Healthsharing

Spring, 1991
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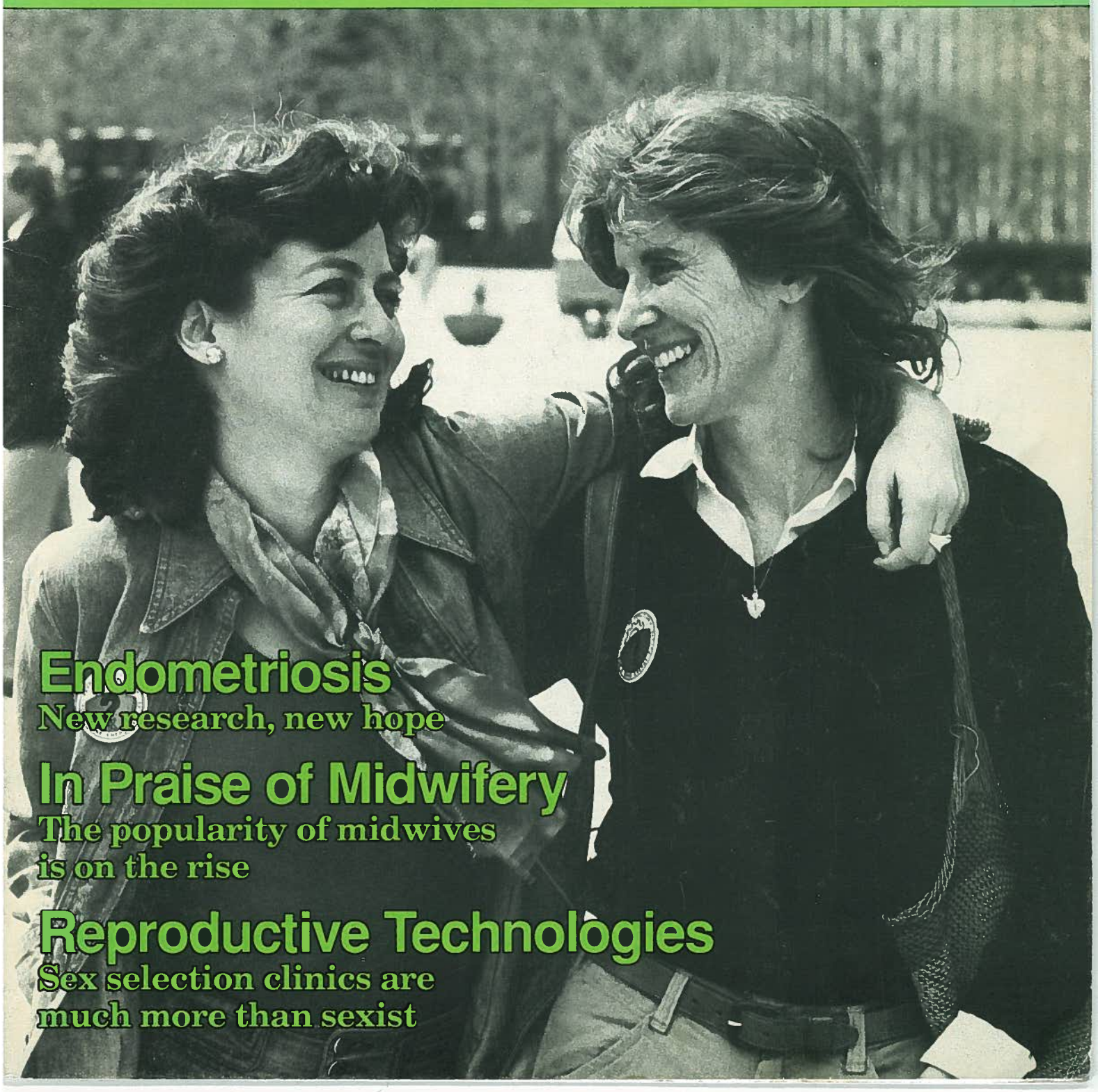
A CANADIAN WOMEN'S HEALTH QUARTERLY



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Barbara Pasternak

Healthsharing

Vol 12:1 May, 1991

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HEALTHLINES

Sheer Madness

The survival of *Healthsharing* has been an act of political will and sheer madness. Madness in the sense that we are swimming against the tide and we have refused to give up. Almost 16 months after our major funding from the Secretary of State Women's Program was slashed completely by the Tory government, we are still publishing the voices of women, still bringing an insightful analysis and health information to thousands of women. Along with many people across Canada, we are fighters.

We may have weathered the crisis – the worst in our history. But that doesn't mean we're facing a secure future; we're strengthened, both in our resolve to survive and through an infusion of funds from the Health Promotion Directorate, Health and Welfare. During the economic and political backlash we have been sustained by the tremendous support from our subscribers. Donations of all sizes arrived at *Healthsharing,* along with many words of encouragement for us and outrage at the budgets cuts. You sent us over $32,000 from April 1990 to March of this year! That kept us going and gave us the stability to plan for the future. We thank all of you.

But financial crises take their toll. Our 12 year always-on-time quarterly production schedule was one of the first casualties. Hence the lateness of this Spring issue. But with the strengthening of our financial base and our energetic six-month old community board, we are hoping to get back on schedule by the end of the year.

We are excited to be starting a new phase of our work, thanks to the transfer of a grant from the Health Promotion Directorate, Health and Welfare. We have taken over the coordination of the Canadian Women's Health Network, a project that has been in the works for a number of years. Through this three-year project we hope to build on feminist health activism and create stronger connections between groups doing work on women's health. We need to share our stories of organizing and develop a common agenda and strategies for strengthening the movement for women's health. Women are organizing on many fronts to gain more control over our health. We are active in self-help groups, in community action around AIDS, in the choice movement, in the debate around reproductive technologies and in making the health care system respond to our needs. At the same time, we face regional and national divergences, race and class differences, differences in physical ability and in our sexuality. This project is an opportunity to make connections, to hear the diversity of our voices and to look at the feasibility of a more formal network for feminist health activism.

Concretely, the project will focus on three central activities:

- Regional networking and animation which will involve six regional projects to showcase feminist health activities, regionally-defined issues, promote existing organizations and projects and facilitate information sharing within the region and across the country. Networking within each region will be coordinated by a regional animator/editor hired on a short-term contract. This person, in conjunction with the project coordinator at *Healthsharing,* will plan the regional report and collect regionally-focused articles, information and resources which will then be compiled and published in *Healthsharing.*
- A Canada-wide consultation on women's health which will focus on linking our struggles, developing a common agenda, discussing strategies and the possibility of setting up a formal network.
- Conference proceedings will be published in *Healthsharing* highlighting conference sessions, encouraging common actions and promoting more permanent networking.

We feel that this project will provide *Healthsharing* with an important opportunity to grow in terms of regional representation and in terms of the diversity of voices heard in the magazine. It will also be a major challenge for an organization, based in Toronto, to coordinate a project which is primarily regionally-based. After surviving the last year and a half, we're feeling more up for this challenge, though we recognize that it is no easy undertaking. And that's why we need input from you, our readers, writers and supporters. Please write us with your suggestions or if you would like to be involved in putting together a regional report.

We welcome our new managing editor Hazelle, (left) and say goodbye to Amy.

We are starting this new project with a new managing editor, Hazelle Palmer. Amy Gottlieb, managing editor for the past three and a half years is leaving her staff position to begin work as a freelance editor and photographer and to devote more of her time to her artwork. We want to thank Amy for her political vision and commitment, for the ways she changed our organization and for her central role in the survival of *Healthsharing.* Her leadership during the rough times was essential. And though we are very sorry to see her go, we are indebted to her for helping to secure a future for the organization.

Amy will be passing the torch on to Hazelle, whose experience includes writing, editing, visual communications and health counseling. She is also active in the publishing community, with SisterVision Press. We wish Hazelle as easy transition into her new job and know that she will do wonderful things for the magazine.

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 right to edit letters for length, and print them, unless marked "not for publication."*

Hot Flashes

I very much enjoyed your last issue on menopause but feel that I must comment critically on two of the points which were made. The introductory paragraph to one of the articles stated that "two centuries ago many women died around the time of menopause." This commonly held belief is incorrect. The average life expectancy was much lower two centuries ago, but this was due to high infant mortality and to the fact that many women died in childbirth. Those who survived to the age of 40 had an extremely good chance of going on to reach an old age of 65 years or more. A good number of old people have existed since classical times at least. Suggesting that menopause is a "recent" phenomenon is not only erroneous but dangerous, because it allows certain interested parties to promote the idea that post-menopausal women are "unnatural" and therefore that they must be medicated, otherwise they are very likely to disintegrate.

The second point is in connection with the article by Ann Voda whose ongoing research in connection with hot flashes continues to produce very valuable data. However, I think it should be stressed that whereas Dr. Voda states that more than 88 per cent of women in the U.S. will experience the hot flash, the results of some outstanding research with large samples of women from the general population do not support this assertion.

Longitudinal research of Drs. Patricia Kaufert in Manitoba with 2500 women, and Sonja McKinlay in Massachusetts with over 8000 women aged 45 to 55, who were drawn from the general population, demonstrates that the incidence of hot flashes is much lower than Voda suggests. In Kaufert's study, for example, only 65 per cent of women reported ever having experienced a hot flash, and only 31 per cent of them reported having had a hot flash in the two weeks prior to filling out the questionnaire. McKinlay, a biostatistician, states as a result of her research that one needs a sample of more than 1000 women who are followed up for at least five years before one can make any general assertions about the parameters of the menopausal transition. This is not to disqualify Voda's important work, but simply to emphasize that we are not in a position yet to make broad statements about menopause, as the articles by Janine O'Leary Cobb and myself and the work of Kaufert and McKinlay clearly demonstrate.

M.Lock,
Montreal, Quebec

Lesbian Perspective

Thank you for such an informative issue on menopause. I was thrilled to read a perspective of a lesbian–too often we are left out of health related publications. And there are lots of us in the health profession, especially in the fields of alternative medicine.

N. Issenman,
Victoria, B.C.

Don't Go Under!

Thank you for raising my consciousness. I devour every issue. I often finish an article to realize that my subconscious feelings about women and medicine have been put into print. After 15 years in general practice, I've come to rely on *Healthsharing* to show me issues in a new perspective. Don't go under!

B. Varty,
Toronto, Ontario

Not Going Crazy

To all those responsible for the Winter 1990 issue on menopause - its about time we can finally say the word menopause without feeling silly. To read such well written articles, so very informative, yet simple to understand, it's really a blessing to realize one is not going crazy and reading and talking about these weird years is rich, rewarding and educating. I congratulate each of you for putting this issue out and do hope to see a follow-up on any new information that may help us to further comprehend our bodies as well as our minds.

D. Bayliss,
Pierrefonds, Quebec

On the Cover

Thank you for a wonderful lesson. Thank you for putting my picture on the cover of your magazine [*Healthsharing*, Winter,1990]. I must explain first to those of you [in the collective] who do not know me, that I am not fond of getting my picture taken. I did agree to it because I feel that the magazine performs a valuable service and because I respect the work of the person whose article I was to be illustrating.

I was surprised when people started to react to me differently after the magazine was published. Some people treated me with more respect. I appear to have become (as one woman put it) more politically correct. The

Nicole Hollander

power of the media really shocked me. I was relieved when some other women said what a nice picture it was and how it captured my smile. Another group of women took it as an opportunity to talk about the magazine and how valuable it is to them. The real shocker though, were the ones who asked me what my picture was doing there. They wanted to know if I had written an article or if an article was about me. I would explain that I was there illustrating the article on menopause in Japan. They would tell me then that I really didn't have anything to do with the magazine. It started to dawn on me that I hadn't "earned" the right to be on the cover. I also started to think that no one ever questions all the pretty young faces on most women's magazines. The "ordinary" or "odd" looking faces are there only because those women have "earned" the right to be on the cover.

So thank you *Healthsharing* for putting a middle-aged, ordinary, oriental-Canadian woman's face on the cover. I know I haven't "earned" my place there but I have had a great lesson from the experience. I think it is wonderful that you use photographs of "ordinary" women.

E. Anderson,
Toronto, Ontario

Editor's Note: We want to thank Ellen for agreeing to have her photo on the cover of the magazine. But we do have one quibble with her—we feel that she has earned her place on our cover, as an activist, a mother and a friend. And that's exactly why we feature "ordinary" women on our covers, because they really aren't ordinary at all. We honour the spirit of women struggling to create a better world.

Breastfeeding Support

In your March 1990 issue there was an article on breastfeeding—"A Natural Resource—Rediscovering Breastfeeding" by Leslie Ayre-Jaschke [*Healthsharing*, Spring 1990]. While I generally agree with the views in her article, I think she has failed to include a valuable source of help for new mothers—the actual maternity nurses in the hospitals.

I had two girls at the Misericordia Hospital in Edmonton. With the first in 1985, I was there for 1 1/2 days, but the nurses helped me with nursing from the delivery chair on. The nurses were very pro-nursing and made sure that everything was going fine before we left hospital. In the second case, in 1988, I had to have an epidural C-section. The nurses again were incredibly supportive. I nursed my daughter as soon as I was out of the recovery room. The nurses had me ring them so they could place her with me to feed and then ring them so they could place her back in the bassinet. Even with the C-section she roomed with me!

I was very lucky to have such positive support.–I was able to get off to a good start through the help of the maternity ward nurses.

Keep up the good work in putting out *Healthsharing*. Each of my issues that has arrived here has gone through many hands—all with positive comments!

J. Mulder,
Swaziland, Africa

Easily Readable

You manage to cover a lot of complicated and difficult issues in an easily readable, comprehensible and cogent way.

I look forward to each and every issue of *Healthsharing* and read it from cover to cover each time. It improves the quality of my life immensely. Thank you!

M. Gurevich,
Toronto, Ontario

Doctors Are Doctors

Your tendency to characterize doctors as the "problem" shows a complete lack of understanding of the government control over health care. Your issue containing "Patient's Rights: An Agenda for the Nineties" [by Maggie Burston, *Healthsharing*, Summer, 1990], is a perfect example of the magazine's shortcomings. (Your shortcoming is a relative one: you're a fine political document, but medically lacking).

Burston writes that modern medicine uses "drastic intervention" but doesn't teach [patients] how to avoid getting sick. Charming, but shallow. Does Burston make appointments with her doctor to chat about health or does she like most people, only see a doctor when she is quite sick?

A "lack of research" on health? In a country which spends less per capita than Turkey on basic research, just where are Canadian scientists supposed to get funding for these studies?

Burston's article also talks of the "educational process" whereby we view patients as "incompetent" for "too complex and specialized information" - most people seem to have a "fix it or throw it away" mentality that extends into health care. "I'm too busy living my life to care about my health" seems far more prevalent than "teach me."

Let me finish by pointing out that doctors are doctors - we're not librarians or magicians or nutritionists or massage therapists. You don't ask your dentist to be a theatre critic; don't ask us to somehow play every role and know everything about every vaguely related health issue and therapy.

Z. Goldberg,
Toronto, Ontario

UPDATE

Taboo tax Canada

Did you know that sanitary pad and tampons are non-essential? Well they might be to Brian Mulroney and the majority of his cohorts, but to most women they are absolutely basic and not just a luxury accessory. An Ontario woman has started a petition campaign to protest against GST being charged on sanitary products. The petition reads:

"In the Spring of 1982 the Progressive Conservative government of Ontario placed a sales tax on women's sanitary pads and tampons claiming these items as non-essential. A province-wide petition protest played a major role in having the tax removed after the Tories were defeated.

Now in the Spring of 1991, the federal Conservative government has decided that, unlike canoe rentals and potatoes, women's sanitary products are not essential items. This government is therefore implying that women, through their bodily functions, are considered "goods" and/or "services" and therefore subject to the GST! The Taboo Tax Canada protest will underline the government's systematic oppression of women through funding cuts to women's centres, programs, education, health, etc. and now this personal assault through the taxing of our menstrual cycles.

The petition is presently circulating throughout Canada and by April over 5000 signatures had been received. This is a national issue so please join the protest by circulating petitions in your area. People are literally lining up to sign! It is our intention to gather all petitions at the address listed below and have them presented during National Women's Lobby Day on June 17th in Ottawa. We want to ensure the government hears our voices! All opposition members of parliament have been asked to raise questions about this tax and all daily newspapers will receive a press release. Please contact your local media to let them know you or your group are working on this protest.

Barbara Saunders/Jackie Burnett, 13-64 Peppler Street, Waterloo, Ontario, N2J 4P7."

Rape shield law appealed

The Supreme Court is hearing the appeal of two men charged with sexual assault to have the "rape shield" provision in the Criminal Code struck down. The "rape shield" provision, which was enacted in 1982 to make the criminal justice system more accessible to women and children, limits the questioning of survivors of sexual assault about their prior sexual conduct and reputation. Seaboyer and Gayme, the two men appealing the provision backed by the Canadian Civil Liberties Association, contend that the law violates their right to a fair trial.

Six women's organizations have formed a coalition to argue that the laws are necessary to protect women and children who have been raped by providing them with equal benefit and protection of the criminal justice system. The coalition includes Metro Action Committee on Violence Against Women and Children (METRAC), Women's Legal Education and Action Fund (LEAF), the Barbara Schlifer Commemorative Clinic, Metropolitan Toronto Special Committee on Child Abuse, Women's College Hospital Sexual Assault Care Centre Team and the Canadian Association of Sexual Assault Centres. Before 1982, the law allowed wide-ranging cross examination of rape survivors about their previous sexual conduct, based on the assumption that a women's or child's sexual history tells something about their credibility or suggests they may have even consented to the rape.

"What we are seeing is a line drawn between chastity and credibility," says Pat Marshall, executive director of METRAC, "a link which has already kept most women from reporting rapes."

It is common knowledge that sexual assault is the most under reported violent crime and the major reason women give for not reporting is distrust of the justice system and the experience of being put on trial. If the appeal wins, it is almost certain that even fewer women will report sexual assault.

MEGAN WILLIAMS

Boycott is back

Consumers are once again being asked to boycott Nestlé products to protest their infant formula marketing strategy in Third World countries.

In 1981, the World Health Organization (WHO) and UNICEF called for an end to dangerous promotion of breastmilk substitutes, particularly free samples and promotion in hospitals. Although they agreed in 1984 to follow the WHO guidelines to end the first boycott, Nestlé have continued to violate them. Like many other companies, Nestlé still provides free formula to maternity wards in Third World hospitals.

Health organizations are concerned because once bottle-feeding starts, breast milk dries up, leaving a physical need to buy formula. There is always the temptation to over-dilute the powder to make it last longer. Bottle fed babies in the Third World are twice as likely to die as breastfed babies.

Even though Nestlé denies that donating formula is a marketing strategy (they see it as "altruistic") it is interesting that in the Ivory Coast between 1985 and 1987 Nestlé increased their free supplies when the government ran a campaign to encourage breastfeeding. Yet in Brazil, where Nestlé has the market all to itself, no free supplies have been given to hospitals at all.

Action for Corporate Accountability, together with the International Nestlé Boycott Committee have targeted Nestlé and American Home Products (Wyeth), the two largest manufacturers of infant formula and their subsidiaries for a new boycott. For more information contact INFACT Canada, Trinity Square, Toronto, ON, M5G 1B1, (416) 595-9819.

Nestlé products include: Nescafé and Taster's Choice Instant Coffee, Nestlé and Rowntree candy bars, Smarties, Carnation milk products and pet foods, Libby, Laura Secord and Crystal Springs. AHP products include: Anacin, Advil, Chef Boyardee, Easy Off, Black Flag, Dristan, Preparation H, Pam cooking sprays, Today condoms, Aerowax and Woolite.

WHS

Midwives charged

In April, 1990 two Manitoba midwives were charged with criminal negligence in connection with a home birth they attended. The midwives allege that after the normal birth of a first twin, a mother in labour with her second twin was transported to the hospital, because the second twin was in distress. The midwives state that upon their arrival at the hospital they recommended a cesarean section. The infant was apparently delivered vaginally two hours later, stillborn.

The charges against the two midwives were subsequently dropped pending an inquest which will take place in June. This is happening at a time when Manitoba is studying the possibility of integrating midwifery into the health care system. Two committees have been appointed by the provincial government to investigate the issue—The Alternative Task Force of the Health Advisory Network and a joint nurse/physician committee, both of which are producing reports without calling for public input from the community of women concerned.

The Home Birth Network is developing creative ways of raising awareness and funds around the issue of midwifery in Manitoba and The Women's Health Clinic in Winnipeg, concerned about the lack of public input on the role of midwifery in Manitoba's health care system, is pursuing funding for education in this area and to ensure that women's views on midwifery are heard.

CLARICE FOSTER

Northern Ontario update

Over the past year, the Northwestern Ontario Women's Health Information Network, (WHIN) has undergone an extensive evaluation of the organization and its activities. Although we've produced some excellent resources that we are very proud of, the costs have been high in terms of volunteer time and burnout. We've come out of the board development process rejuvenated and with next year's plans in hand.

In 1991, we have three projects planned. The first is a car rally in April. Roads are the ribbons that hold us together in the north. The unpredictable weather and the difficulties in maintaining roads in this area both contribute to accidents. We want to focus attention on health issues of highway safety.

In the fall of 1991, we plan to tour high schools in Northwestern Ontario with a play called "The Crane Dance." Written by Lennie Albanese, a local playwright and actress, the play is about body image and eating disorders. A workshop kit and resource materials will accompany performances.

We are also planning to produce a Peri-Natal Services Pamphlet for the Thunder Bay area with a complete list of resources available in our area for pregnant women up to and including the first year after birth.

WHIN

Health effects of domestic violence

In a ground-breaking study of the long term health effects of violence against women by their spouses, it was revealed that more than 75 per cent of victims of domestic violence continued to suffer psychological problems more than a year after having left a women's shelter. These women were eight times more likely to suffer mental and physical problems than women from the general population, and four times more likely than women in their same social and economic group. Seventy-six per cent of battered women experience mental health problems, compared with 45 per cent of women from the same social and economic group. The stress-related problems included back and head aches, ulcers and digestion problems, vision impairment and high blood pressure. An alarmingly high percentage of the children of these women suffered from mental problems and allergies. Further disconcerting evidence revealed that women who have been physically or emotionally abused need to visit health workers twice as often as non-battered women from the same social and economic group, and were much more likely to take tranquilizers and other prescription medication.

The study, released this February by the Community Health Department of the Rimouski Regional Hospital in Quebec, is the first of its kind to look at the long term health repercussions of domestic violence against women and children.The health of women and children temporarily residing in one of four women's shelters in the Lower St. Lawrence and Gaspé Peninsula was compared over a two year period with women and children who had not visited the shelters.

Helen Cadrin, a researcher at the Health Centre who conducted the study, was alarmed at the findings. "What we are seeing is poor, isolated women coming to the shelters for protection and support, and then having to return to even worse circumstances of poverty," she said, "What the results show is that violence against women is not a personal problem, but a social, economic and medical one."

The large majority of the women in the study (over 85 per cent) live in poverty with an annual income of less that $12,000. Over 70 per cent remain economically dependent on their violent spouses after leaving them.

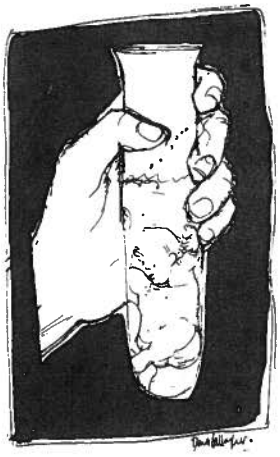
"These women need long-term help and so far it's clear they are not getting it," Cadrin concluded.

For a copy of the study, Helen Cadrin can be reached at 418-724-8469 or write Département de santé communautaire, Centre hospitalier regional de Rimouski, 150 ave. Rouleau, Rimouski, PQ, G5L 5T1.

MEGAN WILLIAMS

Royal Commission extended another year

The Royal Commission on New Reproductive Technologies held public hearings from September 11 until the end of November 1990. An update released in January 1991 reports that the Commission heard from over 550 people, representing 250 organizations. Briefs were presented by community, consumer, health, religious and medical groups, women's organizations, and academics.



Several themes emerged from the hearings. Many presenters were concerned about the lack of reliable, impartial and standardized information and data on reproductive technologies. Only with this kind of information, it was argued, can women make informed choices about their reproductive health and fertility.

Many women expressed concern that doctors and the medical system are not listening to women nor treating them as full participants in decisions about their health. At an institutional level, it was pointed out that not enough women are involved in hospital boards, ethic committees and research funding decisions.

There was a general consensus among women on the need for support mechanisms for infertile people before, during and after undergoing any medical procedure. The commission was told that the impact of infertility on a family is strongly dependent on the support available and on the social service system which is now being threatened by government cutbacks.

Various regional, racial and ethnic concerns emerged as well. In the North, the commission heard that access to basic health care services is more pressing than new reproductive technologies. Native women and minority women also stressed the importance of culturally appropriate services.

One concern voiced repeatedly during the hearing was the need for infertility prevention. The primary cause of infertility is sexually transmitted diseases, and many groups pressed for an education campaign to prevent the transmission of these diseases. Occupational and environmental hazards were also cited as causes of infertility.

In April, 1991, the federal government extended the mandate of the commission for an additional year beyond October 1991. While the commission would like to receive information as soon as possible, all material received up until April 30, 1992 will be included in its deliberations. Those who have already made submissions to the commission now have the opportunity to send additional information. The commission can be contacted at (613) 954-9999 or toll free at 1-800-668-7060.

MEGAN WILLIAMS

Ontario sex-abuse inquiry

In an historic, precedent-setting move, the College of Physicians and Surgeons of Ontario, the self-regulatory body of the medical profession, has launched an inquiry into sexual abuse of patients by Ontario doctors. The task force, which began its hearings in January, 1991, produced its interim report on May 27, 1991. A final report will be released September 16, 1991.
So far, the five member committee has received hundreds of phone calls and over 50 letters recounting heart wrenching experiences of abuse by doctors. As well, both public and private presentations by sexually abused patients have been made to the committee.

Pat Marshall, the executive director of METRAC (Metro Action Committee on Violence Against Women and Children) and a task force member, has been amazed at the extent at which the abuses by doctors have been covered up by other medical authorities. "So many of the women who reported abuse to another doctor or medical worker were told to keep quiet about it or simply not taken seriously," she says, "This made the experience of abuse all the more devastating and the act of coming forth with their stories now all the more courageous."

Some of the abuse dates back over 20 years, and the pain felt today by these women is a terrible reminder of the depth of the harm caused.

Marshall expressed great concern about doctors who have been convicted of sexual abuse, but who are in the process of appealing the decision to revoke their medical licences. These doctors are still entitled to hospital privileges and may continue to target vulnerable people.

Although the intention of the task force is not to single out doctors guilty of misconduct, survivors of sexual abuse can initiate a separate complaint with a representative of the College of Physicians and Surgeons.

MEGAN WILLIAMS

Sunera Thobani

More Than Sexist...

The use of sex selection and other reproductive technologies reveals much more than sexism. Issues of race and class are also front and centre

Phyllis Wong Kun

On the 17th of August, 1990, an advertisement appeared in *The Link* promoting the use of ultrasound scanning techniques to determine the sex of a fetus as early as 12 weeks into a pregnancy. *The Link* is an Indo-Canadian community newspaper based in Vancouver, and the advertisement was placed by a doctor from California, Dr. John D. Stephens. Stephens is based in San Jose and operates four clinics, one of which, Koala Labs, is located in Blaine, Washington. Blaine is within easy driving distance of Vancouver.

The fee charged for this patented scanning technique is $500 US. Stephens claims 100 per cent accuracy in his determination of the sex of the fetus, an assertion that has been challenged by other doctors who conduct ultrasound tests. In an advertisement written in Punjabi and mailed to gynecologists and members of the Indo-Canadian community in British Columbia, Stephens offers a free video recording of the ultrasound to prospective clients.

The *Vancouver Sun* reported in September that 10,000 Indo-Canadians were being targeted by Stephens in a direct mail campaign. An article also appeared in *Kinesis* which mentioned this doctor's targeting of Indo-Canadian women (October 1990: "Sex selection: the ultimate sexist act.")

A number of issues are raised by this incident and the manner in which it has been reported. Let us begin by looking at the larger issues involved here. Sex selection techniques are part of the package of reproductive technologies, and can only be fully understood within the context of this totality. Ultrasound, the technique this particular doctor is promoting, is also used as part of the in-vitro fertilization process, for detecting ectopic pregnancies, fetal deformities, etc.

So not only are reproductive technologies being developed as spin-offs from each other, they are also intrinsically related in that they extend control over women's reproductive abilities by the scientific and medical community.

Reproductive technologies are being presented as being an issue of a woman's right to choice, the choice that will make it possible for women to design and plan the making of their families, of their children.

In reality, these technologies have very little to do with women's choice. The technologies have to be understood within the context of the power relations of our world today and collectively, women have very little power in this world. Certain groups of women, depending on their race and class, do have relatively more power than other groups of women. Reproductive technologies target all women, although specific groups of women are being targeted with specific techniques which reflect these divisions of race and class among women.

Techniques such as in-vitro fertilization and surrogacy, for example are directed towards white, middle and upper class women. With surrogacy costing about $30,000 US only a particular group of women have access to it. These women have gone out and hired "surrogate mothers" to bear children who are contractually turned over to them upon birth. The Baby M case is a tragic example of the consequences for the women who are so hired (see *Kinesis,* September, 1990.) The "surrogate mothers" who are hired are working class and poor women. With the development of gestational surrogacy, we will increasingly see women of colour being drawn into surrogacy.

Gestational surrogacy makes it possible for a women's egg to be extracted from her body, then fertilized by sperm and implanted into the womb of a "surrogate mother." This "surrogate mother" has no genetic relation to the embryo. If the egg and sperm donors are both white, the "surrogate mother" can potentially be a woman of colour without the embryo also being genetically of mixed race. The experience of Anna Johnson, a Black woman in California who recently lost the first round of a custody battle for the baby she gave birth to in this arrangement, is a sign of the kind of exploitation women of colour will face increasingly.

On the other hand, sex selection, in the Stephens case, is targeting Indo-Canadian women. Techniques that determine the sex of the fetus have been the prelude to the practice of femicide—the aborting of female fetuses on the basis of their sex. Yet we know that it is not only Indo-Canadian women who undergo these techniques.

These tests are often used to detect disabilities in the fetus. In the age of "designer babies," the characteristics of groups of people who are devalued in our world today are deemed undesirable and sufficient cause for extermination. Bhooma Bhayana, a physician, says she was "never taught that being female was a genetic illness." We are being taught that now: being born female is to be devalued in every community in Canadian society today. With regard to femicide, consider the following:

- Caucasians in North America are said to have "a preference that the first-born child be male," according to recent report of the Vanier Institute of the Family in Ottawa.
- In Britain, a "made to order" male infant was born in August, 1986. When reported in the *Daily Express*, a doctor claimed his clinic was "swamped" with similar requests for boys.
- The use of abortion for sex selection in Pennsylvania has been banned in a bill that went into effect in January, 1990.
- In Denmark, a woman demanded an abortion when she discovered the fetus she was carrying was female. As abortions are available on demand in Denmark until 12 weeks gestation, doctors presently cannot disclose the sex of the fetus until after 12 weeks.
- A doctor who has sex selection clinics in 46 countries in Europe, America, Asia, and Latin America, stated that of 263 couples who approached him, 248 elected to have boys.

Clearly it is not only women of Indian origin and their use of sex selection who are provoking this kind of response all over the world. Yet while these practices occur in the mainstream white community too, the myth being created is that only Third World communities - the Indian community in this case - practice femicide. Furthermore, femicide by selective abortion is now presented as part of our "culture."

We don't know how widespread the use of sex selection techniques is in the Indo-Canadian community in British Columbia. What we do know is that promoting them in this manner only serves to increase the extent to which they are being used. We don't know how widespread the use of these techniques is in other communities in Canadian society either. We do know that it happens at a scale that makes possible the analysis such as that of the Vanier Institute mentioned above.

What the advertisement in *The Link* has done is revive a racist stereotype of Indian culture, a stereotype that has time and time again stated that such crimes against women are an inherent feature of our culture.

Stephens was quoted in the *Vancouver Sun,* saying, "Why should I cut my financial throat? Why should I have to go out on my own to change their cultural attitudes?"

Since colonial times, peoples of colour and our cultures have been under attack. The racist stereotyping of our cultures mystifies the actual power relations in the world by blaming everything upon the "backwardness" of these cultures.

A Matter of Gender

Canadian society reacted with repugnance when newspaper stories appeared about the East Indian community using Dr. Stephens' services to determine the sex of a fetus for the purpose of aborting female fetuses. The reactions from the East Indian community were very diverse. Some screamed racism, some expressed disgust and some said that, while things like that may happen in India, they do not happen in Canada. I, along with perhaps many of those who remained silent, know that aborting female fetuses is a common practice in South Asian communities. But we also know that it is common in many other cultures as well and we abhor Dr. Stephens targeting our community. Aborting female fetuses is not an inherent feature of South Asian culture, but rather a reflection of a deep-seated sexism which permeates all cultures.

