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A Vancouver Women's Health Booklet
Roslyn Smyth

Prepared with the aid of
Opportunities for Youth
grants.

This booklet has been the collective effort of many women over many months. It's difficult - if not impossible - to imagine how it could have been done otherwise. We're not going to even try to list the names of everyone involved; that would take pages! And there are many names we don't even have - all the women who filled out questionnaires with us, sharing their experiences with us to help us all get better medical care.

The last week before printing - when a lot of us were madly writing articles, typing them, doing the layout - was exhausting but at same time really exciting. Our own health care needs and experiences and those of all our sisters really do need to be heard - and now it's happening. For many of us this has been one of the best 'jobs' we've ever had. Just by working on this book we've experienced the capability that we women have to do something, IF we get together and share our experiences and knowledge to do it.

If you want to reprint parts of our book, go ahead. We would appreciate credit and feedback.

Written by the collective effort of many women at:
A Woman's Place,
1766 West Broadway,
Vancouver, B.C.
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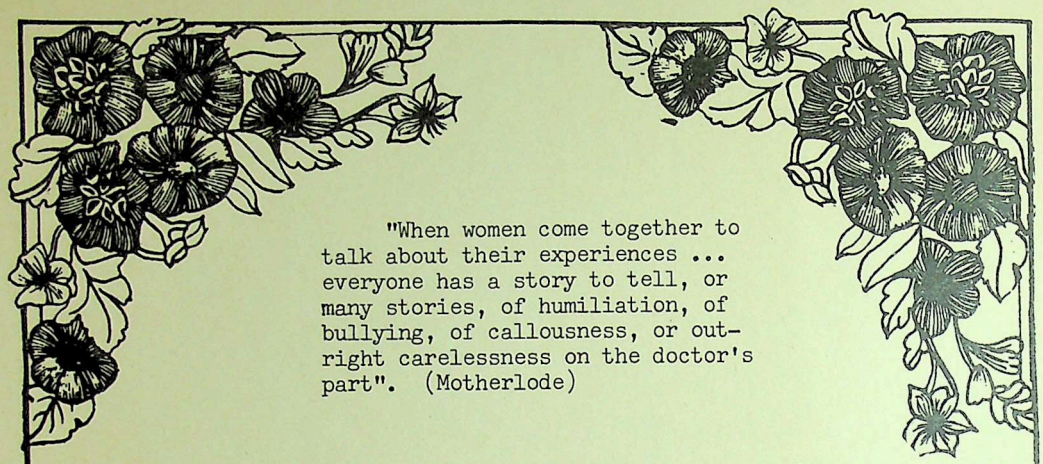
CONTENTS



"When women come together to talk about their experiences ... everyone has a story to tell, or many stories, of humiliation, of bullying, of callousness, or outright carelessness on the doctor's part". (Motherlode)

That quote is very nearly the story of this book. A group of women met all last winter at A Woman's Place to talk about their bodies and their health. All of us were dissatisfied with the kind of care we as women had been receiving, to a lesser or greater degree.

This being so, something had to be done about it. To make the case stronger required proof that our experiences are not isolated exceptions. Some of us drew up a questionnaire with the hope of finding out how a great many other women in Vancouver felt about doctors - specifically with regard to gynecological problems. (Women's Health Survey). Some of us investigated women's expectations and satisfactions with childbirth facilities (Childbirth Practices Study Group). Some of us investigated abortion availability (Women's Referral Bureau).

One of the purposes of our surveys was to discover what facilities are available in Vancouver to meet the expressed needs of women. The appendices at the end of this joint report list doctors and other health services which have been recommended by women.

The report outlines the nature and extent of dissatisfaction reported to us. Thus we ask: "Why is this so?" From the descriptive data we gathered one cannot draw direct causal connections. However, we include articles which analyse the cultural bias regarding women in the training of doctors, medical literature, and actual practice. Since a reiterated criticism is that the doctor's attitude is often more moralistic than it is medical, a look at the cultural orientation influencing how he sees our physical condition is not unfounded.

We then come back to the original question - how to begin to change this situation? We include descriptions of several ways in which women are coming together to try to change their health situation - to offer alternatives to the traditional doctor-patient relationship. If simple ignorance on the part of certain doctors is behind bad health delivery, we hope this booklet, by expressing needs and expectations as women report them, will be a step to improving our health care.

But there is a suspicion in our minds that there is a good deal more 'behind' poor capacity for or inadequate delivery of health care than 'ignorance', or even individual moralism. Two powerful shadows are present when practitioner meets patient: the shadow of the medical machine directing the doctor, the shadow of culture and society encompassing and limiting both. When we look to what we should do next, it must be to decipher these, to pinpoint what larger changes in the total health situation are necessary.

What began as our undirected anger over the pain and frustration that can be part of seeking medical treatment has developed into an attitude and a commitment toward building a rational, non-sexist health care system.

Summary

This report aims to:

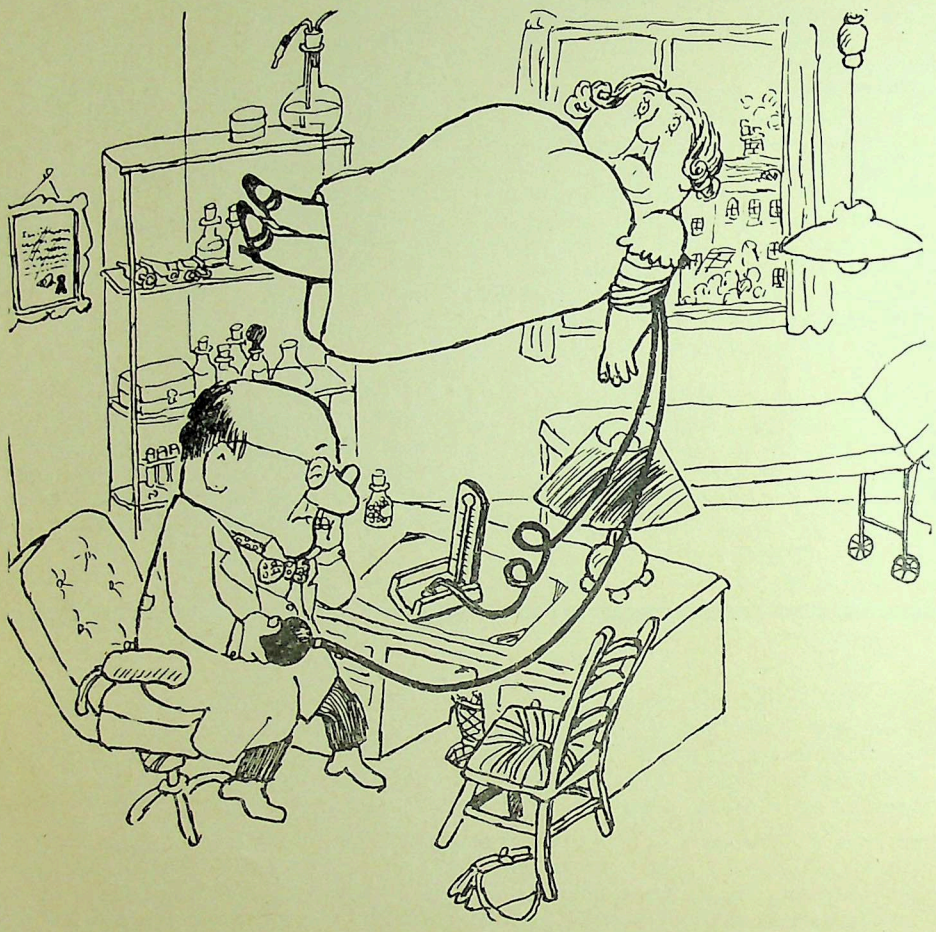
1. Make doctors more aware of what women want.
2. To make it easier for a woman to find good health care in Vancouver ("good" in terms of what is presently available).
3. To encourage women to formulate and DEMAND the changes they feel are essential.

The most valuable results of our work, however, are the contacts made with women whose personal experiences deepened our consciousness and gave us the directions and the energy for this struggle.

This is our second printing. As we had hoped, we have had responses from many women who received the first edition: women grateful for more information and facts; women grateful for support in their own feelings of dissatisfaction with their doctors; women who want to help other women by sharing their experiences and energy.

We have also spoken to some doctors who have read the book - some think it's great, some have mixed feelings (mainly due to the critical attitude to doctors we express). We are hoping now to establish communication with more doctors. We can let them know the changes we want, and give them support for the aspects of their practices we appreciate. We also want to find out what it's like from their end.

If you are interested in becoming involved in what we are doing now - health groups, the woman's clinic, talking to more women about their doctors, talking to doctors - come down to or call A Woman's Place (1766 West Broadway, 731-9619). The more we work together, the more we can help each other.



YOU AND YOUR DOCTORS

OR ....

THEY NEVER ASKED A WOMAN BEFORE

Health Survey Results

We include here a summary of how the health survey was done for two reasons:

1. To share what we learned of the difficulties and mistakes we made with other women who wish to find out similar information on the medical experience of women in their areas.
2. The limitation of the method and therefore the limitation of the results (how valid or invalid it is to extrapolate from the results to the whole 'relevant population') can be judged on reviewing the method.

Our time and energy were divided between the two approaches of A) a random, geographical sample, and B) an unsystematic distribution to any group or individual wishing to share their experiences.

A: THE GEOGRAPHICAL SAMPLE

The 'relevant population' which we sampled is defined by criteria as follows:

1. Woman aged 15 to 55
2. Who goes to/has gone to a G.P. or Gynecologistabout one or more of the health problems covered in the questionnaire.
3. Resident in Vancouver and is the patient of a Vancouver doctor.
4. Facility with English.

