsorbency are the same substance implicated in the development of Toxic Shock Syndrome (TSS) in Rely brand tampon wearers.

The crystals in question turn to gel when wet, absorbing up to 80 times their weight before saturation. After product-liability trials forced Proctor and Gamble to remove its superabsorbent Rely tampons from the market the company began testing polyacrylate for use in its disposable diapers. Not surprisingly, many members of the medical panel now proclaiming the diapers' safety also testified on behalf of Proctor and Gamble in the Rely tampon trials.

But even among independent experts, there is disagreement and confusion regarding the safety of the diapers. One American pediatrician believes that the convenience of the superabsorbency may lead to too infrequent changing, thought to be a factor in TSS. Harvard professor Edward H. Kass, whose research supported the link between Rely tampons and TSS, feels the diapers would pose a risk only in the presence of an open lesion. However, although he admits that lesions such as those caused by diaper rash are far from rare, he inexplicably calls the related risk "tiny and remote."

The Wall Street Journal reported that "P&G's consumer complaint line received 250 calls in one month from worried parents who had noticed beads of the gel clinging to their babies' skin. It turned out that speeded-up production lines were shaking some of the crystals through the diaper linings."

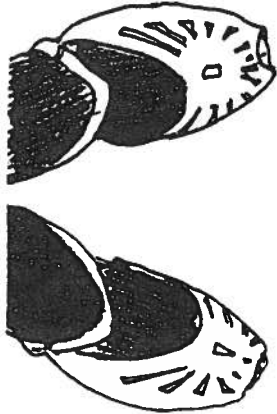
Ironically, amidst all the concerns about potential health risks, the main selling feature of the new superabsorbents — their super-convenience — may be dubious. While juries of medical experts and corporate executives are still reserving judgement, for at least one Vancouver mother, the bottom line is practicality.

"What they don't emphasize on television," she reports, "is that it takes two minutes for those crystals to absorb liquid. In the meantime, the pee just trickles down baby's leg — and onto my very absorbent wool carpet."

LYNNE MELCOMBE



Anne Rochon Ford



The Ties that Bind: Women and Footwear

For many women, shoes, like clothes, are a reflection of our personality, a statement about who we are. Some of my strongest childhood memories have to do with shoes: the black and white saddle shoes which my mother bought me around grade two, which I hated and dragged behind me on the pavement to scruff them up; my first pair of red leather shoes which, even though they pinched a bit, I wore with pride because no other little girl I knew had red leather shoes; my first pair of penny loafers which I recall shining with such serious intent the Labour Day evening before returning to grade five. In high school, I bought a pair of clogs — brown suede — and felt so cool stomping down the hallways making just a little more noise than I knew was acceptable to the high school authorities — such defiance I thought!

Males and females are born with an identical foot structure. By the time they have reached their elder years, however, women's foot problems outnumber men's by four to one. The reason? Barring certain systemic disorders, the answer is, quite simply, the shoes we wear. "Ideally, the foot was not designed to wear a shoe or to walk on hard surfaces," says Donna Lawrenson, director of the Foot Care Centre at Women's College Hospital in Toronto. Putting our foot into a shoe is like putting it into a splint; it can't really exercise or breathe the way it ought to. Much footwear, predominantly women's, goes even further than this and actually creates problems which were

once not there; corns, bunions, calluses, hammer toes, plantar fasciitis and Achilles tendonitis (see box). Much of women's footwear will, furthermore, aggravate existing bio-mechanical problems which we may have had from birth or developed over our lifetime.

For some of us who work indoors or at jobs which require even a modicum of fashion in our dress, our relationship to footwear can become conflicted. We may be torn between the desire for comfort and the dictates of fashion. If we try to be "sensible" and have both, we find that there is very little available for us which is both comfortable and attractive. With few exceptions, true comfort seems to be antithetical to

fashion in the footwear industry. Stores which do carry lines of shoes which are both comfortable and fashionable are often referred to as "speciality" stores.

Such is not the case with men's footwear. By and large, styles are wider, with lower heels and rounded toes, geared as much to comfort as to fashion. Men's shoes generally allow for greater mobility, not just because the heels are closer to the ground, but because the shoe tends to cover a larger part of the foot, making it easier to keep the shoe on.

Not all of us, of course, feel trapped into wearing uncomfortable and disabling shoes. Without a doubt, women have more choice now in footwear than we have ever had. A perusal of recent fashion magazines shows that flat shoes have gained a (re)new(ed) acceptance. Unfortunately, most of them are pointed-toed. And, if shoe store windows and fashion magazines are any indication, the flat shoe is not replacing the high-heeled shoe which continues to hold its place as the height of fashionable footwear for women. A *Vogue* magazine ad for a very high-heeled boot describes wearing this boot as "the difference between being dressed and well-dressed."

Wearing a high-heeled shoe (having a heel of 1" or higher) forces the ball of the foot to absorb 50 per cent of the entire body weight, as opposed to having the weight evenly distributed over the entire foot. Lawrenson uses the following analogy to make her point: Wearing a high-

Choosing a Good Shoe

Look for:

- a low heel
- a firm, rubber sole to absorb impact (Note rubber, and not crepe, which is not as stable or as safe as rubber and is heavier.)
- rounded toes
- a long reinforced medial counter (the support around the heel and inside of the shoe)
- an appropriate width for your foot (Remember that a "too-wide" shoe can cause problems too: frictional calluses, burns)
- a broad (and not a narrow) heel base (the surface of the heel contacting the ground)



From poster series by Daria Stermac

heeled shoe on the surfaces most of us walk on — concrete, wood — is comparable to smashing the knuckle part of the palm of your hand against a brick wall over and over again, with only a few strips of leather between you and the wall for cushioning.

From the early practice of Chinese footbinding to the contemporary equivalent of stuffing feet into pointed-toe high heels, women have inflicted untold horrors onto their weary feet. Of course, women have not always been the ones doing the inflicting. The practice of footbinding was a custom over which women had little control. If you were of a certain class in pre-19th century China, it was imperative that your feet be bound in order to make them smaller and force you to walk in a quick, hobbled manner. This was seen to be erotic. Many sources also indicate that the intent of footbinding was also to prevent women from

“getting away.”

Some women today have recognized the connection between vulnerability and footwear and have switched from high heels to sneakers just so they can “get away.” One woman quoted in an article on sneakers in a recent issue of *The Walking Magazine* says “I would never wear heels that prevented me from walking fast in the city. I feel more secure in sneakers.” Rape crisis centres counsel women to wear flat shoes and rape prevention training courses, such as Wen-Do women’s self-defence, teach women to do the same.

It may seem almost a cliché to be drawing parallels between Chinese footbinding and contemporary women’s footwear, and yet a glance around almost any public place (in urban centres, anyway) demonstrates that we have not made much progress in emancipating women from constricting footwear. What

seems not to have changed very much in footwear over the centuries is the sexual component of what covers our feet. One foot specialist devoted an entire book, *The Sex Life of the Foot and Shoe*, to the premise that the foot is an erotic organ and the shoe is its sexual covering. With women’s footwear, it seems the more constricting the shoe, i.e. tight and with pointed toes, and the more it limits the wearer’s mobility, i.e. open backed, high heels, the more sexy and attractive. Although many of us may find this thought disturbing, we need only look at much of contemporary fashion advertising and fashion magazines to see the extent to which it is being perpetuated. Women use any number of ways to describe why they like to wear high-heeled shoes, but they rarely acknowledge that these shoes put them in compromising positions and limit their mobility. Underlying the erotic component of high-heeled shoes — just as with Chinese footbinding — is the fact that helplessness in women is supposed to be sexually appealing. Important questions to ask are: What is really erotic and what have we been socialized into thinking is erotic? How much is inherent? What is culturally defined?

Women are willing to tolerate incredible pain in exchange for this reward of seemingly looking sexy. One very typical client at the Women’s College Foot Care Centre came in complaining of pain in her feet and her increasing inability to walk any distance. Over the years, she has become accustomed to the fact that when she walks any distance in her regular shoes (high heels), she must constantly be looking around for places where she can sit to rest and rub her feet. She can only walk for 10 minutes at a stretch. An orthopedic surgeon in Toronto has spoken of women who enter the hospital to have bunions surgically removed only to leave the hospital wearing the very same shoes that caused the bunions in the first place. For women who began wearing high-heeled shoes in their teens or twenties, the transition to flatter shoes when they are older can be so painful as to be impossible because the tendons have become permanently shortened. Similarly, when women

become pregnant and suddenly shift from wearing high-heeled shoes to flat shoes for more comfort, their pelvis must make two transitions — one to accommodate the shift in the centre of balance from the pregnancy itself and a second because of the shoes.

In the foreword to *A History of Shoe Fashion*, published in 1969, the author writes that "fashion feeds on success and on the limit of daring and fashion-consciousness to which a receptive public can be attuned." It also seems to feed on the amount of pain to which a receptive public can become attuned. Lawrenson notes that complaints to shoe manufacturers that they are not producing enough shoes which are both comfortable and fashionable usually elicit the response that they are giving women what they want. Their market research indicates that great numbers of women want shoes with pointed toes and high heels. This prompts two concerns in me: "How is their market research being conducted?" and, if their research is accurate, "Why do women keep asking for these foot killers?" The answer to the latter question can only be rooted in a deep-seated female psycho-

Diabetes and Feet

Diabetes can cause circulatory disorders as a result of decreased nerve function. This results in poor blood circulation to the feet — the furthest extremity from the heart — and insufficient nourishment to soft tissues and bones.

As a result of the poor circulation and nerve function, diabetics are often slow in sensing pain to their feet. An improper shoe on a diabetic is more dangerous than on a non-diabetic, since the diabetic may not feel that a callus or corn or other deformity is occurring until it begins to ulcerate. For this reason, prevention is vital. The feet of diabetics need close attention by someone who knows what to look for. Any footwear which will inhibit circulation or cause friction should be avoided. Circulation can, of course, be greatly helped by regular exercise.

logical conditioning which tells us that we must be sexually attractive at any cost and that our sexual attractiveness lies in our vulnerability.

This is not to absolve the footwear industry or the advertising industry from major responsibility for keeping these notions alive. The language of the footwear industry is very telling in this respect; shoes which are designated as comfort shoes are also referred to as "mama shoes." In his book, *The Sex Life of the Foot and Shoe*, author Rossi attempts to match up shoe styles with psycho-sexual personalities. He categorizes men's shoes as "sensuous, masculine, peacock, eunuch or macho" while women's are "sexy, sexless, neuter or unisex." If we accept his definitions, our options are pretty limited! According to Rossi, shoes which are sexless are those which are "dull and drab, lack personality, are sexually recessive." They are known by such names as "mama shoes," "sensible shoes," or "old ladies' running shoes." They are worn by elderly or senile women with whom sex holds only minimal interest, or by women with strong sexual inhibitions, or those who feel threatened by sex." I hesitate to give this author credence by repeating his offensive remarks, but they do illustrate the thinking of some shoe manufacturers. Sales representatives use terms like "my mama line" or "my old lady line" in a most matter-of-fact way.

Nowhere in Rossi's descriptions of the various types of shoe-wearers is there any consideration for comfort, mobility or any concern with the general health of one's foot in our choice of shoes. And yet there are signs that mobility, comfort and health are concerns which increasing numbers of women have about their feet. It is hard to distinguish whether the latest trend among some urban women to wear running shoes to get to and from work, along with their otherwise appropriate office attire, is simply a fad which will go the way of negative-heel shoes. Let's hope not. Toronto podiatrist Glenn Copeland, author of *The Foot Doctor*, maintains that the running shoe comes about the closest we get to an ideal shoe, meeting the criteria of flexibility, stability and shock absorption better

Glossary of Terms

Achilles tendonitis — inflammation of the Achilles tendon, the soft tissue which is attached to the heel bone and runs up the back of the ankle.

Bunion — a bump-like deviation in the big toe joint. Although this is usually the result of a fault in the way the foot pronates (which can be hereditary) the condition can be aggravated by poorly-fitting shoes.

Callus — build-up of skin on the bottom ("ball") of the foot to protect bones beneath which are receiving undue stress.

Hammer toes — toes which, in a relaxed position, are unusually bent instead of lying more or less flat. They can be caused both by ill-fitting shoes (especially high-heeled) and by a biomechanical fault in the foot's structure.

Corn — a thickened layer of skin which forms on top of the toes.

than any other type of shoe.

When we are young, it's easy enough to continue to ram our feet into shoes which sacrifice comfort for fashion. We can continue to delude ourselves into thinking that pointed-toe high-heels are alright for our feet and we can become quite adept at getting around in them. But speak to people who work in senior citizens homes, or chiropodists or podiatrists about what they see in the aging foot of a woman who spent her youth in high heels and pointed toes. There is a price to pay later down the line for the sake of fashion today and women pay the highest price.

So take a chance. If enough women challenge the dictates of fashion and sexual attractiveness, we might even develop a new ethic about footwear. Wear running shoes tomorrow!

Anne Rochon Ford is Policy and Program Advisor on women's health care issues at Women's College Hospital, Toronto. She is a member of the Ontario Advisory Council on Women's Issues.

Thanks to Donna Lawrenson of Women's College Hospital for her assistance in preparing this article.

How to write for people with low literacy skills

To be readable by a particular audience, written materials have to be tailored to meet the needs of that audience. This may seem blatantly obvious, but it is often forgotten by writers of health information, who too often write what they need to say rather than what their audience needs to hear. The process of developing readable materials requires that the writer determine the needs of the audience and then produce materials which reflect those needs.

Producing an accurate reflection is a two step process. First, the writer must develop a working knowledge of her audience; she must learn from them, both what they want to know and what they don't want to know. She must resist the temptation to write about what she wants them to learn. Only then can she proceed to the second step in which, based on her understanding of her audience, she produces materials which reflect their needs.

"Get to know your audience." As a first step in developing readable health information, this advice sounds simple. It isn't always. You need to meet the people you will be writing for, talk with them and keep talking with them. Don't start to write until you feel comfortable in your understanding of your audience. If you can't answer these questions about your readers you won't be able to reflect their needs.

- What is the sex, age, educational background, cultural background and economic status of your readers?
- What do they want to know about?
- How much do they already know (or not know) about it?
- How badly do they want or need to know this information? How highly motivated are they to acquire it?
- How well can they read? How much information will they be able to acquire from written material?

This process of getting to know your reader is crucial in developing effective written materials. Using an interactive model throughout the process of producing materials, is one of the most effective ways to ensure that written material is both readable and relevant to the intended audience. In an interactive model, members of the intended audience are involved and consulted throughout the writing process and their input guides the writer.

Once you've established contact with your audience and developed some understanding of their needs, you can move on to the second step: producing useable, readable materials. Writing for readers with limited skills is, in itself, a skill. For literate, highly skilled writers, acquiring this skill often involves unlearning many of the techniques which we have been taught are the hallmarks of good writing. We have to learn to consider:

The reading level of the material.

This is usually measured by a formula or other readability technique. A readability formula is a regression equation into which counts of language variables, like number of words per sentence, number of polysyllabic words, or number of sentences per 100 words, are inserted. The calculation from this equation yields a score which is interpreted as an index of the readability of the material. A word of warning: a readability formula is a

useful tool when used to help guide the development of written material, but no formula is reliable or accurate enough to be used as a sole predictor of readability.

The style in which the material is written.

- Is the purpose of the material clear? Will your reader know *why* she should read it?
- Is the style relaxed, informal and conversational? Does it have any "human interest"?
- Is the language used that of the audience? Does it "sound right" to them? Does it sound like people talking?
- Do your examples reflect the daily life of your readers? Are they appropriate to age, ethnic and economic background of your audience?
- Is the active voice used?
- Is the tone positive? How many times do the words "Do not" appear?
- Are new technical words or concepts defined using familiar words?
- Do sentences have a maximum of two clauses? Is sentence length varied?

The layout and organization of the material.

- Is the material broken up into manageable units with clear topic headings?
- Does the information flow logically? Is new material introduced in a way that relates to and builds on previously explained material? Are important ideas repeated?
- Does the item have a table of contents? Is it easy to find information within the document?
- Does locating information rely heavily on an index? If so, how complicated is the index?

The visual impact and appeal of the material

- Is the type size fairly large? Type size should be at least 12 point. (To compare, this article is set in 10 point.)
- Is the type face easy to read? Serif type (which looks like this) is usually easier to read than sanserif type (which looks like this).
- Are type variations which make reading easier (like **boldface**, or underlining) used to emphasize important points and to add visual interest?
- Is the printing clear, visible and unsmudged?
- Do the paper and ink colours add to the overall readability? (For example, orange ink on pink paper may have impact, but it isn't easy to read.)
- Do the paragraphs appear to be crowded and heavy or are they well-spaced, with margins and illustrations to make the material seem less intimidating?
- Are the illustrations appropriate to the age, ethnic and class background of your audience? Are they clear and accurate? Well-placed in the text? Not dated? (Illustrations with outdated clothing and hairstyles tend to make readers think that the text is equally outdated and irrelevant.)

Overall, is this the kind of material your reader will want to pick up and read? Or does it look too dull and difficult for her to bother with?

This page relates to Can She Read It? Readability and Literacy in Health Education, by Mary Breen and Jan Catano, published in Healthsharing, Summer, 1987.

Being Pregnant

Daphne Morrison



J.D. Crawford — CBC Television

Being pregnant is a state many women experience at some point in their lives. There are similarities and differences among women's pregnancy experiences. These two pages share some of the experiences, worries and emotions of a woman who was twenty-five at the time of this pregnancy. Sharon, who was diagnosed with rheumatoid arthritis at the age of 18, worried about how her arthritis would affect her pregnancy and her ability to be a good mother.

Sharon was lucky — her arthritis stayed in remission throughout her pregnancy. Even so, the arthritis "is with you all the time," says Sharon, "It's a constant pain. Other people have no idea."

This article is taken from a longer interview with Sharon, who is now 28 and lives outside Vancouver. It is just one of 15 interviews which make up Being Pregnant: Conversations with Women, a new book by Daphne Morrison published by New Star Books.

I decided to take the chance and become pregnant. Everyone was trying to reassure me that I'd be alright, I felt healthy and I wasn't on medication. I think I have a good outlook on my illness, so I tried to put my worries to the back of my mind.

Most of the way through my pregnancy, I felt exceptionally good. Better than I'd ever felt in the last five or six years. I was happy and excited; maybe that helped. I only had two days of morning sickness, and I didn't even know it was morning sickness until later when I thought, "Oh, so that's what that must have been." I said to myself, "Here I am, going through a typical pregnancy. This is fantastic. I'm doing so well." I was feeling so good physically my arthritis didn't concern me. The doctors kept saying, "You've got to watch it," but I didn't really. And, of course, my body was changing and the fetus was getting large enough that I could feel kicking. Everybody was telling me I was looking good. It

was all positive reinforcement.

I wondered what I should be doing about exercise. A lot of women nowadays take exercise classes when they're pregnant, to stay healthy and improve their circulation. But it becomes a problem when you're physically handicapped in any way. You know how they say, "Okay, everybody down on the ground and curl up your legs six times!" Well, I can curl up my leg but I can't get down on the ground, not without my husband or somebody to help me. And then I can't just keep getting up and down and up and down the way you have to.

We have a friend who teaches Tai Chi. Before I was pregnant, my hands would get quite stiff and sore from doing puppetry — I used to do it as part of my job at the library. I'd often go over to my friend's place and he'd stretch my hands back out and work on them. I asked him what he thought of me taking Tai Chi when I was pregnant. He thought it

was fine. My husband and I both enrolled in his class, and I think it was great for everyone to see a pregnant lady doing it. I became more aware of my body, and my balance point, and the class helped me to feel even better about myself and not to feel awkward. I learned about it, too, to know that I was doing my arthritic exercises at the same time.

I started going to childbirth classes, too. I felt a little leery about these at first. My worries are all very private ones. We walked into the class and the first thing I said to my husband was, "I can't get down on the floor." He said, "That's okay." But you're worried that everybody's going to look at you and they're going to ask, "What's wrong?" Someone did say to me, "You're big. That's why you can't get down on the ground, right?" I said, "It had nothing to do with my pregnancy. I have arthritis." Then, of course, that shocks people. They say, "I thought only old people got arthritis." And then you have to tell them the whole story. I guess they got used to me. Some days I'd get down on the floor, and when I didn't feel like it I wouldn't. I'd make my husband do it. I'd say, "You get down, you pretend and practise." What the heck!

When I was pregnant, when I felt the child in me, I used to daydream about what he was going to be like. I always thought I was going to have a boy. Couldn't imagine a girl. I don't know about other people, but when I dream at night I don't have my illness. I dream that I can move easily. So it was odd when I was pregnant I'd be lying in the sun, say, daydreaming, and I'd see myself not being able to get down and play with the baby. It weighed heavily on my mind because, of course, I went in for education, and you were told that you never talk down to a child, you always get down to a child's level, and I've agreed with that. Then I started thinking, how stupid, Sharon, you've worked for seven years with kids and they all liked me, and I never knelt down to them.

Then I'd imagine a friend saying, "I'm going to take my kid for a walk. Do you want to come along?" And not being able to. Because I don't go for walks. I could see myself ex-

cluded from other people and activities. I think with everybody there's a bit of selfishness, too. You want your child to like you even more than his daddy, and daddy wants him to like him even more than mommy, and daddy can do a lot of things that mommy can't. But you compensate. I played with my son Bryan on the bed instead of on the floor. When he was six months old I took him to swimming lessons, because in the pool I can do just about everything that anybody else can. And because he grew up with me he learned quickly what I could and couldn't do.

Another thing that bothered me when I was pregnant was wondering how I was going to be able to deliver this kid, because I can't bend my knees. I thought about it every time I went for my examination at the doctor's. You have to put your legs in the stirrups and I always had problems with that. Finally, I did ask my doctor. He said, "Don't worry. It's just that you've seen someone having a baby in the movies and the knees look really bent. But you don't have to do it that way. As long as your legs open up, you'll be fine." I had to work myself up to ask that because it's very embarrassing. But he was good that way, and quite calming.

As it turned out, the birth happened very quickly. I woke in the night and had what I thought were these gas pains. I went to the bathroom and thought, "Gee, what did I eat tonight?" The stupid thing was that I was already a week overdue. It finally dawned on me that maybe it was labour.

So I started timing the contractions, and I thought it was two minutes apart, but then I thought, "It can't be two minutes, it's supposed to be twenty minutes." I decided to wake my husband Mark anyway and I called the hospital and they said, "Oh, you've got to be wrong on your timing." Well, we live quite a long ways from the hospital, so we ended up calling my doctor. He said, "Yes, you're in labour. Come in and I'll meet you at the hospital." I'm timing my contractions in the car and they're a minute and a half apart. At the hospital we told the nurses. They're all calm and saying, "No, no,

you can't be that far along." Sure enough, the nurse checked me and I was already seven centimetres dilated. She said, "Maybe you are!" Everything progressed very quickly from then.

Getting pregnant, if you have arthritis, depends on how bad you want it. It also depends on your type of arthritis and on how many joints are affected. You have to sum up your own situation.

I go to a young women's arthritis group through the Arthritis Foundation. I didn't even know it existed until after my pregnancy. It's good because women come up to me and say, "So you've had a child," and it's a place where they can meet somebody who's actually gone through it. Because they're scared. They don't know whether to take that step, or should they just put it out of their mind and go on with their lives. If they're rushing into it they should probably be stopped, because they don't know what they're dealing with.

The silly thing is that if I'd known about it, I could've gone to a group like the young women's group for years. I could've met women with kids and seen that their children don't have arthritis, and I could've asked them, "How did you get up in the middle of the night? How did you feel when you were pregnant? Did your knees give out?" I wish I'd known about this group before.

I would never give this time back. Even in my worst moments I've said to myself, if I end up that I can't walk, it won't matter. I wouldn't trade having Bryan for anything. I've heard other people say to their children, "All the pain I went through for you . . ." You'll never catch me saying that.

Daphne Morrison is a writer, editor and researcher living in Vancouver.

Thanks is given to New Star Books for permission to excerpt from Being Pregnant: Conversations with Women, Daphne Morrison, New Star Books, Vancouver, 1987, 208 pp., \$9.95 paper. Order from your local bookseller or contact New Star Books, 2504 York Ave., Vancouver, B.C. V6K 1E3 (604) 738-9429.

HEALTHWISE

Alcohol & Medicine Don't Mix

Bonnie Lafave

At one time or another, most of us will take either a prescribed medication or an over-the-counter drug. As well, most of us occasionally drink alcohol — a glass of wine with dinner, a beer at the baseball game. Chances are, there will come a time when we have both alcohol and some type of medication in our system at the same time. Because we tend to think of alcohol as a food not a drug, we often don't consider that side effects may occur when the two are mixed. But alcohol is a drug, a powerful central nervous system depressant, and its effects, alone or in combination with certain medications, can be powerful.