While it is not surprising that many women use sex selection services, we must look at the underlying causes and find a way to challenge this practice.

In 1989, South Asian Family Support Services conducted research to study the issue of wife abuse in the South Asian community living in Scarborough, Ontario. Of the 100 women interviewed, 22 said that they had been unable to produce a son and this was the main cause of abuse in their marriage. The other 78 stated that until they had given birth to a son they had lived in constant fear and uncertainty. They knew that their marital status could become worse if they did not give birth to a son. Several of these women attended support groups for battered women and their fears were confirmed by those women who had been divorced because they had been unable to have a son. Seventeen of the 22 women without a son had been in the hospital receiving psychiatric care at one time or another. The women blamed themselves for not being able to have an "heir." They felt that they had failed as daughters and as wives. It was very difficult for these women to share the blame with their husbands. They often made excuses such as, "What can a man do? He must have a son," or "One can expect a man to go mad once in a while, especially if he has to come home and look at daughters."

In the East Indian culture a female is socialized from the first moments of her life into a culturally defined sex role which teaches self sacrifice, self deprivation, renunciation, humility and death before complaining. This role of the ideal woman is defined through sacred scripture, believed to be divinely inspired and unalterable. This same scripture also states that the nature of a female is wicked and deceptive; being a girl is a penalty for sin committed in the previous incarnation. A woman's only way to salvation is to bear a son so that her husband can receive incarnation, a good form of life in the next world.

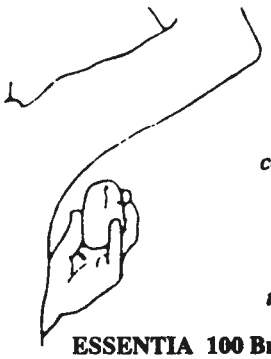
These cultural values are secured by a variety of means; gender inequality from birth, educational deprivation and dividing women from one another. For example, special songs of respect are sung for women who are mothers of male offspring and when a woman marries, she receives the blessing "pray you have a dozen sons."

Why did South Asian women become the biggest clients of Dr. Stephens? The abused women in my support group said that they are not only the victims of their religion and culture, but of the racist and misogynist Canadian society they live in. It is difficult for South Asian women in such situations to visit friends who have sons; they are always in fear of any conversation turning to the subject of children and ultimately, to having sons. They feel humiliated and ashamed for having failed as a wife. Some women stated that they live in constant dread that their daughters might be harmed or that the daughters will do something that will shame the family. This would reflect upon the mother and intensify the abuse.

In cases where police or other social service agencies have become involved, often the abuse has escalated. When the agency was able to assist the woman to leave and go to a shelter, the anxiety about the future, the concern that no South Asian man will marry a divorced woman's daughter, the lack of financial and emotional support from relatives, and the lack of social support systems usually forced a return to the family. Their state of mind is unimaginable. These women feel they have not only failed as women by not producing a son, but they have also destroyed their marriage.

Until South Asians come to terms with the fact that women in our community and in Canadian society as a whole, do not have the same rights and equality as men and until the community decides that women have the right to live with dignity, Dr. Stephens and his cronies will continue to exploit us. South Asian women are taking steps towards change. We're making our contribution to putting Dr. Stephens out of business.

Aruna Papp has worked with South Asian battered women for the past 15 years and is founder and executive director of South Asian Family Support Services.



Here we have a doctor who is making money by targeting our community with technologies that we have had no hand in fashioning and over which we have no control, and who then justifies himself by blaming us for the very practices which exploit and devalue us further.

Of course women are oppressed and exploited in the Indian community. But in which society today are women not exploited, oppressed and devalued? I am not condoning this exploitation of women. What I am interested in is challenging the racist underpinnings of both the advertisement and the articles written about it.

The Indo-Canadian community is not a monolith with identical attitudes and practices. If there are people in our communities who defend such practices, there are many who are outraged and determined to stop it. Again and again, we are quoted the statistics of this practice in India. Rarely do we hear of the women's movement in India and the militant activism around this issue.

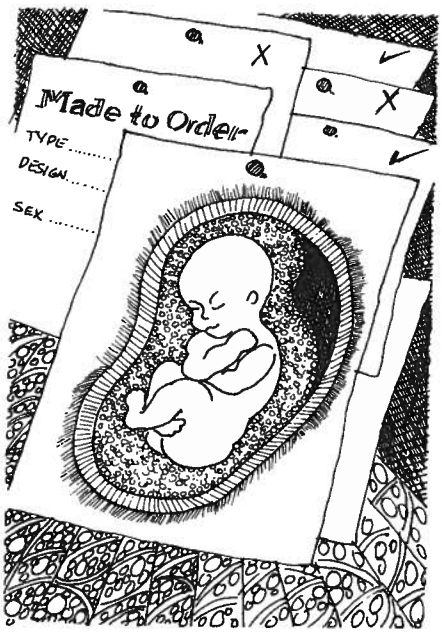
Again and again we hear of the backwardness of our culture which is to be blamed for women's exploitation in our community. Rarely do we hear how patriarchal relations within the Indo-Canadian community are transformed and strengthened through the workings of the Canadian patriarchal and racist state and economy.

Reproductive technologies are directed at all women. They serve to increase the control by the racist, patriarchal, scientific and medical communities over women's reproductive abilities. The control of women's reproductive ability and sexuality, the control of women's bodies, is a cornerstone of patriarchal power. We are seeing the extension of this patriarchal control over women's bodies through the development of this technology.

As women of colour, we have learned lessons from our history. We recognize that this is not an issue of a woman's right to choice.

We have cleaned white women's houses, we have sexually served their white husbands. We have wiped their babies' bottoms and we have cleaned their toilets. With the development of the reproductive technology that allows gestational surrogacy, we will also be made to carry their children while they are busy with their professions and careers and writing books and articles about us. It is no wonder then, that the discussion of this particular technology continues to focus on our culture only.

Understanding the full consequences of reproductive technologies is an urgent matter. For women of colour, it is an issue of life and death. These technologies make possible the realization of the goals of the eugenics movement, the technologically engineered reproduction of a "superior" race of people. We know that this "superior race" will be defined by the dominant values of a racist, patriarchal, imperialist society. The Nazis taught the world what this would mean in human terms. What is truly alarming is that these technologies are already available in the marketplace of scientifically-controlled human reproduction.



Phyllis Wong Kun

The issue of reproductive technologies has the potential to force the white feminist movement to challenge its own privileges: to identify the potential threat to all women as well as to recognize their complicity in the continued exploitation of women of colour. For women of colour, the threat of racist and sexist extermination is real. Thus we recognize the potential threat these technologies present toward all women. We also see how we are being used against each other yet again, both by the racist blaming of our cultures for this crime against women, and also by being made to bear the brunt of oppression and exploitation. White and middle-class women can continue to present this as an issue of women's choice. To persist in defining the problem of reproductive technologies as being specific to certain races and cultural groups will only demonstrate the white feminist movement's complicity with the hierarchy of power relations. Reproductive technologies are recreating the divisions that already exist among women along the lines of race and class. It is crucial to recognize this and to act upon this recognition.

Indo-Canadian women have taken up the fight against Stephens; we are still waiting for other groups of women to take up this fight with us. We put pressure on *The Link* whose editor withdrew the ad and stated he will not reprint it. The ads also appeared in stores that serve the Indo-Canadian community. Women have approached owners of some stores and asked that these ads be removed. Indradhanush, a local community television program, presented a discussion of this incident and some of the larger issues involved. We are also in the process of preparing a brief for the Royal Commission on Reproductive Technologies. Our brief will contain specific recommendations regarding sex selection techniques.

Much remains to be done by feminists everywhere. In the case of this doctor, he is based in California and operates out of Washington. Women's organizations there can take up this issue and bring pressure from their communities on Stephens. However, women's organizations will only take up this fight if and when they realize this is their issue too.

Sunera Thobani is a woman of colour writer living in Vancouver, B.C.

This article is reprinted from *Kinesis*, Dec 90–Jan 91 issue.

Christina Starr

In Praise of Midwifery

I WANT TO WRITE AGAINST A LIE. I want to tell women what their choices really are in childbirth. It is not necessary or safer and in some cases it is not even a good idea to give birth in a hospital. But it is largely an unquestioned practice. Midwives and their services are, in most women's lives, an unknown alternative to the medicalized and anesthetized procedure of hospital births only because medical doctors own and maintain a monopoly on pregnancy and obstetrical care.

Canadian women have been giving birth without the regular assistance of midwives for about the last hundred years, and have been giving birth in hospitals since the 1930s.

Confinement, as birth was blushingly termed in North America and Europe, used to take place at home with the attendance of a midwife or the assistance of a doctor in difficult cases. It wasn't until 1865 that a statute passed by the Province of Canada placed midwifery under the jurisdiction of licensed medical practitioners, i.e. those who could attend and be licensed by a medical college, a college which, like any other in the 19th century, did not admit women. The interest was not so much in securing the safety and health of mothers and children but in assuring the economic stability of the medical profession. Childbirth could provide a steady income for doctors, especially in a profession whose ranks had become somewhat crowded. Doctors charged more for childbirth than midwives had previously and, in an ironic twist fuelled by classist prejudices, the higher fee contributed to the unemployment of midwives since it became a measure of status to have a doctor assist in the delivery of one's children. In the 1870s the College of Physicians and Surgeons of Ontario began prosecuting those it considered to be practising medicine without a license. Midwives suffered the brunt of the attack.

At the beginning of the 20th century the medical profession was becoming more established and the need arose for more institutions of training and apprenticeship for eager young men. In response, hospitals sought to attract a higher quantity and broader range of obstetrical patients and practising doctors encouraged women to consider having their children in hospital. The medical profession waged a concerted campaign to convince women that hospitals were the safest place to give birth. But there was absolutely no medical advantage to birthing in a hospital as demonstrated by the rise of maternal mortality with the initial increase in hospital births (5.3 deaths per 1000 births in hospital as compared to 2.3 deaths per 1000 births at home at about the mid-1930s). Hospitals were generally overcrowded, unventilated and unhygenic, not an appropriate environment for a vulnerable new life. In fact, giving birth in a hospital was not an advantage until the use of antibiotics and blood transfusions became routine and as one researcher on the subject has concluded, these methods were used most frequently to treat hospital-caused infections and doctor-induced hemorrhages.

In the post-World War II years, Canadian men returned from overseas in droves, flooding the employment market. Many societal shifts occurred that encouraged women to give up their jobs to men and to acquiesce again to male power and authority. It was in this context in 1947 that the Canadian Medical Association passed a resolution making licensed physicians fully responsible for labour and childbirth. They would no longer retain childbirth simply within their jurisdiction or under their supervision but attend to it themselves. Midwives were out of a job. Those few who remained active were post-World War II immigrants from England, Scotland, Ireland and Europe who had been trained as nurse-midwives and took up positions in hospital obstetrical wards or who continued to provide full midwifery services in isolated places (such as the north or rural Maritimes) where doctors were not willing to locate.

