THE WOMEN'S HEALTH RAG

Vol. 1, No. 2 June 1992

Devaluing Disabled People Through Reproductive Technologies

Ingrid Deringer

In 1990 a Royal Commission on Reproductive Technologies was established to bring together the concerns Canadians have about reproductive technologies. One question that Canadians had was: is it morally right to use these technologies? One group in particular, disabled women, questioned the use of reproductive technologies as a way to rid society of disabled people. For them, selectively aborting disabled foetuses is a blatant example of how disabled people are discriminated against and devalued by society.

Pre-natal diagnosis is a controversial reproductive technology that is used to detect if a foetus has a specific disability. The first type of pre-natal diagnostic technology performed in utero was amniocentesis in 1954. Chorionic Villus Sampling (CVS) is another type of pre-natal diagnostic technology. However, it is still in the experimental stages.

To date there are more than forty disabilities that can be identified prenatally and the number is growing daily. Some of the more common disabilities that can be identified through amniocentesis are Downs Syndrome, Spina Bifida, Huntingtons Disease, and Cystic Fibrosis.

Amniocentesis is performed at the sixteenth week of pregnancy if one is searching for a genetic disorder. (It can also be used to determine the sex of the child) Results of the amniocentesis take two to three weeks to get back. Ninety-five percent of all amniocentesis performed indicate that the foetus does *not* have any detectable disability. CVS is similar to amniocentesis but is performed earlier in the pregnancy and the results can be obtained more quickly.

One problem with amniocentesis is that it is becoming common to use on women who are not even at risk of carrying a disabled foetus. This may be due to the fact that it is expensive and therefore in the financial interests of the health care industry to perform more and more of them. Probably the greatest concern with pre-natal diagnosis is that it is used for selective abortions. Disabled Women's Network (DAWN) Canada reported that ninety percent of people who receive a positive result, abort their foetus *because it is disabled*..

The reasons used to justify amniocentesis and

(cont. on page 2)

INSIDE...

Headaches&Migraines.....p.3

Women and HIV.....p.5

Book Reviews: *I in 3* & *Whitewashed*.....p.6

In Search of Bedside Manners.....p.8

Abortion Access Update.....p.9

WWHIC Update.....p.10

(cont. from page 1)

CVS as a means to selective abortions are varied. Three reasons why doctors and researchers have advocated the use of prenatal diagnosis are: 1) in dollars and cents figures if one calculates the cost of lifetime institutional care for disabled children versus the cost to monitor the pregnancies of high risk women there would be a ten fold return; 2) that nature often takes care of abnormal foetuses by spontaneously aborting them and that the "abnormal" foetuses that do not abort naturally are the exception. Thus, detecting "abnormalities" in utero is "a way to compensate for nature's blind spots" ; and 3) people desire "normal" children.

Pre-natal diagnosis has become more common and routine in women (especially those over forty), and as a result, there is now the assumption that any woman would abort a foetus that she knew was disabled because no one wants to bring a disabled child into this world *on purpose*. As well, there seems to be pressure to abort because it is the "responsible thing to do". DAWN Canada reported to the Royal Commission on Reproductive Technologies that "some doctors require women to agree before they have testing that they will abort if there is a 'defect' in the foetus." It is not, as Brodsky points out, that prenatal testing "exists but rather that it exists within a coercive framework in which abortion of disabled foetuses is compulsory." The message is loud and clear - disabled people are worthless, unwanted, burdensome, unproductive people.

...ninety percent of people who receive a positive result, abort their foetus *because it is disabled.*

This message is also clear if one examines the Abortion Rights Movement. Since pre-natal diagnosis has become available there has been a shift in arguments for abortion rights. Finger states that whereas the focus was on the woman's choice to abort because she did not want a child, *any* child, now with such technologies as ultra sound and amniocentesis, a woman can choose whether or not she wants a particular child (e.g., girl, boy, disabled).

Finger also states that feminists fighting for reproductive rights use the argument that "the right-wing would even force us to give birth to a child who was deformed", as if to say that giving birth to a disabled child is a disaster. Because of this attitude, Finger states that "many disabled women find involvement in the reproductive rights movement problematic".

Asch and Fine have urged women in the reproductive rights movement and other feminists neither to "pressure nor to prescribe any reason (for example, 'the tragedy of the defective fetus') for an abortion, just as we would not advocate the 'tragedy of a female fetus' as a legitimate reason for an abortion." Abortion rights should centre around abortion being "safe, legal, and funded" and not have anything to do with whether a foetus is disabled or not.