Factors limiting how reprsentative of this population our survey sample are:

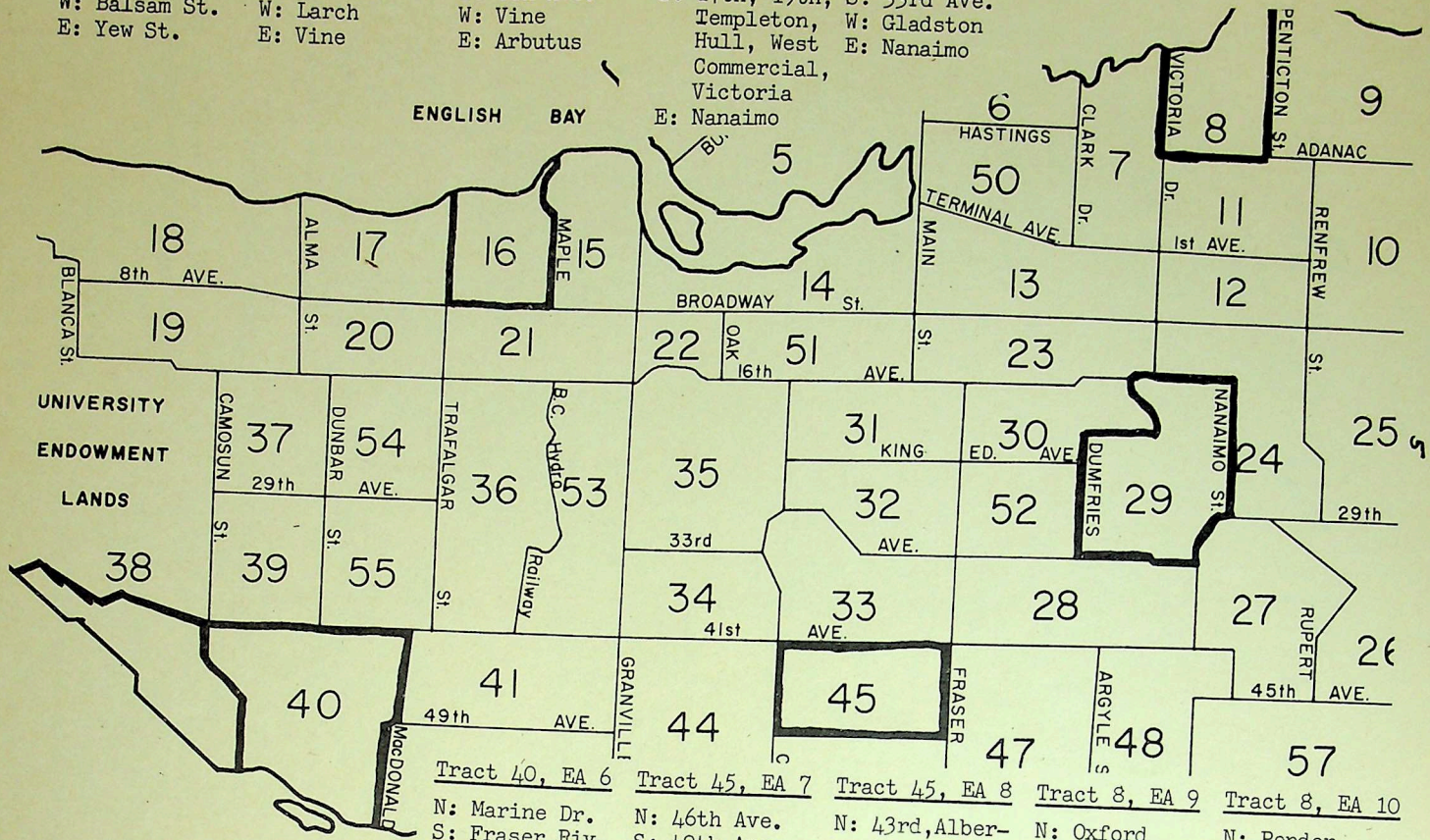
1. Kind of information requested: willingness to discuss these areas in itself is an indication of a certain criticalness and openness. (Therefore, we include a short discussion of the nature of refusals - roughly 50%)
2. Did not include in the sample the residents of the West End.
3. Have no income or religion data. (*See discussion of conflict of purposes below.)
4. Kind of information requested: The number of respondents of 20 to 24 years is disproportionate to their distribution in the city. This is perhaps because they are most affected by certain concerns of the questionnaire.

Age	Respondents in Age Group	Distribution Generally (Vancouver,'66)
15-19	8	16,129 (14%)
20-24	26	17,798 (16%)
25-34	32	24,677 (22%)
35-44	19	26,472 (23%)
45-54	13	28,494 (25%)
	98	113,570

Selection of Sample

Number of interviews per tract was chosen proportionate to:

a) total female population of the Tracts surveyed.
b) representation of income and geographical distributions.



Tract 16, EA 1
N: 1st Ave
S: 2nd Ave.
W: Balsam St.
E: Yew St.

Tract 16, EA 2
N: 3rd Ave.
S: 5th Ave.
W: Larch
E: Vine

Tract 16, EA 3
N: 5th Ave.
S: 6th Ave.
W: Vine
E: Arbutus

Tract 29, EA 4
N: 15th Ave.
S: 17th, 19th, Templeton, Hull, West Commercial, Victoria
E: Nanaimo

Tract 29, EA 5
N: 29th Ave.
S: 33rd Ave.
W: Gladston
E: Nanaimo

Tract 40, EA 6
N: Marine Dr.
S: Fraser Riv.
W: Blenheim
E: McCleary Course, 43rd, Balaclava

Tract 45, EA 7
N: 46th Ave.
S: 49th Ave.
W: Columbia
E: Ontario

Tract 45, EA 8
N: 43rd, Alberta, 44th
S: 46th, Alberta, 45th
W: Cambie
E: Manitoba

Tract 8, EA 9
N: Oxford
S: Pandora
W: Kamloops
E: Penticton

Tract 8, EA 10
N: Pender
S: Adanac
W: Lakewood
E: Nanaimo

a) Using 1966 Population Data (96-627DBS)

Tract	Total Female Pop.	Proportion of Total Pop. of Tracts	Interviews
16	5680	30%	60
29	3998	20%	40
40	1923	10%	20
45	3405	20%	40
8	3521	20%	40
		Total Sample:	200

b) Using 1961 Income Data (95-541DBS)

Tract	E.A.	Average Annual Household Income	% of Respondents	Location
8	9,10	$4,610	40	N.E.
29	4,5	4,963		N.W.
16	1,2,3	5,149	40	E.
45	7,8	5,860		S.
40	6	11,180	10	W.

Compare with city of Vancouver:

Average annual Income of Family Households	Number Pop.	Proportion of Total
Under $1,000 to $4,999	42,143	47%
$5,000 - $9,999	38,518	43%
$10,000 +	9,181	10%
Total:	89,842	100%

DIFFICULTIES .....AND BRICK WALLS

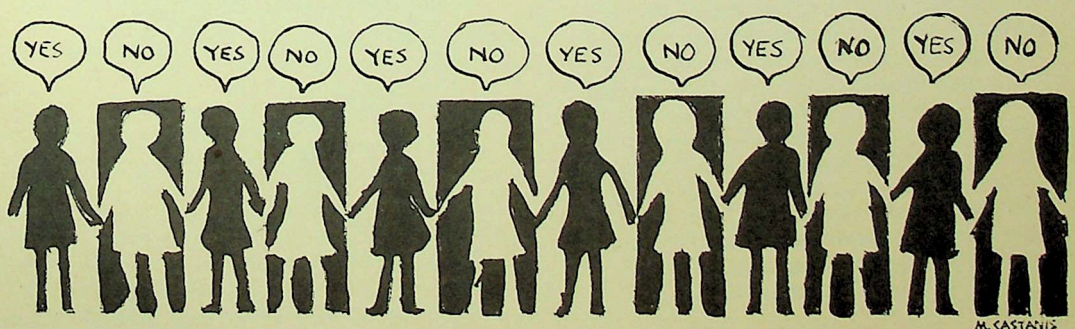
If you are looking for statistically unassailable data, it isn't found here, and for reasons that are significant in themselves. One can roughly break these difficulties and brick walls down as follows: problems with the process, problems with the tool (Questionnaire), and problems with the intent.

1. Saying No

The overall refusal rate for the 200-sample survey was 51%; that is, 98 women consented to being interviewed, 102 refused. The refusal rate was as high as 80% in E.A.#7, and as low as 30% in E.A.'s #2 and 3.

E.A.	TRACT	YES	NO
1	16	12	8
2	16	14	6
3	16	14	6
4	29	11	9
5	29	9	11
6	40	8	12
7	45	4	16
8	45	9	11
9	8	9	11
10	8	10	10
Totals:		98	102

Those who refused were not generally very expressive of their reasons for refusing. (About 70% gave no reason or stated simply that they were too busy or not interested. With a few exceptions, the refusals were well-tempered.)



Because of the process of door-step interviewing, it is hard to distinguish a refusal because a routine has been disrupted from a refusal based on another reason. Is apparent indifference to the issue explained by satisfaction with doctors, or equally possibly by
- embarassment about "taboo" subjects
- has dissatisfaction but sees no usefulness in telling anyone of it?
- antipathy to "nosey researchers"?
- has no dissatisfaction because protected by income?
- shock at questioning a doctor's infallibility?

It is interesting that the highest refusal rates are in tracts 40 and 45, also the areas with the highest average annual household income. One woman in EA #6 insisted that women in Canada have freedom of choice and that if a woman is not satisfied with her doctor she can "choose another". A woman in EA #7 insisted that it was every woman's job to find her own doctor, and she strongly objected to sharing her experiences.

A number of women who refused said that they don't see a doctor or see a doctor rarely. This is indicative of the belief, reinforced by the busyness of most doctors, that one only seeks health care when one is sick.

A number of women found the questionnaire topics "too personal" to discuss. In some cases it seems an element behind this response was that the women themselves had internalized a "taboo" attitude towards their own sexuality: one older woman in EA #8 who seemed interested in the questionnaire for her daughter quickly replied that "no one in the family would be interested in filling it out" when she learned that the questions were mainly concerned with gynecologists. An unhappy extreme of this was a retired nurse who objected on the grounds that the questionnaire had "to do with women's liberation". She was opposed to "sexual freedom for women", which to her meant birth control and abortion.

In one instance the long arm of fear or awe of doctors was the reason for a woman's refusal.

2. Problems With the Tool

One of the criteria we wanted to judge doctors by was the degree to which he (a) established empathy in his relationship with patients, (b) was informative, and (c) did not assume more authority than that justified by his 'situational authority'. The questions used to elicit this information are as follows:

A. Some women have a comfortable relationship with their doctor, others don't. How do you feel with your doctor? (Choose one or more as applicable and please describe)
   a) relaxed (code +ve)
   b) tense (" -ve)
   c) uneasy (" -ve)
   d) trusting (" +ve)
   e) unhurried (" +ve)
   f) rushed (" -ve)
   g) afraid (" -ve)
   h) no strong feelings
   i) other

   Does your doctor encourage you to ask questions? Yes___ No___

   Does he/she answer your questions fully about:
   a) treatment_____
   b) medication_____
   c) test results_____
   d) other problems_____

   There are certain concerns that many women have frequently (i.e. specifically female concerns ... ..). Is your doctor interested and helpful in discussing these?

The final question following these was:

B. On the basis of his/her medical routine and general relationship with you, would you recommend your doctor to another woman?

Results

i.	-ve responses to 33 (-ve, +ve) A, +ve to B.
ii.	+ve responses to 51 (+ve,+ve) A, +ve to B.
iii.	-ve responses to 14 (-ve,-ve) A, -ve to B.
	98

Out of 84 women who recommended their doctors, 33 did so in contradiction to one or more negative answers to set A. This indicates that 39% of the recommendations are based on factors other than patient-doctor relationship.

Conclusion:

Our questions did not effectively isolate judging "doctor-patient communication" from the other variables such as convenience, trust in the doctor's professional skill, etc. "Would you recommend ...? is a far more encompassing issue than "Are you satisfied with his informativeness, with his concern for you as an individual, with your feelings about your health situation?"

It is unfortunate that we did not ask the right questions that would allow us to estimate whether good rapport between woman and doctor existed. For it is our position that (both in terms of doctors' goals and the woman's goals) professional competence INCLUDES personal competence. This position is supported by the findings of Barbara Korsch and Vida Negrete ("Doctor-Patient Communication", Scientific American, August 1972) who found a strong correlation of doctor's "understanding of the patient's concern" with the patients' satisfaction with their doctors. And in turn, satisfaction with doctors was strongly correlated with compliance with instructions.

In other words, "failure to establish empathy with patients can be a serious bar to communication and ... a serious ommission. However well informed a physician may be, and however conscientious, ... if he cannot get his message across to the patient, his competence is not going to be helpful."

3. Conflict of Purposes -
or - Triple Entente

The brick wall we ran up against was simply that we were trying to do three things at once:

1. To get a picture of women's experiences and attitudes towards them, of their needs and expectations re health care.

   FOCUS ON WOMEN

   Requires: Information-getting. Questions general enough to be applicable to all respondents. So few had experience with certain subjects (menopause, tubal ligation, infertility) that this is far too small a "sample" from which to extrapolate to the whole "relevant population".

2. To incite a process of evaluation of interest to the woman herself.

   FOCUS ON WOMAN

   Requires: Information-giving. Questions on detailed particular health problems, giving information as best we understand it on the medical issues involved. Conversely, requires questionnaire to be non-threatening: no questions re religion, income, etc.

3. To get a directory of recommended doctors.

   Requires: Focus on doctor's attitudes and conduct. Questions to get information relevant to his "recommendability".

Therefore, Data from the geographical sample that can be used validly (for estimating similar data for the whole relevant population) is largely available only in the "general information and "general routine" sections. (see above)

On the "childbirth" and "pill" sections also, a lesser but still large number of respondents found these questions applicable. (see below)

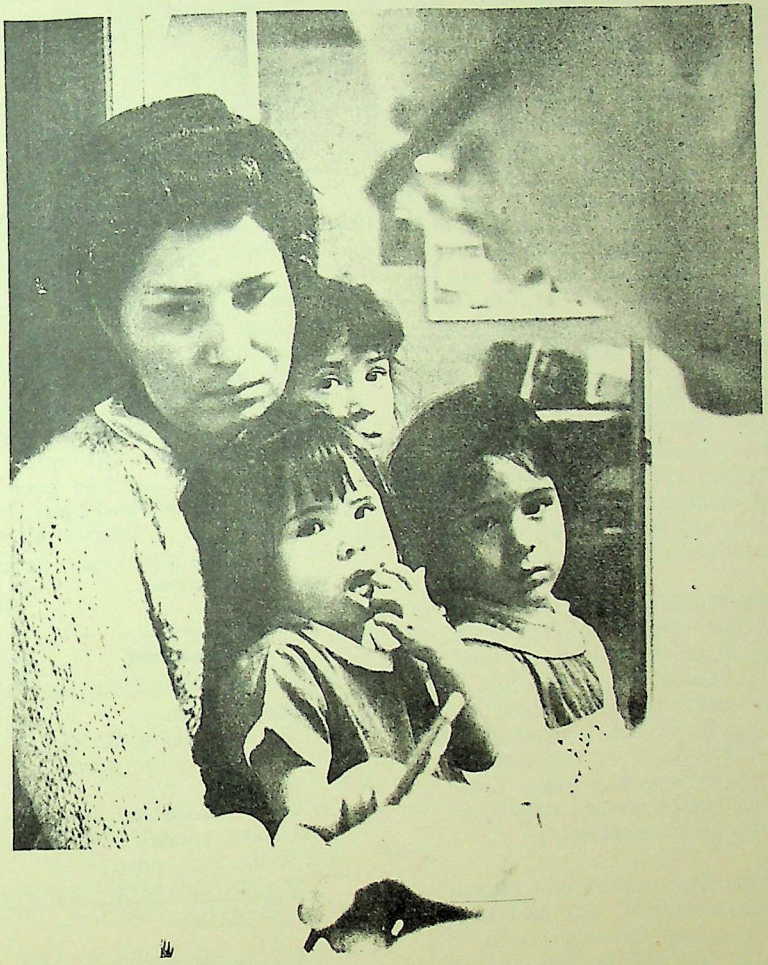
Judgementally, however, 'statistically significant' is a misleading and unjust perspective from which to judge good health care. Just because "bad eyesight" is more prevalent than "normal eyesight", NO ONE CLAIMS WE SHOULD ALL HAVE BAD EYES!
CONVERSELY, if one woman in 1,000 suffers emotional or physical humiliation or "actual" harm in her dealings with the health system, IS IT NOT CRITICAL?

In law, the only crime where the onus is on the victim to prove the crime is rape. If this report of ill-treatment is evaded on the basis that "ah - it's only a few cases" it is a too-familiar, too-callous parallel.

B. GENERAL DISTRIBUTION

To complement the geographical sample, and to get more reports on doctors for the Directory, about 150 more questionnaires were answered. This was done both in group interviews and with one woman at a time.

In the following section-by-section report, the statistics are from the geographical sample, the comments are from both the controlled and the general samples. The questions cited are not the whole questionnaire.



MENSTRUAL DIFFICULTIES

The colloquial name "Curse" is a clear indication that many women are plagued by painful monthly periods. Over half the women in this survey reported that they had experienced cramps or pain with their periods. The name "Curse" also implies that in our society, period-pains and pre-menstrual tension are considered to be "a woman's lot", to bear as best she can. Two-thirds of the women who reported that they had experienced menstrual pain, also reported that they had discussed this problem with their doctors. Only about one-third of the women who reported that they had experienced "tension/irritability/depression" before their periods also reported that they had discussed the problem with their doctors. A number of doctors reportedly said that menstrual pain and pre-menstrual tension were "normal", and many women accept this assumption.

Menstrual difficulties are an age-old and common medical problem, but a problem that has received little interest from men, and hence from the medical profession. Menstruation is not a disease, but a normal function of the female reproductive system. Why, then, must some women endure monthly a recurrence of suffering?

Women themselves can learn to deal with menstrual difficulties. If we are going to take on the job of helping our own bodies cope with their own functions smoothly and easily, we must first understand how our reproductive system works, and not be forced to appeal to some "authority" to be taught about ourselves. Menstrual difficulties can be treated in other ways besides drugs, which were reported as the kind of treatment doctors recommended most often. Drugs can give some relief, but most have depressive side-effects, making one sleepy and sluggish. Few women reported that their doctors recommended exercise or diet change. Erna Wright has published a booklet which describes exercises that prepare a woman for her period and help her cope with it when it arrives (see below). Yoga has also been reported as helpful in dealing with period-pain. Deficiencies of oil, Vitamin A, or Vitamin B_{12} cause menstrual difficulties. Iron-deficiency causes the uterus to work inefficiently, and this can cause menstrual pain. A deficiency of calcium has been linked with pre-menstrual tension. Herbalists offer a number of remedies to decrease menstrual pain or the menstrual flow.

Why Suffer?

For charts and diagrams, write to:
Tampax Inc.,
161 East 42nd Street,
New York, New York.

To learn about the menstrual cycle and remedies for menstrual difficulties, read:

The McGill Birth Control Handbook, 1970 ed., p. 7-10.

Let's Eat Right to Keep Fit, Adele Davis, Signet Books

Periods Without Pain, Erna Wright, Tandem Books

Vaginal Infections and Women's Troubles, (pamphlet) at A Woman's Place library.

QUESTIONS	RESULTS OF SURVEY
1. Have you ever had cramps/pain with your period? Yes___ No___	34 - (1) Yes (2) Yes 18 - (1) Yes (2) No 25 - (1) No
2. Have you ever discussed this with your doctor? Yes___ No___	
3. If YES: a) Did he/she discuss this with you helpfully or not? _____ b) Did he/she recommend treatment? Yes___ No___ If YES, what kind of treatment did he/she recommend? i) medication ii) exercise iii) diet changes (eg. increase in iron or calcium intake) iv) other. Was the treatment helpful? Yes___ No___	Judged on responses to all parts of # 3: 25 - helpful 7 - not helpful 1 - not ascertained
4. Women frequently experience tension/ irritability/depression before their periods. Have you experienced this? Yes___ No___	16 - (4) Yes (5) Yes 29 - (4) Yes (5) No 16 - (4) No
5. Have you discussed pre-menstrual tension with your doctor? Yes___ No___	
6. If YES: a) Did he/she discuss this with you helpfully or not? _____ b) Has he/she recommended treatment? Yes___ No___ If YES, what kind of treatment? i) medication ii) diet changes (eg increase in Vitamin B intake) iii) counselling iv) other. Was the treatment helpful? Yes___ No___	Judged on responses to all parts of # 6: 12 - helpful 4 - not helpful
7. If you have experienced other difficulties, such as amenorrhea or irregular periods, was your doctor helpful? Yes___ No___	19 - helpful 9 - not helpful 3 - had a problem, didn't ask doctor.
8. Would you recommend your doctor to another woman? _____	41 - Yes 4 - No 3 - Uncertain

Vaginal Infections

Over half the women interviewed reported that they had experienced an itchy or painful discharge. Vaginal infections (Yeast, Trichomonas, and Non-Specific Vaginitis, collectively called vaginitis) are common and on the increase. It is estimated that three out of four women will have vaginitis at some time or another in their lives. Non-Specific or Bacterial Vaginitis is a vaginal infection for which doctors cannot pinpoint the blame. Bacteria normally live in the vagin, and any change in the balance may cause an infection. The specific imbalance, i.e. the exact cause of the infection, can not always be detected under a microscope. Treatment is often hit - and - miss. Many women find douches and suppositories, the methods of treatment that were reportedly prescribed by doctors most often, awkward and annoying. A recurrent or chronic vaginal infections is, to say the least, frustrating. A number of women reported that they have "given up" going to a doctor for treatment.

An infection that cannot be identified or that does not respond to treatment presents a special problem to the doctor. When he admits that he cannot cure an illness, he implies that doctors are human and fallible. He can solve the problem by blaming the failure for treatment on the patient, for example, by suggesting that the infection is pyschological in origin, or by suggesting that it is caused by 'improper hygiene'. Doctors don't like being tried! A number of women reported that their doctors seemed annoyed or bothered when they returned for treatment of a recurrent infection.

For the purposes of this survey, a doctor was considered informative in regards to vaginitis if a woman gave 2 out of 4 positive responses to questions 5 to 7. Even by these criteria, 36% of doctors were judged to be not informative. Thirty-six women reported that they would recommend their doctors to another woman. One-quarter of those thirty-six, however, reported that their doctors were <u>not</u> informative. (We wonder what criteria women use for recommendations.) If you have unanswered questions about vaginitis (symptons, diagnosis, prevention, treatment), the library at A Woman's Place has a number of informative pamphlets. (Ask for file E4.) Some knowledge of your condition can at least make you a better judge of your doctor's competence.

When you <u>do</u> seek medical attention for an unusual discharge or vaginal itch (the drugs for treatment can only be acquired by a doctor's prescription*), encourage the doctor to explain the diagnostic and treatment procedures. Ask how the infection was caused, or how you can try to prevent it from recurring. Enough demanding patients may stir up some further medical interest in these frustrating infections.

*One pamphlet available at A Woman's Place, entitled "Vaginal Infections and Women's Troubles", describes a number of <u>alternative</u> methods of treatment and prevention, such as a plain yogurt douche to replace the useful bacteria in the vagina that are killed by antibiotics.

QUESTIONS	RESULTS OF SURVEY
1. Have you ever experienced an itchy or painful discharge? Yes___ No___	45 - (1) Yes (2) Yes 5 - (1) Yes (2) No 41 - (1) No
2. Have you ever consulted your doctor for treatment? Yes___ No___	
3. If YES, what treatment did he/she prescribe? i) pills ii) vaginal suppository iii) douching iv) other.	#'s 3 and 4: 36 - treated, satisfied 7 - treated, not satisfied 2 - not ascertained
4. Are you satisfied with the treatment you have received? Yes___ No___	
5. Did he/she relate to you exactly what type of infection you were troubled with? Yes___ No___	#'s 5, 6, and 7: two out of four Yes means informative: 28 - informative 16 - not informative 1 - not ascertained
6. Did he/she explain how your infection was caused, or how you might try to prevent it from recurring? Yes___ No___	
7. Did your doctor explain the common occurence of vaginal infections while taking antibiotics? Yes___ No___ or while taking birth control pills? Yes___ No___	
8. Would you recommend your doctor to another woman? Yes___ No___	36 - Yes 4 - No 2 - Uncertain 5 - not ascertained

TYPES OF VAGINAL INFECTIONS

1. Trichimonas - a parasitic protozoan. The 2 main symptons are a vaginal discharge and a burning feeling when urinating.
2. Yeast Infection - the symptons are a thick white discharge, itching in the vagina or outer genital area, and sometimes burning after urination.
3. Non-Specific Vaginitis - inflammation of the vagina, caused by bacteria. May be accompanied by frequent and burning urination, lower back pain, and cramps.

Birth Control

There is a variety of methods of birth control available. The following is a table of these methods showing their clinical failure rate, ie. the number of pregnancies in 100 women using the method for 1 year:

Method	Failure Rate
The Pill	.05
I.U.D.	1.5 - 8
Condom	10 - 15
Diaphragm & Jelly	10 - 20
Vaginal Spermicide	15 - 25
Rhythm Method	15 - 30
Coitus Interruptus	20 - 30

(From McGill Birth Control Handbook)

To choose the best method for yourself, it is necessary to have the above information, and to know the other factors involved, both pro and con, eg. possible side effects, convenience, etc. We believe that it is essential that your doctor discuss all methods with you, giving you the information to make the best choice for yourself. The doctors of 45% of the women in our survey using some form of birth control did not do this. (13% of these women had their minds made up when they went to their doctors - would they have reconsidered if given this information?)

Some doctors have their own favorite method which they choose for their patients. They either do not encourage a decision by a woman herself, or they misinterpret a woman's rejection of their favorite.

> One doctor's reaction to a woman who did not want to use the Pill, because of her concern about the side effects, both short and long range: "She wants to get pregnant" !!!

We must demand that information be made available to us so that we can make our own choices!

Checking for Cancer

A Pap Smear is a test for abnormal cells in the cervix. The test results will show either (a) that there are no abnormal cells, or (b) that there are abnormal cells and further tests should be made. Cancer cells are one of the types of abnormal cells found. Since it takes a couple of years for cancer to develop, annual or semi-annual Pap Smears are a simple way of finding cancer in time to treat it. It is quite curable if discovered soon enough. A number of women we spoke to know the importance of having Pap Smears, but don't get around to it. Our health is important - let's take the time to look after ourselves.

Of the women who answered our question about Pap Smears, approximately 15% have doctors who don't encourage them to come in at least annually for a Smear.

A very simple thing you can do for yourself is to examine your breasts for lumps. After your period, feel your breasts with the flat of your hand (see diagram); if there are any abnormal lumps, check with your doctor. If you do this regularly, you will soon know what you feel like and easily recognize an abnormal lump. Only 45% of the women who answered question 2 responded Yes to both parts. Why don't our doctors tell us how to help ourselves?

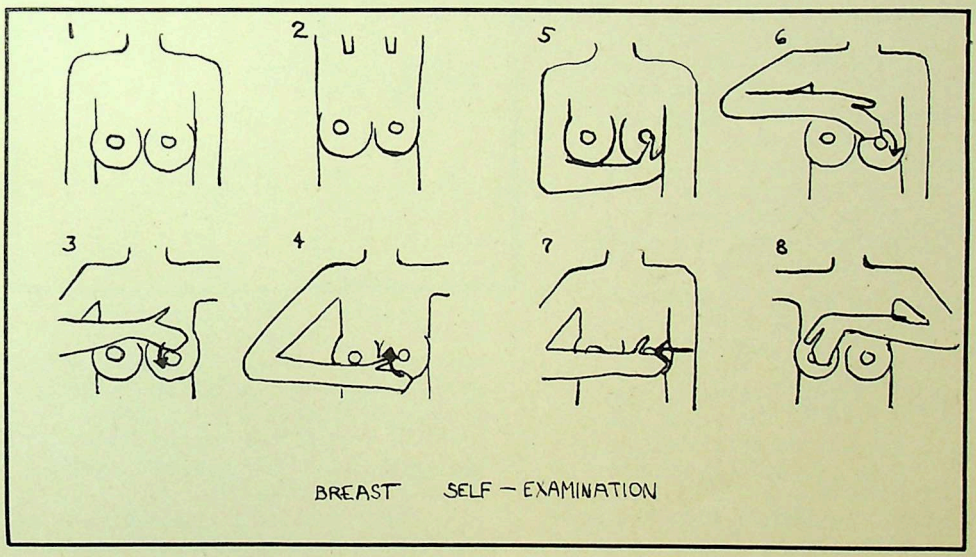
QUESTIONS

RESULTS OF SURVEY

Did your doctor discuss fully with you all the methods of birth control before you made your choice? Yes___ No___

36 - Yes
21 - No
9 - No, had mind made up beforehand
32 - Not applicable

Amount of cancer of the cervix in every 100,000 women in B.C.:
with Pap Test..... 4.2
without Pap Test..28.8



1. Pap Smears should be done regularly, at least once a year.
   Did your doctor ask you to come in for one: once a year? Yes ___ No___
   once every 6 months? Yes ___ No___

63 - Yes, to either
11 - No, to both
24 - Not ascertained

2. a) Does your doctor encourage you to examine your breasts for lumps?
   Yes___ No___
   b) Did he teach you how to do this?
   Yes___ No___

35 - (a) Yes (b) Yes
8 - (a) Yes (b) No
31 - (a) No (b) No
24 - Not ascertained

THE PILL

The Pill is unique in that it is usually not prescribed to treat or prevent a disease but rather is prescribed to healthy women to prevent pregnancy. This fact has prompted the Dept. of National Health and Welfare to urge that "the patient be fully informed and participate in the decision of whether or not she should use an oral contraceptive". 40% of the women surveyed who had used the Pill had doctors who did not discuss all methods of birth control with them before they chose the form of birth control they use.

The advantages of the Pill are:

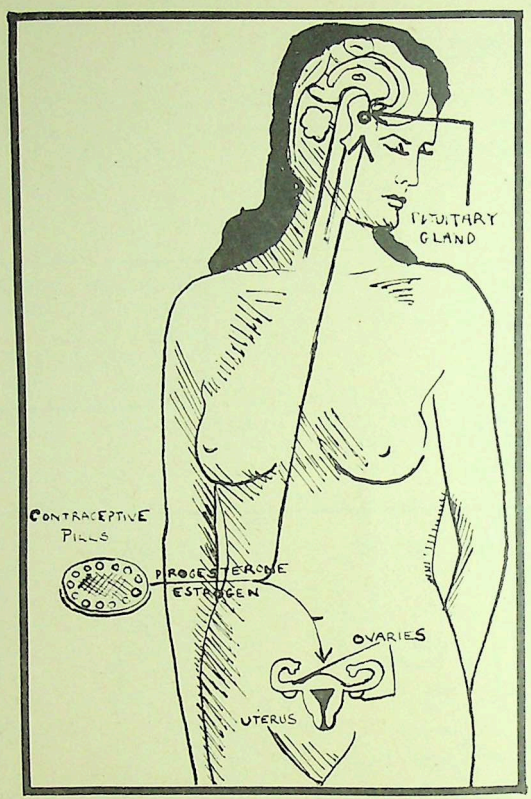
a) It's easy to use and the the most effective method, <u>if</u> you don't forget to take it.

b) It's independent of the sex act - you don't have to do anything right before, during, or after intercourse.

c) It regularizes menstrual periods, lightens the flow, and may eliminate cramps.

d) It isn't subject to the errors of use after sexual interest is aroused that mechanical methods are.

But the possible disadvantages to you must also be known. Oral contraceptives, like all potent medication, must not be used by certain women. For example, women who have had heart disease, serious vascular disease, or any form of cancer must not take the Pill. Therefore, your doctor should review your medical history carefully before prescribing the Pill - 32% of the women surveyed said that their doctor did not adequately check their medical history.



A second disadvantage is the possibility of experiencing side effects that resemble symptons of early pregnancy, and which commonly disappear after the first few months. Two-thirds of the women surveyed did experience one or more of these side effects.

There are still unanswered questions about possible connections between taking the Pill and acquiring cancer, metabolic effects, genetic effects, and failure to menstruate after going off the Pill.

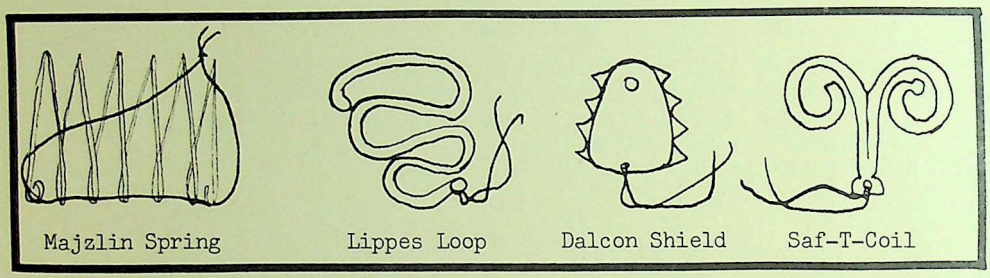
The Pill, then, is not necessarily the obvious choice for you to make. We're not advocating that everyone go off the Pill. But we do hope that you consider the pros and cons, review your medical history with your doctor, and <u>then</u> make up your mind.

QUESTIONS	RESULTS OF SURVEY
1. Do you think that your doctor knows enough about your medical history so that you feel that the Pill is "safe" for you? (ie, did your doctor take a full medical history before prescribing the Pill?) Yes___ No___	39 - Yes 18 - No 2 - Not ascertained
2. a) Some of the side effects connected with the Pill are weight gain, nausea, and depression. Did your doctor discuss these with you? Yes___ No___ b) Which side effects have you experienced?	37 - Yes 17 - No 4 - Not ascertained 11 - Depression 5 - Weight gain 3 - Nausea 1 - Headaches 2 - Other 15 - More than one of the above
3. Were you made aware that you can minimize the dangers of side effects by (a) using a Pill containing the lowest possible amount of estrogen, (b) using a combination-type rather than sequentials, and (c) using the 20-Pill type? Yes___ No___ 4. Were you made aware that the Pill is considered safe for only a 2-year period? Yes___ No___	#'s 3 and 4: 16 - Yes to both 41 - No to either or both. NOTE: There is now some controversy about the validity of these statements.
5. How long have you been taking the Pill?	16 - up to 1 year 16 - more than 1, to 2 years 16 - more than 2, to 5 years 1 - more than 5, to 10 years
6. Did your doctor do a Pap Smear before prescribing the Pill? Yes___ No___	44 - Yes 14 - No
7. Would you recommend your doctor to another woman (for the Pill)? Yes___ No___	36 - Yes 12 - No 6 - Uncertain

I.U.D.

The I.U.D. (intra-uterine device) as a birth control method is becoming more popular. A plastic device (coil, loop, shield, etc.) is inserted through the cervical canal into the uterus. Although IUD's have been in existence for centuries, no one is precisely sure of how they prevent conception.

The official failure rate for the IUD is generally given as 1-5%, but this does not take into account the large number of women who have had the IUD removed due to side effects.



Majzlin Spring Lippes Loop Dalcon Shield Saf-T-Coil

"I experienced labour for 5 days after insertion and then had the IUD removed. Also, the doctor (at a clinic) laughed at the 'horror stories' he had heard from women concerning pain following insertion of IUD's"

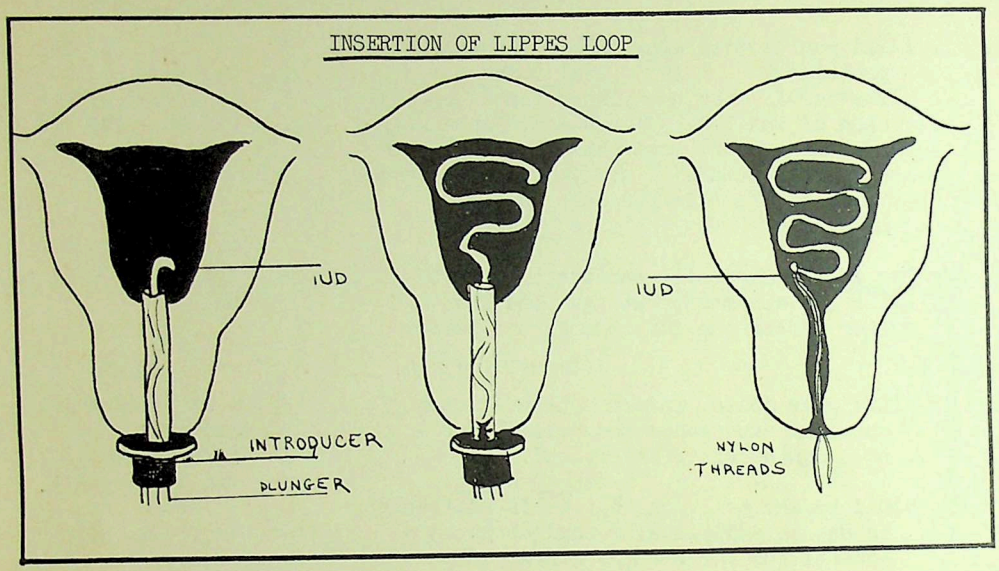
"I was referred to Dr. G by my G.P. to have an IUD put in. I found his manner rough and his attitude insulting while he carried out the procedure. He gave me no idea that it could be painful and became belligerently angry at me when I jumped during the procedure. I was reminded of an arrogant amateur vet artificially inseminating a cow. Damn it - I'm still furious - 2 years later!"

In our sample of 98 women, 13 had tried the IUD. Of these 13, 7 had it removed. A majority of women find the insertion procedure painful to varying degrees (10 out of 13). Some characterize it as a 'horrible experience' and tell of no warning from the doctor that pain would occur, no medication given, etc. If you are already tense from anxieties, unanswered questions, your body will react more strongly to any pain there is. A doctor who take the time to explain the insertion procedure, who is aware that it probably will be painful and is sensitive to your pain, and who gives you medication before insertion will help you to be more relaxed for the insertion. Why do some doctors not give us this necessary support?

Does this happen because the doctor (usually male) cannot understand that dilation of the cervix can be painful? And that the 'slight' cramping experienced after insertion (sometimes for months) can be so severe as to be unbearable? From our survey, 8/13 women experienced 2 or more side effects, and in 4 women these were severe enough to force her to have the device removed.

QUESTIONS	RESULTS OF SURVEY
1. a)Did your doctor expalin the insertion procedure? Yes___ No___ b)The cervix must be dilated for insertion of the IUD. Many women, especially if they have not had children, find this procedure painful. Was your doctor sensitive to the pain you felt during insertion? Yes___ No___	6 - (a) Yes (b) Yes 3 - (a) Yes (b) No 3 - (a) Yes (b) N/A 1 - (a) No (b) Yes
2. The IUD is generally easiest to insert while you are menstruating. Did your doctor insert the IUD during your period? Yes___ No___	4 - Yes 5 - No
3. a)Did your doctor inform you that women commonly experience some cramps for 1 to 3 months after insertion? Yes___ No___ b)Did he/she tell you that it is advisable to use an additional method of birth control for the first 3 months after insertion? Yes___ No___ c)Did your doctor explain the advantages of the different types of IUD's to you? Yes___ No___	2 out of 3 Yes means informative: 7 - informative 6 - not informative
4. Problems associated with the IUD include pain, breakthrough bleeding, heavier periods, etc. Have you had any of these?	3 - Breakthrough bleeding 8 - 2 or more side effects
5. Did your doctor explain that it is possible to check for the string of the IUD to make sure the device is in place? Yes___ No___	11 - Yes 2 - No
6. If you wished to have the IUD removed, what were your reasons? _____	3 - failure of the method 4 - dissatisfaction - side effects
7. Would you recommend your doctor to another woman (for an IUD)? Yes___ No___	10 - Yes 2 - No 1 - Uncertain 1 - Not ascertained

Who knows why an IUD works? Arabs have, for centuries, been putting stones into the uterus of their camels to prevent them from getting pregnant on long treks.



Almost half of the doctors of the 13 women did not provide what we consider important information:- a) that there may be pain after insertion - contractions as the uterus tries to expel the IUD, b) that an additional birth control method is advisable for the 1st 3 months, c) that the string on the IUD is there primarily so that you can check to make sure the IUD is still in place.

The IUD can, for many of us, be the answer to our concern about the Pill and our our hesitation to use any of the mechanical methods of birth control. There are doctors who are sensitive to our fears about using an IUD, are informative, and who are sensitive to the pain many of us feel during and after insertion.

If you're thinking of getting an IUD, get support from other women who have them and choose your doctor carefully.

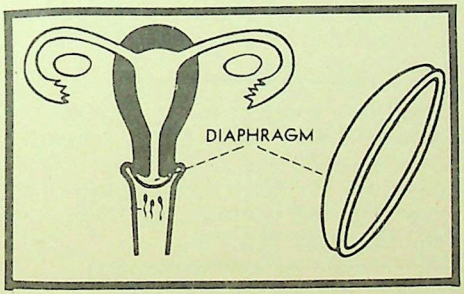
"I went for a first appointment to talk about my fears regarding getting an IUD. The doctor took half an hour to explain and answer my questions. He gave me no feeling that I was taking up his time unnecessarily. Before the insertion he gave me demerol - I was spaced out for 4 hours, but had little pain. He let the man I live with be in the room for the insertion and stay with me while I recovered. That was very important to me because a) I wanted him to know what had been done so that he could understand any pain I might have to put up with later (luckily, it wasn't much), and b) it makes a hell of a difference to not be alone when you're going through something painful and exhausting."

DIAPHRAGM

The diaphragm, used extensively before the advent of the Pill and the IUD, is a fairly reliable birth control method when used with spermicidal jelly, and with no adverse side effects.

The diaphragm fits snuggly over the cervix, acting as a mechanical barrier to sperm and also providing an anchorage for the spermicidal jelly. It is thought that it is the presence of the spermicidal jelly which provides most of the contraceptive effect.

The diaphragm must be properly fitted for each individual woman. For this reason it is necessary to visit a doctor or clinic to be measured for the correct size diaphragm.



"In 1946 I became pregnant as a result of a grossly misfitted diaphragm. I tried to induce an abortion but in vain ... As can be guessed, this little piece of ignorance on the part of an Australian lady doctor has changed my life."

We feel that it is vitally important that the doctor explain fully to the woman the insertion procedure, why the diaphragm works, how and when to apply the jelly, how long to leave the diaphragm in (at least 6 hours after intercourse), etc.

"I like the diaphragm best and know it is safe for me."

In our survey, we found only 8 out of 98 women who were using or had recently used the diaphragm. Two out of 8 had not received sufficient information from their doctors.

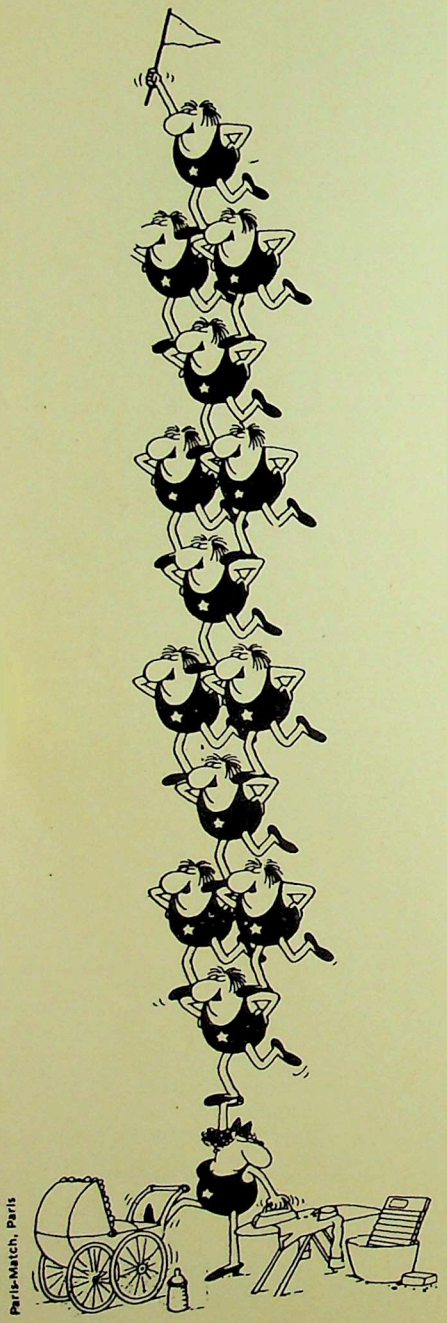
"I only used the diaphragm 3 months until I discovered I was pregnant."

Other Methods

The less reliable birth control methods most used are condoms, vaginal creams and foams, rhythm, and withdrawal. The major advantage of these methods is that they can be used without consulting a doctor. The drawback, of course, is that they don't work all that well.

"I now use condoms as it means I do not have to communicate with doctors on this subject."

"Used vaginal foams. I didn't feel secure with it. Foam has a way of unfoaming and leaking out. I felt unprotected."



Out of the 98 women in our survey, 29 answered that they had used or were using one of these methods. 17 out of 29 were satisfied with the method they used. 12 weren't. A typical reason:

> "Vaginal foams and withdrawal interfere with the mood or emotions at the time - especially withdrawal."

We found that women in Vancouver using these methods were (a) very young and had difficulty finding a source of birth control information without hassles, or (b) did not wish to consult a doctor or clinic, or (c) were talking about experiences before the Pill and IUD were popular.

> "My doctor was Catholic. She recommended rhythm method only."
> "Were you satisfied with this method?"
> "Yes. I only got pregnant two times."

The best birth control method of the ones named above is a combination of condoms and foam. The failure rate for this combination is extremely low - rivalling that of the Pill, and the IUD.

> "I used condoms in the past.
> "Any problems?"
> "Yes - unpleasant for my husband. He had to stop to put it on."

We listed vasectomy in the 'other methods' section and found several doctors who advocated vasectomy. Generally the women expressed great satisfaction with this method when the man in the case consented to it.

QUESTIONS (DIAPHRAGM)

1. As a method of birth control the diaphragm is older than the Pill or the IUD. Did your doctor explain to you how the diaphragm works? Yes___ No___

2. The diaphragm must be fitted to sit snuggly in place. Did your doctor show you how to insert the diaphragm and make sure you were able to insert it yourself? Yes___ No___

3. Did he/she tell you how long before intercourse to insert the diaphragm and how long before it can be removed after intercourse? Yes___ No___

4. The diaphragm is a mechanical device. The only protection against conception is the chemical one provided by a spermicidal agent (cream or jelly) that is applied to the diaphragm. Did your doctor explain how to apply the cream or jelly and how much to use? Yes___ No___

5. Did he/she advise you to add more cream or jelly before each additional act of intercourse? Yes___ No___

RESULTS OF SURVEY

8 women answered this section.

6 - Informative doctor - Yes to all questions.
2 - Inadequate information - one or more No

Would the woman who answered the questionnaire saying she was 'completely satisfied' with her birth control method which she described merely as an 'Indian herbal preparation' PLEASE come forward and share her secret with the rest of us?

(OTHER METHODS)

1. Some other methods of birth control are condoms, vaginal foams and creams, withdrawal, rhythm, and vasectomy. If you use one of these methods, do you find it satisfactory? Yes___ No___

17 - Yes
12 - No

2. If you consulted with your doctor about any problems you had with this method, were you satisfied with his/her response? Yes___ No___

6 - Yes
3 - No

Tubal Ligation (Sterilization)

Tubal ligation is a sterilization operation for women. The Fallopian tubes are cut; this means an egg cannot move down the tubes into the uterus. The operation is seldom reversible. If you are considering having a tubal ligation, you should know that there are several methods available.

At Lion's Gate Hospital, in North Vancouver, most ligations are done vaginally: a general anesthetic is given, the doctor makes an incision in the back of the vagina, removes a small piece of each Fallopian tube, and then seals the cut ends. Hospitalization is generally overnight, rarely longer. Discomfort is minimal, and there is no visible scar.

Most often hospitals in the Vancouver area perform tubal ligations abdominally: a general anesthetic is given, the doctor makes an incision in the abdomen, and then cuts the tubes and seals the ends. This is major surgery - it may require up to a week in hospital; there may be a lot of discomfort; there will be a scar.

With each method it sometimes happens that the tubes rejoin (in which case, you may get pregnant). The doctor may perform more complex and elaborate techniques with the abdominal operation, such as implanting the cut ends in tissue, making it most unlikely that the tubes will ever rejoin.

It is most important for you to know precisely what technique your doctor is going to use, especially if you are having abdominal surgery - it would not seem worthwhile to have abdominal surgery unless the doctor is going to do a more complex procedure.

The contrast between the extended comments by women who got the operation and the women who tried and are trying desperately to get it is painfully sharp. Of the combined sample (general and geographical), one-third (8 out of 23) were refused - on non-medical grounds.

REFUSAL REASON	WOMAN'S ATTITUDE TO IT
"Doctor refused on the grounds - 'too young and attractive' (age 27, has 2 children), 'too newly divorced'. I have to get down on my hands and knees."	"Feel really free emotionally. No depression. As Martin Luther King said: 'Free at last, free at last, Great God Almighty, I'm free at last'!" (3 children)
(age 25) "not legal because too young and has no kids." She wants no children but he refused.	(age 25, 2 children) Doctor was "open, frank, told us the negative aspects and left the decision to me."

QUESTIONS

1. Have you requested a tubal ligation?
   Yes___ No___

2. If YES, was your doctor's response:
   a) encouraging
   b) informative
   c) discouraging
   d) unwilling to discuss it
   e) other, negative

3. If you have had a tubal ligation, please describe your feelings about the operation and its implications on your life.

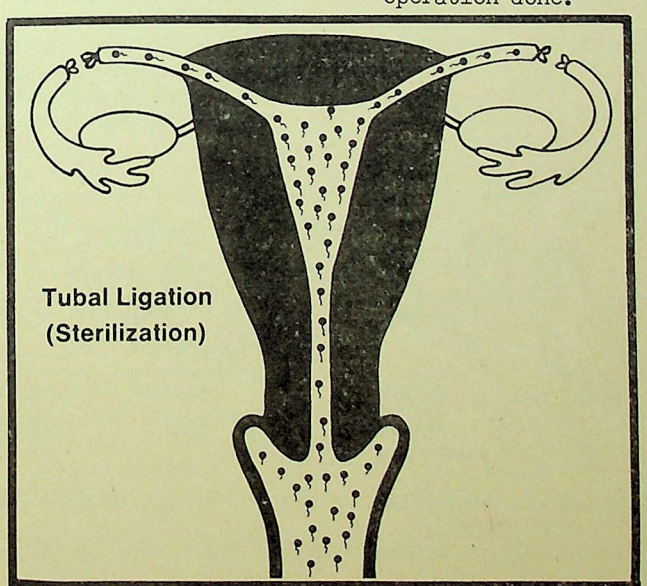
RESULTS OF SURVEY

14 - Yes
84 - No

Woman's Age	Doctor's Response	# of Respondents	% of Drs Giving -ve Response
21-25	a & b	1	33.3
	a	1	
	e	1	
26-30	a	3	62.5
	c	3	
	d	1	
	e	1	
36-40	a	1	50
	d	1	
41-45	a	1	-
Totals		14	50

1 - positive physically
3 - positive emotionally
1 - no comment

5 women actually got the operation done.



Are there Really Legal Limitations?

"The use of sterilization as a birth control method has been limited by the fear of unknown effects..."

"by linking it to the eugenics movement, and by the attitude of medical authorities who consider it dubious practice to sterilize patients for birth control reasons."

"The only laws dealing with the subject in Canada ... prohibit compulsory eugenic sterilization."

C.M.A. position
"with written permission of patient and spouse."[1]

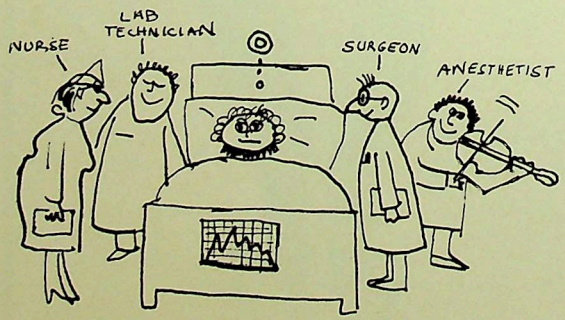
"However, sterilization is usually carried out for medical reasons only ... At stake for the physician is the question of his criminal or civil liability ... The law is not clear as to liability if the consent of the spouse is not obtained."[1]

Is Tubal Ligation Painful or Dangerous?

"The operation does not remove any organ, nor does it interfere with sexual desire or performance. It does not create a hormone imbalance."[1]

"In the traditional sterilization operation for a woman, a fairly large abdominal incision is made, a piece of each fallopian tube is cut out and the two ends are tied off. A more recent development is the laparoscope technique, in which a tube with mirrors and lights is inserted through a small incision, the tubes visually located, and the tubes cauterized (burned) by a small instrument inserted through another incision. The traditional tubal ligation is major surgery, unless entrance can be made through the vagina. It requires a 4-5 day hospital stay ... The laparoscopic sterilization requires only one day hospital stay ..."[2]

The traditional operation is surgically easiest 48 hours of birth of a baby becasue of the change in the disposition of the organs due to pregnancy. It may not be the best time for you.



1. Report of the Royal Commission on the Status of Women in Canada. Ottawa: 1970. pp 280-281.
2. Our Bodies, Our Selves: A Course By and For Women. p.59

The humiliation seems to cut both ways. Not only are some women involuntarily sterilized (see comment on unnecessary hysterectomy in later section); but also some women, against their expressed needs, cannot find a doctor to do a voluntary sterilization. If part of this is due to legal confusion, the laws must be changed so that our right to make our own choice is clear.

And if a residual moralism or conservatism underlies limits by age/number of children, it is well to remember George Bernard Shaw's dictum from Man and Superman:

> "Do not unto others as you would have them do unto you; their tastes may not be the same."

INFERTILITY

Unwanted infertility - in contrast to the problem of being refused a tubal ligation - is a problem that concerns some women. The whole process of finding causes for it can be exhausting and depressing. It takes a great deal of strength for a woman to go through some or all of the tests. The doctor can be of great help to the woman when she/he is sensitive to the woman's reactions to both the problem and the tests.

Our questions on this focussed entirely on the doctor's helpfulness, since to probe to find a woman's feelings on this would be, we felt, very uncomfortable for the woman, given today's prejudices about 'barren' women.

This section applied to 3 women in our survey. Two out of the three were happy with the consideration and treatment received from their doctors.

> "She recommended: taking temperatures in the morning, a marital book, sent me for tests to specialist. Gave us lots of ideas to help."

This pattern of helpfulness and the woman's satisfaction with it is generally reinforced by comments other respondents made. (The section on infertility applied to 8 out of 250 respondents.)

> "The doctor recommended 'patience'. I had already had the routine tests and he said they should still be valid. He seemed sensitive and reassuring. He suggested the possiblity of a D & C, but only after a longer time. He was very thorough and serious."

Comparison of Doctors' Responses:
Tubal Ligation and Infertility

No woman found a doctor who would not help with infertility, in contrast to women looking for a doctor's help with tubal ligation.

Comparing the two situations: From the viewpoint of the woman involved, both situations are urgent problems, require medical help, and can often touch off a searching self-analysis. Why, then, is there such a different response from M.D.'s?

We have an idea of the reasons behind the contrast:

Model of the Relationship (asking for Tubal Ligation)	Model of the Relationship (asking help for infertility)
I. Society' disapproval of the aims of the woman, ie elective surgery for her own purposes(non-medical reasons) Aim: Infertility THEREFORE: high incidence of doctors' minimizing her problem.	I. Society's approval of the aims of the woman, ie elective surgery for her own purposes(non medical reasons) Aim: Fertility THEREFORE: high incidence of doctors'empathy with her problem.
II. Does not fit in with traditional model of "therapist-patient" ("parent-child") relationship.[1]	II. Does fit in with traditional model.[1]

If either speculation as to cause is true, in EITHER situation we do not accept (i) the implied definition that the society (and the profession?) will only help those who fit its present mores, and (ii) that the 'healthy' person is equivalent to one who is adjusted to 'good' social role behaviour.

1. see "Patient-Practitioner Relations", in The Sociology of Health, Robert N. Wilson, ed., (N.Y. Random House, '70) pp 13-32.

V. D.

More women are being exposed to venereal disease today than in the past. Because of its association with 'illicit sex' the subject of VD is still taboo. Syphilis and gonorrhes can be treated like any other communicable disease; both can be cured if found and treated in time.

Syphilis affects men and women in the same way. In the early stages a doctor can determine its presence by taking scrapings from the sores that may appear. A blood test can detect the presence of syphilis in the second stage. Although more harmful in the later stages and more damaging then, syphilis does not pose as great a problem to women as gonorrhes which has reached epidemic proportions in North America.

If a man has sexual contact with someone who has gonorrhea, in a few days he will probably notice a burning when urinating, and then a discharge of pus from his penis. A smear of this discharge can be placed on a slide, stained, and examined under a microscope for germs; or a culture can be grown.

Gonorrhea does not always produce symptoms in women. If early symptoms do appear, they do not appear as early as in men. Pain on urinating may be a symptom. A vaginal discharge may also be a symptom: a smear should ALWAYS be taken (the cervix, urethra, vagina, and rectum are areas of infection), sent to the provincial lab where a culture can be seen to grow if g.c. is present. The gonoccocus may, however, die before reaching the lab, resulting in a false test. Diagnostic tests are not wholly reliable for women. Sometimes a woman does not learn she is infected until an infected male with whom she has had sexual contact tells her that he has it. Later symptoms and results of untreated gonorrhea can include severe abdominal pains, infected tubes, bladder, and/or rectum, sterility, arthritis, blindness and death!

The only way a woman can tell if she is cured of gonorrhea is to be tested - a woman should have 3 negative tests before being discharged as cured. Just being treated is NOT enough.

In 1971 there were 7,475 reported cases of VD in British Columbia: 72% in men, 24% in women (age or sex not stated in the other 4% - DBS-82-201). Tragically, the undetected presence of gonorrhea in some women may partly account for the discrepancy between the number of cases in men and women.

We feel that it is essential that women be tested routinely for gonorrhea at the same time that they have Pap Smears. One woman in this survey who approached a doctor for this reason was met by a lecture on morality and birth control. In view of the frightening facts about gonorrhea in women, we must be encouraged to seek treatment and to insist on tests for cure once treated. The medical profession must abandon its disapproving or scornful attitude toward gonorrhea as well as toward syphilis. We cannot control our bodies and determine when we would like to bear children unless VD, which can make us sterile or less fertile, is controlled.

For information on the symptoms of VD, see:

Our Bodies, Our Selves

(McGill) VD Handbook

For treatment in Vancouver, turn to page 90.

MENOPAUSE

Menopause - the aging process of the reproductive system; found in all women and becoming noticeable between the ages of 40 and 55. Symptons are an upset in the pattern of periods (irregular bleeding, increased or decreased amount) caused by the aging of the ovaries which decreases the amount of hormones released and which in turn lessens the production of eggs each month. Finally bleeding stops because sufficient hormones are not produced to stimulate menstruation. Other symptons are hot flushes, headaches, dizziness and depression.

Many doctors used to dismiss symptons as "imaginary" (imagine that!), but now they link them with the lack of Estrogen and cure them with regulated dosages of hormones (estrogen, progesterone).

If a woman's periods at the time of menopause become heavier, she should consult her doctor immediately. Most often, it is just unbalanced hormone ration; but, at this age, women are more susceptible to cancer, fribroid tumours, polyps, pelvic endometriosis (internal bleeding). A pelvic examination should be done regularly at this time. It should be noted that light bleeding does not occur if a woman is taking estrogen hormones.

5 out of the 7 women in our survey who consulted their doctors about menopause were satisfied with her/his response and/or treatment. Similarly, from the total sample, note a sympathetic attitude:

> "The doctor gave extra attention to this when she thought it was "in her head". Recommended medication. Woman said it was a "relief to understand".

However, some comments did indicate an indifferent or inadequate response:

> "The doctor said: 'It's one of those things that all women go through'. He prescribed tranquillizers!"

In one case, the treatment was surgery - a hysterectomy!

Nine out of 32 women had no problems or did not consider it important: "Can't turn to a doctor about everything." In answer to these, here is a remark from a UBC gynecolgy professor: "Menopause is caused by failure of the ovaries. God has been stingy to women that way ... we don't tell a woman who is hyperthyroid, 'I'm sorry, your thyroid gave out. It's a physiological process and you must put up with it.' "

What causes the "failure of the ovaries"? Would better nutrition play a role in this? Controversy over these questions is not yet resolved. More research needs to be done.

At present, estrogen replacement helps with the symptons of menopause. Replacement should only be advocated, we feel, with due attention to the woman's hormone balance and cycle. As with the Pill, side effects of estrogen replacement have been reported - eg "bled for 6 weeks".

Society usually puts an even worse idea in women's minds than "you must put up with it, it's all you can do". "Planned obselescence" is a harsh reality for many women of middle age in a society that madly extols woman as sexpot, baby-machine, and 'young, always young'. Have you ever seen a book or ad that protrays women in the way men are portrayed? - with the lines of experience of human toil, suffering and joy written on their faces, with recognition that this is beautiful because it is appropriate to the season of life shown. Few, very few.

A woman's fear of menopause and of old age is learned in this culture, is realistic. No one dares say which is the biological, which the social process (of menopause), until women live in a society in which they can grow with the respect and options due all humans.

"Mother, what is a Feminist?"
"A Feminist, my daughter,
Is any woman now who cares
To think about her own affairs
As men don't think she oughter."

— Alice Duer Miller, 1915

Abortion

An abortion is legal in Canada if the conditions set down within the Criminal Code 1971, Section 251 are upheld. The conditions are:

a) approval in writing by a majority of a therapeutic abortion committee,
b) in an accredited or approved hospital,
c) with the woman's permission (under 19 - with parental approval),
d) if continuation of the pregnancy would be dangerous to the woman's life or health.

What happens in practice is that each separate hospital board is free to interpret the word 'health' as it wishes. This results in an uneven distribution of services since one hospital may use religious or moral grounds to reject the possibility of abortion completely while another may feel 'health' covers all phases of a patient's physical and mental condition. (eg VGH has interpreted 'health' to mean 'the highest quality of life' desired by the woman). Those hospitals which take the latter view found themselves severely overburdened soon after the law was passed. There were very long waiting periods for the patients and as a result, increased risk. VGH, for example, was forced to implement residency requirements to reduce their load. While over 80 abortions a week are performed at VGH, this is well within its capacity. These regulations were of great benefit to the women of Vancouver, but they have made the situation for women in outlying regions, especially the Interior, that much more difficult. Women in southwestern B.C. are a privileged group; not only are abortions readily available, but they are the cheapest in North America.

Women in the Interior are at the mercy of their local doctor. If he will not agree to perform the operation, she is forced to travel to another centre. There are several sympathetic doctors living in this region; however, considering the vast area of our province and the population, they do not meet the demand.

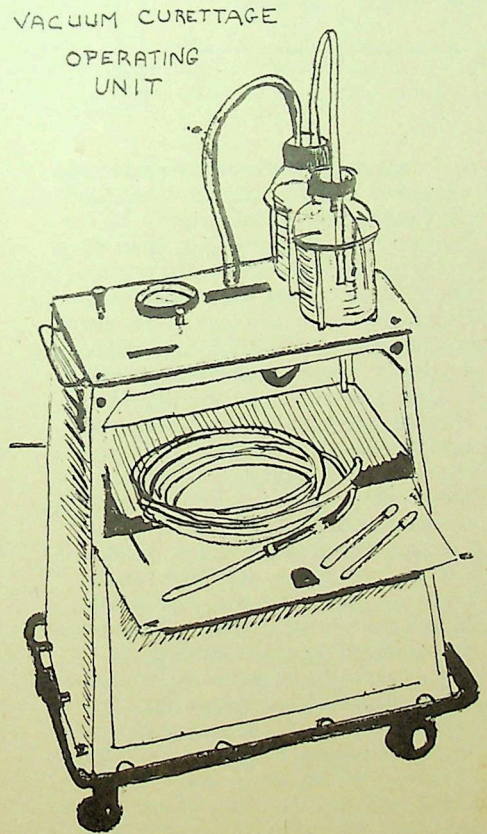
Abortion is legal; however, it is <u>in fact</u> only available to those in a favorable geographic as well as financial situation.

QUESTIONS	RESULTS OF SURVEY
1. Would your doctor be helpful if you wanted an abortion? Yes___ No___	22 - Yes 7 - No 35 - Don't know
2. Have you had an abortion? Describe.	1 - legal, with ease 2 - self-induced 1 - had the child
3. Was your doctor supportive before, during, and after the abortion?	1 - critical of doctor/hospital
4. Would you recommend your doctor to another woman on the basis of his/her actions on this issue? Yes___ No___	1 - Yes 1 - No

Only 22 out of 98 women in our survey felt that their doctor would be sympathetic and helpful if they wanted an abortion.

"Dr. B hassles women seeking abortions. Gives them big moral trip. Tries to scare them about the abortion itself and charges them $50 on top of BC Med. Typical B. remark 'Why don't you get married?' "

Only 4 of the 98 women interviewed had actually needed an abortion. Of these, 2 had self-induced abortions, 1 had a legal abortion, and 1 woman had the child.



"One woman had a back-street abortion 30 years ago. She had an abortion in February which didn't work. She went back twice. Finally she started bleeding in June, ending up in a hospital where a D & C was done. Her womb was packed; when the packing was removed, doctors stood around laughing. She felt very resentful. 'I felt totally ignorant about my body. It was a very demoralizing and traumatic experience. Most of my contemporaries have had abortions - either self-induced (knitting needles, etc.) or back street - so it's nothing new.' "

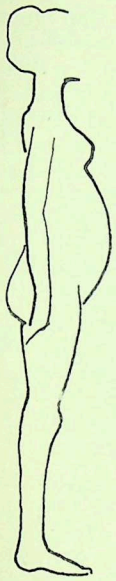
"I was emotionally involved whereas everyone else appeared ultra-clinical. A few softer words make a giant difference. Other than that (and my own misconceptions) it was extremely efficient and well-handled." (at VGH)

The difference between the two quotes above describes more eloquently than any rhetoric the rationale for abortion on demand.

"UBC Health Service told a married woman seeking an abortion that it was 'a dangerous operation, hard to get, and a serious moral decision'."

The decision must be the woman's, not the doctor's!!

Pregnancy & Childbirth



The issue of Childbirtn raises many important questions for women today. We women are bombarded daily by the media, which reflect our whole culture, to believe that Motherhood is the only proper fulfillment of a woman's potential. The sense of usefulness, of completeness, of identity are all supposed to be born within the woman along with the baby. We know it doesn't always happen like this.

Quote from an obstetrician: "The first rule in Obstetrics is- Never trust the woman."

"What you need, dear, is to have a baby."

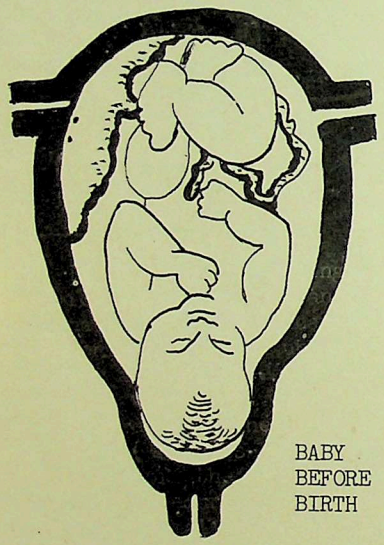
The role of Motherhood has been one of the last to be questioned or examined and hence women approach their pregnancies ignorant of the physical, the emotional, and the social implications involved. We need to understand the physiological processes of pregnancy and childbirth in order to prepare ourselves for active participation in our children's births. We need to examine the emotional aspects of bearing a child, of being a Mother in a world which defines women primarily in terms of their capacity as child-producers. We need to examine the possibilites in our society of adequate Day Care, of maternity leave for both parents, of adoption as an alternative to 'our own' children, of Mid-Wife cum Health Education clinics, of single-parent group homes and of raising our children collectively. Perhaps only then can women approach Motherhood capable of making free and informed choices.

About one-third of the women surveyed had experienced childbirth. Of these, 75% of them felt their doctor had adequately helped them prepare for the physical aspects of the pregnancy and delivery although questions were not asked in order to determine how much the women had actually understood about their bodies (or cared to know), or whether the doctor had remained ultimately responsible and in charge. Similarly, 76% of the women who discussed their emotional changes and problems with their doctors received helpful care. 20% of the women had emotional problems but they did not raise them with their doctors. However, we cannot determine how many women were never able to articulate their emotional changes and the larger implications pregnancy has on a woman's life. Only 25% of these women were encouraged by their doctors to focus beyond the delivery in preparation for the baby.

QUESTIONS	RESULTS OF SURVEY
	Total # of respondents: 37
1. Did your doctor recommend: a) good pre-natal classes b) good reading material c) special nutrition needs?	3 - (a) Yes 2 - (b) Yes 4 - (c) Yes 2 - (a) & (b) Yes 2 - (a) & (c) Yes 3 - (b) & (c) Yes 15 - All Yes 2 - learned everything from classes
2. Most women anticipate physical changes such as fatigue and increased appetite. Many doctors deal adequately with these problems, but only when the woman asks about them. Did your doctor encourage you to discuss your physical state during pregnancy? Yes___ No___	28 - Yes 9 - No
3. Was she/he able to deal helpfully with: a) fatigue Yes___ No___ b) excessively increased appetite Yes___ No___ c) insomnia Yes___ No___ d) nausea Yes___ No___	26 - Yes 6 - No 5 - Not ascertained
4. Many emotional changes accompany pregnancy, such as depression. Did your doctor discuss these with you adequately, helpfully, brushed them off?	6 - adequately 8 - helpfully 2 - brushed them off 7 - didn't bring up problem with Dr. 14 - expressed no problems.
5. Many women have said they wanted their doctors to help them focus beyond their delivery date. a) Did your doctor help you prepare for the physical care of your baby? Yes__ No__ b) Did she/he help you prepare for the physical care of yourself after delivery? Yes__ No__ c) Did your doctor encourage you to think about the changes in your life which a baby would bring? Yes__ No__	7 - All No 3 - (a) only Yes 4 - (b) only Yes 3 - (c) only Yes 5 - (a) & (b) Yes 1 - (a) & (c) Yes 2 - (b) & (c) Yes 8 - all Yes 4 - Not ascertained

"In sorrow shalt thou bring forth children."
Genesis 13:16

And thus the Hebrew was translated and the sorrow (correctly translated as 'labour') of childbirth was accepted in the Western world as a law of God and nature. So strong was this belief that Queen Victoria's physician was harshly criticized by the Church for administering a painkiller to her during one of her labours!



BABY BEFORE BIRTH

Natural childbirth, better named 'prepared childbirth' since we have all been previously 'prepared' to expect sorrow, is increasingly popular. Slightly more than half (54%) of the women were interested in natural childbirth, and of these 95% received support from their doctors. One-quarter of the women wished the child's father or a close friend present at the delivery, and of these only two-thirds were encouraged by their doctors. There appeared to be many strong opinions over this issue; some doctors practically insist the woman be accompanied for support and others insist that a husband-friend would necessitate extra hospital staff to catch the 'fainting fathers'. Surely the fact that the sight of one's own child being born is thought to be nauseating points to greater malaise of our society.

The hospital routine of separating the mother and child was reported as very distressing for only about 17% of the women interviewed. However, women reacted to the question by saying they had never questioned the hospital policies. Several strong statements came from the women who did have rooming-in (their babies were allowed to stay in the same rooms with them alone) stressing the joys in contrast to the frustrating normal routine they had experienced with previous children.

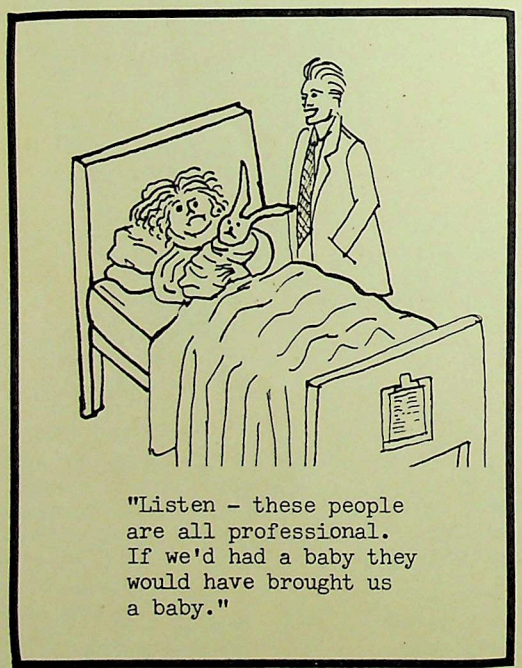
"She cared not to sleep. Exctiement was beating through her. She was longing for the morning - perhaps then she might be allowed to feed the baby. The women slept heavily all around her, reminding her, with their heavy breathing, of cows on a dark hillside. But her mind was at the other end of the building, in the room full of babies. She watched the stars move across the windows, and wished they might hurry, hurry, hurry to the dawn. Then a baby began crying, a faint persistent wail, and soon they were all crying. The women began stirring and listening in their beds."

Doris Lessing, A Proper Marriage

QUESTIONS	RESULTS OF SURVEY
6. Many women are eager to experience natural childbirth (without a general anesthetic, eg Lamaze method). Were you interested in this method of delivery? Yes___ No___	20 - Yes 17 - No
If YES, would you describe your doctor's attitude as: supportive encouraging accepting discouraging disapproving	11 - supportive 6 - encouraging 2 - accepting 1 - discouraging
7. Did you want the child's father or some other close relative or friend present at the delivery? Yes___ No___	9 - Yes 28 - No
If YES, was the doctor helpful in arranging this or discouraging and unwilling to arrange it?	6 - helpful 3 - unwilling
8. Did you find the hospital routine unsettling (eg keeping mother & infant separate becasue of hygiene precautions, etc) Yes___ No___	7 - