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Healthsharing

A CANADIAN WOMEN'S HEALTH QUARTERLY

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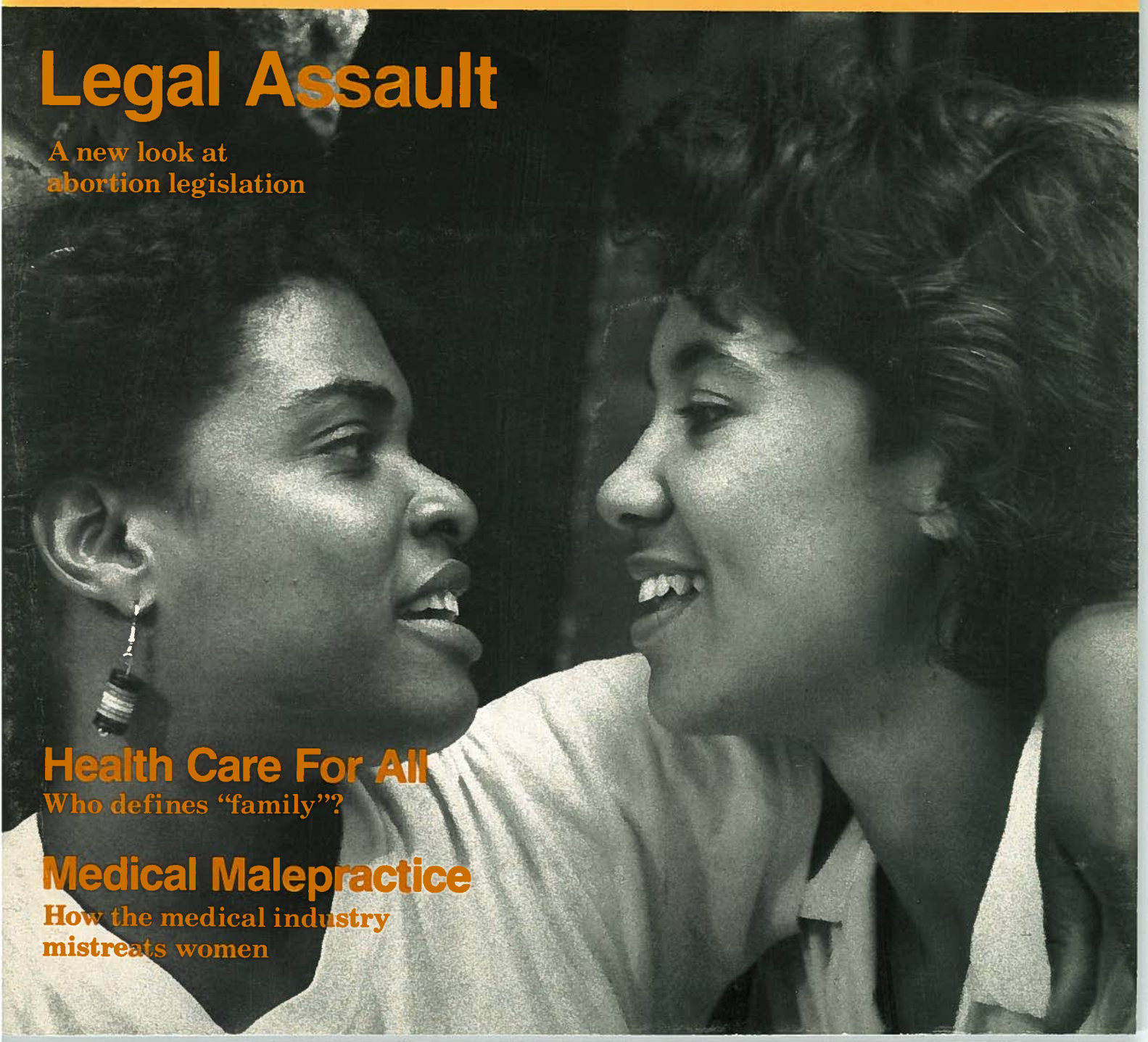
A new look at
abortion legislation

Health Care For All

Who defines "family"?

Medical Malepractice

How the medical industry
mistreats women



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Healthsharing

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COLLECTIVE NOTES

The New Witch Hunt

These are times of backlash against women, from the attack on women's right to choose, to R.E.A.L. Women's fight to return us to the patriarchal family of violence, to numerous pronouncements that the women's movement is dead. The conservative government is taking advantage of this, enlisting their own form of backlash — economic. In the last budget introduced on April 27, 1989 a small detail went unnoticed and unchallenged by the media and most opposition politicians. The Women's Program budget under the Secretary of State was cut by 15 per cent, a move that will adversely affect the future of women's equality.

Most women's groups working to improve the status of women in Canada are heavily dependent on federal government funding. Last year, the Women's Program funded more than 700 groups across Canada. Healthsharing is one of them; we've been cut 15 per cent. We receive more than 30 per cent of our budget from this program. This money goes to pay for one part-time and one full-time staff member, the rent, and some editorial and material costs. The National Action Committee on the Status of Women has been particularly hard hit, more so than other women's groups. Their funding will be cut 50 per cent over the next three years. Why? Because they dared say that women are far from equal and that class and race have to be considered in assessing women's position in Canada.

As access to government money decreases, the private sector which benefits from women's inequality is not likely to fund groups fighting for equality. Less than two per cent of donations from charitable foundations goes to support women's issues in Canada. The budget of the Women's Program, whose mandate is to fund groups across Canada

which attempt to eliminate systemic discrimination against more than half the population, was frozen at \$13.2 million two years ago. Now the government has cut \$2 million from this budget at a time when women are far from equal.

We have made advancements in spite of these setbacks. But our gains are being eroded. Although the goals and aspirations of Canadian women may have changed, material conditions for most women have not. And though there are more women participating in every realm of Canadian life than in our mothers' or grandmothers' times the real indicators of equality haven't changed much. Women still face barriers and obstacles to full equality. Nineteen years after the Royal Commission on the Status of Women, women earn only 60 per cent of what men earn. Fifty-five per cent of Canadian women work outside the home and comprise about 44 per cent of the total work force; yet women are still concentrated in the pink ghettos and the service industry. In 1987 women constituted less than nine per cent of the executive category in the federal public service (223 out of its 90,000 female employees). Women are still primarily responsible for child care and housework. This year the federal government will spend **\$11.66 billion** on the military, over one thousand times as much as will be spent supporting women's equality.

Most women want a decent affordable place to live, good educational opportunities for themselves and their children, freedom from sexual violence and assault, publicly-funded day care, access to safe and affordable abortion, a clean environment, good health care, freedom from sickness, freedom from boring jobs, freedom from discrimination and full equality — in essence, social and economic justice.

The Tories say they care for Canadian women. In 1985, at a conference of Federal and Provincial Ministers Responsible for the Status of Women, held in Halifax, N.S. November 28 to 29, the ministers endorsed a statement with a commitment to action which reads, in part:

"... All governments in Canada are committed to achieving the goal of true economic equality for women ..."

Where is the action? How can the government so easily cut 15 per cent from the Women's Program in a time of expanding needs. Government did not spontaneously hand us the Women's Program in 1973 — they established it in response to women vigorously fighting for equality: the budget has always been small, the work those funds generated large. But the dollars have never been enough. And now that women of colour and disabled women are claiming legitimate space in our society, there's a lot less money to do the work that needs to be done.

In chapter 10, section 9, the Report of the Royal Commission on the Status of Women in Canada reads: *"... Perhaps no prejudice in human society is so deeply imbedded or so little understood. To create equality it will be necessary to create a totally new climate, a totally new frame of reference against which every question affecting women can be assessed ..."*

It seems this climate has yet to be created. Feminism means justice for all, and equal opportunity for all. But a new witch hunt is under way against women. Women and children, who comprise the largest number of the poor are being forced to pay for the fiscal deficit — not those who reap billions of dollars in profits from underpaying women's work, but you and me, the poor, the unemployed, the elderly, ... women. The excuse of deficit reduction is a way of keeping women down.

We're angry. But it takes a lot to fight. It takes energy and it takes money. Feminists believe in equality for all human beings, initiatives for everyone supported by everyone. We need to organize and fight for our rights. Make your voice heard.

Women Healthsharing Collective

LETTERS

We encourage readers to write. Your comments and criticism are just as important as the original articles and columns published in the magazine. Please take the time to share your opinions with other readers.

Healthsharing reserves the option to edit letters for length, and print them, unless they are marked 'not for publication.'

Protest Psychological Manipulation

Your Collective Notes and Maggie Burston's excellent piece, "Sick but Not Silenced," (*Healthsharing*, Spring 1989) confirm my long-standing conviction that the once considerable margin of "personal responsibility" for one's own health has narrowed to a negligible edge in the presence of chemical overkill, air-, water- and soil-pollution.

Imagine, therefore, the misplaced burden of guilt on the cancer-patient when told by some "pop-psychologist" who is sadly out of touch with socio/political realities that she has a "typical cancer-personality" (and usually this implies suppressed anger) and brought this dreadful disease on herself. If only she could change her negative thought-patterns!!

The casual abrogation of blame by the responsible parties and callous shifting of guilt onto the victim herself is, as I perceive it, one of the most hideous by-products of the system you describe.

I think that it is, therefore, imperative that we protest the

psychological manipulation, designed to silence the woman with an illness, by those who espouse simplistic, erroneous cause-and-effect theories. The last thing the woman with a serious health problem needs is to carry a burden that does not belong to her.

Thank you for a fine publication.
Chris Karras
Markdale, Ont.

Infant Vaccination in Denmark

I accidentally read "Shots In The Dark" by Anna Kohn (*Healthsharing*, Spring 1989). As a Danish doctor, formerly in family practice, I am shocked. We had these problems in Denmark many years ago and have found a solution. How is it possible that these things still occur in Canada, a civilized country? As I am writing this on the spur of the moment, and on a holiday, I have no exact statistics, but they can be obtained from the Danish Medical Association.

(Danish) children now receive the whooping-cough vaccine separately. We feel that this is most important to get the pertussis-vaccine out of the cocktail, so that it can be given individually, i.e. in smaller doses and at longer, shorter intervals. It is now weaker than before. That means also, less effective, i.e. the protection against the disease only lasts a few years. But that is the period where the real danger is. After that, children often do get whooping-cough, but in a milder, less typical form.

Because we wish to protect the very small child — whooping-cough is extremely dangerous to children under six months, even under 12-months — we start vaccination at five weeks. Then again after four-to-six weeks, and again after eight-to-ten months. Of course it is the duty of the doctor before every shot to examine the child and speak to the parents in order to rule out risk-factors. And of course, the vaccination is not compulsory — but almost everyone has it.

If there is any doubt as to whether the child had an adverse reaction, the program is discontinued, or perhaps continued at a slower rate with a smaller dose. As far as I know there have not been such serious reactions as the article describes since these alterations were made.
Maiken Siber,
Denmark

ABCs of Immunology

With respect to the article "ABCs of Immunology" (*Healthsharing*, Spring 1989) — I found it very informative. There is one comment I would like to make about the thymus gland. My understanding of the thymus gland is that it is a temporary structure. It is most active in the induction of a normal immune response in the neonatal period (when we are most vulnerable to attack) and attains its largest size at puberty, after which it will shrink at least in the majority of people. The theory is that by age 12-14 years, you have probably been exposed to every virus or bacteria that you ever will be and the thymus is no longer needed to produce further antibodies. A persistent, enlarged or tumorous thymus gland is found in 80 per cent of people with a disease called Myasthenia Gravis, a rare condition thought to be autoimmune in origin.

I would like to know more

about the effects of stress on the thymus gland and would welcome a reference if possible.

Thank you for producing a much needed women's health journal.

Joanne Liutkus
Hamilton, Ont.

Body Defenses by Marilyn Dunlop (listed in *Thematic Resources*, Healthsharing, Spring 1989) has a chapter on the effect of stress and the immune system.

Driven Into Depression

I read the article on depression (Update, *Healthsharing* Summer 1989) with great interest . . . in the calamity of being female on this planet, it seems to be necessary that women "depress" themselves as a requirement of the culture. Their anger must only be on behalf of someone else; their sexuality is still held against them; if they're too "uppity" or "come on too strong" they're supposedly "unfeminine."

In my article published in *Women, Power and Therapy* (Harrington Park Press, 1987), I point out that women are in what is known as a *folie a deux* with their partners. They are, in this situation, often driven close to madness and certainly into depression due to the indoctrination of their upbringing and the ongoing expectation that men are smarter, more rational and superior to women. Even in lesbian and gay male relationships one often finds that the partner is seen in this way by the depressed other.

I urge therapists to watch closely when one person seems to be hysterical, tearful and filled with self doubt and to look immediately for an indoctrinator or authority figure who is secretly treating her like a puppet. There will be one in the bushes somewhere! A parent, partner,

Research making a difference

Action based research by community and consumer health action groups is making a difference around the world. Groups working on pharmaceutical issues met in Europe this spring to share experiences.

The Australian Consumer's Association and the Combined Pensioner's Association conducted interviews and workshops to study medicine use by older persons. Up to 84 per cent of the people responding misinterpreted label instructions. They reported being talked down to and side effects they reported were often attributed to "old age." Most of those taking nonsteroidal anti-inflammatory drugs or tranquilizers reported that they had never been informed of possible side effects or associated risks. An action kit was developed out of the strategies for change generated by the project.

Also in Australia, the Consumer's Health Forum released a proposal in April, 1989 for a national medical drug policy for the country. The Forum coordinates research and gives consumer and community groups a stronger voice in national policy, planning and service directions which affect health.

The New South Wales Women and Pharmaceutical Drugs Working Group conducted a phone-in survey for women on tranquilizers. The response was overwhelming and led to training programs for counselors. Now many physicians refer women to the women's centres where support and counseling provide an alternative to tranquilizers.

A Belgium drug information group investigating doctors' prescribing habits found that by sending glossy information

questioning tranquilizer prescribing, there was a five per cent reduction in the practice. After a visit from someone who could provide alternative information, prescribing decreased by fifteen per cent.

In Asia, action groups are working for public protection from unsafe, ineffective and irrational drugs. Groups in seven Asian countries recently completed field studies. They interviewed women and monitored clinics, pharmacies and advertising to evaluate the adequacy of information given to mothers about medicine prescribed for their children. For example, Dipyrone, the active ingredient in Baralgina and Novalgina, is banned in several countries including Canada for its dangerous side effects. Baralgina is widely promoted in third world countries for pain, colic, cramps, vomiting, viral infections and asthma in children. Warning of its serious side effects are absent in advertisements and information provided to doctors and consumers. Pressure from the Malaysian Consumer Association led to a ban of dipyrone products and five other hazardous drugs in their country.

In each of these studies health action groups defined what needed to be done, made links with health workers and researchers and contributed to change while doing their research. Planning is currently under way for field studies on the use and testing of long term hormonal contraceptives in several countries.

DIANNE PATYCHUK



Babytalk

The New Parent Information Line offers support to any parent or professional working with parents in the Ontario region. Eileen Beltzner is the founder of New Parent Information, Education, Supports and Services (NPIESS), a subsidiary of Aid For New Mothers. She says the help line offers a vital telephone link to parents who find it difficult to get out of the house. A "buddy program" attempts to match callers with telephone volunteers who are trained to deal with anything and everything a parent might encounter with a new baby, including referrals to services available in the community.

Beltzner, also the author of *The Handbook for First Time Parents*, has done extensive research into postpartum depression. She stresses that many of the approximately ten to 20 per cent of new mothers who suffer from profound postpartum depression never seek treatment. The New Parent Information Line hopes to reach these women by making it easier to seek help.

The New Parent Information Line can be reached at (416) 897-6262 or by writing P.O. Box 7282, Oakville, Ont., L6J 6C6.

WENDY L. HAAF

Every day in my office, I am struck by the fact that the health care system is definitely not working for women. The medical profession is notoriously conservative, patriarchal and slow to change. Doctors receive no training in how to treat women equally. To survive in a male-dominated system, women doctors often have to sacrifice their feelings and their insights as women. Still, the increase of women doctors has served to humanize the profession.

Carolyn DeMarco

Medical Malepractice

Even now, how women are treated is largely determined by their gender: women's complaints are not given equal weight to men's; women's work at home is not recognized, careers are regarded skeptically at best.

Over the last 16 years of medical practice, I have seen many women suffer needlessly because their doctors did not really listen to them, told them that physically-based complaints were all in their heads and treated normal events in a woman's life as if they were diseases. Time and time again I have seen women paying a heavy price for the careless prescription of antibiotics, birth control pills, hormones and tranquilizers.

In my practice, with two other holistic doctors, we see a lot of women who have fallen between the cracks of the system and these cracks are getting pretty big. These women have seen many doctors, specialists and sometimes naturopaths as well, for multiple health problems — chronic fatigue, re-occurring viral illnesses, severe pre-menstrual syndrome, recurrent yeast infections, chronic bladder problems.

Chronic fatigue is a number one complaint among women today. Few statistics have been compiled on this problem. Why? I would estimate that between 20 to 40 per cent of women experience chronic fatigue. Fatigue is

a vital warning signal from your body that the load is simply too great. Long term fatigue can weaken your immune system and make you more susceptible to illness and accidents. At least 25 to 30 per cent of chronic fatigue is caused by real physical conditions — often missed by women's doctors who assume fatigue is psychological. But to me the main cause of chronic fatigue for women is stress and overwork. Women have always done more than their share of work, but now women's work loads have dramatically increased. Studies show that women spend anywhere from one to 50 hours a week on household and childcare duties, on top of a 40-hour work week. The same study shows that working women with preschool children put in an average of 77 hours per week. In contrast, in the last 10 years men have increased the amount of time they spend doing housework by less than one half hour per week.

Women who are full time homemakers spend up to 100 hours a week at 12 different labours; and face the stresses of isolation, lack of recognition for their work and internal and external pressure to work outside the home. Very few doctors recognize the stresses of this kind of unequal division of work. Often combined with this combination of overwork and stress are a number of other unhealthy factors — poor diet, environmental pollution of food, air and water, a woman's inner conflict with the demands of motherhood and career, sexual harassment at work, unfavourable working conditions, overuse of prescription drugs, and stresses of biological events such as pregnancy, menstruation and menopause. It's no surprise that a woman's health starts to go down the drain. In fact, the biological rhythms of women usually have to be denied or covered up in order to exist in today's workplace.

Women are not getting healthier, in fact we see the opposite trend in our practice. The long term use of the birth control pill and prolonged use of antibiotics weaken the immune system and tend to make women more prone to lingering or re-occurring viral infections. The yeast syndrome has been dismissed by doc-

This article is based on a speech by Dr. Carolyn DeMarco to The Canadian Advisory Council on the Status of Women at their Symposium on Women and Well-Being, March, 1989.

tors as just another health fad. When I first heard about it, I was very cynical. I read the book *The Yeast Connection* by Dr. William Crook and at first I thought the symptoms were too generalized and resembled a lot of other conditions.

Since that time, I have educated myself extensively on the topic and realized you can recognize, diagnose and successfully treat this problem. Very few doctors have had the time or desire to look into the evidence. More importantly, I started treating women and children for chronic yeast infection and the results are impressive. Why is the medical profession so loath to accept that chronic yeast infections exist? They are supposedly waiting for controlled double blind studies. These require that a new drug or treatment be tested by giving half a patient group a placebo and the other half the drug or treatment for a specified period of time. Then the procedure is reversed. Measures are taken to ensure that everyone involved in the study, patients, researchers and doctors do not know who receives the drug or treatment for the purpose of the study. This is done to ensure objectivity.

Maggie Burston, who founded CRIF, Candida Research and Information Society after years of desperate struggle with chronic candida (yeast), has been lobbying for research money to conduct such studies without success. Meanwhile, she has accumulated an extensive library on candida including over 1,000 scientific articles. CRIF also puts out a newsletter and offers patient self-help study groups and individual counseling.

Double blind studies may be interesting to the medical profession in its quest to be "scientific" but personally I question the whole system and whose interest it serves. I see no need for double blind studies into safe, reliable, natural treatments that have been used for hundreds of years with no ill effects. In any case, there already exists a large body of scientific literature documenting the use of vitamins and herbs which few doctors downgrading these forms of treatment have read. Why, all of a sudden, since women historically have been the healers and keepers of

herbal knowledge is it so dangerous for women to give herbal teas to each other to alleviate pain and treat health problems? My colleague, Dr. Carolyn Dean, had a fight with a pediatric professor at Dalhousie Medical School when she argued that breast milk was better for babies than formula. A lot of research money and a lot of double blind studies later, and lo and behold we discover the astounding fact that breast milk is better than formula. Who determines research priorities? And then who determines which drugs are given preferential treatment?

Pre-menstrual Syndrome (PMS) is an example of a condition greatly relieved by simple means such as diet and vitamins. In Yarmouth, Nova Scotia, Robyn McKenzie founder of *The First Canadian Letter on PMS*, decided to show the National Film Board movie on PMS, expecting a dozen people to show up. Over 10 times that number came and women have been stopping her on the street ever since. By and large, women, especially in the rural areas, are not getting the information they need. Significant PMS affects 40 per cent of women yet not enough good research has been done on the topic.

While rigorous criterion are demanded in the case of new or alternative medical treatments, the hazards of certain drugs are blithely overlooked by the medical profession. What happens when valid well-designed studies turn up the ill effects of a medication? What if this medication is taken by one and a half million Canadian women and backed by major drug companies? Three new studies have linked the birth control pill to an increased incidence of breast cancer. Researchers say the final answer will not be in for another 20 years.

Why does Health and Welfare Canada glibly dismiss these new and important finding saying they will issue no new warnings on the package insert? Again my colleague, Dr. Carolyn Dean, poses the question, "Since one in nine or 10 women will develop breast cancer, how can you know in advance if you are one of these women?" One thing is known for sure and that is the pill will worsen breast cancer and may well cause a precancerous growth to



Ingrid Muevhofer

women historically
have been the keepers
of herbal knowledge

turn into cancer. Dr. Dean is also concerned that no one has considered what the cumulative long term effects might be of years of pill use followed by years of hormone replacement for menopause. As a result she says that she can't follow the Hippocratic oath and continue to prescribe either the pill or hormones for menopause.

Recently, when I wrote an article on the pill for the magazine, *Today's Health*, the editor said she couldn't print it because it would be too scary and most women wouldn't want to know. However, I later found out that the decision not to publish was made as a result of pressure from a major drug company that manufactures birth control pills. My article is taken almost verbatim from the government report on oral contraceptives and the patient insert for the pill, except for the update on cancer and my commentary. Most women have

no idea the risks they are taking on the pill. Some people justify the widespread prescribing of the pill by saying that it is safer than pregnancy. This assumes that women are so unreliable that if they don't have their fertility controlled by the pill they will inevitably become pregnant. Safer methods of birth control such as the condom, diaphragm, cervical cap and fertility awareness are regarded as second rate methods at best by most doctors.

Why is this? Robyn McKenzie, puts it this way: "I was amused at the recent press coverage of Ben Johnson's steroid use. The side effects included decreased testicular size and lowered sex drive. The general opinion was that no Man in his right mind or who was not misled would subject himself to this hormone horror. Why is it okay to let millions of women be subjected to poorly understood hormone treatments?"

In a court ruling in January, 1986 awarding damages to a 22-year-old woman who had suffered a stroke while on the pill, the judges noted that the pills "have presented society with problems unique in the history of human therapeutics At no time have so many people voluntarily taken such potent drugs over such a protracted period of time for an objective other than the control of disease."

My article ended with this statement: "Between one million and one and a half million women in Canada use the birth control pill, a steroid medication, with serious and proven risks believing that they have no choice. Of course pregnancy itself is risky, but the choice is not between pregnancy and the pill but between the pill and safer methods of birth control."

There are other questions that must be answered. Where is the funding to improve and investigate the cervical cap which is a highly reliable and safe form of birth control? Why is so much money pumped into infertility clinics and research? Why is the pill sanctioned from on high?

Chronic cystitis is a major cause of disability for women. It took a female urologist, Dr. Larrain Gillespie, to elucidate the fact that there are two different kinds of cystitis — one caused by an infection and one



male urologists claim a woman's urethra is too short and located in the wrong place

caused by inflammation. Through research Dr. Gillespie proved that this type of cystitis — interstitial cystitis — was a lot more common than urologists had previously believed. Urology is very much a male-dominated speciality. There are only 100 female urologists in North America. Male urologists have always assumed that women are prone to chronic cystitis because of their urinary system. They claimed a woman's urethra was too short and located in the wrong place. In fact a woman's urinary system is perfectly designed. The women's urethra is like a corrugated tube with a large surface area that can stretch and flatten out during child birth to allow the baby's head to pass through. Women have a muscle sphincter located in the wall along the whole length of the urethra which acts like an on-off valve.

Urologists used to think women didn't have his external sphincter and unknowingly ruptured this muscle by performing urethral dilations. Dr. Gillespie called this "the rape of the female urethra." These dilations cause more harm than good yet urologists are still doing them.

Medical interventions into birth, fetal monitors, episiotomies, epidurals, induction of labour, etc., pose serious risks to both mother and child. By the way, episiotomies which are the most common operation performed on women without their consent, are usually totally unnecessary and have absolutely no scientific validation for their use. The so-called wonders of modern technology and hospital births still put us second to a country like Holland which has a well organized system of midwifery and supervised home births.

In British Columbia, I ran a large home birth clinic and trained and supervised lay midwives. At first, I was excited watching developments in midwifery in Ontario. But now, I fear, that midwives will be forced to become part of a hospital system tightly controlled by obstetricians. The net gain to women would be very little. I would prefer to see an autonomous midwife profession as exists in Britain and Holland.

Perhaps how the medical profession really feels about women's bodies can be summed up in this statistic. Hysterectomy is the most common major operation performed in North America today. If the present trend continues, 60 per cent of us will have our uterus removed by age 60. The Montreal Health Press, which in my opinion has made an outstanding contribution to women's health education, states in their new book on menopause, "Hysterectomy rates vary depending on where you live and your socio-economic status. For example, rates are much higher in the Atlantic provinces than in the rest of Canada. In the U. S. women with health insurance have twice as many hysterectomies as those without. Also, higher hysterectomy rates exist in countries where doctors are paid per operation than in those countries where doctors are salaried." In fact, if you are a rural woman you are likely to receive an inferior level of health care. You are

not only likely to have a hysterectomy, you are also likely to have an unnecessary repeat cesarean section. Repeat cesarean sections, that is 40 per cent of the c-sections done, are usually totally unnecessary. In fact, The Society of Obstetricians and Gynaecologists of Canada issued a statement to that effect a few years ago. This has not reached all the rural areas yet.

Meanwhile, health care costs are spiraling out of control. The national expenditure for medical care in Canada in 1988 has risen to approximately \$51 billion — an increase of \$29 billion since 1980. In Ontario, the health care budget is \$13 billion — or 32 per cent of the budget — and is growing at three times the rate of inflation. This increase is particularly due to the use of expensive tests and drugs and the use of expensive technologies.

Dr. Augustin Roy, a Quebec physician, wrote in a recent *Canadian Medical Association Journal*: "Some of the alternative therapists' success stems from physicians' overreliance on drug therapy and lack of interpersonal skills . . . Pills or drugs work in some cases but they are not a panacea. I feel it is a warning to physicians. Open your eyes before it is too late."

Doctors who practice holistic and/or preventive medicine are not only penalized financially, but they are under the gun constantly from government medical plans and regulating boards. In B.C. I was issued a computer printout saying my counseling average was above the norm and warned me to bring my practice into line with that of the average general practitioner. My cost per patient was the same. But I actually cost the taxpayer a lot less since I used fewer X-rays, less expensive technology and made fewer specialist referrals. I also spent a lot more time with my patients. This is in an area where there is 50 per cent unemployment and a severe shortage of mental health facilities. The structure of the fee schedules in most provinces favours excessive prescription writing. Doctors are paid per patient and not for time spent. In 10 or 15 minutes, what else do you have time to do?

Two years ago Dr. Dean faced a

costly audit because she billed for a lot of counseling. Dr. Dean, like myself, counsels women who have fallen through the cracks of the system, women who have seen countless doctors and specialists with no help being offered. Their problems are complex and time-consuming. Dr. Dean won her audit. It cost her a lot of time and a lot of money. She still had to pay a fine even though it was never disputed that she spent the time and provided the services to the patients.

Doctors are taught nothing about true prevention. If you asked your doctor what prevention means to her, chances are that she would say Pap smears, mammograms, up to date vaccinations, blood cholesterol and triglyceride levels, annual physicals, screening for hidden blood in the stool, etc. This concept of prevention really has nothing to do with prevention and everything to do with looking for something after it is too late to stop the process. How healthy can it be to examine your breast with your mind and your emotions focused on the word cancer?

The cornerstones of decreased health care costs have to be education, prevention and self-reliance. And most of all, decreased health care costs mean a return to safer, cheaper and more sane methods of therapy. When women turn to alternative therapies, they are using systems of healing that work to stimulate the body's own natural healing abilities. They are working with a system that assumes that normal biological milestones in a woman's life are a healthy and even enjoyable part of life. They learn to listen to and trust their bodies. More importantly, they take control of their health and put it into their own hands. As I mentioned earlier, by turning to alternative medicine, women are also returning to their heritage as midwives and healers.

Unfortunately, some doctors dismiss women who seek such alternatives. They feel they are misguided and that the therapies are dangerous. I disagree. Alternative medicine or a holistic approach to health means dealing with the whole person, addressing not only the emotional, physical, mental and spiritual aspects of a person's life but also the social,



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cultural, economic and political realities. For women this means operating in a world where sexual discrimination and harassment are still rampant, where women with children are penalized, where there are inadequate daycare facilities, where working conditions are far from ideal and where the health care system is not serving their needs. Choosing more natural methods of health care is sane and sensible. Here are some guidelines for women seeking alternative care.

1. If it works for you and has no side effects then use it.
2. Trust your own perceptions about natural remedies and whether they are working for you. Trust your perceptions about your alternative practitioner.
3. Ask your friends! Ask around. Find out who is the best, consult your local women's centre, health networks, women's clinics or publications like *Healthsharing*.
4. Choose your alternative health care practitioner like you would any other service — by quality, experience, reputation and lack of sexism.
5. Herbs, vitamins, homeopathic remedies very rarely have severe side effects. It is very difficult to overdose on either vitamins or herbs. Most vitamins are safe even in high doses. You have to take an extremely large amount of herbs to overdose on them.

For some reason, naturopathy and homeopathy, which have equal status to Western medicine in Europe, are regarded as fringe medicine here. In England, the Royal family has always had a homeopathic physician. And also in England, 42 to 48 per cent of conventional medical doctors refer to homeopaths. In France, 25 per cent of the prescriptions written are for homeopathic medications. The average cost of a homeopathic medicine is one third the cost of conventional drugs. Yet right here in Ontario, a regulated and reputable profession is about to be deregulated to appease the medical profession and other unknown interests. If naturopathy is de-



Ingrid Mayrhofer

choosing more natural
methods of health care
is sane and sensible

regulated in Ontario, it will be even harder for women there to choose an alternative health practitioner. One of the very few good things about the B.C. medical system is naturopaths are covered by the provincial medical insurance plan. However, the naturopaths are paid very little.

Homeopathy is a medical science begun in the 1700s. In homeopathy, preventive medicine means that the body has innate healing abilities that just have to be stimulated to bring the body into balance. Symptoms are good positive responses of the body to stressors and represent the best effort of the body to heal itself. Therefore treating the symptoms is of no value. The idea in homeopathy is to get at the root cause which produces the symptoms and treat the cause.

Recently, convincing evidence of the efficacy of microdoses of homeopathy was published in *Nature Magazine*, the prestigious British science journal. In these experiments a very dilute homeopathic solution of an antibody raised a consistent and measurable reaction among white

blood cells. The homeopathic solution used was so diluted that no molecules of the original antibody remained. Although these experiments were replicated in three labs, including the University of Toronto, the results caused an uproar in the scientific community. The results were refuted not on scientific grounds, but because "(they) strike at the roots of two centuries of observation and rationalization." And, I would add, at male-dominated medicine.

An estimated 2000 to 3000 M.D.s, N.D.s (doctors of naturopathy), and other licensed health care providers now practice homeopathy in the U.S. The U.S. Federal Drug Administration recently noted a 1000 per cent increase in sales of homeopathic medicines, leading to American retail sales in 1988 of about \$50 to \$80 million, worldwide sales reached about a billion. Sales are especially strong in countries like France, England, Argentina and India, where homeopathy is flourishing.

It is time for women to speak up and demand to have an input into how health care dollars are spent and what kind of medicine the system is going to favour. It is time for women to evaluate the medical literature using their own criteria. It is time for women to ask whose interests medical research is really serving. It is time for women to support the right of naturopaths and other alternative practitioners to practice without repression by the medical profession. It's time, as Monique Bégin said in her speech yesterday, for women to fall out of love with modern technology and make a clear choice in favour of saner and more natural approaches.

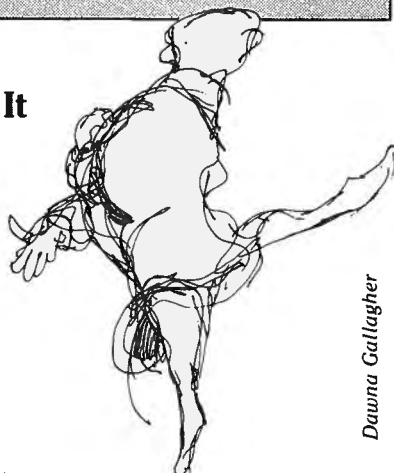
In the Cherokee wisdom tradition, the people are asked to consider the effects of their thoughts, speech and action for seven generations to come. We could do well to learn from them. For in Western medicine as well as in the environment as a whole, we are using drugs and technology as if there were no tomorrow.

Carolyn DeMarco is one of four doctors who writes for the public in Canada. She works as holistic health consultant in Toronto and BC.

HEALTHWISE

Incontinence: Let's Talk About It

Anne Konrad



Dawna Gallagher

"Mom," my university-going daughter said, "You really need to exercise. Look at . . . well, why don't you come to my aerobics class? They have beginners."

I packed my jogging suit into my briefcase, and after work I joined her and that whole roomful of sweating, gyrating, healthy bodies. Two rounds. The music abruptly changed and we began a fast kicking routine. Dribble. By the time a quarter hour had elapsed, I was sitting, knees up, against the back of the wall waving at my daughter. Exhausted? No. I had wet my pants.

The aerobics class made me face up to my "secret." Whenever I moved unexpectedly, coughed or laughed suddenly, there it was, that humiliation.

My regular gynecologist asked questions about children (three), age (49), infections, took a history of the complaint and said it seemed to be classic "urinary stress incontinence" (see glossary).

Incontinence! I felt ashamed.

The doctor ordered a urine culture, did a pelvic examination, took a blood sugar measurement and scheduled an X-ray study of my bladder capacity and function before the diagnosis was confirmed.

Even after it was definite, the most I wanted to tell anyone was that I had a "bladder problem." When a nurse friend assured me it is quite common ("from having babies"), I thought she was indulging me. It was only a year later, after an operation, and after hearing about other women whose similar operations had failed, that I actually researched the topic.

Why hadn't I asked more questions at the doctors' offices? Why hadn't I read about this condition? When I went to the public library, why could I find only dated nursing texts and

medical dictionaries with scant information? Don't we women have the right to know more about our bodies?

"Can I get it repaired?" was all I asked.

I was told that there were several common treatments, all of which sounded threatening or unfamiliar to me. I could have a vaginal hysterectomy and anterior and posterior colporrhaphy, or a hysterectomy and Burch suspension, or a simple anterior colporrhaphy (see glossary).

The gynecologist advised me to have a hysterectomy and colporrhaphy repair. When I shrank back at the need for a radical procedure like hysterectomy, the answer was, that was "the only right way" for 100 per cent success.

I got a second opinion.

This specialist said a hysterectomy was not needed because my transferred records and the second examination showed no prolapse of the uterus ("where the uterus sags, drops into the vagina," translated my nurse friend). The doctor said plastic surgery repair (sketched and wrote it out for me, "colporrhaphy") would tighten up the weakened muscles. Then a wink and a smile, "We'll stitch you up so you'll be like 21 down there."

Did I want to be 21? No, I just wanted my problem solved fast and quietly.

What I did not know was that my problem was ordinary. There are thousands of women needlessly putting up with inhibitions at their jobs, in their sexual, personal or social

lives — because of incontinence.

According to Dr. Harold Drutz, of the Mt. Sinai Gynecological Urology and Urodynamic Investigative Unit in Toronto, 15 per cent of all women, all ages, all over the world, have bladder problems; 25 per cent of all women at any given time have urinary tract infections. The Mt. Sinai clinic sees 3500 patients annually, 750 of whom are new patients. One-third have already had one or more failed operations, have chronic disorders, or come here as a last resort.

Dr. Drutz quotes figures for 1987 in the U.S.A. that show \$10.3 billion spent on the overall management of incontinent patients, as contrasted with \$1.8 billion spent on AIDS.

If some form of incontinence is such a common problem ("It spans the spectrum from age 15 to 102. The average age is 49.2"), I asked Dr. Drutz, why don't we hear more about it? "It's obvious," he said, "If you're wearing diapers you don't talk about it."

Dr. Maria Zorzitto of Toronto's Sunnybrook Medical Centre conducts an outpatient clinic mostly for elderly incontinence patients. She estimates that the figures for women with some form of incontinence is higher than 15 per cent, up to 40 per cent.

Why are so many of us, one out of four, on average, leaking?

In their childhood and reproductive years, Dr. Drutz maintains, women have 10 times as many bladder problems as men. Much of the reason for this lies in the arrangement of our "plumbing" organs, he says.

The female urethra or drainage tube, which leads from the storage bladder, is relatively short, compared to the male anatomy. Perfectly designed so it can stretch and flatten out during childbirth, it is nevertheless easily exposed to contamination from tampons, intercourse, bacteria, etc. Therefore, it is easily irritated or inflamed.

Some incontinence problems may be the result of urinary tract conditions that have not been properly diagnosed or treated. For example 40 per cent of the patients treated for urinary tract infections at the Urodynamic Clinic at Mt. Sinai come without having documented positive cultures. That is, they may have appeared to have an infection, but actu-

ally there was no infection present. Usually, however there is more than just one factor at work.

Aging, with its accompanying reduction in hormones, notably estrogen, can result in a thinning of bladder muscle membranes and weakening of muscle tone, which may lead to that age-50 drip or stress incontinence.

Neurological problems can affect bladder control of women of all ages. For example, conditions such as spina bifida, multiple sclerosis, tumors, cerebrovascular disease, dementia, or Parkinson's Disease can all inhibit the neural pathways causing incontinence.

Drugs, or pelvic nerve injuries can also be a cause.

Incontinence may occur as a result of habits such as incomplete voiding, holding it in too long or poor toilet training. There may be a carry over from childhood bedwetting.

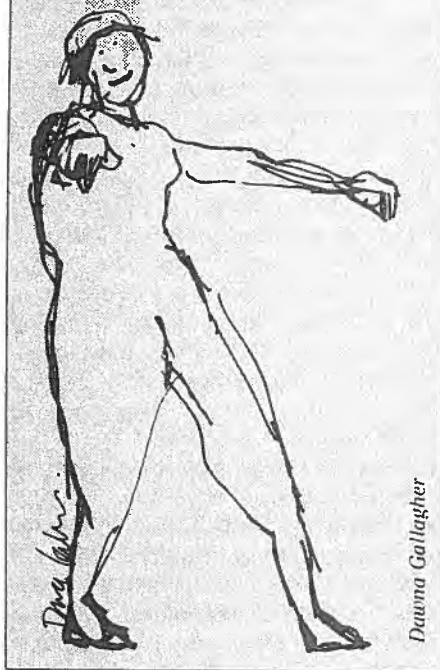
Social factors may play a role. When you can't get to a toilet quickly because of inadequate working conditions, or there are few public facilities, or you live in housing where bathrooms are shared — many factors contribute.

It seems that childbearing, as my nursing friend had said is one of many factors. Medical people use different classifications of urinary incontinence: stress incontinence, a "leaking" brought on by sudden pressures like coughing or sneezing and associated with a sphincter weakness; urge incontinence, which is characterized by a strong desire to urinate before, after or during the incontinent episode and is caused by an unstable bladder or an inflammation of the urethra; reflex incontinence, where impending urination is not sensed; overflow incontinence, from a paralysis of the bladder, and psychogenic incontinence, the term for patients who wet, know they are wetting, but do nothing to stop because of a psychotic or neurotic condition. (Mt Sinai Urodynamic Clinic information video; Snustad and Rosenthal in *American Family Physician*, Nov., 1985.)

Still ignorant of anything but that I could be stitched up, I took vacation time for a colporrhaphy operation. The routine seven to 10 day stay became for me a 16-day marathon.