When in July of 1989, I suspected I was pregnant I visited my doctor, a somewhat conservative though open and caring individual. I immediately broached the question of midwives, aware that they existed and practised in Toronto but naively unsuspecting that a doctor's office was not the place to find information about them. She shuddered and returned "I hope you're not thinking of a home birth." Generous enough to book me an appointment with a highly

respected and briskly competent general practitioner (GP) specializing in obstetrics who had worked with midwives, she nonetheless warned me in serious tones of the very high risk associated with home birth. "It could," she said, "turn what should be a happy and exciting event into a sudden tragedy."

Her stunning lack of information and her medically-induced bias strengthened my determination to find and contract a midwife but her warnings stayed with me. To be honest, I hadn't been thinking of a home birth; that was for women more courageous and more radical than I, who were willing to accept the extra risk. A hospital was known to me as a safe place to have a baby and for my first I wanted to do what was safe. But I was interested. And once in the company of midwives I broached the question of home birth.

Julia Blushak

FROM THE 1930S ONWARD, medical doctors grabbed the empire of childbirth for their own interest and profit and slapped it into a rude awakening of pain, interference, solitude and fear. The lithotomy position (the woman lying on her back, often strapped to the bed, with her pelvis lifted, her legs spread and her feet in stirrups), forceps delivery, episiotomy (a surgical procedure to cut the opening of the vagina usually performed without the consent of the patient), intravenous drip and the denial of food or water to the labouring woman (in case she might need emergency surgery) all became routine, and the rate of cesarean sections increased alarmingly.

Understandably, in what has been called "the cycle of intervention," if a woman in labour is treated as if she is going to develop complications during the birth process, she is more likely to do so. For example, a woman who has not been allowed to eat or drink during her many hours of exhausting work will undoubtedly be too weak to push her baby out and becomes a prime candidate for artificially augmented labour, forceps or a cesarean section. In the lithotomy position, delivery is always much easier if an episiotomy is performed and/or forceps are used.

Even before a woman gets to the hospital, medical timetables about the duration of a pregnancy or the length of each stage of labour may indicate inducing labour. The extremely painful nature of the contractions when labour is induced, usually leads to the use of an anesthetic which often leads in turn to an episiotomy and forceps delivery.

My mother's story exemplifies this cycle of intervention. She felt twinging contractions, which could have been false labour or was at most very early labour and called her doctor. He advised her to go to the hospital immediately, where her contractions subsequently stopped. Instead of sending her home to wait again, he ordered an enema, gave her castor oil to drink and administered pitocin to induce labour. Nothing happened. He ordered her membrane ruptured which often results in a sudden escalation in contractions and also increases the risk of infection to the baby. Still nothing happened. Just as he was considering a cesarean section (there is an accepted time limit for delivery after the membrane has been ruptured) she went into the most excruciating labour which she endured by herself (nurses in and out) for a number of insupportable hours before a general anesthetic was ordered and my oldest sister was pulled into the world by forceps.

Yes, that was a long time ago (about thirty-five years). Yes, hospitals have changed to try to take into account the comfort of the woman in labour (funny how long it took for the medical system to connect the emotional state and physical comfort of a woman to her physical ability in labour). As late as the mid-70s it was still unquestioned hospital policy in many places to allow fathers or friends in the labour room but not in the delivery room, to perform episiotomies routinely and to allow mothers to be with their infants only at four-hour intervals for feeding. Even now the Canadian Medical Association is self-congratulatory about its "major progress" in areas such as "breast-feeding on demand," "rooming-in" and "sibling visits." Is it possible to trust a system that still routinely induces labour by rupturing the membrane and administering oxytocin, regularly imposes continuous fetal monitoring, administers anesthetics, performs episiotomies and always holds cesarean sections in reserve for the moment when the natural process slips ever so slightly from the "norm"? I decided no.

And many women before me decided no. A resurgence in midwifery began in the 1970s and '80s and with it an interest in home birth. Not all women were convinced that childbirth need be a medically controlled event, and some decided it might be nice to stay where they felt most at home, with the support and company of a partner, friends or family.

In response to the interest, midwives began to attend home births across the country, sometimes in cooperation with doctors who offered medical back-up. In 1983 the College of Physicians and Surgeons of Ontario pressured doctors to

stop attending home births. Midwives in Ontario began attending home births on their own, as midwives in other provinces had done a few years earlier. Many provincial medical associations across the country adopted policies hostile to midwifery and home birth. But rather than stamping out the practice of midwifery this medical opposition strengthened the midwives resolve and the option of a midwife-attended homebirth became a possibility again.

UNFORTUNATELY, THE STORY does not end with midwives as visible, accepted and busy practitioners across Canada offering prenatal support and education to pregnant women, catching babies in warm and familiar environments and reassuring newly-made mothers in the first postpartum weeks.

In Ontario and Quebec, legislation that would incorporate midwifery into the arena of regulated (and licensed) medical professions is pending but in other provinces the situation has regressed.

Though the government of Alberta, too, claims to be studying ways to officially sanction midwifery, Noreen Walker, an experienced and competent midwife in Edmonton, was criminally charged in the fall of 1990 with practising medicine without a license after she had attended a home birth. Not because the baby died or was injured, not because the mother was transferred to hospital in the middle of a difficult labour needing technological assistance (in fact, the birth went smoothly), but because the medical profession refuses to relinquish its monopoly over childbirth or allow women themselves to decide what is best for them and their babies.

"There is a risk," says Dr. Ted Boadway, Director of Health Policy for the Ontario Medical Association (OMA), over his car phone, "that a small percentage of babies of low risk mothers will get into trouble in the latter stages of delivery. We like to know that we can respond to that emergency as quickly and efficiently as possible." Someone must speak for the child, he goes on to say, who in this situation doesn't have a voice. "As a professional I would not be willing to subject the child to any risk, however minimal, because it is impossible to tell beforehand which deliveries will end up with complications." This is yet one more example of the way women's reproductive lives are controlled by the medical system and state policies.

The medical profession refuses to relinquish its monopoly over childbirth or allow women themselves to decide what is best for them and their babies

In the face of the now almost certain regulation and legislation of midwifery in Ontario, the OMA's policy on midwifery has softened in what appears to be an admirable endeavour to insure smooth integration. But it maintains an unjustifiable and unnecessary policy on home birth. The same is true for the College of Physicians and Surgeons of Ontario ("The College ... does not consider home births to be safe or in the patient's best interest.") and the Canadian Medical Association ("The CMA, supported by the Society of Obstetricians and Gynecologists of Canada, believes that a planned home delivery in the absence of the full range of normally available hospital facilities can jeopardize the safety of both mother and infant.") The CMA also denies midwives any role whatsoever in pregnancy and childbirth ("...the CMA has concluded that the present system contains all the resources and personnel required to provide excellent obstetrical care"). In the same policy statement the CMA acknowledges that the number of obstetricians and general practitioners specializing in obstetrical care in Canada is on the wane, yet it refuses to admit that midwives could meet this need. Instead, the CMA proposes that GPs revert to obstetrical care and nurses be trained to accept more obstetrical responsibility.

In none of these policies are the concerns of women who want a choice in childbirth, taken into consideration. Even if we are a "small vocal minority," as the CMA calls us, our numbers would undoubtedly grow if more information about midwifery and home birth was available. The idea that parents could be informed of the risks of both hospital and home births and accept the responsibility for either choice is heresy.

THIS, FINALLY, IS WHAT MY partner and I realized was our course: to accept full responsibility for the conditions of birth of our child and only in our own home would we be allowed to do so. I shed my lingering doubt that, should anything go wrong, I would feel I hadn't taken every precaution. I decided that the most that would probably happen (and the most common complication in home births) would be a long and arduous labour during which I might need to be transferred to the hospital for pain relief in order to gather strength for the final push. I began to excitedly anticipate giving birth through my own ability and with the support and participation of those I loved and wanted near.

My due date was March 20. On the morning of Sunday, March 4, I sensed small spasms, little twinges of pain in my abdomen that were nevertheless extremely regular. I went about my day as I had planned and at 10:30 that evening I decided to call Anne Nixon, my midwife. She advised, as my partner and I had expected, that it was probably false labour and to relax, take a warm bath and keep her posted.

As I squatted into the bathtub I

felt a small pop that I knew must be my membrane bursting. Out of the tub, I called Anne again and she timed several contractions on the phone until I realized I was going to throw up. Her advice was much the same; though labour was now obviously under way it was still a good idea to get some rest in order to be energized for the difficult work to come. She would either phone back in an hour or send over my back-up midwife.

Heather Brechin arrived at 12:30 and by then my contractions were strong enough that I had begun to doubt my ability to stand them for many more hours. She checked the fetal heartbeat and helped me mount and descend a few pains when suddenly my body convulsed in an amazingly different contraction and I blurted excitedly, "I'm pushing!"

Heather checked me internally and was surprised to find the baby's head already descended into my vagina. Knowing Anne was on the way we agreed to pant through the urge to push until everybody was present and ready for the birth. This was the most difficult part. My urge to push was irresistible; the baby's head crowned on my perineum in no time. Anne arrived within minutes, sterilized her equipment, took her place at the foot of our bed and gave me permission to push along with my body. The baby's head appeared and with the next contraction her body gushed out of mine and was immediately placed, messy and wrinkled and quietly alive, on my belly. We fondled and touched and caressed her before she was snugly wrapped into receiving blankets, and after she'd mastered her first sucks on my breast her newborn vital signs were recorded. When it was confirmed that both of us were fine, Anne and Heather left us and her father alone together, Anne remaining in the apartment until 5:00 a.m. (three hours after the birth) and Heather until the morning of the next day to ensure we all continued well.

Had I expected to go to the hospital my story would have been about birth in a taxicab or an elevator (an exciting story afterwards but at the time would have been hell) or about trying to pee out a urine sample when all I want to do is give birth. Instead, my partner, my daughter and I were hardly parted in the first few days of her life and I recovered in the comfort and familiarity of my own home. The flowers and gifts that arrived enlivened our apartment like spring suddenly in flourish. Like almost any other woman who has had the chance to choose for herself and her child, my final statement is that I wouldn't do it any other way.

I feel very emotional about the birth: amazed that I ever did it, amazed that it was she who travelled down my canal, amazed that this is how she arrived to lie, now sleeping soundly under blankets and towels in a basket beside me. I love her tremendously.
[Journal entry March 9, 1990]

Christina Starr is editor of Women's Education des Femmes. *Her daughter is 15 months old now.*

Further Reading

Midwifery is Catching, Eleanor Barrington, NC Press, Toronto, 1984.

Current Issue Paper #53, Home Births: the debate over safety, Bob Gardner, Ontario Provincial Government Legislative Research Services, 1986.

A Retrospective Descriptive Study of 1,001 Home Births, Holliday Tyson, Masters thesis: McMaster University, 1989.

Safer Childbirth? A Critical History of Maternity Care, Marjorie Tew, Chapman and Hall, London, 1990.

Small 'p' Politics: The Midwifery Example, Patricia O'Reilly, in *The Future of Human Reproduction*, Edited by Christine Overall, The Women's Press, Toronto, 1989.

The Home Birth Alternative to the Medicalization of Childbirth: Safety and Ethical Responsibility, Paul Thompson in *The Future of Human Reproduction*, Edited by Christine Overall, The Women's Press, Toronto, 1989.