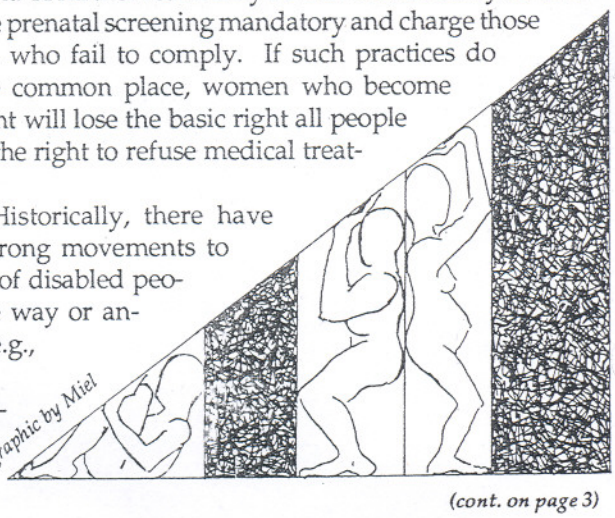
Disabled people report feeling uncomfortable and hurt when it comes to the question of aborting a disabled foetus. They ask where is the cut-off line going to be? "Does it stop at the blind, deaf child? Does it stop because a child may limp? Does it stop at minor brain damage?" Who decides?

Disabled women are not saying that women who abort because they are carrying a disabled fetus, should be punished. For ultimately, many believe that it should be the right of the woman to have an abortion regardless of her reason.

Amniocentesis is usually performed at the sixteenth week of pregnancy although it can be done later. The results take two to three weeks to get back. This time constraint causes a lot of problems. Firstly, there is a risk of aborting a viable (alive) foetus. This risk will likely increase in the future since the ability to keep premature infants alive at a younger and younger age is advancing quickly. Secondly, there are more psychological and physical risks to the mother when a late abortion is performed. And thirdly, there is little time for parents to make an informed decision whether or not to abort the foetus.

One of the arguments that DAWN Toronto and DAWN Canada used to the Royal Commission on Reproductive Technologies, was that doctors are not providing unbiased information to women who are carrying known disabled foetuses. Both Canadian organisations feel that it is important for these women to hear about examples of people with disabilities who live full and productive lives. As DAWN Canada states, women need information that "gives the facts - not the stereotypes!" Women who carry known disabled foetuses need to be able to make their decision whether or not to abort based on information that is not biased. And as Brodsky states, "central to any definition of choice is the autonomy to make an uncoerced, informed choice". If an option is to have a late abortion it is also imperative that this unbiased information is given quickly.

It seems that the easier it becomes to prevent the birth of disabled people, the more society is going to be intolerant of disabled people. Ruth Hubbard reports that parents of disabled children, and the children themselves are beginning to sue physicians for not warning mothers more forcefully about all the possible risks of disability and about prenatal diagnosis. As well, she points out that a child who is born with a health problem that might have been detected and improved prenatally can probably sue the mother if she refused to be tested while pregnant. A further result may be that the state may be able to make prenatal screening mandatory and charge those women who fail to comply. If such practices do become common place, women who become pregnant will lose the basic right all people have - the right to refuse medical treatment.



Historically, there have been strong movements to get rid of disabled people one way or another (e.g., sterilizing disa-

(cont. on page 3)

(cont. from page 2)

bled people was legal in Canada up until 1972, segregating, and killing disabled people was common in the 1930's and 40's in Nazi Germany). Today the movement is manifested in the pressure to selectively abort disabled foetuses. Whether it was yesterday or today, the underlying goal has been to ultimately rid society of all disabled people. This, of course, is an impossible feat. As Hubbard points out, "many inborn disabilities cannot be predicted or prevented and the incidence of disabilities resulting from accidents or exposure to chemicals or radiation is likely to increase rather than decrease in the near future". Disability is not something that is going to go away.

The basic assumptions underlying the use of prenatal diagnosis are that disabled people are unpleasant, unhappy, helpless, hopeless, burdensome, and in psychological and physical pain at all times. It is obvious that the majority of people do not understand what it is like to be disabled.

Most disabled people live very productive, pleasant lives. Most of what is disabling for disabled people is not the disability but the attitudes of non-disabled people towards them and the resulting oppression. The suffering disabled people experience is, as Saxton points out, "a result of not enough human caring, acceptance and respect". I have heard of many women who went through a phase in their pregnancy (including myself) when they feared they would give birth to a disabled child. Most of the fear, I believe, comes from the fear of not being able to cope with a disabled child and fear of having your child suffer. Another reason for this fear is that mothers are often the sole caretakers of children with disabilities and since there are few resources available to mothers, they become very isolated. The fear of being soley responsible for a disabled person is a valid fear in our society.

> "some doctors require women to agree before they have testing that they will abort if there is a 'defect' in the foetus."

The goal then *should* be for society to take more responsibility for the welfare of disabled people, become more informed about people who are disabled and to begin to see disability in a positive light. However, for the time being, disabled people are not valued, are not understood and do not have their needs met. For those reasons, although it is disabled women who are at present fighting to stop the discrimination and devaluing of disabled people, disabled women themselves have mixed feelings about actually choosing selective abortion when a foetus is disabled.

Women in Matthews book, **Disabled Women Speak Out**, said "they wouldn't mind having a disabled child, but they would be terrified for the children's sake. They would want to spare their offspring the problems they had faced ... one woman gestured to her deformities. 'No way would I wish this on a kid' she said."

So it is not only able bodied women but disabled women as well that fear disability for their children. Disabled women know first hand that there is still a lot of work to be done before society's view of disabled people changes to the point where disabled people are accepted as equal and valued members of society.

graphic by Miel

Kate McCandless

No one likes or wants Headaches, but so many of us suffer from them. Some of us are incapacitated by them. Many consume alarming quantities of over-the-counter and prescription drugs combating them. Giving some attention to discovering what may be causing our headaches, then doing what we can to prevent them, and learning how to treat ourselves gently when we do get them, can not only reduce our headache misery, but improve our general well-being.

It is relatively easy to identify causes of tension headaches in our stressful lives. Migraine are more mysterious and difficult to pin down. I've chosen to discuss both here, because there is a fair amount of overlap in alternative approaches to dealing with them.

Tension headaches usually come on and leave slowly and may be felt as a tight band of pain around the head and/or at the back of the neck. They may be caused by anxiety, fatigue, eyestrain, stress, and too much or too little sleep. Exercise (perhaps the most important headache preventative), massage, relaxation techniques, and a healthy diet can

(cont. on page 4)

(cont. from page 3)

virtually eliminate tension headaches. Be aware of sources of repetitive or continuous strain and find ways of taking short breaks to relax and massage your muscles. Becoming aware of emotional strain and finding ways to release it are also very important. All of this is easy to say, not so easy to do. But patience and persistence are the watchwords here.

This is all the more important when dealing with migraines. These notorious headaches occur when arteries in the face and scalp become dilated and inflamed, for reasons that are not well understood. The throbbing pain is characteristically on one side of the head and is often accompanied by nausea, even vomiting, and sensitivity to sound, light and smells. Attacks may go on for hours, even days and be completely debilitating. Ten to twenty percent of migraine sufferers also experience visual disturbances, called aura, such as temporary loss of peripheral vision, blind spots with jagged edges, or zigzag shooting lights, which are often the first warning signs of the onset of a headache. Managing migraines with medication is not by any means a reliable solution. Some medications have undesirable side effects and some can even make migraines worse if taken over too long a period.

Migraine patterns are highly individual, and recognizing your own warning signs can be a key to fending off the headache in time, before it becomes debilitating. Sometimes resting and relaxing in a dark quiet room can be enough. Exercise when you have a migraine may be approprate for some and not for others. One woman in a survey reported being able to stop migraines by running for as long as she could, then taking a cool shower. Massage/shiatsu to the temples, forehead and neck, particularly the base of the skull can bring relief, as can cold packs on the head and neck. Many people have had success with a long hot shower followed by a cold shower to contract swollen blood vessels.

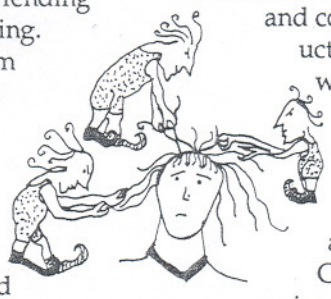
Some people feel that emotional states play a role in their migraines and have experimented with techniques of releasing strong emotions to relieve migraines. (See Women and Migraine, pamphlet by a British women's collective in the Health Collective's information file.) Others have found chiropractic treatment very helpful, as spinal misalignment can cause muscular tension and pinched nerves, triggering headache. Still others have found biofeedback an effective way of averting migraines.

Obviously it takes determination (and often desperation) to find a way out of your own migraine maze. Identifying what factors trigger your attacks can be an important key. Try to keep a record of your migraines and see if you can see any patterns. Common triggers are hormonal, environmental and dietary. It is well-known that birth control pills can cause or aggravate migraines. Many women are prone to migraine at certain times in their menstural cycle, due to hormonal fluctuations. This might be a good time to reduce other stresses and elimate dietary triggers to help avert a migraine. Regular sleeping and eating habits are particularly important for those vulnerable to migraine.

graphic by Alexa Berton

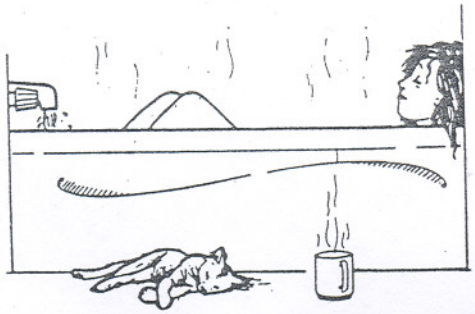
Some environmental triggers are: noise, bright sunlight, flickrering or glaring artificial light, fatigue (particularly from crowds, shopping, etc.), stuffy air, tobacco smoke, intense or penetrating smells (including chemicals & perfumes), changes in barometric pressure.

Possible dietary migraine triggers include: chocolate and cola drinks, alcohol, cheese and dairy products, citrus, legumes (peas, beans, peanuts), wheat, yeast, and sugar.



Generally speaking, an anti-headache diet is one high in vitamins, minerals and protein, and low in sugar and fat. Supplementing the B vitamins, vitamin C, calcium and magnesium may help prevent migraines. Camomile, peppermint, or catnip tea is soothing for headaches, and three leaves a day of feverfew is a proven migraine preventative.

As with tension headaches, reducing physical and emotional stress is an important element of migraine prevention. If all this prevention seems like too much work and one more source of stress, go easy. Deal with what you can at any given time, and don't berate yourself when you do get a headache. Take courage from the many women who have found relief through the process of learning to treat and prevent their own headaches, and to care for themselves.



graphic by Cathy Beaumont

WOMEN & HIV

Robin Barnett

AIDS is a new disease, only first described in 1981. It will take years before the true role of HIV, disease among other conditions, will be revealed. It is possible that HIV will be described as just one more issue in the scope of women's health.

People who work with HIV and AIDS issues say that AIDS highlights inequities which already exist in our societies, such as discrimination against gay and lesbian people, racism and the role of poverty in health. Indeed, the difficulties women face in HIV and AIDS issues merely reflect the gender discrimination in health care and in society.

Women with HIV and AIDS face numerous obstacles because they are women. We hear about cases of misdiagnosis, of lack of research and treatment relevant to women, and women living shorter lengths of time after diagnosis than men. Many of us are outraged and angered that this happens.

Family physicians are often influenced by media reports and hold stereotypical ideas about what kind of women get HIV. The spread of STDs has traditionally been blamed on prostitutes and promiscuous women. Many doctors assume that women with HIV or AIDS are promiscuous or drug users, even though women living with HIV come from all backgrounds and lifestyles. HIV positive women tell stories of doctors refusing to give them the HIV antibody test, or trying to talk them out of having it because they do not live the stereotypical lifestyle of a woman with HIV.

Women have been infected with HIV since the reporting of the earliest cases, however, the number of women has never been significantly high. This has been one justification for the small amount of research around the effect of HIV, as well as the drugs used to treat it, on women's bodies. AZT, a major drug used to fight AIDS, was never tested on women. No one really knows how it will interact with women's hormonal cycle over time.

Another reason for the lack of research is the so called "non-compliant" behaviour of women, particularly in the United States where the bulk of research is funded. "Non-compliant" usually means that research participants do not keep regular appointments and do not follow treatment protocols. HIV women are often poor Black and Hispanic mothers, possibly caregivers to a partner with AIDS. Maybe they are not able to get childcare or bus fare, and maybe they are just too busy or too sick to seek treatment. Considering the living condiditons of many HIV positive women, the demands made upon participants in traditional research projects are unrealistic.