Bladder Control Drills

1. Avoid excessive intake of caffeine-containing liquids — coffee, tea, pop — and alcohol.
2. Drink plenty of other fluids and systematically increase the intervals between urinating or voiding, to retrain the bladder.
3. Practice double voiding to empty the bladder completely — when you think you are through urinating, push and void again.
4. Strengthen the muscles with Kegel's exercises; that is, pinch the lower bottom muscles together and hold the muscles taut for five minutes and then release. Do this often (on the subway, driving, phoning, waiting at the checkout counter — anywhere), three to four times a day. The muscles that stop urination midstream are strengthened in this way.



I had nightmares of never freeing myself of that catheter.

Luckily I did not know at this point that operations do not help everyone. Dr. Maria Zorzitto estimates that 90 per cent of operations are successful and says that younger women might prefer a "one shot cure," but Dr. Harold Drutz's judgement is much bleaker. He states that "an awful lot of women are exposed to operations that don't help them. There is a 50

per cent failure rate within two years of the operation for those women who have vaginal operations for stress incontinence." He maintains that 90 per cent of all incontinence cases can successfully be treated non-surgically.

Urodynamic clinics for women represent a new trend in treatment for incontinence. In Toronto, in addition to Dr. Drutz's "pioneer" clinic for women at Mt. Sinai (recently a second unit for geriatric patients has been opened at Baycrest Centre), there is a small unit at Women's College Hospital under Dr. Morgan and also a male and female clinic at Sunnybrook Hospital. (Similar clinics exist in Buffalo, New York and Ann Arbor, Michigan in the U.S.A.) All of these clinics stress therapy treatment rather than surgery.

"We treat first," says Dr. Zorzitto of Sunnybrook Hospital. "If that does not work, fine, we refer to a gynecologist or urologist."

At Mt. Sinai, therapy begins with a thorough evaluation which includes a condition history, physical examinations, laboratory studies, functional assessments, incontinence charts, videoscope probes and other urodynamic studies. All are put into the computer for complete analyses. A preliminary diagnosis, to be followed up in a month by a final diagnosis, is made and the patient is put on a conservative regime. For example, the patient may be given antibiotics for urethral infections or be started on estrogen. She will be advised to reduce her caffeine intake and instructed in basic drills for bladder control (see Box).

Drs. Diane Snustad and J. Thomas Rosenthal of the University of Pittsburgh School of Medicine, writing about elderly incontinent patients, stated that such techniques are successful without surgery for up to 80 per cent of stress and urge incontinence patients. (*American Family Physician*, Nov. '85)

If therapy is so successful, why do we women still emerge from doctors' offices with surgery appointments? Dr. Zorzitto thinks "women don't ask." She finds that women are far more accepting than men, that they have not been taught to question. "They need to know that a second opinion is O.K.."

Similarly, we need to learn the medical terms, not be coddled. In the hospital it is easy to be treated like a child. The clinical clerk asks about "pee," not urine, "belly-button," not navel, "hold it in," or "did you go?" The nurses say, "I'll get a bag," which means a catheter or urine collector, and the doctor asks if I "fool around" (you guessed it, sex).

Women crave advice, want someone willing to listen, someone who has had a similar problem to compare notes, or just anyone who is a stranger.

There we sat in our velour, corduroy or filmy negligees, plastic tubes dangling from our bodies, holding cushions under or over our sore places, we housewives, television producers, realtors, lawyers, secretaries, barmaids, teachers — one community of women. We were waiting for operations or recuperating from a legion of female complaints: bleeding, abortions, miscarriages, sterilizations, fertility problems, and, yes, incontinence.

Late into the night when the visitors were all gone, we sat on the green and yellow leatherette chairs in the lounges, many chain-smoking. "What are you in for?" "What did you have?" Everyone told. Breech births, rapes, hard stools, irregular discharges, marital brutality, birth control methods, sex urges, sex practices — everything was open for discussion. It's safe. You'll never see them again so you can ask anything. Outside of a gynecology ward, who will share?

My body was leakproof again and what had I learned? Women need to know more, to ask more. We should insist on seeing detailed diagrams or sketches. Doctors have plastic models. We should not be embarrassed about "holding up" busy doctors or asking "naive" questions. We should read more, find out what our body parts are called. We should ask our doctors if they are going to arrange bladder function studies before we are booked for operations. We could request public libraries to stock medical journals in lay language. Ask about therapy clinics.

If famous artist Judy Chicago could make statements about women's bodies through her porcelain "Dinner Party" (as well as embroidery art

works), symbolically using female organs, and have line-ups at her exhibitions, why can't we talk about incontinence?

Do we have to buy care products ("bladder control sufferers — 10 million in America"), or can we come out of the gynecology wards (fixed up, giggle), out in the open and say incontinence is a very common problem. It can be cured, in most cases without surgery.

All of us "nice girls," let's ask, let's talk about it.

*Anne Konrad has published in various journals, taught high school, and is the author of *The Blue Jar* (Queenston House Press, 1985).*

Glossary

1. Urinary stress incontinence — "a condition occurring in otherwise normal women, leakage of urine as a result of coughing, straining, or sudden involuntary movements due to weakness of the muscles around the neck of the bladder and surrounding the vagina, resulting in an incompetent internal vesical sphincter." Stedman's Medical Dictionary, 21st ed., 1970.

2. Colporrhaphy — an operation done through the vagina in which the urethra is pulled into normal position by a sling or stitching procedure. Then the vagina is tightened by removing wedges of stretched-out tissue and sewing the edges back together to ensure that the supporting tissues of the bladder and rectum are back in normal alignment.

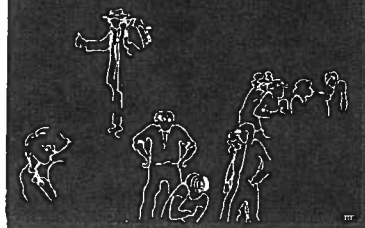
3. anterior colporrhaphy — the repair surgery used when the bladder herniates (bulges) into the vagina and creates a "cystocele."

4. posterior colporrhaphy — the repair surgery when the rectal wall herniates into the vagina (rectocele). Often associated with hemorrhoids.

5. hysterectomy — removal of the uterus. This surgery may be necessary when the uterus has dropped, causing the vaginal walls to relax and protrude through the vaginal opening.

between the lines

CRITICAL PATHS



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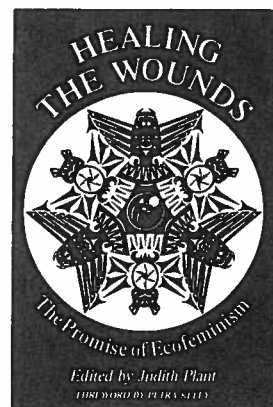
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Karen Andrews

We Are Family

In June 1983, the woman with whom I had lived since 1978, decided to leave her clerical job and return to school on a full-time basis. The economic repercussions of such a decision were obvious but a large and hidden cost was the loss of drug, dental and hospitalization insurance that her former employer paid as part of her employment benefits. Mary and I then began to debate whether I should pursue those benefits for her through my employer who readily offered benefits to those in other non-traditional relationships. There was, however, a lot to consider. Would I suffer at work by admitting to my lesbian family? Would we find our lives spread across the pages of *The Toronto Sun*? Would we get a brick through our front window? Would Mary's daughters object? Would custody be contested? Finally, after months of struggling to support four people on a clerical salary, we resolved to fight for the benefits that are intended to be a social good for everyone.

Since 1979, my employer, The Toronto Public Library, and my union, The Canadian Union of Public Employees, have had in effect a non-discrimination clause in the collective agreement. A section of this clause forbids discrimination on the basis of family arrangement, marital status and sexual orientation with respect to executing any part of the collective agreement. Benefits are part of the language of the collective agreement. Benefits are also clearly part of salary as evidenced by such pieces of legislation as wage and price controls in the 1970s. To deny

health and pension benefits because I was gay, I believed to be as discriminatory as denying vacations, pay raises or promotions solely on that basis as well. My local's executive committee concurred with me and in June, 1985, I launched a grievance against my employer for failing to provide Mary and the children with health benefits citing the non-discrimination clause.

My employer argued that they were unable to accommodate me because of the rules and regulations of the health carriers that they used. This was the response that I had anticipated. By launching a grievance, I could highlight the conflict that existed between a progressive, well-intentioned employer and an anachronistic and prejudiced provincial health insurance bureaucracy. In the early 1980s, sexual orientation was not an enumerated ground in the equality provisions of the newly enacted Charter of Rights and Freedoms. Sexual orientation was also not an enumerated ground in the Ontario Human Rights Code. Shamefully, there existed no legislative or statutory protections for me anywhere but in my collective agreement and my strategy was to garner all that could be gained from that document. It was not my problem that the health carriers would not cover my family — it was my employer's problem. My employer could cover Mary and the children separately to honour their contract with me. Better still, my employer could lobby the provincial government, who ran the Ontario Hospital Insurance Plan, and CUMBA, a privately

owned company, to change their rules to allow my family's full participation. Such solutions were not immediately found and in July, 1986, I began the arbitration process against my employer.

The case lingered for two years in arbitration. During that time, CUMBA, the extended health carrier, departed from OHIP's practices and offered us family coverage. To their credit, my employer paid the premium which settled half the dispute. Also during that time, the Ontario Legislature amended the Human Rights Code to include "sexual orientation" as a prohibited ground for discrimination. Ontario's Ombudsman Daniel Hill also entered the fray by supporting my claim that "OHIP's administrative practice appears dated and inappropriate." In a five-page document to the Minister of Health, Dr. Hill decided, among other things, that since Mary could be denied welfare assistance because of my financial support of her she could therefore then benefit by my OHIP coverage because of my financial support of her. Because the Ombudsman's recommendations were made part of his report to the legislature, the Minister of Health was pressed to respond. When Mr. Elston refused outright to consider changes to the way that OHIP administered family coverage, my lawyers recommended that we redirect our resources against OHIP itself. By this point, my employer was completely willing to pay a family premium on my behalf. The problem was that OHIP repeatedly refused to accept it.

The case had been going on for



L. Emily Elliott

three years by the time it reached the Supreme Court of Ontario. My pragmatic nature told me that it had gone well. Three large extended health carriers had changed their policies to reflect this newly acknowledged, but certainly not new, family situation. My battle earned the moral and financial support of the labour movement. All my dealings with the media were positive and I think it was largely due to the media's influence that my extended health carrier changed its mind about offering family coverage. Working in a city library, I anxiously anticipated the reaction of my co-workers and the public. My co-workers, as it turned out, could not have been more supportive and the public offered only their good wishes and encouragement. In short, no bricks were thrown through our windows, my job was not threatened, the kids got accustomed to the rigours of a political struggle and we could all go to the dentist or the pharmacy without incurring major financial hardship.

The gains of those three years were accomplished without the help of the provincial government. Indeed, Ontario's Liberal government was the greatest obstacle I faced. The Minister of Health completely disregarded the recommendations of the Ombudsman which, for me, called into question the point of having an Ombudsman at all. The Minister of Health (along with a majority of his colleagues) voted to include "sexual orientation" as a prohibited ground for discrimination with respect to housing, employment and services yet he would not support

changes to the Health Act that would remove discrimination with respect to who got family coverage. The provincial government told me that they would rather have Mary on premium assistance than have my employer pay the premium for her. OHIP, it seemed, would rather Mary allege a common-law relationship with Svend Robinson and thereby gain access to his coverage than have her tell the truth and gain access to my coverage.

There are common-law couples who share OHIP coverage when both parties are married to other people. There are divorced couples who share OHIP coverage and though it is an infraction of the rules, OHIP seldom checks. There are even gay couples who share OHIP coverage because they do not indicate gender on the form. The day Mary's oldest daughter moved in with her boyfriend, she became eligible for his coverage. Her mother cannot get my coverage after 11 years. The irony of this situation is that OHIP is free if you need it and free OHIP will be back-dated if you are found to be without it. Offering gay and lesbian couples family OHIP is just one other way to facilitate people's participation in the plan. When this position is accepted, there will be a redistribution of who is on who's plan which more accurately reflects people's living situations. More gay people are not going to be created because we have access to our partner's OHIP but more people will have more options for coverage.

As a community, we are in agreement that socialized medicine is a

good thing. Gay people need eyeglasses too, especially if they are driving and you are in the crosswalk. The health crisis in the gay community means that thousands of men need access to AZT and other drugs to prolong their lives, to keep them out of hospitals and to lessen their suffering. Such treatment is expensive and doors to health care should be opened to them so we can all share the cost. The children who live with us need coverage and it is insane that the lesbian custodial parent may have to rely on a vengeful ex-husband for her child's health care. In an affidavit to the court on my behalf, noted scholar Margrit Eichler pointed out the inappropriateness of how OHIP family coverage is administered. Clearly the system has to be totally revamped to reflect the changes that have occurred in today's family. Changes that will benefit lesbian and gay couples and our dependents will eliminate fraudulent ways that some people use to get coverage; consequently the changes will benefit the community as a whole.

The provincial government does not agree. I believe that it is fundamentally a political problem and the government will not make changes that are perceived to benefit lesbian and gay people directly. The government will not make its practices fairer voluntarily because it would believe itself to be legitimizing gay relationships. Change, when it comes, will be sold to the community at large as benefiting reconstituted heterosexual families and the gay family will get to come in the back

OHIP Changes: Silencing the opposition?

In its May 1989 budget, the Ontario government announced the elimination of the premium system for the Ontario Health Insurance Plan (OHIP). Premiums will be replaced by a tax levied on businesses effective January 1990 and a new computer system will be introduced to phase out family OHIP numbers and replace them with individual numbers. While many including myself applaud this new democratic and unbiased approach to administering health care, it is difficult not to believe that the government is trying to sidestep some extremely important issues that my court case is trying to raise.