Carolyn DeMarco

New Research and Treatments for

Endometriosis

In 1600 BC, Egyptian writings documented possibly the first case of endometriosis ever recorded in history. However, endometriosis is really a 20th century phenomenon. In the past, endometriosis was either rare or undiagnosed and modern medicine has only recently recognized it as a specific disease. During the last century, endometriosis has risen steadily in importance and incidence In North America. Yet, in spite of over 80 years of research, very little is known about this disease, what causes it or why it does or does not respond to treatment.

Today, endometriosis affects an estimated half million women in Canada and five to 10 million in the United States.

What is Endometriosis?
Endometriosis is normal tissue in an abnormal location. It occurs when endometrial tissue which lines the inside of the uterus grows in other parts of the body where it isn't normally found. This happens most commonly in the pelvic area - on the ovaries, fallopian tubes, ligaments, outside surfaces of the uterus, lower end of the large bowel and on the membranes covering the bladder. Occasionally, endometrial tissue spreads to the small intestines, appendix, bladder, cervix, vagina, old abdominal scars and navel and very rarely, to the lungs.

What are the Symptoms?
Pelvic pain is the most common symptom of endometriosis, although some women with severe endometriosis will have no pain. Their endometriosis may be diagnosed during an investigation for infertility or surgery for other reasons or even during a routine pelvic examination. The location of the endometrial tissue is what is important in determining how much pain and what type of pain will occur. A small endometrial implant in a sensitive area such as on the supporting ligaments of the uterus or in the pockets between the uterus and the large bowel may cause a lot of pain whereas extensive involvement of the ovaries may cause no pain at all.

The type of pain can also tell you where the endometriosis might be located. If the large bowel is involved, painful bowel movements can occur, if the bladder is involved, there may be painful urination or blood in the urine. If the ovaries are involved, there may be spotting between periods, excessive menstrual bleeding or irregular menstrual cycles. Severe back and leg pain can also be caused by endometriosis. Orthopedic surgeons are usually not aware of this potential cause of back pain.

Nancy Petersen, RN, director of the endometriosis treatment program at St. Charles Medical Centre in Bend, Oregon, feels that women's complaints of pelvic pain are not taken seriously and women are thought to be exaggerating. Seventy-five per cent of the women treated for endometriosis at the clinic had been dismissed in the past by their doctors as being neurotic.

Petersen feels it is logical to expect that anything that causes irritation or inflammation of the peritoneum (the clear saran-wrap like covering of the abdominal organs) is likely to be extremely painful. The pain is usually described as sharp, stinging and burning in nature, and is not necessarily associated with menstrual periods.

Diagnosing Endometriosis
The diagnosis of endometriosis is tentatively made through a careful pelvic examination. There may be extreme tenderness of the ligaments supporting the uterus. Sometimes small lumps or nodules can be felt on these ligaments or just behind the uterus. A cyst may be felt on the ovaries. Usually, however, a laparoscopy is necessary to establish a definite diagnosis.

Laparoscopy is a minor operation done under general anaesthetic. The doctor inserts a slender light-containing telescope into the abdomen (through a small incision in the umbilicus) to look at the pelvic organs. A small sample or biopsy of the suspected endometriosis is taken and sent to a lab for microscopic examination to confirm the diagnosis.

Ultrasound examination is another useful diagnostic tool. It gives an idea of the extent of the endometriosis or the size of ovarian cysts. It's normally done prior to laparoscopy. However, the appearance of endometriosis on ultrasound pictures is not specific enough to distinguish it from other

types of pelvic growths.

A decade ago, endometriosis was thought to occur mainly in women in their 30s or 40s and traditionally in white career women of middle class status who had delayed childbearing. With the widespread use of laparoscopy this has been proved to be only partially true. It also occurs in black women, young women and women who have had early pregnancies. Endometriosis can even occur in teenagers.

Moreover, there is a very significant heredity factor. A woman whose mother, sister or daughter has endometriosis has a greater chance of developing it than someone with no family history of the disease.

If a woman has no symptoms and does not wish to conceive, then no treatment is necessary, and she only needs to see her doctor every six months to a year to check on the progress of the disease. Otherwise treatment may be necessary for pain relief or for fertility enhancement.

Conventional Medical Treatments

If a woman has only mild symptoms and infertility is not a problem, simple pain killers or alternative treatments such as acupuncture, a change in diet or chinese herbs may be all that is necessary. For certain women with mild to moderate pain during their periods, drugs which inhibit the production of prostaglandins offer good pain relief.

For more serious symptoms or those that do not respond to other simpler treatments, and to increase the chance of pregnancy, hormonal treatments may be considered.

In the past, birth control pills with a high progesterone content were a popular treatment, based on the theory that suppressing ovarian function and menstrual bleeding would alleviate symptoms. However, side effects were numerous. Recently, smaller doses have been found to produce the same results.

Progesterone by itself has also been used to suppress periods. However, breakthrough bleeding, nausea, weight gain and depression are potential side effects.

Currently favoured by some doctors is danazol - a derivative of the male hormone testosterone. Danazol produces a pseudo-menopause and causes periods to stop altogether. It has two serious problems, however. First, it is very expensive - $95-190 per month depending on the dosage. Secondly, it can cause some unpleasant side effects including weight gain, fatigue, depression, oily skin and acne, decreased breast size and development of facial hair. This last side effect does not necessarily reverse after treatment stops.

Danazol can, however, cause endometrial implants to shrink and it can increase the chance of pregnancy in infertile women. Pregnancy rates after six months of treatment with danazol are between 40 and 50 per cent - approximately the same as that after conservative surgery and greater than with other types of hormonal therapy. However, after treatment with danazol ends, symptoms recur in about 40 per cent of women. The long term side effects of danazol are unknown.

GnRH (which stands for gonadotropin releasing hormone) drugs are newcomers on the market. Synarel, lupron, zoladex and buserelin are their brand names. These drugs affect the production

Before resorting to either powerful drugs or major surgery, I would urge women to return to their heritage as wise women and healers and explore natural alternatives

HEALTH WANTED

Attention Artists!
Healthsharing is always looking for artwork for upcoming issues of the magazine. We welcome drawings, photographs, contact sheets, collages, cover images etc. For more information, contact Healthsharing, 14 Skey Lane, Toronto, ON, M6J 3S4, (416) 532-0812 or Fax (416) 588-6638.

Call for Papers
Canadian Women's Studies/les cahiers de la femme invites contributions to a special issue of the journal on the topic of Women and Aging, to be published the Fall of 1991. Deadline for submissions is August 31, 1991. For more information please contact: Canadian Women's Studies, 212 Founders College, York University, 4700 Keele, Downsview, ON, M3J 1P3, (416) 736-5356.

Health and Disabled Women
DisAbled Women's Network (DAWN) Toronto has received funding for a three year project to address the health care needs and issues of women with disabilities. Regional workshops across Ontario, a symposium scheduled for October 2-4, 1992, and the formation of a provincial network of women with disabilities - DAWN Ontario - are the project goals. Disabled and non disabled women who are interested in this project and wish to be on a mailing list or directly involved, please contact Health and Disabled Women Project, 4 Warner Avenue, Toronto, ON, M4A 1Z3, (416) 750-3296, voice or TDD 364-7065, Fax 288-8147.

Pap Test Research
A female graduate student doing research on doctor-patient interaction would like to interview women who have had an abnormal pap test result about their experience with the diagnosis and treatment of cervical abnormalities. Contact 661-7638. Confidentiality respected.

of GnRH by the hypothalamus in the brain. GnRH normally controls the release of other hormones from the pituitary gland, which in turn trigger ovarian hormones and thus control ovulation and menstruation.

The net effect of GnRH drugs is, like danazol, a pseudo-menopause, but more severe. The major side effect seems to be hot flashes. Other side effects include vaginal dryness, headaches, depression, mood swings and a decreased sex drive.

Another major concern about these drugs is that they cause decreased bone density that can lead to osteoporosis. Estrogen levels are reduced much more than with danazol. Therefore, the usual maximum course of treatment is six months. A woman should have a bone scan done before she attempts a second course of any of these drugs.

Only synarel has been officially approved for use in endometriosis. The other drugs are approved only for use in prostate cancer but are being prescribed for endometriosis.

All these drugs are very new, very powerful and very expensive. The long term effects may not be known for years and the effect on fertility is still unknown.

The relative merits of hormonal versus surgical treatment are still being debated. Surgery can either be conservative or radical.

"Conservative" surgery means removing endometrial implants while preserving the ovaries, tubes and uterus as much as possible and thus preserving childbearing ability. Tissue is removed by cutting, burning or with a laser beam. "Radical" surgery is considered a last resort and reserved for severe endometriosis that does not respond to any other form of treatment and for women who have severe and disabling pain and/or bleeding. Radical surgery means the removal of tubes, ovaries and uterus (total hysterectomy).

Breaking New Ground

Recently, Dr. David Redwine, gynecologist and director of the Endometriosis Institute in Bend, Oregon, concluded a detailed study of 143 patients with endometriosis who were examined between 1979 and 1984. He has also developed a new conservative surgical treatment for endometriosis and has treated approximately 800 patients. Thirty-five per cent of his patients are Canadians unable to receive comparable treatment in Canada.

Katie Pellizzari

What his research revealed surprised him and did not support the common cliches about the illness - beliefs that have been handed down in textbooks but not backed by any scientifically valid studies:
1. "The ovary is the most common site of endometriosis." In fact, three modern studies have refuted this. Redwine found that in his study, the most common site of endometriosis was the peritoneum, especially behind the uterus in the "cul de sac" or the bottom most part of the pelvis. The ovaries and the fallopian tubes were found to be less common sites for endometriosis.
2. "Endometriosis can be identified by the classic tiny blueberry spots or black spots known as powder burns or by cysts that are bluish or dark brown in colour." In fact, endometriosis can have many different appearances and colours. In Redwine's study, only 36 per cent of women had the typical blue or black implants that doctors are always looking for. More than 43 per cent had atypical implants only. These women would have had their endometriosis completely missed by a doctor looking only for blue or black implants.

This was the case of a 26 year old surgical nurse with severe pelvic pain that was interfering with her work. After a laparoscopy, her gynecologist told her she had a normal pelvis and perhaps the pain was in her head. Another one

The will to get well and determination are the keys to turning around any major illness

and a half years of pain later she finally saw Redwine. He found that the back of her pelvis was riddled with endometriosis that was predominantly a white colour.

In microscopic studies of tissue samples, Redwine found few or no blood vessels and little or no blood. From this he concluded that misplaced endometrial tissue does not bleed in the way he had been taught. Instead, he believes that the endometriosis tissue secretes a chemical that causes nearby blood vessels to bleed. The blood becomes trapped under the peritoneum and as it ages, turns from clear, white and yellow to red and blue and finally black. He found that women under 30 were more likely to have clear, yellow or red lesions and women over 30, the characteristic black powder burn lesions.

3. "Pregnancy prevents or cures the disease in women who have never been pregnant." In fact, endometriosis is predominantly a disease of fertile women. Only 27 per cent of the women with endometriosis in Redwine's study were infertile.

4. "Endometriosis is a disease that is progressive and recurrent." In fact, Redwine believes endometriosis is a static disease and that you are born with it. From his study there was no statistical evidence that the number of areas in the pelvis involved with endometriosis increased with age.

5. "The only cure is menopause." In fact, the oldest person diagnosed with endometriosis was 78.

Many theories have been advanced to explain the cause of endometriosis. One of the most frequently mentioned is that of Dr. John Sampson, who in 1927 maintained that endometriosis resulted from menstrual blood flowing backward through the uterus and out through the tubes. This endometrial tissue then implanted randomly on various structures in the pelvis and bled every month like the tissue that normally lines the uterus.

Another theory popular today is that endometriosis may be the result of some type of auto-immune disease. This means the body rejects the abnormal endometrial-like tissue located in the pelvis, with both local and generalized effects.

Redwine has a new theory. From his observations, he concludes that endometriosis is a static disease, persistent, but not recurrent, in women of all ages, with pain as the most common problem. It also occurs independently of periods and most of the growths are atypical in appearance.

He postulates that endometriosis is caused by cells left behind during fetal development. The uterus, tubes, ovaries and peritoneum develop from cells of the fetus known as the Mullerian duct system. They migrate along the back of the pelvic wall during the first few weeks of fetal development. Some of these cells are destined to become endometrial cells and if they get left behind, endometriosis may result later in life.

Treatments Revaluated

Redwine believes that drug therapy with danazol or newer drugs like synarel and lupron is expensive, has serious side effects, does not destroy endometriosis and has a

high rate of pain recurrence as soon as treatment is stopped.

Redwine's method of conservative surgery is simple but painstaking. Using a laparoscope, all abnormal looking tissue is carefully cut out. This can take anywhere from two-and-a-half to seven hours.

"It is," he says, "very tedious surgery, but perhaps the most challenging surgery in gynecology."

Joan Leslie (not her real name) 35, is from the Hamilton area and recently returned from Redwine's clinic where she underwent seven hours of surgery for extensive endometriosis. "The issue of time is very critical," she says, "There is no way a doctor in Ontario would have taken that long."

Although a few doctors in Canada can perform similar surgery (several have gone to Bend to study the procedure), Ontario doctors, for example can only bill for about two hours of endometriosis surgery. And even if they were willing to work for nothing after the two hours, there's still the problem of getting the operating room time and other medical staff.

In December, 1989, Alberta became the first jurisdiction in Canada to approve Redwine's surgery for use by the province's doctors. While doctors are being trained in his techniques, the government is paying for the surgery and travel expenses of women who go to Bend. However, each applicant must first pass a medical board in Alberta which decides whether sufficient treatment could be received in the province. Those who don't pass, but still want the treatment, must pay out of their own pockets.

Many theories have been advanced to explain the cause of endometriosis

Women should make sure doctors are aware of the many and varied appearances of endometriosis and the most effective way of removing it. Women should also resist drug treatments that do not destroy the disease or alter its course. And finally, before agreeing to surgical or medical therapy, it is important for women to find out whether long term follow-up studies for pain recurrence as well as infertility have been carried out.

Alternative Treatments

Dr. Redwine's ideas have been a major breakthrough for women in dispelling the antiquated and unscientific myths about endometriosis perpetrated by the medical profession.

Before resorting to either powerful drugs or major surgery, I would urge women to return to their heritage as wise women and healers and explore natural alternatives that assist the body in healing itself.

If necessary, women can use conventional drugs temporarily, to buy the time to research and experiment with more natural methods.

There is no doubt that the symptoms of endometriosis, especially pain, can be alleviated through natural means. However, such approaches require time, patience and commitment. They are not as cut and dried as taking a pill or getting abnormal tissue cut out.

Some women have found that the pain completely disappears with a major change in diet. Several cases of remission of symptoms have been reported with a macrobiotic diet. However, it is important to know that long term adherence to a strict macrobiotic diet can lead to vitamin B12 deficiency, which can be corrected by taking B12 supplements. For most women I believe that diet change could provide part of the solution.

One of the reasons that diet is so important is the strong connection between chronic yeast infections (Candida) and endometriosis. If there is a history suggesting chronic yeast is present, often found after prolonged antibiotic or hormone usage, then the yeast infection must be treated as the top priority. Candida is treated through a low-carbohydrate diet, acidophilus and anti-yeast medications.

The same low carbohydrate diet is suggested by Dr. Robert Atkins for endometriosis in his book, *Dr. Atkin's Health Revolution.* He also suggests the following supplements to help lower the estrogen in the body: choline, methionine, inositol, evening primrose oil, vitamin E, vitamin C and bioflavinoids.

Western herbs as well as Chinese herbs have been useful in the treatment of endometriosis. Some women have found acupuncture very helpful. A minimum of six ses-

sions is required before you can see whether this treatment holds promise for you. The TENS machine, a small hand-held machine that stimulates acupuncture points electrically has been useful for treating the pain accompanying endometriosis.

Homeopathy also has a lot to offer. With minute doses of natural substances, healing can be stimulated.

Any kind of alternative therapy is best done under the supervision of an experienced naturopath, homeopath or medical doctor.

It is important not to overlook the emotional effects of a disabling disease. Visualization, affirmations and relaxation are essential and very practical tools that I recommend to anyone dealing with a chronic illness.

The will to get well and determination to do it whatever it takes are the keys to turning around any major illness.

Carolyn DeMarco is a doctor who works as a holistic health consultant in Toronto and B.C.

Resources

Endometriosis Network, P.O. Box 3125, Markham Industrial Park, Markham, ON, L3R 6G5, (416) 968-3717

Endometriosis Association, U.S. and Canada Headquarters, 8585 North 76th Place, WI 53223, USA
The Endometriosis Association provides support and information, conducts research and educates doctors and the public. They publish a newsletter six times per year. Branches are found in:
Vancouver, B.C.: (604) 943-4057
Edmonton, Alberta: (403) 456-6899
London, Ontario: (416) 473-3620

Overcoming Endometriosis: New Help from the Endometriosis Association, Mary Lou Ballweg and The Endometriosis Association, Congdon and Weed, New York, 1987. An invaluable book that gathers together research and treatment information.

Living With Endometriosis, Kate Weinstein, Addison-Wesley, Toronto, 1987. A useful book written by a Canadian.

St. Charles Medical Centre, Endometriosis Treatment Program, 2500 N.E. Neff Road, Bend, Oregon, USA, 97701-6015

MY STORY, OUR STORY

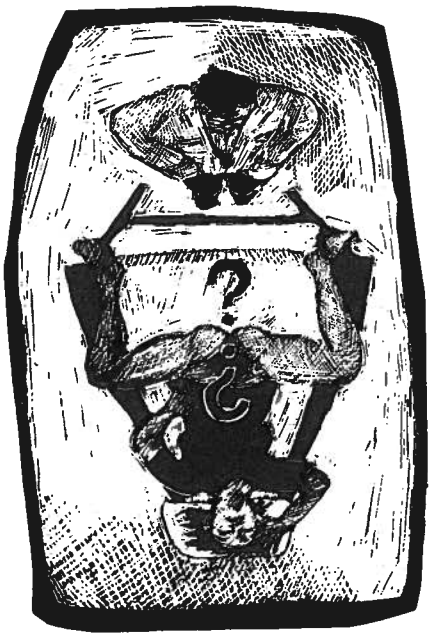
Do I Really Want to Get Pregnant?

Jenny Horsman

I AM LYING WITH MY FEET UP ON those awful stirrups, knees apart, feeling uncomfortable. The cervical cap to hold my partner's sperm against my cervix, which I have just been fitted with, hurts.* The doctor, sympathetic and kindly, tells my partner that he should take me out to buy me a silk blouse as I have been through a lot to give him a son. I am furious and I look to see how my partner is reacting. What will he say? He is as amazed as I. He tries to say something, knowing I'm watching, and manages, "That is not quite how we see it."

Later I complain when the doctor says, "That doesn't hurt does it?" as he places a speculum in my vagina. "Yes," I say, "it does." He mutters something about that's fine and continues. I repeat that it is not all right and, surprised, he stops and starts again, saying, "My, aren't we tender." I know that I was not supposed to tell him that it hurt.

Finally, two and a half hours after the cap was first inserted it is removed. He makes some comment about how that wasn't so bad was it. Again I take his question as a real one and tell him, "Yes, it was very uncomfortable." He laughs and obviously doesn't take me seriously. I insist that he is not hearing what I am saying and repeat that it *was* uncomfortable, not agony, but definitely quite painful. My partner begins to join in and say that it did hurt, but I am furious at him too. He doesn't know what I am feeling in *my* body either. At last the doctor hears us and says how surprised he is, he has been doing the test for years and no one has ever told him it hurts. Clearly I am odd.



Kelly Aitken

But how many other women have felt the same pain, the same fury and the same dehumanization during these procedures and not spoken out? And how long will I continue to respond to his questions that I know he does not intend me to answer? At first I tried to get through it by absenting myself, pretending it was not my body he was hurting, but then I felt disempowered, it allowed him to disregard me more. Yet it is hard to know what to say when your reality is systematically denied—from the pain you are feeling to the nature of your relationship.

I was warned that most of the doctors that work in fertility clinics are misogynist white men. I was warned that the process was dehumanizing, that you are sucked into their timelines, not yours. But I hadn't understood that you can *not* simply find out why you cannot get pregnant. I hadn't understood that the process would come between me and my partner—that he would be drawn into complicity with the doctor—lured into speak-

ing man to man with him, while I lay on the examining couch.

I hadn't understood that gradually I would begin *not* to want a child. I would begin not to want a child that this doctor, this man, had anything to do with. He tells me that my mucus is hostile, but that maybe he can solve that by inseminating me. It will have to be intrauterine, not easy, but he can do it. It is perfect—I'm not surprised my mucus is hostile—my whole being is becoming increasingly hostile to men.

I knew from the first meeting that this was not going to be easy. Carefully, I set our first appointment with the specialist for 9:00—that way I felt sure he could not yet be running late and we could both get back to work as soon as possible. My crazy, busy schedule doesn't expand easily to fit doctor's appointments. We were told to arrive at 8:30 to fill in forms. Dutifully we got there in time, filled in forms and waited. At 9:30 I asked the receptionist how long he would be, stating that I would have to reschedule appointments. I was told that he shouldn't be long, he just had a few letters to dictate. After complaining to my partner about the insult I felt this was–it seemed to me that our time was deemed irrelevant, he was not delayed by an emergency, simply writing letters while we waited–a receptionist came over, put her hand on my shoulder and said sympathetically, she understood that I was very anxious, but the doctor wouldn't be long! Already I was being turned into a neurotic woman, not a person who was busy and valued her own time.

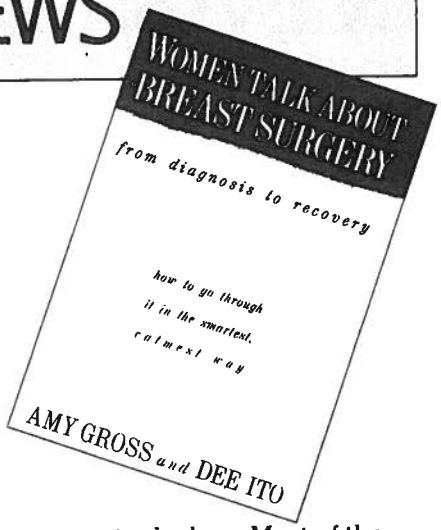
Finally we got to see the doctor. He missed the irony when my partner said how good it was of him to see us. The doctor shook my partner's hand. He didn't seem to think there was any need to shake mine. After we had given our history, while I went to undress to be examined, the doctor chatted to my partner about the causes of our infertility—not to me. At the end of the appointment, again shaking my partner's hand, he said we were kind of a nice couple and deserved to have children and he was sure he could help us. I wanted to ask what factors made us "kind of a nice couple?" Our heterosexuality, our white skin, our middle-class backgrounds, our education level? There was a clear implication that this was a process only for those he considered nice. But, of course, I was being extreme—but I could not stop feeling he was playing god. It was clear he assumed we were middle-class, not bothering to mention that for our next appointment we would need to pay $250 as it would be at his private clinic. Some we would get back eventually from OHIP but for now a cheque would be needed. Already I felt I was compromising my principles. This was a process for the white, middle class, heterosexual couple, and by participating I too was complicit in this system.

At the moment I'm hanging in for a little while. I still want to know why I can't get pregnant. But only the support of women friends I can share my fury with, will help me to analyze what is happening, enable me to talk about it with my partner, and so make the process endurable. I know I am fortunate that I may still be able to get pregnant. I often see women crying as they are told that for another month the miracles of modern science haven't made them pregnant. But I am hoping that I will have the courage to extract myself before I feel, not merely compromised by the male medical system, but raped by it.

Jenny Horsman is a freelance literary worker who lives in Toronto and Nova Scotia.

**Cervical mucus is an effective barrier between the normal bacteria of the vagina and the uterus, preventing infections that could lead to pelvic inflammatory disease. However, sometimes a woman's mucus is too acidic or contains antibodies that kill sperm. The test described above is carried out by inseminating the woman with her partner's semen and using a cervical cap to keep the semen in contact with her mucus for 2-3 hours. When the cap is removed, the semen is examined under a microscope to see if the sperm are still viable.*

REVIEWS



Women talk about breast surgery: from diagnosis to recovery

Amy Gross and Dee Ito, Clarkson Potter, New York, 1990, 333 pp.

Reviewed by Susan Klement

"Forget about reading! Put yourself in the hands of a good doctor," admonished my 80 year-old aunt, as I prepared for abdominal surgery.

The interviews in this book with 22 intelligent, articulate women confronting breast cancer show very clearly the folly of such advice. Time and again the women reported erroneous diagnoses, dangerous suggestions and deplorable behaviour on the part of doctors, even though most of them were highly recommended. Almost every woman realized she must take charge of her own situation, do research and make decisions, and the women accomplished this with courage and even humour. Despite shock and the need to act quickly, they shopped for the right physicians to hire, determined which treatment course to follow and made changes in the way they ate, exercised and dealt with stress. The decisions they made reflected knowledge of themselves and their needs.

Gross and Ito begin their book with two brief overviews, "The patient as expert" and "The patient as pilgrim; mapping the routes from diagnosis to recovery." They then briefly describe some common procedures: biopsy, lumpectomy, mastectomy, chemotherapy, hormonal treatment and reconstructive plastic surgery. Their sensitive yet probing questions elicit full discussions from the women. A significant sentence from each interview acts as an intriguing title and we immediately learn the profession of each woman, how old she was when she discovered her lump, what treatment course she chose and how long ago the events took place. Most of the women seem fully aware of the specifics of their disease and treatment; some of the accounts could almost function as reference sources for others facing the same circumstances. In addition to the technical aspects, we learn about the women's emotional reactions and those of their friends and relatives - not always supportive, unfortunately. Many report how they handled their work, family and other responsibilities during the crisis, and what effect cancer had on their post-recovery lives.

In the third section of the book, interviews with specialists give their views on anesthesiology, chemotherapy, oncology nursing, radiation therapy, breast reconstruction, breast health nursing and cancer risk analysis. There are sample consent forms for surgery, anesthesia and chemotherapy, which clearly document what patients face, and descriptions of the hospital admitting process, (American) insurance plans and breast health centres. A discussion of patients' rights and a script of questions to ask doctors are particularly valuable. The book ends with a useful glossary and a brief but helpful bibliography of works for the educated lay person. The competently compiled index helps the reader to match treatment courses, particularly drugs, to specific situations.

Books that go beyond the specifics of diseases and their treatment to describe, in detail, how actual patients deal with the eventualities they encounter are extremely valuable but hard to find. Perhaps the most important lesson here is that, in most if not all medical circumstances, there are options and patients must make choices. Those choices require knowledgeable, involved people who are fully aware, not only of the technical possibilities but also of themselves and the effect that each choice might have on them and their loved ones. It is clear, too, how much damage is done by physicians who are unwilling to recognize that, as in the rest of life, there is no certainty in medicine. Patients must realize - and insist that their doctors realize - that "I'm not sure," or "I don't know," are acceptable answers.

Although some of the women suffered brutal treatment from doctors, medical office staff, nurses and family members, most received sympathetic and caring responses. The breast, after all, signifies nurturing for almost everyone, male and female. Many women regard it as the symbol of their femininity. Men suck at it as babes and fondle it as lovers. The uterus is different; having left the womb, men have no further need of it. They can make love to a woman without a uterus and be unaware of her loss. Does this partially account for the number of questionable hysterectomies done each year? Gynecologists often tell a middle-aged woman that she has no further need for her uterus or ovaries and even imply that wanting to keep them is irrational. Thus, women contemplating hysterectomies must do at least as much research as those facing breast surgery. The courage and persistence of the 22 interviewees empowers us all.

It would be a shame if the audience for this outstanding book was limited to women confronting breast surgery. It should be read by all women. Not only is it best to have some knowledge in advance if one has to deal with such a disturbing eventuality, but the stories, far from being depressing or frightening, are inspiring. They prove we all have reserves of strength to confront and surmount whatever may befall us.

Since 1969, Susan Klement has been offering consulting, information brokerage, indexing, editing and other services to clients world-wide. She also teaches graduate library education courses.

RESOURCES & EVENTS

Sexuality Conference

The 13th Annual Guelph Conference on Sexuality will be held June 17 to 19, 1991. "Improving Relationships in the 1990's" will cover a diversity of topics on human sexuality, with several workshops about AIDS. Dr. Eli Coleman is the keynote speaker and Dr. Joseph LoPiccolo will lead the plenary.

For more information contact: Division of Continuing Education, University of Guelph, Guelph, ON, N1G 2W1, (519) 767-5000.

Catching Our Breath

Catching Our Breath: A Journal about Change for Women who Smoke is a 130-page publication by the Women's Health Clinic in Winnipeg. It contains 13 chapters of information, writing exercises and relaxation methods to help women explore the reasons they smoke and help them to remain smoke free. Designed to be used on its own or in a group setting together with its companion booklet *Catching Our Breath: A Guide for Facilitators*, which includes information on organizing and facilitating smoking cessation groups for women.

Both publications are available for $10 per copy from the Women's Health Clinic, 3rd floor, 419 Graham Ave, Winnipeg, MB, R3C 0M3.

Take Charge of Your Body

Take Charge of Your Body, A Woman's Guide to Health is an easy to read book with crucial information on chronic fatigue, cystitis, yeast, PMS, hysterectomy and many other health topics.

Available for $10.95 plus $2 postage & handling, (cheque or money order) from: Dr. Carolyn DeMarco, Box 130, Winlaw, BC, V0G 2J0.

Sexual Response & Hysterectomy

The December, 1990 issue of the newsletter, *HealthFacts*, is entitled Sexual Response After Hysterectomy and is six pages of information and resources on this topic. *HealthFacts* is published 12 times per year by the Center for Medical Consumers, Inc., a non-profit organization.

Subscriptions are $18 per year (US). Back issues including this one and bulk rates are available from HealthFacts, 237 Thompson Street, New York, New York, 10012.

Breast Self-Examination

BSE For Every Woman: A New Approach to Breast Self-Examination is an 18 minute educational video developed to promote and teach consistent and clear procedure for BSE with a thorough explanation and realistic demonstration of self-examination .The video also presents information about high risk, when to perform BSE and a description of common symptoms of breast disease. With statistics showing that 1 in 10 women will develop breast cancer during her lifetime, this is an excellent aid in helping women develop a personal plan for breast health.

Available from the Canadian Cancer Society in your area or by calling the Canadian Cancer Society in Calgary, (403) 228-4487.

Women and the Environment

Some environmental problems are specifically women's issues, states the Ontario Advisory Council on Women's Issues in its newest book, *Women and the Environment*. Pesticides in breast milk and chemicals used in the production of sanitary products are two examples. The 50 page book presents a feminist perspective on environmental issues. It is packed with practical information on how women can significantly change things in the workplace, home and community.

Available free of charge from Council, 880 Bay Street, 5th floor, Toronto, ON, M7A 1N3 or call (416) 326-1840. (Ontario residents may call collect.)

FROM THE NATI

IADA

Films and videos that support women's networks and educational, community, and cultural organizations in bringing women's experiences and perspectives to public and private discussion.

THE WOMEN'S MOVEMENT

REPRODUCTIVE CHOICES

ECONOMIC INEQUALITY

NATIVE WOMEN

AGING WOMEN

MALE VIOLENCE AND SEXUAL ABUSE

HEALTH AND WELL-BEING

GLOBAL ISSUES

For further information and resource materials, write to

Women's Market Development, D-5
National Film Board of Canada
P.O. Box 6100, Station A
Montreal, Quebec
H3C 3H5

National Film Board of Canada / Office national du film du Canada

STUDIO D

AFTER THE MONTREAL MASSACRE

(C 0190 097) 25 min. 40 sec.
This video looks at the issues of male violence, women's fear and what we as a society must do.

BABY BLUES

(C 0190 071) 24 min. 32 sec.
A drama about teenage pregnancy and the consequences of unprotected sex.

AFRICAN MARKET WOMEN SERIES

(C 0190 105) 70 min.
A series of three films — From the Shore, Where Credit Is Due, Fair Trade — about innovative women who are taking steps to establish themselves in the marketplace in East Africa.

NO TIME TO STOP: Stories of Immigrant and Visible Minority Women

(C 0190 027) 29 min. 20 sec.
Three women articulate the personal and employment barriers facing working-class immigrant women in Canada.

PLAYING FOR KEEPS

(C 0190 095) 45 min. 33 sec.
A documentary about the lives of three young women who become mothers before their own adult lives begin.

THE POWER OF TIME

(C 0189 114) 28 min. 43 sec.
A look at community supports which are beginning to develop to help aging women maintain a sense of independence and well-being.

SANDRA'S GARDEN

(C 0190 059) 34 min.
An honest look at one woman's struggle to overcome the trauma of incest.

TOYING WITH THEIR FUTURE

(C 0190 065) 30 min.
A critical look at the multi-million dollar toy industry, its products, marketing ploys, philosophy, and the children who use these products.

TO PREVIEW, RENT OR PURCHASE THESE AND OTHER FILMS AND VIDEOS, PLEASE CALL YOUR NEAREST NFB OFFICE.

Atlantic	1-800-561-7104
Ontario	1-800-267-7710
Quebec	1-800-363-0328
Prairies, B.C., and the North	1-800-661-9867