A drug interaction occurs whenever one drug alters the effect of another. Alcohol and drugs can affect each other's absorption and metabolism. For example, alcohol may slow down the metabolism of a drug, prolonging its action and effect and increasing the chances of side effects which might not otherwise be a problem. Drugs and alcohol may also combine to either increase or decrease each other's intended effects. The following are some examples of medications and the potential interactions which may result when they are taken in combination with alcohol.

Alcohol-sensitizing agents

Disulfiram (Antabuse) The interaction between this drug and alcohol is exploited for therapeutic use. Antabuse is taken by alcoholics who are trying to stop drinking. The drug inhibits the metabolism of alcohol and if the person has a drink she may develop shortness of breath, flushing of her face and neck, a rapid heart rate, headache, nausea and vomiting. This type of reaction, when seen in other drug-alcohol interactions, is called a "disulfiram-like" reaction.

Acetaminophen

(Anacin-3, Tylenol, Datri) Liver damage may be the result of taking large amounts of Tylenol over long periods of time in combination with alcohol.

Acetylsalicylic Acid

(Bayer Aspirin, Bufferin, Anacin) Alcohol may reduce the rate of metabolism of Aspirin, enhancing its activity and side effects. Consumption of alcohol and Aspirin together may cause gastrointestinal irritation and eventually ulceration and bleeding of the stomach wall.

Anticoagulents

Warfarin (Coumadin) Alcohol consumption may disrupt the delicate balance required in the use of anticoagulant medications by inhibiting the metabolism of the drug. An individual may become "over anticoagulated" and may be at risk of hemorrhaging especially if she falls or has some other kind of accident.

Antidiabetics

Tolazamide (Tolinase) When taken with alcohol, the effect of hypoglycemic agents such as Tolinase, may be increased. Alcohol may cause a dangerous drop in the blood sugar level and symptoms of hypoglycemia — nervousness, faintness, sweating and confusion — may result.

Anti-infective agents

Metronidazol (Flagyl) This particular anti-infective agent is commonly used to treat *Trichomonas vaginalis*, a type of vaginitis. When taking Flagyl orally or as a vaginal suppository, alcohol consumption may cause a disulfiram-like reaction.

Drugs which act on the central nervous system

Antidepressants such as Elavil, Asendin, Desyrel ;
Antipsychotics such as Haldol, Mellaril, Trilafon ;
Narcotics such as Demerol,

Percodan, Codeine products ;
Tranquilizers such as Ativan, Librium, Valium ;
Sleeping pills such as Alurax, Nembutal, Seconal ;
Painkillers with Propoxyphene such as Darvocet-N, Darvon, Dolene .
 Alcohol enhances the effect of all these medications. The combination can be very dangerous, even deadly.

The significance of different types of drug and alcohol interactions may vary depending on a number of factors — individual sensitivity to alcohol and medications, the chemistry and quantity of the drug, the type and amount of alcohol and the sequence in which they are taken.

The subject of alcohol and drug interactions is a complex one. We might be tempted to ignore the possibilities and hope for the best or just stop taking medications or drinking alcohol, or both. But there are resources available to us. Most pharmacists and nurses are more than willing to answer questions and we need to continue to ask our physicians for information. Although much of the pharmaceutical literature available seems to originate in the United States, there are books which include Canadian brand names. *The Essential Guide to Prescription Drugs* by James W. Long is one of these. If we keep ourselves informed, we can continue to enjoy an alcoholic beverage now and then, take medications when we need them and stay healthy.

Bonnie Lafave is a registered nurse with a strong interest in women's health issues. She works in Toronto.

Further Reading

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Barbara Mintzes

Maze

the Medical

Through

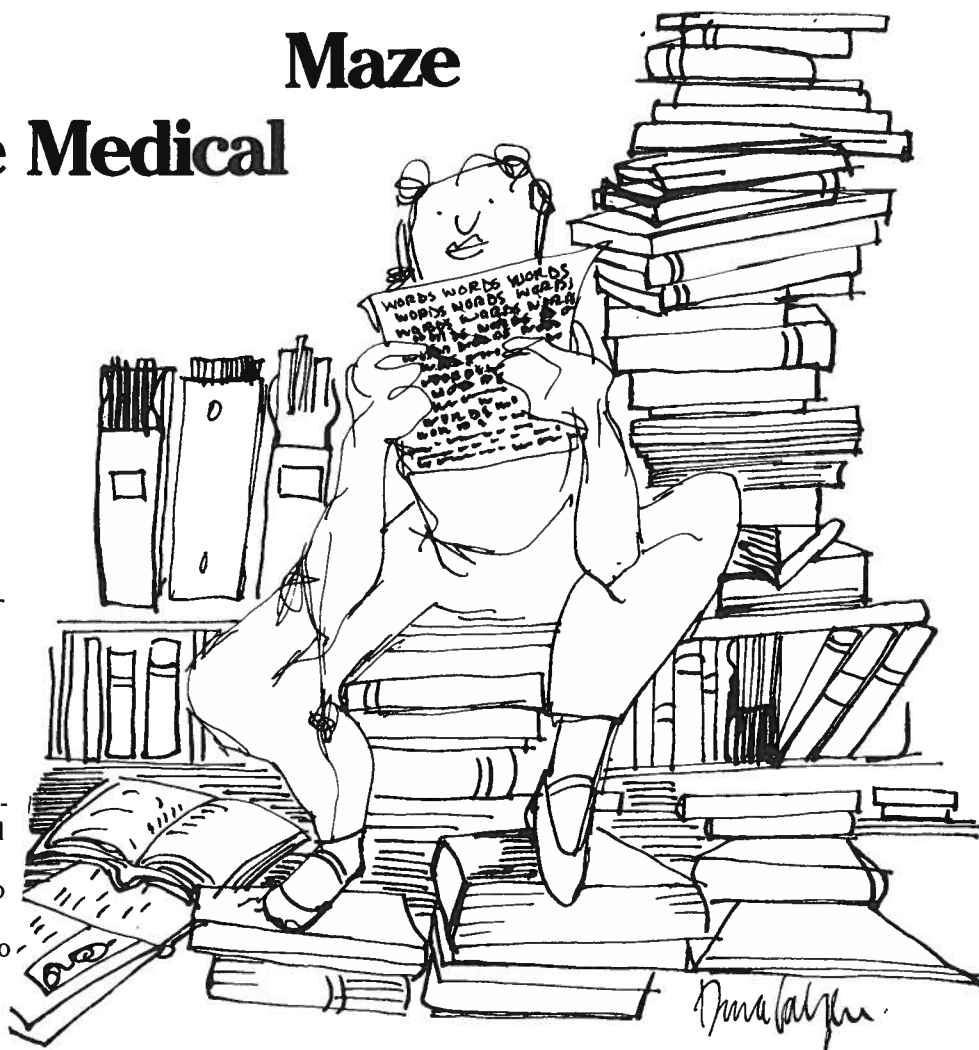
A woman who works in a community health clinic is invited to attend government hearings on contraception. Many of the presentations are on Depo Provera, a drug the federal government is considering for approval as a contraceptive. She hears references to many conflicting results of medical studies. Depo Provera appears either to be very risky for women to use, or completely safe. Medical studies are used to back both positions.

To go beyond her hunches on who stands to gain from an unsafe drug being approved, this woman needs to be able to read and judge medical studies for herself.

A woman may also want to read medical studies in order to make decisions about her own or her family's health care, or to decide what to do if she has received two different medical opinions on a health problem.

What we, as women and health consumers, need is information on how to read and judge medical studies. Many medical studies provide unreliable information due to problems in design. Unfortunately, some of this is intentional, as researchers sometimes receive funding for their research from foundations or corporations who have an interest in promoting certain "facts" and ignoring others. In order to examine the literature properly, we need to have a means of picking out which information to trust.

When considering where to begin, first choose what articles to read. A good approach is to look for recent reviews on a topic. A good review



will summarize the results of all major studies on the topic and point out the main areas of disagreement among researchers.

Recent reviews can be found in *Indicus Medicus*, a listing of published medical studies available in university and some main branch city libraries. *Indicus Medicus* has separate volumes for each month of the current year and separate volumes by year for each preceding year. Studies are organized by subject. Review articles usually contain the word "review" in the title.

It is important not to stop at a literature review, since reviewers are often biased in the way they select, present, and interpret information. Therefore, you should check the original sources listed in the review and look for studies which the reviewer did not mention. This can be done either by using *Indicus Medicus* or by conducting a computerized lit-

erature search.

A computerized literature search is done for a fee, by a university or medical librarian who will also help you limit your topic to produce a useful list of articles. A properly conducted computerized literature search, including a list of titles and abstracts, should cost less than \$50. You may also be able to get a search done for free. Doctors have access to a yearly allotment of free literature searches, and a friendly doctor may agree to arrange to have a search done for you.

Not all of the articles that you find will be useful to you. After reading the titles and abstracts, you can decide which are not relevant or obviously badly designed. If the study does seem worthwhile, read the whole study, since the abstract is so short that it omits a lot of information, and findings may be overdramatized or misrepresented.

Types of studies:

Randomized controlled or experimental trial This type of study usually uses volunteers to test the usefulness or safety of a drug or another type of treatment. The volunteers who receive the treatment form the study group and those who do not form the comparison or control group. In a well-designed study, there should be a random selection process such that everyone who enters the study has an equal chance of ending up in one group or the other, in the same way that a flipped coin has an equal chance of ending up as heads or tails. The study must also be "double-blinded," so that neither the volunteers nor the people who assess the effectiveness of the treatment know who is in the study or control group. Otherwise, people who know they are receiving a drug or other treatment may be more likely to get better because they know something is being done for them, and researchers who know that a person has received treatment may tend to judge that person as healthier than someone who has received no treatment.

A randomized controlled trial provides the only good evidence for whether a drug or other treatment is actually useful. Unfortunately, drugs are used for many purposes for which they have not been adequately tested or for which randomized controlled trials have not found them to be useful. For example, progesterone is used for the treatment of premenstrual syndrome in spite of randomized controlled trials which have shown it to be no more useful than a placebo. (In one trial, the placebo was more effective than the progesterone.) Unfortunately, many alternative treatments which may provide a safe and holistic way of treating health problems have not been tested for effectiveness in randomized controlled trials.

Cohort or prospective study A cohort or prospective study determines whether exposure to something causes a disease by following a group of exposed and unexposed people over a period of time. An example would be a study of two groups of women — women using the pill (the study group) and women using other

forms of birth control — who are followed for 20 years in order to see if more women using the pill develop breast cancer.

Case-control or retrospective study This study looks back in time rather than forward. People with a disease or a condition are compared to people who do not have the disease. For example, in case-controlled studies of the pill and breast cancer women with breast cancer are interviewed to see whether and for how long they used the pill; the same questions are asked of a control group of women without breast cancer. A case-control study is much cheaper to do than a cohort study because study subjects don't need to be followed over a long period of time. Often, a problem is first identified with case-control studies and is later checked out in more depth using cohort studies.

Case-control studies are very useful for studying rare diseases. For example, strokes in young women are so rare that thousands of women on the pill could be followed in a cohort study without showing an increased risk of strokes in young women. However, a case-control study of young women who have had strokes can quickly show that women who have had strokes are more likely to have been on the pill.

Individual case study An individual case study looks at the development or treatment of disease in one individual and reports that something out of the ordinary happened. An example would be a case study of a man exposed to the drug DES before birth who developed testicular cancer.

Case series A case series reports on a group of people either with a similar disease or a similar exposure, without comparing them to a control group. A case series of a large number of people may look impressive, but it could provide misleading information. An example is the case series of 632 women who were given DES in the 1940s to help them with problem pregnancies. Based on the apparently positive results of this case series, DES was recommended for use in pregnancy to prevent miscarriage. As a result of these recommendations, the drug was prescribed to large numbers of pregnant wo-

Glossary

Abstract: a short summary of the contents of an article.

Association: If two things happen together more often than would be expected by chance, they are said to be associated. This points to the possibility that one was caused by the other, but is not proof.

Blind study: A study in which people are unaware of whether they are in the study group or the control group. A study is double-blind if the people assessing the results also don't know.

Control group: A comparison group, consisting of people who are generally like the group being studied in all ways except the one characteristic being studied.

Matching: Choosing people for the control group with the same characteristics (such as age, sex, smoking) as people in the study group.

Odds ratio: This is an estimate of the relative risk (see below) which is calculated in case-control studies.

P value: The p value is the probability of the results occurring by chance or coincidence in the particular sample of people being studied. P=.05 translates to "the probability of this result occurring by chance is 5 per cent."

Placebo: (often referred to as a "sugar pill.") A substance with no physical effects, but which looks like a medicine or another substance being tested.

men. However, a randomized controlled trial of DES in 1952 found it to be no more useful than a placebo in preventing miscarriage. In spite of this evidence, physicians continued to prescribe DES for this purpose until it was banned for use in pregnancy in 1971 because it was found to cause cancer in the daughters of women given the drug.

Study design:

Sampling A group of people are usually studied in order to apply the study results to a larger group, such as people in general, women in gen-

Placebo effect: The proportion of people who will get better when taking a placebo.

Population: The larger group of people represented by a sample. It could be all women going through menopause, all Canadians, all pregnant women over 35, etc. depending on the study.

Random assignment: (randomization) Choosing who will be in the control or the study group in such a way that each person has an equal chance of being chosen for either group.

Relative risk: The probability of an exposed person developing a condition compared to the probability of a non-exposed person developing the same condition.

Sample: A group of people who are part of a larger group, and are chosen to represent that larger group in a study.

Statistical significance: Study results are generally considered statistically significant if they have been calculated to have less than a 5 per cent or a 1 in 20 chance of having occurred by chance. Statistical significance says nothing about whether results are important or meaningful; it is a calculation of the likelihood that a random sample represents characteristics of a population.

Stratification: Dividing a group into subgroups (or "strata") on the basis of one or more characteristics such as age, sex, smoking, etc.

eral, etc. The group being studied is called a sample. The ability to generalize the results of the study to a larger group of people will depend on how the sample was selected. For example, the results of a study of women with breast cancer can only apply to all women with breast cancer if any women with breast cancer had an equal chance of being selected for the study. The results will not apply to younger women if only women over 50 are selected.

In randomized controlled trials, volunteers are frequently used. It is necessary to know what type of people volunteered for the study. For ex-

ample, many drugs for general use are tested on young men, and the results may not apply to women or older people.

It is also important that roughly no more than 10 per cent of people are "lost to follow-up" in a study. The people who are "lost" may be very different from those who stay in a study, and their loss may bias the study results.

Sample size The larger the group studied, the more likely it is that the results of a study will be accurate, and not be the result of chance. For example, the results of a study of the sex ratio of babies would differ if they were based on the next 10 instead of the next thousand births. In the sample of 10 babies, the sex ratio will probably not be close to 50:50; in the sample of 1000 babies, it probably will.

Sometimes, the sample may appear to be larger than it is. A study may begin with a large sample, but the study results may have been calculated from a much smaller subgroup.

Study and control group Theoretically, the study and control groups are supposed to be identical in all respects except the one being studied. Obviously, this ideal can never be reached. However, researchers should make sure that the most important "risk factors" for the disease or health problem are equally distributed among the study and control group. This is usually done by stratifying the study and control groups, or dividing them into subgroups according to the presence of a risk factor. For example, age is a risk factor for breast cancer, since women are more likely to develop breast cancer as they grow older. A breast cancer study could stratify for age by limiting all comparisons to women of similar age groups. For example, women with breast cancer between the ages of 50 and 54 would be compared only with controls of the same age group.

After reading a few studies, you should become familiar with the most important known risk factors for a disease or condition. Age and sex are almost always major risk factors.

Follow-up period This is something to look for in studies of cancer or

other diseases which are slow to develop. Twenty to 30 years may be needed for cancers to show up as a result of exposure to a cancer-causing substance.

Sometimes studies present follow-up time in terms of "person-years." Person-years is the number of people multiplied by the number of years each was followed. It can be a method of obscuring what really happened as 100 "women-years" may be 200 women followed for 6 months or 20 women followed for 5 years. Studies of effectiveness of birth control methods often use person-years of follow-up. These studies should also state actual numbers and length of time women were followed, as the effectiveness of some methods differs depending on how long a woman has used them.

Judging results:

Sometimes the results of a study will be useless because they are based on a questionable diagnostic test or on incomplete information. For example, a study on the safety of two types of IUDs in the April, 1986 issue of the *Canadian Medical Journal* may have missed many cases of PID. Women were asked whether they had ever had PID, and their medical records were only checked if they answered "yes". A woman who was not told by her doctor that she had a pelvic infection or PID, or who was misdiagnosed, would be classified as not having had PID. Many cases of PID may have been missed, resulting in an overestimate of the safety of the IUDs.

Information from interviews may be undependable if people's memories are affected by their expectations of what should have happened. For example, in a menstrual cycle study, women were asked to keep a daily diary of their mood for three months. At the end of the three months, they were asked to describe their moods during each part of their menstrual cycles during the previous three month period. Women remembered premenstrual time as mostly negative, although the same women had frequently described their mood as "elated" or in other ways very positive in their diaries at the time.

People's memories are also af-

fectured by their opinion of what is good or socially acceptable behaviour. People usually underestimate the amount they drink or smoke and overestimate the amount they exercise. For example, the average alcohol consumption based on interviews is much lower than the average amount consumed based on the amount of alcohol sold in Canada.

Outcomes may be reported which misrepresent the situation. An example of this would be studies of *in vitro* fertilization in which success rates are measured in terms of total number of pregnancies. *In vitro* programs use pregnancy tests which are accurate 7 to 10 days after conception. At this early stage, about one third of the pregnancies end in miscarriage. For women considering *in vitro* fertilization, the important outcome is the number of babies born, not the number of pregnancies.

The results presented in the tables may not always back the claims in the discussion and/or abstract of the article. It is always important to carefully read through the tables, as they present the basic information, from which all conclusions are

drawn. Sometimes the information in the tables is misrepresented in the text.

The results may not always point to a cause and effect relationship. Scientific studies tend to look at whether there is an association between two or more things, that is, whether they tend to happen together. Usually the real reason for the study is to provide evidence for a cause and effect relationship.

There are certain factors to be aware of when deciding whether one thing causes another. For example, is evidence available from randomized controlled trials, since this is considered the most dependable human evidence? Or is there a strong association of cause and effect in a number of studies? On any issue it will be possible to find studies which are contradictory, at which point you may be tempted to throw up your arms in despair. You need to assess each study individually and decide which ones are the most valid. Keep in mind that many studies are funded by groups, such as drug and tobacco companies or government agencies, which are interested in seeing specific results.

Another factor to consider in evaluating causal relationships is did the cause come before the effect? This may seem obvious but is sometimes tricky to establish. For example, a study of stress and infertility would need to distinguish between stress which was caused by infertility and stress which occurred before a person was aware of having fertility problems.

There are many other factors to consider. Is there a dose response? If a higher dose of X-rays causes more cancer than a lower dose, then the argument that X-rays cause cancer becomes stronger. Does the association make biological sense? An argument that AIDS can be spread on toilet seats does not make biological sense if it is known that the virus dies in the air and needs to be transmitted through body fluids. A bit of caution may be needed here, as sometimes accepted "biological sense" may be based on assumptions rather than something which is known. Generally, anyone with a new or outrageous theory should ex-

plain it in terms of how the human body and/or the disease work.

Finally, the usefulness of the results should be assessed. Will they make a difference to what treatments are available to women? Do they give insights into what causes a disease, and therefore how to avoid it? Do they open up new ways of looking at a situation? Are they a help or a hindrance in the struggle toward social equality for women?

Group research:

If you have not done health research or used medical or university libraries before, it can be very helpful to start researching a topic with one or two other women. Not only is it good to have someone to laugh with over outrageous comments from researchers, it is also helpful to have someone with which to check out hunches and directions for research.

At the Vancouver Women's Health Collective, we have started a "Journal Club." Women who are interested in research take turns bringing in an article for everyone to go through in nitpicking detail. It is amazing how much more we are able to pick out as a group. It also means that we build on one another's skills, so that we all are better able to pick out the useful from the useless information, and to bring our own perspective into reading medical literature in a way which values women's health.

Take this guide with you, and happy reading. Becoming familiar with reading and judging medical literature is not only helpful for making health care decisions. It can also take away some of the prestige of "privileged" information which only doctors and professionals seem to have access to. And it can give some insights into the role of science in our society, through a first-hand view of what "good" and "bad" science can be like.

Further Reading

Riegelman, Richard K. *Studying a Study and Testing a Test; How to Read the Medical Literature*, Little, Brown & Co., Boston, 1981.

Barbara Mintzes is a member of the Vancouver Women's Health Collective.

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Doris Marshall

Rachel's Story

An Excerpt from *Silver Threads*

Doris Marshall offers an intimate glimpse of what it means to grow old in Canada. Old age is often a time of increasing frustration, anger, powerlessness and poverty, especially for women. Rachel's Story is an excerpt from Marshall's newly released book Silver Threads: Critical Reflections on Growing Old (September, 1987, Between the Lines, Toronto). Rachel's story vividly describes and analyses the forces — economic, political, social and physical — that affect all of us as we grow older.

Marshall also tells her own story in Silver Threads and the stories of some of her family and friends. In the process we see with new clarity the ways in which the increasing numbers of old people have brought big profits to big business. The "aging industry" has turned caring for our aged into a commodity to be marketed. Whether faced by the dilemma of caring for an older parent no longer able to manage at home or if we ourselves are beginning to consider life in our later years, Marshall gives us sobering and valuable information.

Doris Marshall has worked in the field of aging for over 30 years as an organizer of church and community programs for the elderly. She is an activist and a grandmother living in Toronto.

In February 1972 I went from my job with the United Church national office immediately into a position in a new home for the aged being built in downtown Toronto. I went into the job expecting to be the ac-



tivities director, to set up both a program for the home and a centre for older people who lived in the neighbourhood. The centre was supposed to be built as soon as construction of the home was finished — but never was.

I was taking on a job that did not really fit my qualifications, but I thought it would be a good chance to put into practice some of the things I had learned about aging over the years. Once I started the job I found myself interviewing applicants who wanted to live in this beautiful new place. There was no official admissions policy but I quickly realized that if you had money and good health there was no problem. If you had only good health, it was another matter. Living in the home would cost more than many of the people I

interviewed could afford.

I later learned that disappointment and disillusion were only delayed for many who did take up residence. If they became sick, their money would not help them secure their own spot and they were told they would have to leave, in poor health and that much older. The problem is, governments restrict their reimbursements for nursing care to a certain limited number of hours. In Ontario the law provides for only 1½ hours of daily nursing care for each resident. For those who either appear to need or actually do need more than the allotted hours, few options exist.

A friend of mine, Rachel, decided after a few years of retirement to stop living in her own place. At one time Rachel had been a successful businesswoman. Now, with no close family, she was an independent, self-reliant person whose income meant that she could afford a beautiful single room in the new home for the aged where I was working.

As admissions officer it was my job to interview Rachel about coming into the home. This was one of the easier interviews. Rachel knew exactly what she wanted. We had it, she could pay for it, and there were no obstacles.

The change worked out well for Rachel. The location was excellent, the room exactly what she had envisioned, the meals just to her taste. Rachel was friendly and soon she and the others on her floor were into bridge, tea parties, or shopping trips. She started to develop relationships

HEALTH WANTED

Gall bladder treatments

I would like to know where and how I can find information regarding alternative treatment for gall bladder stones. Non-surgical treatments are what I am trying to find.

Contact: N. Delhaas, 3 Woodglen Dr., St. Catharines, Ont. L2N 2Y6.

Fibroid Tumours

I would appreciate information from readers about experiences with fibroid tumours, referral to literature readers found useful and particularly information about treatment and side effects of the drug Danazol.

Contact: L. Massimiliana, 7 Forsythe Ave., No. 3, Kingston, Ont. K7M 2L8.

Daughters of Alcoholics

Community Resources and Initiatives, a feminist organization, is soliciting submissions for an anthology of writing by and about daughters of alcoholics. Recollections of being a daughter of alcoholic parents, struggles with personal addiction, relationships and healing, poetry, interviews, short stories and diary excerpts are encouraged. Send material to: Natalie Zlodre, 303A Melita Ave., Toronto, Ont. M6G 3X1.



Terri Robertson

that were closer to family than any she had known in her adult life. She looked much younger than her years seemed to indicate. She was active on several committees — library, residents' council, finance. For many years her room was a home where she could entertain friends, read, and watch the TV news. She expected to be there for the rest of her life. She seemed to feel that the personnel in her new surroundings could be counted on as a substitute family.

Although I left my job at the home after only one year, I kept in touch with Rachel and her friends for the next 10 years. Then, ill health struck Rachel. First came cataracts and glaucoma, followed by an operation that resulted in near total loss of sight. The trauma began to have an effect on her general state of health. Eventually she had a fall brought on by a combination of poor vision and someone moving her chair to an unfamiliar spot in the room. The administration of the home decided she could no longer manage alone.