Last year, I was told that family OHIP numbers were necessary to maintain and foster family life in Ontario. Feminists and progressive people were discredited for advocating a health care system that would allow people, whatever their relationship to one another, access to free coverage. The government has provided everyone with exactly that — free coverage (at least for health providers that don't over bill). For four years and at great expense, I maintained that OHIP's practices were discriminatory and that they limited access to health care. Today, the Treasurer proudly announces that the new system will facilitate greater access in health coverage without admitting that there was ever a problem. It is very important to get back into court to reiterate three major concerns related to the premium administration: the heterosexual bias of all government bureaucracies, the need for the provincial government to give direction to private health insurance companies and the legitimacy of a collective agreement between labour and management when government legislation is ambiguous.

By moving now to eliminate premiums the government is clearly trying to silence all discussion on issues germane to the debate that we have been having for four years. I had planned to fight to the bitter end — I did not realize that the government could stop playing in the middle of the match.

My lawyers recognize the importance of appealing the decision that was handed down by the Ontario Supreme Court last March. The Attorney General's office will argue that with the changes in the administration of OHIP, the issue is now moot. Perhaps the best that I can hope for is the knowledge that the health care system that I contribute to will no longer *blatantly* favour heterosexual people — it would just be nice to hear the Premier, the Attorney General or the Minister of Health say the same thing.

K.A.

door. The sad part of it is that my experience indicates that society is ready to hear about gay families now and that only a minority would have us return to the closet to live out our lives in silence. I live in a province that prides itself on the fact that its liquor stores do not stock South African wines. Recently, the Premier lectured us all on the evils of bigotry and intolerance but unfortunately, intolerance is not so evil when it is applied to gays and lesbians. In true Orwellian fashion, in Ontario, some people are more equal than others and that is why in February, 1988, I went to court.

The case against OHIP was built three ways. One: Ontario's Health

Act does not define "spouse" in gender specific terms or limit the meaning of dependent to "spouse" or "child of spouse." OHIP could, if they wanted to, offer gay families coverage since their practice of denying coverage is administratively and not legally based. Two: since the provincial Human Rights Code was amended to include "sexual orientation" as a prohibited ground for discrimination, OHIP's practice of denying lesbians and gays family coverage is no longer tenable. Three: though the Charter does not enumerate our rights, it does not disenfranchise us either. We argued that Section 15 should be interpreted liberally and that, in fact, sexual orien-

tation protection was there. Also, OHIP was discriminating on the basis of Mary's sex and that there was absolutely no difference from Karen and Michael getting family coverage to Karen and Mary getting family coverage except for Mary's gender. The Charter is meant to remove obstacles, either procedural or attitudinal, that limit and obstruct people's ability to lead full and dignified lives. It was the government's responsibility to prove that their rules and regulations regarding family coverage were neither unfair, arbitrary nor irrational. To me they were nothing other than unfair, arbitrary and irrational.

After the judge was presented with two days of evidence, he decided the matter in four days. My lawyers were appalled that a decision that should have taken months could so easily be made in hours. Not only did the judge agree with the arguments made by OHIP and the Attorney General, but he injected some of his own thoughts on the matter. From the judge's point of view, Mary and I were not similarly situated with heterosexual couples because we could not procreate. He raised the fact that Mary and I do not have support obligations to one another even though he was presented with the fact that neither do many of the heterosexual (and even infertile) couples who get family coverage. Though we presented three scholarly affidavits and the Attorney General's office presented the Random House dictionary definition of "spouse," we lost. Much was made of the fact that Mary was sometimes eligible for premium assistance while this battle was on. What the judge did not hear was that sometimes she was not eligible and that the money that we were out of pocket was a significant portion of our monthly income. The most offensive argument used by the Attorney General was the notion that "the family must be protected." He did not elaborate exactly how we represented a threat to the family but the judge was sufficiently terrified by the thought to render his hasty and thoughtless verdict.

In the Fall of 1989, I will be back in court appealing a decision that was not only a serious affront to lesbians and gay men but an affront to any-



one who lives beyond the very narrow definition of what the traditional family is supposed to be. If the next decision fails me, I can take my case to the Ontario Human Rights Commission and then to the Legislative Committee of the Provincial Assembly. Tangentially to my efforts, the Attorney General's office is involved in studying laws and statutes that are affected by the sexual orientation amendment to the Human Rights Code. The provincial government also has long overdue plans to join the majority of other provinces in eliminating the premium payment structure altogether. The challenge to the way Ontario administers its family coverage is far from being over. I have my lawyers to thank for their willingness to work for very little money and I have the generosity of hundreds and hundreds of people to thank for making the appeal a reality.



In arbitration, I was told that the case really belonged in court. In court, I was told that the case really belonged at the Human Rights Commission. When the Ombudsman's representatives went to the Legislative Committee, they were told that the case would not be dealt with because it was in court! I began this struggle because I believe that lesbians and gay men should make the same wage for doing the same jobs as our heterosexual counterparts. I began this struggle because I believe in universal and accessible health care and that truly accessible health care will benefit everyone. I began this struggle because I believe in the legitimacy and validity of my familial obligations. It is to my great regret but not to my great surprise that governments do not see things the same way.

Over \$12,000 has been raised for legal costs, the majority of it from the labour movement. If you are interested in helping with the legal costs of this case you can make a donation in trust to: Harvey Hamburg, 97 Maitland St., Toronto, Ont. M4Y 1E3.

Karen Andrews is a 29 year old library worker who is active in the labour movement and lesbian and gay organizations.



Redefining Family

Karen Andrews is not alone. In recent years gay and lesbian couples across the country have been challenging traditional definitions of spouse and family and are fighting for benefits that are available to heterosexual couples.

In Nova Scotia, two Acadia University professors fought for two years and won medical benefits for their lovers, which were available to the spouses of heterosexual faculty under Acadia's medical plan.

With the support of the Vancouver Municipal Regional Employees Union, teacher Krin Zook won spousal medical benefits for her lover after being refused by the Vancouver School Board. Lesbian and gay couples are now recognized as spouses in the union contract with the school board.

The Canadian University Overseas Service (CUSO) national office has won coverage for all of its lesbian and gay employees through London Life and the *Globe and Mail* has coverage through Blue Cross. Barry Adam, a professor at Windsor, has won coverage through Green Shield, after a two year fight.

The Women's Legal Education and Action Fund (LEAF) has also just adopted a case of a BC lesbian who is trying to get health coverage for her lover through the Treasury Board. Because the Treasury Board is federal, LEAF will take the case to the Canadian Human Rights Tribunal.

Some people have lost despite their courageous fight against narrow and traditional definitions of spouse and family. Jim Carleton, an employee at Carleton University in Ottawa, was refused coverage for his lover on the grounds that the union's collective agreement with Carleton did not include homosexual partners.

When all is said and done, and despite substantial resistance from government and insurance companies, lesbians, gay men and their supporters will never give up the fight. We are family!

WHS

MY STORY, OUR STORY

Miscarriage: The Silent Death

Joni L. Lynch

It has been three years since I lost my child. Secretively, with a vague sense of surprise, I find myself tallying up the time: this is when my child would have been born; this would have been the first birthday; the second. The grief wells up inside and I am lost for a time in quiet sadness. After attempting and failing to conceive for two and a half years, I unexpectedly found myself in Emergency one Christmas Eve. Not only did I learn I might be pregnant, but that if I was, something was wrong. In some way, perhaps it was just as well I had no time to digest the news: no elation with the knowledge of pregnancy; no disappointment with the preparation of its loss. The next day, following surgery, I learned I had had an ectopic pregnancy that had necessitated the removal of the fetus and the ruptured fallopian tube. Only later did I experience a powerful, but bewildering mixture of emotions and discover a society ill-equipped and reluctant to deal with miscarriage.

Our society makes no allowance for grief over the loss of an unborn child. It is a common enough experience — every single day, year after year, thousands of women miscarry. Perhaps because of its frequency and the uncertain status accorded a fetus, not much is said about it and little thought is given for the women who live through it. Unlike our traditional social rituals for death, no outlet exists for the expression of grief over fetal loss; women carry it inside themselves, in silence, as they once did their child.

Miscarriage was previously estimated to occur in approximately 15 to 20 per cent of all conceptions. Accurate statistics are difficult to obtain because of the failure to include very early, unrecognized pregnancies and it is now assumed that the actual rate

is much higher, probably 25 to 30 per cent. Of all miscarriages, 75 to 80 per cent occur within the first 12 weeks of conception, often so early that a woman doesn't even know she's pregnant. The remainder usually occur between 12 and 20 weeks.

Despite it being one of the most common medical phenomena, it remains one of the least understood and until recently, one of the least investigated. Women are left with the overwhelming question of why: why did this happen to me? What did I do wrong? Yet, the causes are as numerous as the women who have miscarriages and usually no conclusive reason can be found. This in large part contributes to women's emotional devastation afterwards — ignorance, fear and misunderstanding so often accompany the experience that they feel they are somehow to blame.

In reality, the causes are almost invariably ones over which a woman has no control. The greatest majority occur in the first trimester with about 50 per cent due to chromosomal abnormalities in the embryo or implantation problems in the uterus; second trimester miscarriages may be caused by maternal illnesses such as blood pressure problems, Rh factor, liver or kidney disease, diabetes or malnutrition; those in the third trimester are often due to an incompetent cervix, structural uterine defects, severe toxemia or premature separation of the placenta from the uterine wall. Other causes, usually in early pregnancy, include after-effects of infections, IUDs, previous therapeutic abortions, advanced age of the mother and environmental factors such as exposure to radiation or certain medications prior to knowledge of pregnancy.

During my stay in the hospital, I felt as if I was living in a daze with

no familiar centre of gravity. A combination of drugs and pain intensified the disorientation and left me existing in a kind of emotional vacuum. The medical profession tap-danced around the issue, offering neither support nor sensitivity. Unable to grasp what had happened, I could only lie passively and return their curious glances. Afterwards, sitting quietly, thinking of nothing or of everything, it would come crashing over me. The tears welled up and I could not force them down. I was overwhelmed by an irresistible urge to give way to the sadness of how it had to be. I wondered whether it was a boy or a girl. I wondered what colour its eyes were, what texture its hair was. And what person it might have been. Even now, these thoughts are sometimes with me.

There are no visible scars. The emotional scar seems, to others, as clean as the surgeon's cut. Yet I know that a part of me is forever altered;



L. Emily Elliott

that the loss of a fetus and a part of my reproductive anatomy has also killed an unnamed part of who I am. I had believed my grief was late in coming. I had also believed that it was unhealthy to dwell too long or too intensely on the life that had been within me. Only later did the magnitude of my loss and its legitimacy set in.

The unexpected and disturbing spectrum of emotional trauma miscarriage commonly creates is one of the hardest difficulties women face. Aggravated by the lack of precise medical answers, guilt can be one of the strongest emotions. Besides the disappointment when pregnancy ends in loss, there is often a sense of failure to accomplish what every "normal" woman does without effort, or even without desire. Her sexuality is challenged and a feeling of resentment and envy may be felt towards others who are bearing children with apparent ease. In addition, women who lose a pregnancy face a unique dilemma — although they may feel they have lost something precious, the loss is largely ignored by others. A fetus is a dubious entity, and its death is minimized. There is no tangible person to mourn and society denies the importance of what has happened. Few people fully understand the impact it may have on a woman. Her loss may not be shared by anyone else, even her partner and consequently she is not permitted to grieve. A sense of unreality and abnormality sets in as she struggles in vain to forget the pain.

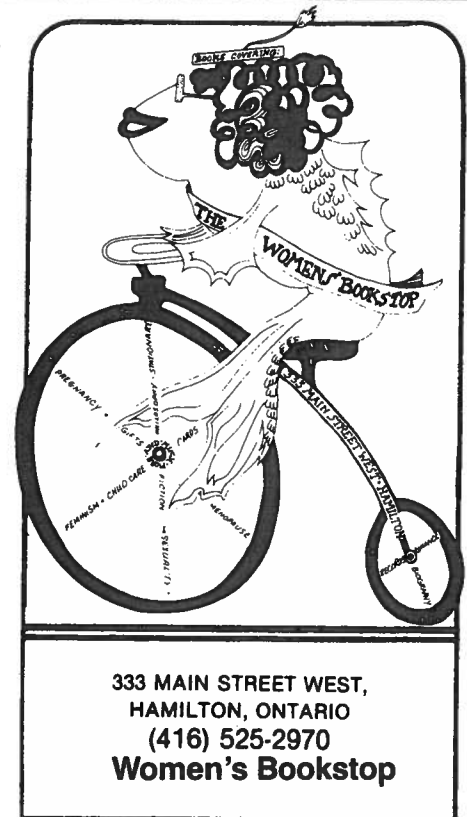
Of course not everyone reacts in the same way, but it is now generally acknowledged that the grieving process is much the same as it is for any bereavement. Confusion, frustration, anger, fear, self-doubt and guilt are all emotions many women grapple with and are a natural, necessary part of healing. Slowly, society is recognizing the necessity for awareness and greater sensitivity towards the women who have this experience.

One of the healthiest ways we cope with stressful and tragic situations is by seeking others who offer solace and empathy. Increasingly, support groups are being organized across the country to fill a need the medical community is unable to meet. They offer a variety of serv-

ices including education and information on miscarriage and its physical and psychological ramifications; they act as referral agencies to clinics and hospitals; and most importantly, they provide an opportunity to meet and share feelings with others who have experienced a similar loss. Elizabeth Northam, Executive Director of Caring Beyond, a non-profit support group based in Calgary, sees this as a most crucial and beneficial service. After a miscarriage, "people will come and support you until they go back into their own lives because it's not an issue for them. But you're still sitting there thinking there's nobody else who feels this way. So when they come to us, there's a room full of parents and the first thing they think is, I'm not alone and I'm not abnormal." In addition, many organizations provide an opportunity to listen and talk to health professionals and to receive 24-hour personal contact with trained volunteers. Calgary's Counselling Institute holds monthly information meetings with guest speakers dealing with a specific aspect of miscarriage at each session. National listings of support organizations can be obtained through Toronto's Women's College Hospital and through the newsletter *Shattered Dreams* published by a Toronto support group. (See Support for Miscarriages Update, *Healthsharing* Vol. 10:3, 1989.)