The following examples are merely specific instances of general women's health problems. Ms. Magazine (November/December 1991) tells us:

> More women than men die from heart disease each year, yet women with heart trouble are less likely to receive cardiac catheterization or coronary bypass surgery, even when the symptoms the women report are consistent with severe heart trouble.
>
> Women are twice as likely as men not to be tested for lung cancer, even though lung cancer is the number one killer of women.

Mirabella, September, 1990, reported that "The safety and effectiveness of drugs and treatments prescribed for everyone - men and women of all ages and ethnic backgrounds - are typically based on clinical trials using only middle aged, white men." Justifications for leaving women out of various medical research include women's hormonal cycles that can interfere with accurate monitoring or not enough females diagnosed with whatever illness is being investigated. Pregnancy is another reason. Women with HIV have asked to be sterilized so that they can participate in drug trials.

Some initiatives have begun for women's health research, but it will take time to correct the sex bias in known medical research. The National Institute for Health in the U.S., a major research funder, now has a women's research section.

Prevention of HIV/AIDS (and other sexually transmitted diseases) is another area where we find examples of the gender gap. Women and HIV/AIDS prevention has become a hot topic because of the growing number of women who are being infected with the virus and because of media reports about women being more easily infected than men.

Traditional health promotion aims to empower individuals to change behaviour to improve their own health and lifestyle. However, preventing HIV means that women need the co-operation of partners for latex protection.

(cont. on page 6)

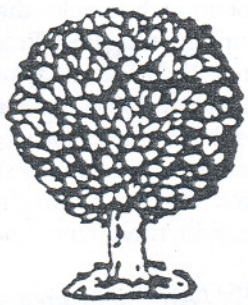
(cont. from page 5)

For heterosexual women, it is men who ultimately have to use condoms for protection. Sex role stereotyping, power imbalances and lack of sexual communication tools leave many women powerless to get their partners to use them.

In addition, many men do not perceive themselves to be at risk for HIV. Societal attitudes, such as homophobia, often contribute to their resistance to condom use. Women and AIDS projects are being created and funded to empower women to protect themselves from HIV. But who is trying to educate heterosexual men to change their attitudes about relationships and condom use?

Doesn't this sound remarkably similar to the whole area of violence against women? There, support workers struggle to cope with the increased incidence of reports of violence against women. Women educate and support women. But, really, who is working with boys and men to change the attitudes underlying the behaviour?

Anyone working to empower women is probably dealing with the same issues that women and HIV/AIDS projects grapple with. HIV and AIDS need to become part of all of our daily work, because women living with HIV come from all backgrounds and communities. Problems like lack of self esteem and lack of sensitive health care affect women's lives in multiple ways. HIV is just one additional area where women face inequalities because of their gender.



The City of Vancouver is sponsoring another condom campaign in November with a possible focus on men. Anyone interested in volunteering to pass condom packages out in nightclubs (very entertaining for the right people) can call Lezlie Wagman at the Vancouver Health Department at 736-2033.

Women's Health And the Enviroment

Kate McCandless

1 in 3: Women with Cancer Confront an Epidemic
edited by Judy Brady. Cleis Press, Pittsburgh and San Francisco, 1991, 286pp., $13.70

Whitewash: Exposing the health and environmental dangers of women's sanitary products and disposable diapers — and what you can do about it
Liz Armstrong and Adrienne Scott. HarperCollins Publishers Ltd. Toronto, 1992, 194pp, $12.95

Here are two books to convince you, if you need convincing, that women's health, the health of our planet, and the health of our societies and political systems are intricately linked.

1 in 3 takes as its title the ominous statistical prediction that one in three American women will face some form of cancer. A further statistic: one in nine will develop breast cancer, and another: The World Health Organisation (WHO) estimates that ninety percent of cancers are caused by human-produced carcinogens. The mind balks at the implications. Why, one wonders, does the medical/cancer establishment still focus so narrowly on finding elusive cures for cancer without giving due attention to this massive assault on our immune systems? And why do so many cancer self-help advocates emphasize a narrow concept of individual responsibility that can verge on victim-blaming?

The women contributors to this anthology, editor Judy Brady herself among them, tackle these questions head-on. They have had to, as cancer victims (a term Brady uses consciously, seeing herself as a victim of "a social crime, the crime of poisoning our environment"), but they are far from passive victims.

(cont. on page 7)

graphic by Alexa Berton

(cont. from page 6)

These women come from a wide variety of ethnic and social backgrounds and write in different genres: essay, political analysis, poetry, and fiction. They all give voice with clarity, passion and anger to their experience of cancer in the context of the world in which they live.