It was convenient for the staff to have Rachel close to the nursing station, so she was moved to a double room, in which the other woman smoked. Although her personal privacy was one of her most prized possessions, it seemed to be of no concern to the decision-makers. This bright, self-reliant woman started to speak with longing about death. It held no fear for her. What *was* terrifying was what would happen in the rest of her life, since the home was not set up to provide the kind of care she now needed.

The days passed and Rachel was in a constant quandary about what to do, until one day she had a sudden heart failure. She was sent — unaccompanied — by ambulance to the hospital. When I phoned the place she'd called home for so many years to ask about her, no one could tell me anything. Although Rachel had made many friends among the residents, there was no close feeling for Rachel among the staff who were in control.

She received excellent care in the hospital and I found that the people in charge were very understanding. Although it had seemed unlikely, Rachel did recover sufficiently to

leave the hospital to live in a nursing home, in an unfamiliar part of the city. She was happy with the care she received there, and arranged for the installation of a phone. Things seemed to be going well, but soon there was another fall and another hospital. This was followed by a return to the nursing home, and then another stint in a second hospital where friends found her totally unaware of who she was, who they were, and where she was.

Our anger and frustration reached a high pitch, and now we really tried to make arrangements for someone to be with her — perhaps a nursing assistant, or just a companion — so that there might be some thread of continuity for her as she lived the uncertain life of being shunted back and forth from hospital to nursing home. I undertook the task of finding out from the trust company that handled her affairs how we could arrange this. I knew she could afford such care, and we all felt she should have it, but I wasn't sure whether the funds would be available.

I should have known the trust company official would say, "It's not that easy." It would take them time to assess the situation, but they would look into it. Now it was out of our hands — and Rachel's. The trust company, a doctor, and the nursing home together would decide what was best for Rachel and if *they* felt there was a need for a companion or a nurse, the trust company would arrange it. Since Rachel had no family or proxy, the trust company was in charge of all the funds. It had the power, for Rachel was said to be too ill by then, and too confused, to make decisions by herself. The nursing home would have to agree to have the extra person around. The trust company would need a doctor's order to proceed. This took a lot of time to work out, given the complexities of the law and the busy schedules of those involved.

Rachel's friends, who knew very well that this could happen, should have been more aggressive much earlier. In retrospect, it's so clear. The friends who tried to be Rachel's real family — people who were well aware of the problems of nursing homes — were unable to get around these complexities in time to help

Rachel. So much for our belated, albeit well-meaning, efforts on her behalf. We really didn't have much to say in the matter, for when it came right down to it, it really did not matter what happened to yet another old woman who was alone — lost in a sea of referrals. But miracles can happen. Rachel finally received institutional permission to have someone with her for part of each day. A few days after the companion started coming, Rachel died. The effort we had made was too little and much too late.

There are many Rachels in Canada, and in other parts of our world, too, it seems. In Japan, for instance. Jean Oda May, in the introduction to Yasushi Inone's book on the aged in Japan, writes:

Many of Japan's aged are now less fortunate than the author's mother, whose family adhered to the Confucian ideal of honouring and cherishing the old. In Japan, as in the West, the elderly today are frequently shunted aside, ignored, or made to feel they are a burden. A sad commentary of this state of affairs is that at special temples for the aged in Japan, the penitents increasingly pray for an early death.

The Rachels of our world do not even have a special temple to go to, but I know there are old people all around us, tucked away in nursing homes or other institutions or even in a spot of their own, who join the Rachels in making their desperate prayers for death every day.

It is maddening that Rachel's "story" occurs on an everyday basis all over the country. It is a very important part of the environment out of which the nursing home industry has sprung. And sprung it has, almost to the top of the country's most profitable corporations.

Since I know very well what troubles for residents can arise in a "non-profit" situation, I am horrified to contemplate how these could be multiplied in an institution run for profit. Although not impossible, it seems to me very improbable that the urge for profit could benefit anyone but the

owner — whether an individual or a large corporation. So I believe that we, old and young alike, must be much more aware and alert to the meaning behind the headlines about the booming healthcare business.

Such undertakings have been and are now going ahead very rapidly and with government blessing. In Ontario one study, *Caring for Profit: The Commercialization of Human Services in Ontario*, showed that 90 per cent of Ontario's 333 nursing homes in 1983 were operated for profit. The same report warned of the potential for serious and far-reaching consequences for this province and the rest of Canada if the trend to reliance on profit-based health care and social services increases without careful investigation into such enterprises. As a result, the Social Planning Council asked the Ontario government to place a "moratorium on commercialism of human services" until an appropriate review

had been undertaken.

Meanwhile, we have arrived at a point where governments are looking for ways to cut expenditures on social programs and business is eyeing the opportunity to make money, while appearing to help the aged. It is a dangerous point, and it may be too late to add our voices to those who have been trying to help us to see that institutional living is not for everyone and is, in fact, only welcomed by or necessary for a very small number, and that there must be alternatives.

Thanks is given to Between the Lines for permission to excerpt from Silver Threads: Critical Reflections on growing Old, Doris Marshall, Between the Lines, Toronto, 160 pp., \$25.95 cloth, \$9.95 paper, 1987. Please order from your local bookseller. Between the Lines can be contacted at 229 College St., Toronto, Ont. M5T 1R4 (416) 597-0328.

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Connie Clement

The Birth of a Network

A Canadian Women's Health Network is in the throes of birth. And labour is progressing well. Creation of a Canadian-wide network will strengthen and expand existing informal contacts between women's health groups.

A coordinating committee with membership from most provinces and territories held its second meeting in Montreal on June 12-14, 1987 (see *Healthsharing*, Spring, 1987 re first meeting). These women have a variety of backgrounds and hold very diverse opinions. Nearly all of Canada's numerous feminist health groups feel excitement about the potential benefits of a Canadian-wide network, yet creating a network that can encompass and respect all groups is a challenging goal.

The achievements of our feminist health movement are easy to identify, but our informal movement is not without difficulties. Because of our country's vast size, we all too often work in isolation from one another and therefore duplicate research, repeat mistakes, re-develop strategies. And while some local groups have had a long, productive existence, many have sprung up, worked very hard and then collapsed from burn-out, lack of funds and lack of recognition. Sustaining energy and achieving social change is easier when mechanisms to support one another exist. A Canadian women's health network can help in many ways (see *Healthsharing*, Spring, 1982).

The weekend meeting in Montreal began with a workshop to explore cultural differences and cross-cultural

understanding. Participants saw how assumptions about other women were often incorrect and prejudiced. The workshop was one effort to understand, respect and integrate issues of concern to Francophones in and outside Quebec, women of colour, rural women, disabled women, lesbians, poor and working class women, older women, immigrant women and women with minimal literacy.

The network will be a bilingual, non-profit network linking feminist organizations. It seeks to be equally accessible to women in the groups above and women who are less likely to suffer from multiple causes of discrimination. Although specific structures are not yet defined, the network will function in a non-hierarchical manner conducive to both sharing of responsibilities and ongoing autonomy of participating groups.



Terri Robertson

Much of the Montreal meeting was spent attempting to agree upon a statement of philosophy to speak for the new network. This statement (still in draft form) will recognize sexism against women, define health, identify causes of ill health for women and support health promotion and prevention. Written out in one sentence, it sounds as though it shouldn't be difficult. But feminism varies greatly, and so do the political perspectives of feminist health groups.

A central component of the network's philosophy, as discussed at the coordinating meetings, has been empowerment of women. To empower women it is understood that the network, and participating groups, seeks means to acknowledge women's experiences, to promote and validate self-help among women, to develop and apply a critical perspective that will both improve and demystify health theories and practices. It is recognized that applying a single political perspective toward both mainstream medicine and so-called alternative health modalities is difficult. Yet the same critical eye must be turned toward any health practice to assess its value adequately.

The objectives for the network are developing. At this time it is envisioned that the network will:

- assist in information-sharing among groups;
- support the development, growth and stabilization of regional networks and local women's health groups;

- undertake public education campaigns and act as a resource for local and regional educational programs;
- work with government and health service organizations to develop health policies and services sensitive to the needs of women;
- increase Canadian contacts and access to women's health organizations internationally.

In order to continue with a slow, progressive development of the network, the January, 1988 meeting in Winnipeg will be a working meeting of approximately 75 women.

Throughout the summer and early fall, each region will select two additional participants to attend the Winnipeg meeting. The mechanism for selection is left to each geographical region and is expected to vary greatly depending upon existing women's health activities in each area. Once the participants chosen through regional selection processes are known, additional participants will be chosen to fill in gaps and ensure that all groups are well represented.

Needed now are discussions among members of local and regional women's health and feminist organizations about the objectives and structures most suitable for a Canadian-wide women's health network. Ask yourselves the following questions:

- What concerns do you feel are most pressing for a Canadian women's health network to address?
- What activities and services would a Canadian network need to offer to benefit your organization?
- In what ways can you contribute to the development of a Canadian women's health network?
- What structure/format do you feel is most applicable to a Canadian network?

Contact any of the following women or organizations to join in regional discussions and have your voice heard prior to the founding meeting in Winnipeg in January, 1988.

Connie Clement is a member of Women Healthsharing.

Provincial Contacts for the Canadian Women's Health Network

Unless otherwise noted, telephone numbers are office numbers. Organizational affiliations are listed only as part of addresses.

British Columbia

Maggie Thompson
Vancouver Women's Health
Collective
888 Burrard St.
Vancouver V6Z 1Z9
(604) 682-4805

Yukon

Lorene Benoit
Box 5641
Whitehorse Y1A 5H4
(403) 668-2207 (H)

Alberta

Joan Hollenberg
Calgary Women's Health
Collective
2340 1st Ave. NW
Calgary T2B 0B8
(403) 270-7478

Saskatchewan

Shannon Buchan
Regina Healthsharing
Box 734
Regina S4P 3A8
(306) 352-1540

Northwest Territories

Pat Alikashuak
Whale Cover
X0C 0J0
(819) 896-9985 (H)

Manitoba

Sari Tudiver
MCIC
60 Maryland, 2nd Floor
Winnipeg R3G 1K7
(204) 786-2106

Northern Ontario

Donna Mikeluk
Box 562
Schreiber P0T 2S0
(807) 824-3050 (H)

Southern Ontario

Valerie Bolton
Women Today
Box 1405
Clinton N0M 1L0

Quebec

Marie Vallee
Federation du Quebec pour le
planning des naissances
3826 St. Hubert
Montreal H2L 4A5
(514) 842-9501

New Brunswick

Someone is joining the committee.
Contact: Carla Marcellis
Women's Health Interaction
58 Arthur St.
Ottawa, Ont. K1R 7B9
(613) 563-4801

Nova Scotia

Alex Keir
R.R. No. 1
Scotsburn B0K 1R0
(902) 485-8202 (H)

Prince Edward Island

Kathy Dewar
146 Brennan Ave.
Summerside C1N 2K7
(902) 436-4756

Newfoundland

Wendy Williams
62 Bonaventure Rd.
St. John's A1C 3Z6
(709) 579-1009

Labrador

Beatrice Watts
Labrador Native Women's
Association
North West River
A0P 1M0
(709) 497-8324

For general information about the network planning contact:
Women's Health Interaction
Manitoba
c/o Sari Tudiver
Manitoba Council for International
Cooperation
60 Maryland, 2nd floor
Winnipeg R3G 1K7
(204) 786-2106

MY STORY, OUR STORY

No Longer Silently Disabled

Betty-Ann Lloyd

I'm sitting in a circle of women who are discussing plans for a solidarity action. The committee looking after the march presents its proposal for a route. It includes a long trek up Halifax hills and suddenly I realize I won't be able to take part. There's no way I can handle that much uphill walking, especially in a fairly fast-moving group.

I feel myself start to withdraw from the meeting, tears come to my eyes and my throat is closing. I don't want to say anything in case I lose control. Obviously I must be pre-menstrual; maybe it's the full moon.

As I try to understand why I'm "over-reacting," I remember an earlier conversation with one of the organizers. When I congratulated her for having the meeting in a wheelchair accessible school she laughed ruefully: "More luck than good management!" No one had realized they were booking one of the four free accessible meeting places in the city.

Certainly a major source of my emotional response is the understanding that if I don't raise the issue of accessibility for the march, no one else will. The next committee is already giving its report. To speak up now would seem to make a big deal out of something others have already accepted. I don't want to embarrass the women doing the organizing. And, perhaps more important, I don't want to draw attention to myself as someone who can't keep up.

On the other hand, I think, why should I keep worrying about the feelings of women who have, yet again, carried on as if we are all able-bodied.