In order for women to receive the benefits of these groups, a concerted effort must be made on the part of the medical community. While hospital personnel may well seem callous, it is not because they ignore the issue. Says Northam: "The doctors and nurses just don't have enough time and energy to give. They know the need is there, but there's only so much they can do in their 12-hour day." However, I believe a physician's responsibility does not end when a woman leaves the hospital and it is part of their role to ensure that follow-up services are available. If a woman is having difficulty coping with her loss or in eventually accepting it, at the very least, health professionals should ensure she is made aware of the counselling and support these organizations provide.

Family members and friends also play a critical role. But uncertain of what to say or do sometimes we



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avoid the woman or the painful subject. When we do try to help our attempts may be awkward. All too often after a miscarriage, a woman is confronted by a series of inept and ill-informed comments that only exacerbate her pain. However well-intended they are, it is far more valuable to offer a supportive ear rather than pretend it didn't happen or convey sentiments that negate the individuality, validity and significance of her loss.

Women who have lost an unborn child do not forget its existence. After three years, my memories still surface and I lose myself briefly in sad contemplation. But I know now this is normal and is part of what makes me human. As with the loss of anyone close to us, the pain is deep. A woman must feel, must know, through words and actions, that she is not alone in her grief; that it is a natural instinctive voice that sounds within her. That voice will not be any the less strong for it, but the wound may heal more easily with a conscious effort of support, caring and communicative sharing.

Joni L. Lynch is a Calgary freelance writer with a special interest in reproductive health issues.

Vicki Van Wagner and B. Lee

Legal Assault

A feminist analysis of the Law Reform Commission's report on abortion legislation

C *Crimes Against the Fetus* is the provocative title of a February, 1989 working document on reforming the criminal law relating to 'birth offenses.' Published by the Law Reform Commission of Canada, it concludes that the existing law in relation to the fetus is needlessly complex, inconsistent, incomplete and outdated in light of the development of medical science and the Canadian Charter of Rights and Freedoms. Although strictly advisory, the Law Reform Commission is the federal body which analyzes criminal law and makes recommendations for its reform and rationalization.

Crimes Against the Fetus comes at a particularly important time in the debate over abortion, but it could also have a significant influence in ongoing debates about state and medical intervention in pregnancy and childbirth. The Commission rejects majority public opinion that abortion should be a woman's personal decision and recommends resurrecting criminal regulation. As evidenced by the title of the report, the Commission's overriding concern is the protection of the fetus. We believe it is vital to reverse this focus and ask what their reform proposals mean from the standpoint of women.

Crimes Against the Fetus acknowledges the irreconcilable differences of values and belief in contemporary society on the status of the fetus. Moreover, there is not even a basis of agreement on how the 'problem of the fetus' could be discussed and settled. The Commission argues that in situations where differences of political and ethical opinion are so profound, criminal regulation is inappropriate. Up to this point, most feminists would not disagree.

Yet despite its own strong argument against using the coercive powers of the state in such sensitive areas, the Commission asserts that there are grounds for a criminal law to prevent "unjustified destruction of the unborn." Rather than explicitly stating its rationale for criminalizing abortion, it hides this important issue under an umbrella law to protect the fetus from unspecified kinds of harm. It also fails to clearly outline just what kind of serious harm it is concerned with and who decides what constitutes fetal destruction. While acknowledging the legal principle that the fetus is not a person, it compares fetal protection to protection of animals and the environment. This leaves out the central fact that the fetus is located in a woman's body.

The Law Reform Commission lands squarely in the middle of the most sustained conflict between the contemporary women's movement and the state — the long struggle to ensure that abortion is freely and equally available to all women who need it. The report comes at a particularly opportune time for the federal government as it continues to search for ways to justify a new criminal law on abortion. The Commission's recommendations are doubly important because they buttress the preferred policy option of the government, to restrict availability of abortion through gestational time limits.

The Commission's majority proposal is a two-stage model: abortion would be legal until the fetus becomes viable, which it defines as the 22nd week of gestation, but only when duly authorized by a physician that the woman's physical and psychological health is threatened. After that point abortion would only be allowed when serious physical injury or the mother's death may result or when the fetus is suffering from lethal defects; two physicians must authorize the termination. The Commission also offers an alternative minority recommendation with three stages: in the first 12 weeks abortion would be solely a matter for the woman and her doctor; in the second stage (weeks 13 to 22) abortion would only be allowed to protect the woman's physical or psychological health; in the third stage (after the 23rd week) abortion would be restricted to cases where there is risk of death or serious injury to the woman or the fetus has lethal defects.

The Commission rejects the World Health Association's widely accepted definition of health and explicitly excludes social well-being. Incredibly, this makes the allowable grounds for abortion even more restrictive than under the old law overturned by the Supreme Court in the *Morgentaler* case. It is questionable whether the Commission's proposal would be constitutional. The Supreme Court threw out the old law because it violated women's ability to act on their own "priorities and aspirations." The Commission's recommendations would be

just as bad, requiring women to satisfy criteria laid down by doctors.

Feminists challenge the concept of 'medical necessity' that underlies such restrictive views of abortion. Is an abortion for a woman who decides she cannot raise a child decently because she doesn't have adequate housing and lives on minimum wage any less necessary? What gives medical experts the right to decide for such a woman whether or not carrying her pregnancy to term against her will will affect her health? How could it not?

The women's health movement has long argued for an expansive view of health which recognizes the wide range of social and economic factors that affect well-being. Being able to decide when and whether to have children — controlling one's body in this most fundamental way — is as essential to overall well-being as being free of disease. Free and equal access to abortion is a vital precondition of women's reproductive health, sexual freedom, moral integrity and full and equal participation in society.

The restrictive concept of health proposed by *Crimes Against the Fetus* leaves doctors and hospitals as the 'gatekeepers' of access to abortion. How could the Commission ignore the wealth of data presented to the Supreme Court on what happens when medical authorities have such power? Many hospitals across the country simply refuse to provide services at all. Others could adopt their own narrow views of what constitutes proper dangers to "physical and psychological health." What if some doctors are convinced, as the Commission is, that an unwanted pregnancy must "do more than create annoyance or inconvenience?" What if others decide, for example, that the young woman who has been denying to herself that she is pregnant, who has not known where to find counseling or who fears telling her parents has only herself to blame? The result will continue to be huge variations in the availability of abortion and pervasive inequality.

Why does the Commission feel abortion must be criminalized? Obviously it cannot be a pressing need to prevent late abortion: very few



collage: Katie Pellizzari

are performed past its cutoff point of the 22nd week. Does it believe that the absence of an abortion law since the Supreme court's ruling has had adverse social and moral consequences? It never says. Nor does the Commission provide a convincing justification of why abortion should be restricted after the point of fetal viability — a point around which there is considerable medical debate as well as political and ethical controversy.

sponsibility — they cannot be trusted to make the 'right' decision without official regulation. The Commission portentously notes that there must always be "some sufficient reason" for abortion. The ignorance and insult of such a statement is staggering. Can they really imagine that women would undergo a surgical procedure — let alone the bureaucratic hurdles they must overcome; the paternalism or hostility of so many health professionals; leaving their own com-

situation — not doctors, not judges, not politicians, but women themselves.

Women have been struggling not only to win the right to decide when and whether to have children, but also to control the process of birth itself. At first glance, it would appear that the commission takes a



The commission itself recognizes the limits of criminal law as a coercive instrument. It may simply prove ineffective, as Canadian experience shows so well. The Commission admits that criminalizing abortion "may represent too negative an approach."

In one of the only instances in which the actual constraints and conditions within which women make their reproductive decisions are recognized, it notes the lack of effective birth control services and counseling, especially for teenagers; limited support services for parents, especially single parents; and inadequate daycare. Given all this, how could the commission possibly conclude that criminal regulation of abortion is necessary? Because "criminal law, however, can still contribute symbolically by upholding respect for human life." Would not acting on the Commission's recommended "positive improved social programs of education and assistance" provide a more powerful indication of such respect?

Unfortunately the Commission avoids such a broad view: abortion must be regulated for ideological reasons — to define abortion as a moral problem of fundamental importance to society. Here again, the insidious underlying message of the Commission's concern with protecting the fetus is clear: women are seen to be too unreliable and fickle to be trusted with such an important re-

sponsibility because of inadequate access as so many women are forced to do; and the still significant social disapproval for abortion — for "pure whim or caprice?"

Why such a punitive attitude to women having abortions? Underlying state restrictions on access to abortion is not the pious concern for the fetus voiced by the Commission, but the crude message that abortion can never be made 'too easy,' that women must 'pay the price' for sexual activity. Restrictions on abortion are a crucial part of the myriad of state policies and programs that regulate and control women's sexuality: inadequate resources for contraceptive services, sex education and counseling; prostitution, age of consent and pornography laws; taxation, social and welfare policies predicated on the 'nuclear' family; denial of custody rights and family benefits to lesbians; etc.

We can acknowledge that the fetus is potential life worthy of serious consideration in the abortion decision, that fetuses at later stages of development are regarded differently by many people, and that there are many ethical dilemmas involved in the complex meaning of abortion. But we don't need to retreat into the abstract moralism of the Law Reform Commission or the criminal regulation it proposes. We believe that it is the woman herself who is best placed to weigh these complexities and all the other relevant facets of her life

reasonable position here. It recognizes that its new law could place "intolerable restrictions" on pregnant women and exempts them from responsibility for all but purposeful actions which harm the fetus. It sees forced treatment of pregnant women as assault and court-ordered obstetrical interventions and apprehension of the fetus *in utero* as unacceptable. It is ironic that the Commission is opposed to forcing a pregnant woman to have surgery without her consent, but is perfectly willing to force women to continue unwanted pregnancies.

But the key themes of *Crimes Against the Fetus* contribute to a growing trend in modern obstetrics which sees the fetus as a separate patient, needing an advocate for its interests. By emphasizing that the fetus and woman are separate entities and by setting out a key role for the state in balancing fetal and maternal interest, the Commission is intervening, intended or not, in these ongoing conflicts and debates. The same ideological assumptions that the Commission uncritically propounds serve to legitimize increasing obstetrical intervention into pregnancy and birth.

Forced cesarean section is the extreme result of this ideology which paints the physician as the appropriate guardian for the fetus. More routinely, many obstetrical procedures are used despite lack of evidence of benefit, justified by the claim that they are good for the baby. Although

opposing the extreme of court-ordered intervention, the Commission's focus on protection of the fetus reinforces the common view that doctor, not woman, knows best.

While most women may not be directly coerced, the power and authority of medicine put immense pressure on women in pregnancy and labour who want what is best for their babies and trust in expert opinion. Women who question medical authority are not seen as having

Where is its indictment of the pharmaceutical industry for the harm it has caused? If the concern is for the health of the fetus during pregnancy, where is the discussion of the adverse effects of routine but untested medical procedures? If the concern is with the health of the newborn, where is the discussion of the effect of poverty, inadequate nutrition and limited prenatal education and, once born, the lack of daycare, affordable housing and all the other obstacles

What is really needed to ensure that every woman has access to the health care she needs for herself and for healthy babies? There must be no new abortion law, but there must be a commitment from governments to provide the resources to guarantee access for all. There must be community midwifery and birth centres, effective and accessible contraceptive and sexuality counseling, and all the other services and programs needed for women to be able to con-



valid concerns about procedures that are often very poorly researched, but rather 'in conflict' with their fetus. The Ontario Medical Association (OMA) has published a discussion paper for its members titled "When the Pregnant Patient Does Not Follow Your Professional Advice." It refers to the pregnant woman as the "environment" for the fetus. It defines women who wish to choose homebirth, have labour coaches accompany them in labour or vaginal birth after cesarian section as non-compliant, despite extensive evidence of the benefits of these choices for women and babies. In a document condemning homebirth the OMA asks, "Who speaks for the newborn?" The implication is of course that it is doctors who must protect the fetus from women's bad decisions. The focus in *Crimes Against the Fetus* on the fetus as distinct and separate from the mother reinforces this point of view.

Women's demand for choice in pregnancy and childbirth is not a case of their seeking individual autonomy and liberty at the expense of the fetus growing inside their body. They are concerned both with their own health and dignity and the well-being of their fetus. Pregnant women constantly balance their own concerns and their baby's health.

If the Commission is so concerned with crimes against the fetus, where is the discussion of thalidomide, DES, Depo Provero, and fertility drugs?

women face in raising children? Where is the Commission's condemnation of governments that knowingly neglect the social and economic support needed for all children to be raised in decent conditions?

The potential consequences of the Commission's proposals could be devastating. It calls for the criminal regulation of abortion without addressing how to ensure full and equal access and without addressing the consequences for those women unable to obtain essential services. Its proposals could justify increased surveillance and control of pregnancy and birth without addressing the pressing need for improved prenatal care, midwifery, birthing centres and a less interventionist model of obstetrical medicine.

The real message of the Law Reform Commission's narrow focus on fetal protection is that women cannot be trusted — that decisions about abortion and childbirth are too fundamental to be left to women. We reject the Commission's ideological agenda and would start from the opposite point of view — from the standpoint of women's conditions, needs and possibilities. We must establish the social conditions within which women will be able to freely make the best decisions about their reproductive lives.

control their reproduction. The best way to provide all this is through a network of publicly funded community clinics working in whatever language women need, and providing the full range of reproductive care: from safe and effective contraception to abortion, from birthing and midwifery to well-woman and well-baby care, and from sexuality counseling to reproductive technology developed according to women's needs and priorities.