The book is divided into seven sections: *The Politics of Cancer in Women's Lives, The Environmental Connection, Dealing with the Medical Profession, Living in Our Bodies, Cancer and Death, Living in Cancer's Shadow, and Finding our Power*, followed by a resource list. All are highly worthwhile, the writing excellent, often moving and empowering. Women's health activists will be particularly interested in accounts of the genesis and work of Breast Cancer Action and Women's Cancer Research Center in the the San Francisco Bay area.

The authors of **Whitewash** were inspired by the success of the British Women's Environmental Network's campaign for the use of unbleached paper in women's sanitary products and disposable diapers, which forced manufacturers to switch from chlorine bleached paper to non-chlorine bleached or recycled paper. As has been well publicized by Greenpeace and other environmental organizations, chlorine bleaching of pulp and paper produces organo-chlorines such as the particularly deadly dioxins and furans, which all too often are expelled into our waterways and thus enter the food chain. Some residues remain in the paper products themselves. Just how low a level is "safe"? Have we been "whitewashed" into believing that whiter than white equals safe and sanitary?

graphic by Alexa Berton

Armstrong and Scott begin by analyzing the dangers of chlorine bleaching related toxins and the wasteful and unsustainable practices of the pulp and paper industry. They then take on the sanitary products industry, from sanitary napkins, to disposable diapers, to tampons. In their efforts to research the safety of these products they "encountered everything from subtle sins of omission and shifty public relations ploys through to bold and deliberate deceptions, all in the name of protecting profits and preserving business at the expense of a safer environment and women's health." Finally, the authors offer us alternatives (their chapter titled, "Ragtime revisited: The case for reusables" is wonderfully convincing), and suggestions for pressuring the sanitary products industry.

graphic by Alexa Berton

I hope that the documentation in these books of the callous, cynical disregard of big business for the health of ordinary people will make you angry. I hope they will encourage you to speak out from your own experience about health concerns and their individual and social ramifications. Taboos still srurround women's bodily functions and their disorders in our society. Women who have had mastectomies are expected to appear as though nothing had ever happened. And try to find any references to menstruation (let alone BLOOD) in ads for sanitary napkins or tampons.

Finally, I hope these books will incite you to action, personal and collective, whatever you can do, (while looking after your own health), to call government and industry into account for wasteful and toxic practices pursued in desperate greed for short term profit at the expense of our health. We are part of complex social and ecological systems, as active participants, not passive victims of fate. To place sole responsiblitiy for illness and health on either the individual or "external" factors is to be deluded. These books can help us see more of the whole picture.

Whitewashed?
Join us at theHealthInformation Centre for a plan of action meeting around this issue, Monday, July 20th at 7:00 pm.

In Search of Bedside Manners

Winnie Kwok

Recently, I experienced the frustration of being sharply criticized by a doctor for using a natural method of contraception. I tried to explain my reasons for choosing this method, but as I mentioned my personal distaste for the IUD, this doctor interrupted me with along lecture on the merits of the IUD. Even more frustrating was the fact that I had not gone to discuss methods of birth control but for some other problem which the doctor never properly addressed. From my conversations with other women, I know this kind of experience is common. Many women have seen doctors who seem to think that ignoring, interrupting, lecturing and scolding patients are appropriate ways to behave. Authors of popular health books and even medical journal articles speak of the overabundance of authoritarian and judgemental doctors as a major problem. Not suprisingly, doctors' negative attitudes and lack of bedside manners interfere with the doctor-patient relationship and compromise the quality of care.

An authoritarian attitude towards patients has the effect of undermining patient autonomy. Patient autonomy is important because patients who participate in making decisions and take responsibility in improving their own health feel better about themselves and more in control of their lives; positive attitudes have been shown in numerous studies to strengthen the body's natural ability to heal. The body's natural healing ability can also be affected by the kinds of messages patients receive from doctors about their illnesses. The phenomenon of the placebo effect (the power of suggestion) is well known and doctors need to be aware of the importance of giving patients positive messages and refraining from saying potentially harmful things2.