As the meeting continues, I begin to fantasize. I defend women who have hearing problems and have to sit through mumbles and whispers in meetings. I curse long, sitting sessions on behalf of all women with

back problems. I break cigarettes with a single snap on behalf of the asthmatic and buy gallons of apple juice for those with caffeine restricted diets. I ban socializing in taverns on behalf of women with alcohol problems and restrict potlucks on behalf of the diabetic and those who live with candida or food allergies.

I realize I am silently taking my reaction to an extreme because after a while dealing with the reality gets so painful. I know there are lots of straight forward (even out-loud) ways of dealing with this issue. The march route is only a proposal after all. Why don't I just speak up?

Well, that's a big question for all disabled women and, perhaps particularly, for women who have invisible disabilities. One of the reasons I don't speak up is because I'm not exactly out of the closet on the issue of my invisible disability.

I'm embarrassed by the restrictions I feel because of my actual and potential dependency. And why wouldn't I be? I don't see disability issues being used as a basis for unity or being considered a priority in the women's community where I do my political work. Raising them merely draws attention to what is dealt with as my personal problem. In most contexts the issues do seem personal; at least they are individualized.

I have multiple sclerosis (MS). I've had it for almost 15 years and my constant companions are a slight limp (which becomes more noticeable as I walk up hills or stairs), general weakness and lack of coordination in my left leg and arm, intermittent numbness in my face and an extraordinary lethargy that can strike without a moment's notice. While I can usually pull myself together to focus on work, it's often impossible for me to handle



Donna Gallagher

the diffuse noise and relaxed socializing after the work is done. As well, I cannot reduce my physical responsiveness by drinking or letting myself get over-tired.

Until recently I haven't been particularly forthcoming with this information. I've believed that I'm not really different, that every woman has some restriction on her life, mine just has a name. I've been reluctant to talk about "my" problem even when it seems appropriate. The conversation almost always stops cold as women try to find a response. Once they are aware I have MS I become "different" and the resulting awkwardness on everyone's part usually results in an uncomfortable mixture of self-consciousness, curiosity, over-protectiveness or an inability even to respond to what I've said.

And it's true that despite my outward appearance I am different. I have to fight to make myself realize this as much as I fight to have others develop a consciousness of disability issues. There's no doubt that carrying around the knowledge that I have an incurable, virtually untreatable, degenerative neurological disease has changed my life and the way I look at the world. I am very aware that my independence is a present-tense gift, a privilege that I

could wake up without tomorrow morning. Paradoxically I also need to plan minutely for the future, to make sure I have parcelled out my personal resources in the most efficient, effective way.

I feel an affinity with women whose life conditions, or sense of fatalism, gives their day-to-day life that same paradoxical sense of impermanence and need for security. But I am different.

I am also different from the women whose disabilities are, for whatever reason, more visible than mine. In most ways, I have the advantage and I am not so naive as to want to suffer from the public ignorance, mobility problems, visual, aural or speaking problems that visibly disabled women face. However, I have often wanted a sign that says "There's a reason I'm sitting here resting and not stacking tables."

I want women to know that I can't lift anything very heavy, I can't sustain physical activity for very long, I need to stop as soon as my body tells me to stop. I need what often seems to be an excessive amount of quiet time, time to let go of the kind of consciousness it takes just to keep going. I need to be selfish. I have a reason to be selfish.

I'm often the hardest one to convince of all this. I always have a sinking feeling that maybe I'm just unfit, or lazy or burned out and want an excuse to get away to my favourite chair and a good book. To a large extent this comes out of the Protestant work ethic I ingested as a child: You don't stop working, you don't make excuses, until you're confined to bed or in the hospital.

My own inability to take my symptoms seriously also reflects the treatment many women get from the medical profession before (sometimes even after) they get a positive MS diagnosis. We commonly go through months, even years, of being told we are suffering from young-married stress, non-married stress, new-job stress, new-mother stress, student-exam stress, marriage-problem stress. We are told our symptoms (admittedly often unpredictable and non-specific) are the "nerve problems" to which women are so prone.

I have been told by doctors that

MS is the perfect disease (meaning excuse) for someone like me who has a very low pain threshold, enjoys quiet, contemplative work, is well-organized and (it's implied) self-centred. But after 15 years of living with the physical and psychological restrictions of MS, I no longer know how to differentiate between my "personality" and the ways in which I have adapted my life to fit within a framework over which I have no control.

When I am using a wheelchair, even a cane, no one questions why I might need to lie down right now — not 10, 20 or 30 minutes from now. Without the visible signs, I have to either swallow my pride and explain, or simply give up caring about the consequences of leaving mid-process.

Both options are difficult. Although my feminist friends are caring about my needs, the way we behave speaks about the strength and ability of women who are empowered through political action and community. It seems a betrayal, then, not to be able to stand on my own two feet as a witness to this strength. I worry that I betray myself

and the women with whom I work. If we, as feminist women, can't deal with the pressure, can't show that we are able to continue — no matter what — then how, I ask myself, can we convert the masses?

And I continue to fear I will be pitied. My lover will be pitied. My child, housemates, colleagues will be seen as having one extra burden to carry.

Most invisible disabilities seem to be attached to degenerative diseases and the "what-ifs" are often their most difficult component. At what point in relationships should I share the information about having MS? When is it appropriate to consider it a significant issue?

The difficulty of this sharing is amazingly similar, whether it's with a child, employer, lover, affinity group or housemates. It involves a level of vulnerability that is difficult for able-bodied women to understand. It can also involve a future of frustration: able-bodied women simply do not remember from day to day (sometimes from hour to hour) that I have to monitor what I am



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doing constantly. And it doesn't help to have to become vulnerable, yet again: to explain it all, yet again.

So most often I "pass" as able-bodied. In the mainstream world that means keeping my distance, not committing myself to activities that I don't want to have to withdraw from. In the feminist world, it means closing off some parts of myself until there is enough closeness — and consciousness — to risk opening them.

I resent this closing-off. It means either I don't raise political/practical issues of accessibility when they come up, or I raise them as personal concerns about "them," the disabled women, or as political concerns about accessibility in theoretical terms of race, class, affectional preference, physical ability, etc. Obviously, this disconnection from myself is not healthy, but it's a trade-off I've made to keep working in a community that doesn't often take the time, energy or money to develop a consciousness and analysis around this issue.

What I want is to be able to speak in solidarity *with* the many women who are not able to be wherever I am because they couldn't make it up the stairs or because they can't sit for 4, 6, 9 or 12 hours. I also want to speak in solidarity with women who experience exclusion from the women's community — the Euro-Canadian, middle class, heterosexual and able-bodied community — because they don't fit in. I feel uncomfortable adding the privilege of physical ability to my race and class privileges. If I can get to the meeting, I should speak up and make my personal connections clear.

I especially want to make the connections as a Lesbian. I constantly have to come out if I don't want to be assumed to be heterosexual. Coming out as Lesbian or disabled may be equally disruptive to my relationship with an individual or group; may be equally awkward or embarrassing for women who need to respond. Either disclosure may place me in a same position of being seen as 'other,' as needing compassion or assistance. Both may also alienate or threaten women who do not want to deal with difference, who do not wish to face their own vulnerability — or their own privilege.

Coming out as Lesbian, while often tedious, is usually less difficult for me, however, than coming out as disabled. I see my identification as a feminist lesbian as a major source of my strength and contribution to my community. This is hardly the way I have been able to view the unchosen fact of having MS!

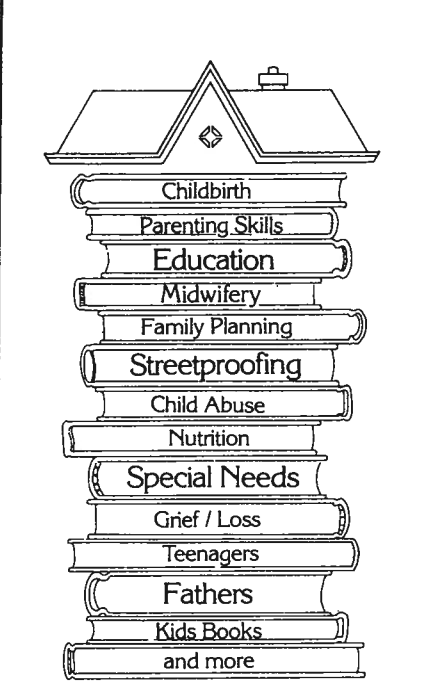
While the personal reality of my physical disability is obviously negative, there are many advantages to keeping quiet. I've started to recognize my feelings of powerlessness when I pass for able-bodied. There are situations where I want my disability and the disabilities of other women recognized as strengths. I do not want to deny my unique abilities that enable me to continue despite the emotional, physical and psychological trials of living with MS; I also want to recognize these abilities in other women.

I have found it very helpful to read Michelle Cliff's writings on "passing," especially her article "If I could Write This in Fire I would Write This in Fire" from *Home Girls: A Black Feminist Anthology*. She talks about claiming her blackness when people assume, because of her light colour, that either she is white or prefers to be considered white:

It is not a question of relinquishing privilege. It is a question of grasping more of myself. I have found that in the real sources are concealed my survival. My speech. My voice. To be colonized is to be rendered insensitive.

"To be colonized" for me means continuing to silence myself when I need to speak out for myself and in solidarity with others. Although I am invisibly disabled most of the time, I am slowly but surely recognizing that I don't have to be silently disabled.

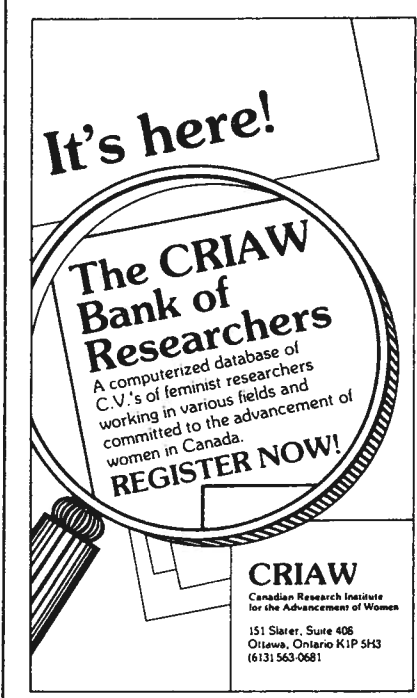
Betty-Ann Lloyd is moving from Halifax to Toronto for a year while she does graduate work in Community Psychology at the Ontario Institute for Studies in Education. She has most recently taught journalism at the University of King's College and been co-ordinating editor of the feminist tabloid Pandora.



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Irene Moch

Our Still Birth

The baby didn't move for several days — or a week — it could have been longer. But then the baby had never moved much anyway. One night I almost woke my husband to tell him, but then thought I'd be worrying him about nothing. Anxieties about the baby are normal, friends had said.

Besides, there was always so much to do. Painting the baby's room. Putting in an upstairs bathroom. Going to all the fitness and prenatal classes.

But when my father greeted me over the phone with his new proud "Hello Mother!" I had to protest: "Dad, please don't say that. I'm not a mother yet!"

I felt superstitious. Friends were always joking about the baby. Whether it would be a boy or a girl — or how well it was growing. Some of them would pat my belly and laugh.

And then, sometime in my eighth month of pregnancy, everything changed. When I went for my regular appointment, the doctor couldn't hear the fetal heartbeat. That afternoon, he sent me to the hospital for an ultrasound. I went into a small room; the technician told me to lie down on the table. She said the test would take only five minutes, but kept repeating it over and over while a man who'd introduced himself as a doctor watched the screen in complete silence. I couldn't understand what I saw on the screen; the images were a wavy grey blur.

Afterwards, our own doctor met us in the hospital. "It's just one of nature's quirks," he explained, "nothing you could have done would have

prevented it." The fetus had some severe deformity; he didn't say what this was. All we knew was the baby was dead.

The two glasses of wine. The week I was sick with the flu in my first trimester. Or maybe something larger. Some lack faith or hope . . . ? I asked myself what I'd done wrong.

Some nights when I couldn't sleep I went into the room meant for the baby. I looked at the crib, the bassinet, the little clothes, the stuffed animals. Then I went back to bed.

My husband held me; he didn't say anything. What was there to say?

"Put the baby things away," friends told us. "Put them away. There'll be another time." But the baby things remained untouched, piled in the spare room.

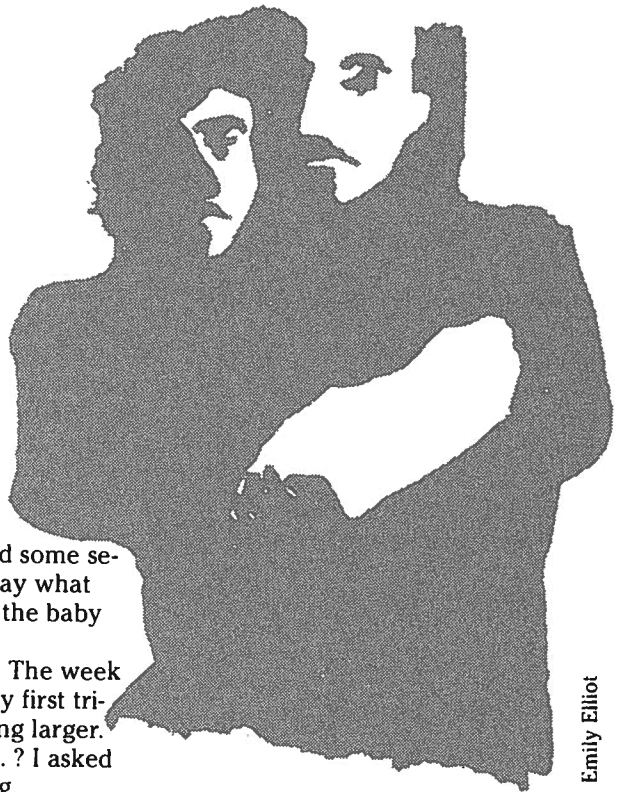
When three weeks had gone by since the last heard fetal heartbeat, our doctor became concerned. A woman who retains a dead fetus for more than three or four weeks, he explained, runs a 20-25 per cent risk of disseminated intravascular coagulation, a condition in which the body tries to expel the fetus as a foreign object.

"If another week or two go by and the baby's still inside you could risk a massive hemorrhage," he told us, "but there's only a small chance of this occurring."

I nodded. I could feel my eyes glaze over. "What would you recommend?"

He looked thoughtful. "You could always have a caesarean section, of course."

"I'd prefer not to."



Emily Elliot

"If you don't want a C-section, that's OK, we can wait — a week, maybe, but I wouldn't want to wait any longer.."

I nodded, but I felt cheated. Couldn't I have anything? At least go through the birth?

Days went by; with the risk of hemorrhage becoming more a reality, we tried to decide what to do. "Get a caesarean," friends advised. "How can you carry it inside you?"

It. They made it all seem so terribly dirty, as if I were walking around with a rotten vegetable, a turnip or a cabbage. "But it isn't having the baby inside that bothers me," I tried to explain. No, it was having the baby taken away from me.

My baby. Stolen in the night.

Eventually, my husband put the little clothes in a bag upstairs. Soon afterwards he dismantled the crib. He put away the stroller, the Snuggli, the bassinet.

A couple expecting their first child at the same time as ours stopped by. We had gone through our pregnancies together discussing everything from the woman's Cheerios and ice cream and my pickled herring and cheese to birth positions and how to avoid "the cut," episiotomy, which had us terrified.

Once I'd asked how she felt about bringing a child into today's world and she replied, "Not hopeful. But even five or six years with the child would be better than nothing." Her admission had shocked me. I realized I now felt a very similar kind of despair.

I looked at her swollen belly, then down at my own. "Is there anything more you need for the baby? Please, go upstairs and see," I said. When she returned her hands hung empty at her side. "We still need a bassinet, but . . . are you sure?"

The *bassinet*. My husband and I found it at a garage sale. We were happy, singing, as we bought the bassinet into the living room. She had once complimented us on our good fortune. "I've gone to all the garage sales and haven't come across one yet. You must be lucky."

I watched my husband carry the bassinet to their car. We stood waving as our friends pulled away. When they were gone we held each other in the driveway.

By the end of the fourth week after the last movement had been felt I

still had not gone into labour. Our local gynecologist wanted to do a C-section; he didn't have the right equipment to allow us to try labour. After much thought, I decided I didn't want to be knocked out for the birth, so my husband and I took the hour long flight to Vancouver's Grace Hospital, a maternity teaching centre for University of British Columbia Medical School students. Grace Hospital had special methods for inducing labour in situations such as ours.

To disguise my pregnant appearance I wrapped myself in my husband's huge raincoat. I was having some contractions — not enough to be in labour. They had only started, irregularly, the night before.

I didn't want strangers cooing over me. I didn't want anyone patting my belly. And above all, I didn't want this baby to be born on the plane. I didn't want anyone to see it. I wasn't sure if even my husband or I would.

Before deciding to go to Vancouver, when I told the gynecologist that we planned to look at the baby, he advised against it. "You never know how you or your husband will react," he said. "And then it will be too late to wish you hadn't."

"But I'm a nurse," I reminded him. "I've seen other babies like this."

He shook his head. "This is your first pregnancy?"

"Yes."

"I'm sorry. I'm very sorry," was all he said.

"What exactly is wrong with the baby? Do you know?"

"Anencephaly."

The word was familiar to me, though I wasn't quite sure what it meant.

"You may not have seen a baby like this before. Often these babies are miscarried very early in pregnancy because the brain is either absent or so poorly developed."

I nodded.

"I don't think you should look at the baby. You might be risking your marriage. It may affect how you make love. Sometimes it can produce such guilt . . ." He paused. "This kind of baby is worse than anything you've seen. Nobody — not even nurses — like these babies."

Alarmed, I promised not to look and made my husband promise also. When I explained this to my mother

at the airport and asked her advice she didn't tell me to look at the baby and she didn't tell me not to. She just said, "But darling, you've always felt physical appearances were superficial."

Embracing her, I felt my mother's strength. It was enormous. It was something I held onto. After I went through to the area marked "Passengers" I realized how lost I was without her. I gripped my husband's hand. "The contractions are becoming more regular."

The nurse at Grace Hospital was quiet and helpful. "Where does it hurt?" she asked, placing a hand on my belly.

I lowered her hand, "Here. Deep inside."

She began to remove her hand.

"Wait," I said, "I feel one coming."

The pain was physical, intense, and I welcomed it because finally it was real. I felt my whole body opening up, alive.

"That's good," she said. "The pain you feel means the contractions are working. You just walk around a little, and let me know when they get stronger."

My husband and I went down the corridor. I was glad he was with me, though it was hard to concentrate on anything but the contractions.

Hours later, the membranes broke naturally and a flood of water gushed out and I was giggling, I felt so jubilant, the baby was coming . . .

So now we would look at the baby. My husband and I were alone in the delivery room with the baby and nurse. She took the baby away and slowly wrapped it. The nurse had seen many babies; even these babies. I told her that I wanted to see the baby, but I was scared; I didn't know what to expect.

"Does the baby look human?" I asked.

The nurse said yes.

"Will it be OK for me to look at it?"

She said yes.

There was nothing left to do now but to look. The nurse brought the baby close. She had wrapped it carefully so that the back of its head was covered by the receiving blanket. He had no forehead. He did not look like a baby. I told her, "Please, take it away."



Emily Elliot

The nurse took him away, and we talked about him. She brought the baby back, and we talked again. "I see an old person," my husband said. I didn't say anything. I looked at the baby. I looked away. I cried.

Then, gradually, I took courage. I touched the baby's feet. Cold, very cold, but the toes were perfect. Each had a tiny nail, and the skin at the joints was wrinkled. Then the hands. Cold, peeling, but again perfect.

My husband took the baby in his

arms. I felt tears running down my face and I couldn't stop crying. There was something about the way they looked together, father and son.

He held the baby out to me. "No," I said, "I can't. I can't."

He turned away with the baby but the nurse said, "I think I just saw your arms reach out." I looked at her. Yes. But I was frightened. I could hear myself crying, "I'm afraid. I'm afraid."

My husband cradled him in one

hand while the other stroked his tiny feet. "Darling . . ." he urged, holding my child towards me. I reached out. He was beautiful, so very light, almost like air.

We named him Ariel.

Irene Mock, a former registered nurse, lives in Nelson, British Columbia. She is a writer of fiction and an instructor at Kootney School of Writing and recently became a mother to a healthy baby named Anna.

When a Newborn Dies

There is no acceptable or unacceptable form of behaviour for grieving. Knowing some of the things you can do if your baby should die at birth or shortly after, however, can help you work through loss, and make better use of the limited time you have with your child.

Make contact with your baby

Generally it is easier to grieve for someone who is more fully known to you. You can take the opportunity to see, hold and touch your baby. The bonds between you began long before birth; this baby is part of you. In cases where the baby has serious birth defects, as ours had, making contact can be particularly important. Imagined mental pictures are almost always worse than reality. Holding my baby and reaching out to his essence was the only way I felt I could say goodbye.

Be patient with yourself

You will be asked to sign certificates of birth and death and, perhaps, to decide whether or not to have an autopsy performed. Do not feel hurried by having to take care of these details immediately. Take the time you need to be with your child.

Give the baby a name

A name is a means of talking about your child, of sharing your memories later on. You will be asked if you want your child's

name written on the birth and death certificates or simply "baby boy" or "baby girl." A name identifies your child as a real human being.

Claim mementoes

Photographs, locks of hair, baby's foot and hand prints, birth and death certificates, the plastic arm identification bracelet, a record of weight, length, head and chest measurements, the receiving blanket your baby was first wrapped in — any of these may be important for you to have. Even if the hospital staff does not encourage you to claim keepsakes, or appears uncomfortable if you ask for them, it is important to remember that it is your right to have them.

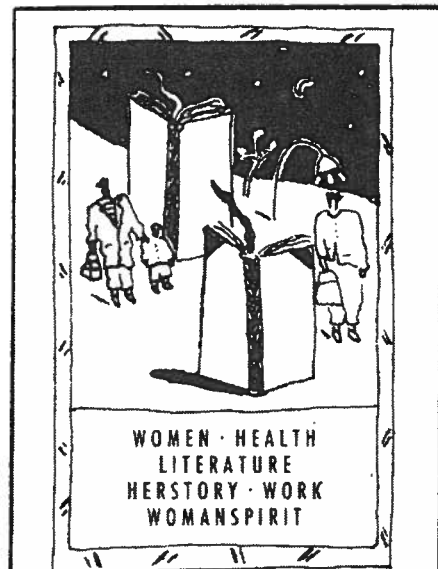
Have a funeral and/or memorial service

Some parents will want to have a funeral service at a cemetery or at their church; others may want to bury their baby on their own land. You'll need to decide what's best for you. We chose to cremate our baby, and to scatter his ashes on a calm, peaceful lake a year later, when we felt "ready" to do this. The important thing to remember is that nobody can make these decisions for you: take your time to decide.

Make your needs known

Don't try to "be strong." Let people know how to help and support you. Friends and family will take their cues from you. There are times when you'll want

to be alone, and times when you'll need people around you. It is always best to let people know what you want.



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REVIEWS

Body Defenses: The Marvels and Mysteries of the Immune System

Marilyn Dunlop, Irwin Publishing, Toronto, 1987, \$12.95, 264 pp.

Reviewed by Susan Elliott

Have you ever wondered why a pregnant woman's body doesn't reject the fetus in the same way it would a mismatched organ transplant? Or how your diet can affect the number and severity of infectious diseases you catch? In *Body Defenses*, Marilyn Dunlop provides explanations for these and many other questions about our immune system and its vital functions. A medical writer for the *Toronto Star* for over 15 years, Dunlop writes in a clear and easily understood manner using everyday analogies to help the general reader understand how the immune system is linked to many diseases. At the same time she goes into enough detail to satisfy the more informed reader.

Beginning with an examination of what immunity is, she explains how the body distinguishes between what is "self" and everything else that is "not self," like organisms that cause disease, tumor cells and transplanted tissues. The metaphor of a community is used throughout the book, with the different community workers or cells introduced in the first chapter along with a description of the role each plays. Certain white blood cells called macrophages, for example, are likened to garbage collectors and certain others called T-helper cells are identified as field commanders who point out the enemy (viruses, bacteria, etc.) and order other cells to mobilize and destroy it.

Once the cast of characters has been introduced, each chapter con-

centrates on one particular aspect of the immune system. "When Body Defenses Don't Work" is a chapter on immune deficiencies exploring what happens when an individual is born without a properly functioning immune system like the famous "boy in the bubble." Until very recently, cases like this provided the only insight to our amazing defense system.

"But," as Dunlop observes, "no one anticipated the electrifying stimulus that was to be given to immune system research in the 1980s. Nobody in their wildest dreams glimpsed a portent of what lay just a few years ahead. It was unthinkable that destruction of the immune system could be spread from person to person. But the unthinkable happened and it was named AIDS." In this timely discussion, Dunlop describes the history of AIDS and the virus that causes it with a precise explanation of events on a cellular level, the tests used to detect the virus and the

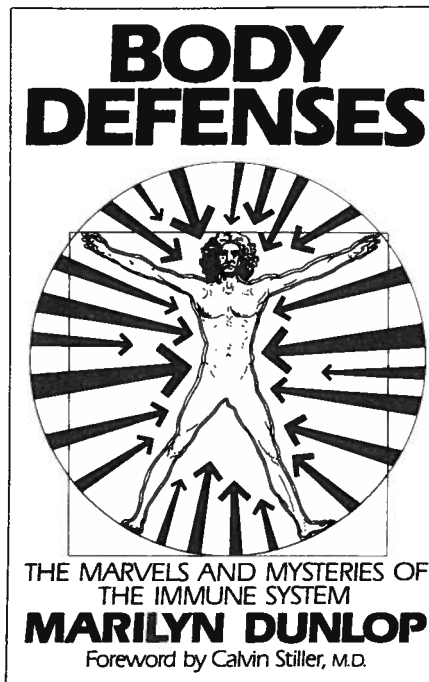
latest treatments being studied.

"Auto-Immune Disease: The Wrong Target" looks at examples of some of the 50 diseases where the body mistakenly identifies its own tissues as foreign and tries to attack them. Examples like multiple sclerosis, arthritis, lupus, myasthenia gravis, and even diabetes are presented from the viewpoint of cell interaction in fascinating detail.

Another intriguing chapter titled "Aging and Sex Differences in Immunity" considers why there is an increased risk of cancer and infections as one gets older, as well as other effects that age and sex have on our body defenses. Interestingly, women tend to reject organ transplants more readily than men which is unexpected when you consider that "women, after all, are designed for pregnancy, and a fetus, like a transplanted organ, is formed of cells and tissue different from the mother. Why, if a woman's immune system is so good at detecting that a transplant is foreign, does she not reject her baby?" According to Dunlop, there are a number of mechanisms initiated by both the fetus and the mother's body to avoid rejection — one of these is that the placenta provokes maternal cells to produce proteins called enhancing antibodies that "cuddle up to fetal cells and make them invisible to maternal immune cells that could destroy them."

The chapter "Cancer: Marshalling Body Defenses Against Tumours" is also worthy of note since this is the forefront of current cancer research. Treatment via the immune system is termed immunotherapy and it works by hooking anticancer drugs to proteins called antibodies which recognize cancer cells, seek them out and attach to their surfaces allowing the drug to kill them. There are also a number of naturally occurring anti-tumour substances that our bodies produce to eliminate potential cancers that researchers are now trying to produce artificially for therapeutic use. Immunotherapy is a new and very exciting weapon to be added to surgery, drug therapy, and radiation in our fight with cancer.

Additional chapters examine the role of stress and the importance of diet in the functioning of the immune system, the mysteries of transplants



and transfusions, and the how and why of vaccines, allergies and 20th century disease or total allergy syndrome.

Recognizing that "many people today want to take more responsibility for their own health," Dunlop has written a wonderfully entertaining primer about a little understood and much talked about body system. Anyone who is interested in learning more about the immune system should definitely read this book.

Susan Elliott worked for a number of years in immunology research and is a member of Women Healthsharing.

The Struggle For Choice

A Horizontal Forest Production, Produced and Directed by Nancy Nichol, 1987, 166 minutes.

Reviewed by Frumie Diamond

Women across Canada, whether in urban or rural settings are being confronted with severely deteriorating access to safe, legal, medically insured abortions. The crisis in accessibility exists despite the years of dedicated organizing and plain hard work by many women and men in the reproductive rights movement. Nancy Nicol, in five half-hour videos, attempts to chronicle the flamboyant history of this movement in *The Struggle for Choice*.

In *Part I: The Abortion Caravan*, Nicol chooses 1969 as the starting point for her historical inquiry. This is the

year the federal law was changed to liberalize access to abortion although not to decriminalize it. The historical forces leading to these changes though are not discussed. Through moving interviews with women from British Columbia to New Brunswick, Nicol presents the grim picture confronting women faced with an unwanted pregnancy at that time despite the changed law. Outraged at these conditions, the newly emerging women's liberation movement took up the call for "Free Abortion on Demand."

Nicol captures the excitement and energy of that time. On video she records a 1985 reunion of the original members of the 1971 Abortion Caravan in Vancouver. They talk about the events leading up to the decision to organize the caravan which travelled across Canada gathering women from town to town culminating in the only demonstration in Ottawa ever to disrupt the House of Commons.

Nicol implies that this was part of a mass working class struggle. If so, what happened to it? We are left hanging, for nowhere else in the video does she talk about the history of the prochoice movement during the 1970s except in Quebec.

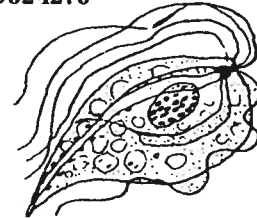
Part II: Access Today, jumps to the present day situation. Access to abortion across the country is deteriorating and Nicol vividly portrays this while talking with front line workers and health care providers. Nicol does attempt to document access problems across the country but large

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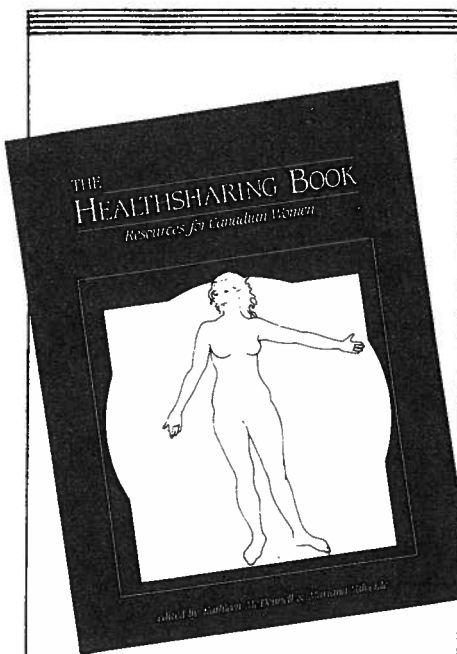
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portions, especially the far north, are left out.

Interviews with women from northern B.C. and P.E.I. who have to leave their communities in search of an abortion brings the situation alive. Juxtaposed against this dismal picture, Nicol does offer some hope and shows a group of B.C. women organizing against the takeover of a hospital board by the antichoice forces. But the victories are few and far between and one is left feeling angry and frustrated.

Part III: Quebec (1971-1980) emphasizes the relationship between the development of the highly politicized labour movement during the rise of the Parti Quebecois and the women's movement that grew out of it.

Quebec's history is unique and Nicol illustrates the events which led up to the establishment of health clinics in which abortions are performed. She downplays the role of Dr. Henry Morgentaler's court cases while emphasizing the role of labour and the women's movement in creating a climate that made the acquittals possible. It is important to note that Nicol gives justification for the women's movement's support of the Morgentaler defense campaign, only because it was one of many strategies. This tactic, however, is not justifiable in English Canada according to Nicol's final analysis in *Part V*.

Part IV: Restraint/Repression attempts to provide us with some understanding of how the economic crisis affects women's right to choose. Through several eloquent speakers, Nicol captures the plight of women who are being forced to raise families in ever increasing poverty. These women have few choices. But instead of documenting this further or including interviews with working class women, Nicol spends much of the video focusing on the demonstrations organized by Operation Solidarity in B.C. and discussing the losses of the labour movement in Quebec. One would think that the other parts of Canada were not affected by economic restraints.

Nicol also fails to include any discussion about ways in which the women's movement and in particular the prochoice movement is organizing itself. She implies by what is left out that the only valid struggle is

dependent on the labour movement. In retrospect, this becomes increasingly clear as *Part V* is viewed.

Part V: The Legal Battle purports to examine the problems of the prochoice movement today in English Canada. Instead it focuses on the opening of the freestanding Morgentaler Clinic in Toronto, documenting the closures, threats and harassment by the antichoice forces and the provincial government. There is only passing mention of the clinic in Winnipeg and no mention at all of the prochoice movement there and in other provinces. Nicol concludes that the Ontario Coalition for Abortion Clinics (OCAC) has "copied" the Quebec strategy, but has taken this strategy out of the context of a mass working class movement. Thus failure is inevitable. This is a blatant misrepresentation of OCAC's position and ignores the many years spent building support in all sectors of society, including the labour movement. If this mass support didn't exist, the clinic could not have remained open for the last two years. Nicol does not include discussions with members of OCAC or with members of the Canadian Abortion Rights Action League, of the events or the conditions leading up to the adoption of this strategy. And if there is disagreement about this strategy, it should come from discussion with other members of the prochoice and women's movement.

Unfortunately, Nicol cannot rise above her own biases and the videos become a platform for her particular analysis which discredits and distorts large segments of the prochoice movement. She does the women in the rest of Canada a great injustice by dismissing their struggles.

However, Nicol's contribution to Canadian history cannot be dismissed and the videos do provide valuable documentation of the struggle through interviews with activists and health care workers that are interspersed with fascinating footage and photographs of events and demonstrations.

Frumie Diamond is a nurse who works in reproductive health. She is a member of Women Healthsharing's article planning committee.

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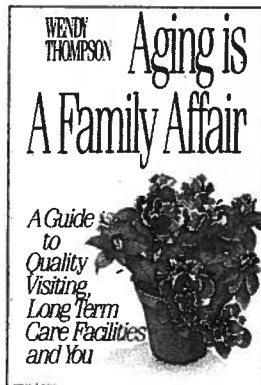
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RESOURCES & EVENTS

Women Healthsharing screens resources before including items in this section. Send a sample copy of any new resource whenever possible.

Please send us notice of upcoming events. Send notice of events far in advance.

Active Health

The federal government has released its first report detailing the results of Canada's 1985 Health Promotion Survey, in which 11,000 Canadians were asked about health issues.

The 43 page *Active Health Report* is available free of charge from regional offices of the Health Promotion Directorate, Health & Welfare Canada or write Jake Epp, the Minister of Health & Welfare, Ottawa, Ont. (no stamp necessary).

Hazards in the Office

Playing With Our Health: Hazards in the Automated Office is a guide published by the Women's Skill Development Society, Burnaby, B.C. for clerical workers, union officials, students and teachers interested in health and safety problems of video display terminals. The information is solution oriented, with suggestions on how to win recognition of VDT related health problems and reduce risks associated with VDT work.

It is available for \$10 (single copies) or \$7 each for orders of 10 or more from: Women's Skill Development Society, 4340 Carson St., Burnaby, B.C. V5J 2X9.

Wife Abuse Manual

A new handbook from the Women's Policy Office in Newfoundland aims to encourage informal community workshops.

Available in the fall from The Women's Policy Office, Department of Career Development and Advanced Studies, Confederation Building, St. John's, Newfoundland (709) 576-5098. There is no charge.

AIDS Video

The *Nature of Things* program with David Suzuki entitled *AIDS — A Report* is now available in video.

AIDS — A Report is 46 minutes long and is available in VHS or BETA format for \$29.95 in bookstores and video outlets. To order call toll-free with a credit card to 1-800-361-5154, or write to CBC Enterprises, Box 4039, Station A, Toronto, Ont. M5W 2P6. (Add \$2.75 for postage and handling.)

Women and Weight

The Boston Women's Health Book Collective, authors of *The New Our Bodies, Ourselves*, has a new resource, *Women and Weight: An Information Packet* containing information and articles on women and weight, the hazards of dieting, fat oppression and liberation, eating problems and body image.

Available for \$15 from the collective's Women's Health Information Center, 47 Nichols Ave., Watertown, Mass., U.S.A. 02172, (617) 924-0271.

Prime of Life Conference

The Committee for Women's Concerns in Port Elgin, Ontario is planning a conference called *Looking Ahead*, for women in mid-life. Tentatively planned for early November, 1987 the conference will coincide with a health fair.

For more information contact the Committee for Women's Concerns, Box 1582, Port Elgin, Ont. N0H 2C0.

Reproductive Freedom

In Fertile Ground: Women Creating Reproductive Freedom is an action manual to assist women in forming groups, sharing stories and taking action. The 40 page, 8 1/2 x 11 booklet is part of a larger project about population control and family planning organized by Women's Health Interaction.

In Fertile Ground is available for \$6.50 including postage, from Women's Health Interaction, 58 Arthur St., Ottawa, Ont. K1R 7B9 (613) 563-4801.

Nursing Conference

Looking Behind the Image/Moving Beyond the Myth is the title of a nationally-oriented conference to be held in Toronto on November 5 and 6, 1987. The conference will take a historical perspective with an eye to the future to analyse trends affecting nursing and to explore the impact and benefits of feminism on nursing.

The fee is \$135.00. For additional information contact Evon Essue, Conference Clerk, Clarke Institute of Psychiatry, 250 College St., Toronto, Ont. M5T 1R8 (416) 979-2221.