The guiding principles of such women's reproductive health centres would be comprehensive care, equal access, informed choice, responsiveness to community needs and, most fundamentally of all, providing care that empowers women. Let these be the goals of public policy and we will see a very different prescription than that offered in *Crimes Against the Fetus*.

Vicki Van Wagner has practiced as a midwife in Toronto for eight years and has been active in the struggle to win legal recognition for midwifery. She is also a member of the Ontario Coalition for Abortion Clinics and has spoken and written extensively on reproductive rights.

B. Lee has worked with the Ontario Coalition of Abortion Clinics in Toronto for six years. He is also a member of the Midwifery Task Force and AIDS Action Now.

Bernice Balfour

A Time for Healing



Barbara Pasternak

*I am alone now, completely alone.
I denied until the bitter end, perhaps I am still denying,
but not quite as much as before.
After all, I saw the lifeless body of my husband at the funeral.
How can there still be doubt in my mind?*

I hear my sister Martha, my dearest friend, talking to me throughout Ted's illness, reassuring me, supporting me, telling me a new cancer drug might be discovered, a remission might occur that would give Ted a few more years, if not a total cure. And then, suddenly and without warning, Martha dies of a massive coronary, just four weeks before Ted becomes comatose.

Alone. Alone except for the constant presence of terror, my faithful and enduring companion. Stark, undeniable terror. Who am I going to turn to, to talk to? I detest Ted's doctor — cold, insensitive — too caught up in self-admiration to understand, let alone show, compassion. I am lost, but no one knows this. How ironic that everyone congratulates me on how well I am handling the double tragedy. How ridiculously easy it is to fool people!

A card drops from my purse. A social worker in the cancer ward had slipped it to me as Ted lay dying. I phone her, and she tells me about a special project at a prominent local hospital especially aimed at helping older people cope with grief. Yes, "older" certainly is an apt description for me now. I am much older than my 60 years now; years older than I was just a few months ago.

I phone the special project and am told that a counsellor will be assigned to me, a clinical social worker, a woman in her 40s with extensive experience, including hospice work. An appointment is set up for the following week. I feel very dubious, cynical at the idea that anyone can help me now. I'm like the proverbial drowning person clutching at a straw!

Her name is Sharon. The first thing I notice is her hair, jet black, cut short, framing an attractive face. She is tall, as tall as I, slender, not skinny as I have become.

I sit down across from her in her small office, feeling vaguely uncomfortable until she smiles. I relax a little and we start to talk. I tell her that I felt abandoned by my husband the last month of his life.

Sharon asks me to write a letter to Ted as though he could hear me. I read it to her at our next meeting.

*

I know you are too good a person to deliberately try to hurt me, perhaps to "get even" for some of the thoughtless or stupid things I have done. But even though I am sure you don't mean to hurt me, you are doing so. How can I feel when you ignore me so completely and confide in others — everyone, it seems, but me! I can't forget there was a time when I, and I alone, was your only confidant. I believe you are pushing me aside at a time when we should be at our closest. I have tried to make allowances for what you are doing. I have tried to tell myself it is your illness that has changed everything between us. But the fact remains: I feel pushed into the background by the new people who have entered your life. I think, in the long run, we are both the losers because I believe we still love each other — if only we could adequately express our love during this sad and stressful time.

*

"He turned to the nurse's aide, the hospice worker, our daughter Jean," I summarize. "He did not seem to be aware of me at all." How ironic, I think, that Jean always accused me of being possessive, of having to be in charge of everything. Here, at least, was one instance when I miserably failed!

"Perhaps, Frieda," Sharon addresses me gently, "he was trying to protect you."

"Protect me? I don't understand."

"You were both at different stages," Sharon explains. "Your husband knew he was going to die. You, however, seem to have been denying this. He may have sensed your feelings and felt it would be less painful to both of you if he talked to others more accepting of his death."

I feel a little better when I arrive home that day, a few moments respite before my faithful companion appears. Nevertheless, I go to the medicine cabinet and check the bottle of phenobarbital. There are almost 30 pills, and I have a prescription for another 30. More than enough, if I need them. More than enough to escape the pain and the emptiness. Then why do I hesitate? Responsibility, I suppose. I do have a daughter and I love her, despite her cruelty, her terrible accusations

about how badly I treated her father.

Sharon listens to these accusations but seems to feel they've been exaggerated, taken out of context.

"I was demanding, I did need to be in control much of the time," I admit. "In this respect I was much like my own father."

"You seem to forget," Sharon says, "that your husband may have chosen you, at least partly, for these very traits."

"You mean he needed someone to take control?" I ask, and Sharon nods.

"He did have a terribly insecure life as a boy," I reminisce. "His mother died the day after his birth and his father committed suicide when he was only four. His father's second wife was very cruel to him."

"Why were you attracted to him?"

"Because he had a certain sweetness about him, a kind of vulnerability. He was so different from other men I knew, so unlike my father whose aggressiveness always frightened me."

"So each of you had certain qualities the other needed."

"Yes, but there were problems. Jean is right about that. We fought a great deal. I was upset that, despite his obvious intelligence, he couldn't seem to hold jobs for very long. He was a technical editor but actually tried out many different jobs. Finally, he ended up working with me, doing freelance editing and writing."

"Do you think you were unique in being upset by his job problems? Don't you think other women would have felt upset, too?"

Of course, I see what Sharon is trying to do. She is attempting to relieve my guilt, to make me see that I wasn't some kind of monster in my marriage. A little bit of the terror is beginning to ebb, even though it never completely leaves me. The nights are the hardest. I wake up throughout the night, frightened, praying for the morning. But when morning comes, I feel the dull ache of depression set in. My work is suffering. I am beginning to lose some of my freelance contacts.

I attend a widows' group at the hospital. All the women cry throughout the meeting — all, that is, except me. I am the only dry-eyed one there. I simply cannot give up



Barbara Pasternak

what little dignity I still possess. My self-esteem is shattered enough as things stand. I talk to Sharon about the group and she asks me if I have ever cried since Ted's death or since my sister's death. I tell her no, that I do not cry easily.

Am I becoming too dependent on these talks with Sharon? Am I looking forward to them too much? There is a small, tree-lined alcove leading to her office, far enough away from the hospital so that one can forget the actual surroundings. There is a lunchroom nearby with a coffee machine, and we sometimes take coffee back with us to her office. For this one hour weekly I do achieve a measure of peace because she is, unquestionably, very good at her job. But the hour must come to an end and I must prepare to face again the terrible void my life has become.

We discuss the various stages of grief and Sharon tells me that the gradual overcoming of grief varies with individuals. She stresses the word *overcoming* for my benefit.

I'm not sure just what stage I am in. Panic, perhaps. Too often now I feel myself sinking into some unknown abyss without beginning or end. I cannot forget the way Ted changed that final month, cannot forget the vacant look in his eyes, his emaciated body, the sunken cheeks. I see him again and again in his wheelchair, his head drooping, his eyes moist. I keep remembering how helpless, how childlike he became — this vital man who once enjoyed so

many things in life.

"I'm afraid I'm not going to make it," I say, again and again, but Sharon just smiles at my fears. Her optimism is spontaneous. She always manages to point out some fragment of light on the horizon which sometimes will change the direction of my thoughts.

"You're going to make it," she says softly. "You're going to be okay."

I know Sharon behaves exactly the same with all her clients, but I try to pretend the intensity of her feeling is meant for me alone.

Just after the New Year's holiday I suffer my first major car accident. Was I accident-prone? Or, worse, did I precipitate the accident? Was it a cry for help? I am too dazed in the emergency room to fully comprehend what has happened. My face is a bloody mess. I have fractured my jaw, knocked out most of my lower teeth, broken my nose. But all I seem concerned about is my totaled car!

Sharon considers the accident a setback for me, but she doesn't think I precipitated it since I have no recollection of planning it. She tells me people suffering the loss of a loved one do become accident-prone and suffer illnesses. It comforts me somehow to realize I am not unique in this respect.

I keep returning to my feeling that Ted no longer cared for me at the end, no longer needed me. Perhaps he was punishing me for past wrongs by ignoring me, withholding affection.

"He was always saying, 'Let Marian (the nurse's aide) help me up,' or 'Let Marian put the drops in my eyes.' He asked Jean to make the funeral arrangements, even though he must have realized I would end up doing it all."

"Again, Frieda," Sharon explains patiently, for she has made the point before, "I believe he was in his own way trying to spare you some pain. You told me many times you kept denying his eventual death."

"That last night was a bad night," I tell Sharon. "Of course, I didn't realize it was his last night, but still, I was impatient with him. Maybe I was angry, too, since earlier in the day he had seemed so attracted to the young hospice worker who visited him. He was talking to me in garbled speech and I couldn't understand him, kept straining to hear him. I actually mimicked him to show him what he sounded like, why I couldn't hear him. Even though he did speak more clearly after that, I felt so ashamed. Jean thought I was horrible to have done this."

"I really don't think you did anything so terrible, Frieda," Sharon says. "You were saying to your husband, 'You can do better,' and he did! Remember, you — not Jean, not the others — were the one with Ted 24 hours a day. It was bound to be stressful at times."

Just then I recall something I'd almost forgotten in my guilt. "I guess it wasn't *all* bad that last month. One night he did turn to me and say, 'Oh, Frieda, I love you so much!'"

Sharon smiles. "Well, now, doesn't that say it all?"

"And that last month I told him he was the only one I had ever wanted to marry."

"So you see," Sharon says, "it wasn't as bad as you thought. There was some closeness, after all." Perhaps, I think, there could have been more had I not feared the pain of too much emotional involvement.

I have been seeing Sharon now for almost nine months, and she asks me if I feel ready to leave now.

"You are doing better, Frieda," she assures me, but something is missing. Then I realize I have never really discussed my grief over my sister Martha's death. Sharon has no idea of how deeply I was affected by this

loss, just a few weeks before Ted died. I have repressed my feelings because I am reluctant to reveal the past, family secrets, painful memories long buried but not forgotten.

"Tell me about Martha. What was she like?" Sharon asks when I, hesitatingly, start to talk about her.

"When we were kids, I worshipped her. She was so pretty, so bright, so popular. I was nine years younger, a shy withdrawn kid who looked like a case of anorexia. I always managed somehow to catch every germ floating around in the air, while Martha was always the healthy one, the one who made the hockey team at the private girls' school she attended. I emulated her, wanted to be — to be just like her."

"What's wrong, Frieda?" Sharon asks. "You're trembling."

"After her college years she shared an apartment with a girlfriend, someone she'd met at college. I visited them one vacation period during my freshman year and I realized they were more than just friends. You see, I had always idolized Martha, emulated her, but in this way I knew I could never be like her."

"Did it change your feeling toward her?"

"No, I still loved her as much as always, and I was determined to keep her secret. Remember, this was the '40s when gays were treated like lepers."

"How long did the relationship last?"

"About seven years. It was a very close relationship, and there was never to be anyone else for Martha. But Ella, her partner, was feeling the pressures of society. She began to see an analyst. She wanted to try for a "normal" life."

"So she left your sister?"

"Yes, and it was devastating for Martha. She suffered a breakdown, attempted suicide by slashing her wrists, came close to dying. She was hospitalized and given shock therapy."

"How did your parents react to all this?"

"My mother never knew. My father found out, though, and visited Martha just as she was beginning to recover. He behaved very badly, so badly she suffered a relapse. He told me he called her crazy, said if she

ever had another relationship like that she could forget about our family. He said she had ruined her life."

"What did you say?"

"I wanted to say that *she* hadn't ruined her life, that it was people like him who had ruined it. But I didn't say much of anything. He was too hurt, too devastated by the knowledge. Martha had always been his favourite."

"What happened to Martha?"

"She eventually recovered with psychotherapy, had a successful career, devoted her life to friends and family. She loved children and was very good with them. I always felt she lived vicariously as a part of other families. She was very devoted to our family," I say, and my voice breaks momentarily.

"You feel a great sadness about Martha, don't you, Frieda?" Sharon asks.



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I start to reply but my voice is choked. I am crying! After all these months with Sharon, I am finally crying. In my present sorrow I am able to feel Martha's aloneness, to know it as I never did before, and it completes the bond between us, a bond that death cannot destroy.

"I believe talking about Martha was very good for you, Frieda," Sharon says gently. "It brought you in touch with your feelings."

At our next meeting Sharon again discusses ending. She says I am better and that she has confidence in me. Although she is a much younger woman, I sometimes feel like the child.

"Have you begun to think about outside activities?" she asks. "I don't

think you're likely to meet many people staying at home."

"Not unless it's some of the repairmen who keep coming," I reply, amused. "Since Ted died, there's been a steady stream of them at the house."

"You're smiling, Frieda. Are you aware of that?"

Yes, I guess I am smiling sometimes now. Perhaps because my companion is not with me so much these days. Every now and then I catch the scent of spring in the air and feel the season's soft breezes steal over me. I cannot believe it has been almost a year since I phoned the special project, a year since I first met Sharon and felt my sanity slowly start to return to me.

At our last meeting I tell Sharon I see my marriage in a more realistic way. "It was a good marriage and, sometimes, a bad marriage. It was a mutually supportive marriage, and, in some ways, a mutually destructive one. But it survived because we wanted it to. We truly did need each other."

Sharon grins widely. "So the light finally dawns!"

I tell her I still feel depressed and that, in fact, the past week has been very hard for me. She tells me that there will be bad days but that I will be better able to handle them in time. She explains, too, that I may be feeling this way partly because it is our last meeting.

"It's a loss for you," she says, "as it is for me."

I joke about the latter thought. "I can't believe that! Sometimes I've felt sorry for you."

I look at my watch and see that it is almost noon, the end of our hour, and the end of our time together. Suddenly, from out of the past, I remember lines from a poem Martha scribbled in my autograph book when we were kids:

'Tis the saddest word on land or ocean —

'Tis called "goodbye."

We embrace, and I know the moment has finally come.

Bernice Balfour lives in California and is a freelance book copy editor who enjoys writing articles and stories between assignments.

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REVIEWS

AIDS: The Women

Ines Rieder and Patricia Ruppelt
(Eds.), Cleis Press, San Francisco,
1988, \$13.50, 252 pp.

Reviewed by Theresa Dobko

The history of women and AIDS really began as a story of women as family, lovers and friends of men with AIDS. So it's not surprising that the book *AIDS: The Women* begins with the perspective of the caregiver. Even the book's cover is of a woman comforting a man. We've travelled a long way from that early role, and this book guides us on that journey — from women as the healthy outsider, fulfilling a traditional role nursing men to stories that place women with HIV and AIDS front and centre. For those of us in North America, gone is our distance as women from those infected and ill. We are women with AIDS, and we are now women working with women not just with men.

When I received my copy of *AIDS: The Women*, the timing could not have been better. We had just received funding for a separate women and AIDS project at the AIDS Committee of Toronto and this book was the first of many accounts of women with AIDS to enter my hands. I read it cover to cover in the first day. I've reread it since, and find it fuller and richer than on the first reading, not quite so novel, more like home than an adventure. Perhaps that is the frightening part; women with AIDS is no longer a new topic and *AIDS: The Women* has come to mirror the ongoing work I do with women. But what a joy to have this book! It provides a definitive account of women affected by AIDS that can be understood by someone new to this disease, and yet can still teach others who are all too battle weary about loving, hope and

AIDS: THE WOMEN



Edited by Ines Rieder and Patricia Ruppelt

the unique struggles of women.

Reading *AIDS: The Women* leads to feeling and sensing. It grips and provokes from the inside out. *AIDS: The Women* takes our first-hand lives as women, those both famous and ordinary, and lays them bare without the filter of objectivity. There are times I miss that objectivity, times when I wish someone would write a summary of each section, so that the individual fibres of these women's lives could be woven into themes; but that longing is far outweighed by the power of the individual stories.

I need you to read this book. I need you to read this for yourselves, so you can know that if you have HIV you are not alone, and so you can know what you may be facing in yourself or others in the future. If I dare to abbreviate some of these women's stories, perhaps I can pull you in. Here is what the women with HIV say of themselves:

I could be anybody's daughter, the girl next door.
(Tema Luft, p. 70)

Being positive means that I belong to a discriminated minority. This really upset me in the beginning, since I have always been integrated into society. All of a sudden I was an outcast.
(Elisabeth, p. 86)

... and of women who are affected by AIDS because someone they know is ill and dying:

This is my disease, I think. This disease is a statement of life. I don't have the virus but I have the disease. It's a disease of exposure. (R. Mayer, p. 20)

The most moving stories are by the caregivers and by the women with HIV and AIDS. In the first two sections a woman's lot is laid open: desires for children, failures in contraceptives, abortions, women as nursemaids, our inequality with male partners, infidelity and dishonesty in long-term relationships, the invisibility of lesbianism, poverty, lack of access to services and abuse.

If the first half of the book moves us to feel and grieve, the second half inspires us to think, to plan and to carry on. Sections on professional caregivers, women AIDS educators and AIDS prevention policies challenge us as women to continually think of AIDS as our issue. There are stories of activists and educators new to AIDS and stories of women who have survived for years in this work. The editors have collected stories of women from around the world, from both "developing" and "developed" nations; stories of women who wield power and hold paid positions in AIDS, stories by women who work as prostitutes, who volunteer in Black, Latino and Haitian communities and women who fight for the lives of drug-using women around the world.

Kate Scannell exposes the gaps in the medical system, with all its "skills and pills," when it comes to treating the dying. Marea Murray writes of how poor women with HIV struggle more with addictions, housing, physical abuse and childcare than they do with experimental treatments. In "Turning Issues Upside Down," Katherine Franke writes one of the most comprehensive and chilling accounts of the issues women face in prevention and care.

If I have any concern about this book, it is about its layout. Stories on the struggles of women with HIV are placed under sections on education; a story written by a lesbian from Brazil recounts what it is like to be a professional caregiver, but does not

address the issue of lesbians and AIDS. Perhaps this is because our lives as women struggling with AIDS rarely fit into one neat category, one section of a book. Yet even with this understanding, I still found it hard sometimes to follow the book's flow; I caution that you will miss a great deal if you do not read every inch of it, thinking that one or more sections may not be of interest.

It will all interest you. It may even disturb you. In the midst of hope and struggle there is a planned suicide and a confession by one AIDS worker that she would take her life if she ever became ill with AIDS. I wonder at the virtue of these pieces and I'm struck with how much focus is on unusual women — women who describe themselves as dominatrix, or as believers in spiritual healing — there is even a lesbian vampire. My experience with AIDS is that most women facing this disease are not unusual, not extraordinary, very likely to be heterosexual, and even closeted about their diagnosis. I find it strange to be saying this, but I wish this book was more ordinary, more a reflection of the ordinary lives of the women most affected by HIV: the women around the world infected from sex with men, or from sharing needles (mostly with men), who have never been seen as different until now.

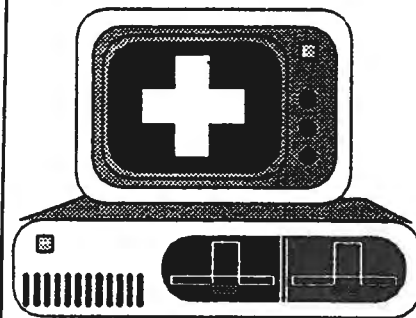
One of the contributors writes a very lyrical piece about her grief that sums up how this book *feels* to me:

All sounds are sudden
Everything is happening for
the first time
Nothing is enough
(Dyana Baust, p. 38)

AIDS is upon us. Now. Everything about women and AIDS is new, raw, untried and sudden. The book *AIDS: The Women* taps this sense of everything for the first time. Nothing is enough. Read the book. Be drawn in. Be moved and challenged and then act.

Theresa Dobko is currently working as the coordinator of the Women and AIDS Project at the AIDS Committee of Toronto. She has worked with ACT for four and a half years.

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A Canadian Women's Health Quarterly

Taking Charge of Your Body: Women's Guide to Health

Carolyn DeMarco, self-published,
1989, \$9.95

Reviewed by Luanne
Armstrong

This is a wonderful little book. Although not a medical reference for women's health, it contains an enormous amount of factual, well researched and often quite new information in several key areas, including pregnancy, birth, birth control and menopause. The book reflects Dr. DeMarco's 17 year commitment to working with women, listening to and learning from her patients and doing her own research. The perspective is refreshing. I had never before read a book written by a doctor which didn't have a slightly patronizing edge to it. There is none of that here.

Going to the doctor would probably be a whole different experience if the medical system would seriously examine the four principles on which this book is based.

These principles are worthy of being repeated here:

1. *You are the most reliable expert on your body and your health care.*
2. *Your body is perfectly constructed for your enjoyment and benefit whether you decide to have children or not.*
3. *Your first period, dealing with your fertility, being pregnant and having a baby, experiencing the monthly fluctuations of the menstrual cycle, and the changes of menopause, are all normal processes for which a woman's body is well designed.*
4. *You have innate and wondrous healing powers which can be supported and encouraged rather than suppressed and denied. Natural healing methods are often beneficial and can stimulate your body's healing capabilities without harmful side effects.*

The introduction also includes a Woman's Health Bill of Rights which provides an excellent basis for thinking about our own health care.

This book presents information with extreme clarity, using simple

language and a well-organized chapter format. It is accessible and useful to women with varying levels of knowledge. DeMarco explained things to me, such as yeast infections, which I thought I already understood, giving me much more information and making it much easier for me to communicate this knowledge.

I particularly enjoyed the chapter on premenstrual syndrome (PMS), for example. I was glad to hear that there is a positive as well as a negative side to this particular health problem. I was also glad to see information on the cervical cap, a method of birth control that too few women have heard about.

I found answers to many long-standing questions here. A few things I missed . . . for example, in the section on dilation and curettage (D&C), I wonder why it was not mentioned that D&C is also a commonly used procedure for abortion. I also wondered, in the chapter on childbirth, if some women might be uncomfortable with references to the fetus as an "unborn child." It's too bad that the anti-choice forces have taken such language and warped it.

My only other minor quibble is that I want more of this excellent kind of information. This is a book that could, and should be regularly enlarged and updated. In fact, I believe that Dr. DeMarco is unique in the kind and extent of research she does. Perhaps, if we're lucky, she could expand her research facility. But she has done us all a service in publishing this first book communicating her perspective on health care and her strength of caring.

Luanne Armstrong is a writer and teacher living in Kamloops. She is executive director of the Women's Resource Centre in Kamloops, and also teaches creative writing classes for women.

Available from the Toronto Women's Bookstore, Parentbooks (Toronto), the Ottawa Women's Bookstore, the Edmonton Women's Bookstore, the Vancouver Women's Bookstore, Status of Women P.E.I., or by ordering directly from C. DeMarco, 598 St. Clair West, Toronto, Ont. M6C 1A6 for \$7.95 plus \$2 postage.

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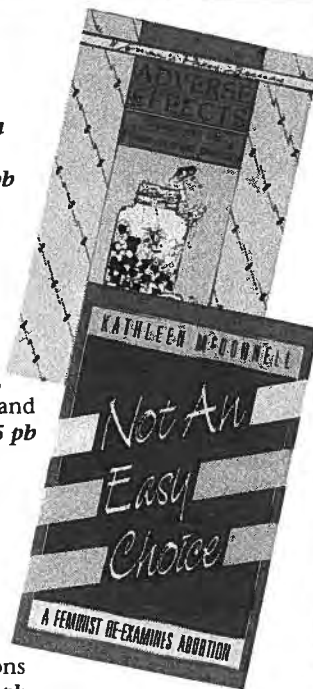
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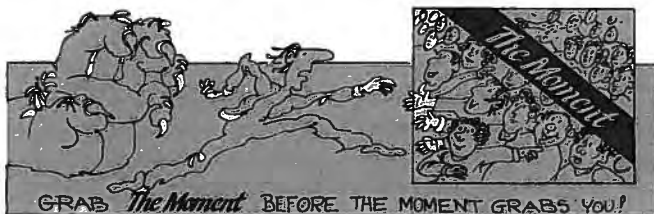
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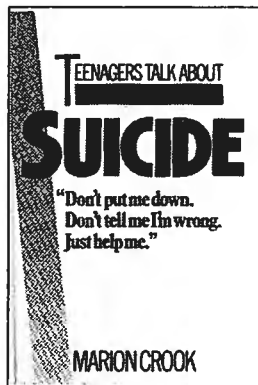
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RESOURCES & EVENTS

Taking Hormones

The National Women's Health Network has published a guide for women considering hormone therapy. "Taking Hormones and Women's Health: Choices, Risks and Benefits" is a feminist critique of estrogen replacement therapy. It carefully examines the claims of researchers and pharmaceutical companies. Reviewed by leading scientists and physicians and backed up by scientific references, this booklet is appropriate for individual women, health educators and feminist health providers. Available for \$5 (bulk rates on request) from National Women's Health Network, 1325 G St. NW Washington, DC 20005.

Caring Across Cultures

Caring Across Cultures — Multicultural Considerations in Palliative Care is a 32 page booklet written by the St. Elizabeth Visiting Nurses Association of Ontario. These nurses provide individualized home care and help patients and their families deal with death and dying. Recognizing that a nurse's knowledge of the personal and cultural background of the patient can help promote a supportive and trusting relationship between the nurse, patient and family, the booklet gives a brief overview of each ethnic group in the metropolitan Toronto area highlighting the unique aspects of its culture.

Already in its second printing, *Caring Across Cultures* can be obtained from the St. Elizabeth Visiting Nurses Association of Ontario, 10 Gateway Blvd., Suite 650, Don Mills, Ont. M3C

3A1 (416) 429-0112. The cost is \$5.00 each or \$4.50 each for an order of 20 or more plus postage.

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Family Violence Catalogue

The Family Violence Audio-Visual Catalogue, second edition, is an updated list of audiovisual resources in the field of family violence. The catalogue includes information on 16mm films, videocassettes, film strips and slide/audio-tape presentations. As well as a title index, there is a subject index and a broad category index. Each entry has a summary of the material and a list of distributors.

Copies are available from the National Clearinghouse on Family Violence, Family Violence Prevention Division, Health and Welfare Canada, Brooke Claxton Bldg., 7th Floor, Ottawa, Ont. K1A 1B5.

Ourselves Growing Older

The Retirement Consultation Centre at York University is hosting a conference *Ourselves Growing Older*, on November 4, 1989. Topics include changes in the family, economics, health care, housing and social concerns. The conference will take place at Osgoode Hall Law School, York University. Registration fee is \$30. For more information contact the Retirement Consultation Centre, York University, 4700 Keele Street, North York, Ontario M3J 1P3 or call (416) 736-2100 ext. 6228.

D.E.S. Conference

D.E.S. Action Canada is holding its annual conference September 16, 1989, in Ottawa. Christine Overall, author of *Ethics and Human Reproduction*, will examine the wide range of moral and socio-political questions pertaining to human reproduction and new reproductive technologies as they relate to the D.E.S. issue. Harriet Simand will speak on D.E.S. litigation in other countries, and Barbara Floria Graham will present a workshop on publicity strategies for grassroots organizations. For more information call D.E.S. Action Canada at (514) 482-3204.

CRIAW/ICREF Conference

The 13th annual CRIAW/ICREF conference *Creating Connections* will be held in Yellowknife, November 10-12, 1989. Some of the topics which will be presented by northern and southern women include: Use of video to create connections, depression in northern women, native women as ritualists, linking women's struggles to end violence against women and the Povungnituk midwifery project.

For more information contact CRIAW Conference 1989 Planning Committee, Box 995, Yellowknife, N.W.T. X1A 2N7 (403) 873-5461.