Negative attitudes towards patients seem to go hand in hand with poor communication skills, especially since good communication involves respecting patients enough to listen to them. Patients often feel anxious about their illnesses and embarrassed about being physically examined and questioned on very personal aspects of their lives. Sensitive doctors recognize how anxiety can block effective communication and they try to reassure patients in order to help provide an environment in which they feel safe enough to talk freely about their problems. Sometimes the opportunity to talk is all a patient needs. Many doctors, however, not only ignore patients' emotional needs, but aggravate the situation by interrupting patients, sometimes with hurtful remarks. In one study, doctors interrupted their patients' initial attempt at stating their concerns in 69% of visits. The interruptions occurred on the average 18 seconds into the statements and only 2% of those interrupted went on to complete their statements3. These doctors then attempted to diagnose the patients' conditions primarily on the basis of the little information they obtained at the beginning of the interviews. This and many other similar studies plainly show how common doctors' poor communication skills are and how negatively they affect patient care.

Why do so many doctors lack communication skills and why do they regard patients, especially women patients, with such disrespect? One reason is the power imbalance between medical professionals and laypeople, and men and women. Doctors' educational and financial status and their exclusive rights to prescribe drugs and perform medical procedures put them in a very powerful position. In addition, doctors have generally been regarded as trustworthy, all-powerful healers. Such an influential position makes it easy for doctors to take patients for granted and to mistreat them either unintentionally or intentionally.

The inequality of power between doctor and patient is also apparent when we consider how vulnerable a patient can be during a consultation with a doctor. Even individuals who are usually confident and assertive can find themselves feeling timid and insecure when in the role of a patient. Women have an especially difficult time being patients. Since women have been socialized to be passive, to deny themselves, and to trust and yield to those in positions of authority, many women find it very difficult to express their own ideas and to stand up for them-

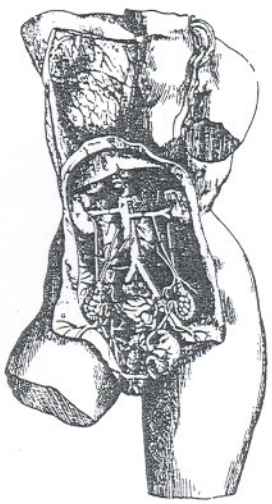
(cont. on p age 9)

...speaking as clearly and succintly as they write

(cont. from page 8)

selves. On the other hand, doctors are trained in a traditionally male setting in which authoritarian values have been passed on for generations. The implications of bringing together a woman patient who feels helpless, with a doctor who thinks he or she knows all the answers and has the right to make all the decisions, are disastrous and all too familiar.

The emphasis on science and technology in medicine is another reason for poor doctor-patient relationships. Western medical training convinces many doctors that they alone have the exclusive ability to treat patients. Anything outside of conventional North American medicine, including naturopathy, acupuncture, midwifery, homebirth, natural family planning, and even vegetarianism, is often seen as quackery, and those who are interested in alternative care are not taken seriously. In other parts of the world, many practices which North Americans consider alternative are the norm. In Holland, for example, where the Dutch enjoy one of the best childbirth safety records in the world, risk-screened, planned homebirths assisted by midwives or family doctors account for nearly 40% of all births4. Yet, Canadian doctors continue to insist that homebirths are much more dangerous than births in the hospital where all their wonderful lifesaving technology is right at hand. Doctors need to realize that they damage their own credibility when they try to defend their often unfounded beliefs with "doctor knows best" and "technology is safest" arguments.



Until quite recently, medical schools have provided little or no training for their students in the art of communicating with patients. As a result, many doctors don't understand the importance of developing genuine relationships with patients and often think that communication is "just a matter of personal style". While patients want to be treated as whole human beings with thoughts and feelings as well as physical problems, doctors often think of them as merely body parts or diseases to which technological treatment must be applied. Fortunately, some medical schools have begun to improve their programs by introducing courses in medical humanities and by changing their entrance requirements in order to obtain students who not only excel in the sciences, but who also show compassion and interpersonal skills. Some of these changes are responses to pressure from patients' rights groups.

As we await a new generation of more humane doctors, is there anything we can do in the meantime to encourage the many not-so-humane doctors still out there to provide better care? Those of us who feel comfortable about making our thoughts known can write letters, phone, or discuss the issue in person. For others, switching doctors may be the only option. The Vancouver Women's Health Information Centre has a newly updated file on doctor-patient relationships. There is also a directory of health practitioners which contains files of womens' experiences with doctors and therapists. Remember, the only way the directory can be kept up to date is if we all contribute to the files!

1. Norman Cousins. **Head First: The Biology of Hope.** New York: E.P. Dutton, 1989.

2. Robert B. Kelly. *Art of therapeutic communication.* Journal of Family Practice. 1991; 32: 13.

3. H.B. Beckman, R.M. Frankel. *The effect of physician behavior on the collection of data.* Annals of Internal Medicine. 1984; 101: 692-6.

4. Sheila Kitzinger. **Homebirth.** Toronto: Macmillan, 1991.

In the last issue of *The Health Rag* , we featured an article on accessing abortion services in British Columbia. At that time, in order to cover costs, both of the free standing clinics in the province were forced to charge women, (regardless of whether or not they had MSP health coverage) a substantial fee. Since that time, representatives from the Everywoman's Health Centre, the Elizabeth Bagshaw Clinic and the Department of Health have successfully negotiated provincial funding for both clinics. Beginning April 1, the two clinics will share approximately one million dollars to cover this year's operating expenses. Thanks to the new provinicial government's commitment to women's reproductive rights, all women who are residents of B.C., regardless of their economic status, now have access to fully funded abortion services. While this is clearly a significant achievement for the B.C. abortion rights movement, it is, more importantly, a victory for all women in this province. For more information call: **The Everywoman's Health Centre at 322-6692, the Elizabeth Bagshaw Clinic at 736-7878 or the Vancouver Women's Health Information Centre at 255-8285.**

The Vancouver Women's Health Information Centre

UpdateUpdateUpdateUpdateUpdate

Its crowded in the Information Centre office these days with both a Challenge '92 grant (for students) and a UI Top Up Grant (tops up the wages of people on UI). We have two women working on the Challenge grant, Ingrid is updating our doctor and therapist files. Mielle is editing, formatting and creating graphics for recently written publications, one on hysterectomy and the other on Candida. We hope to have these two books for sale by fall.

Then, on UI grants, we have:

Earon reorganising, archiving, and updating our entire collection of Information Centre files which will then be computerized, making it easier for the public to find specific information and for us to access the latest information via modem.

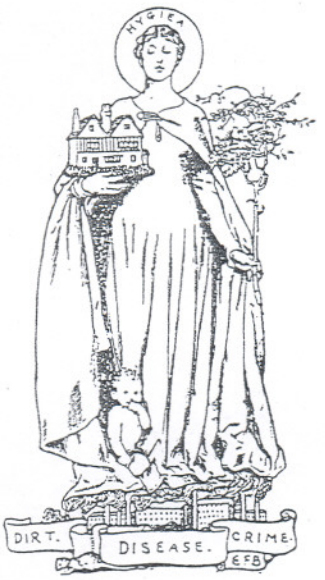
Laura is updating and writing new fact sheets. Some of the new ones will be: Doctor Shopping, Thera pist Shopping, Women and AIDS, The Endocrine System, The Immune System, General Physiology, and Sexual Abuse.

Prima is organising our 20th Anniversary Celebration Conference which will take place over a mid November weekend. She will be inviting speakers, workshop facilitators, and instructors for a feast of wholistic health information lectures, discussions, and work shops. Our fall newsletter will have the de tails, but keep your eyes out for posters!!

We still haven't heard from the Ministry of Health about core funding, but your letters of support have been sent to them. Thank you all of you who wrote letters for us. Meanwhile, we're still continuing to write grants in hopes that we will find monies to help us start up some of the many projects we have in mind including lecture series, video production, research, etc!!

The Women's Health Rag is a quarterly publication offering information about women's health issues and the projects of the Vancouver Women's Health Centre (operated by the Vancouver Women's Health Collective). We welcome letters, ideas, requests, and submissions from our readers. Write to us at:

The Women's Health Rag
302-1720 Grant Street
Vancouver, BC V5N 2Y7



Working on this issue:
Kate McCandless, Ingrid Deringer, Alexa Berton, Valda Dohlen, Winnie Kwok. Copy editing & production: Alexa Berton

Subscribe!

___ Yes! Please sign me up for one year of women's health information that I can't afford not to know about. Enclosed is my cheque/money order for $15.00, or $_____ which is what I can afford.

___Yes! Please send a subscription to my friend/sister/lover/partner/daughter/mother/significant other. Enclosed is my cheque/money order for $15.00.

Name: _____
Address: _____
City: _____
Postal Code: _____

clip & return to:
The Women's Health Rag
#302-1720 Grant St.
Vancouver, BC V5N 2Y7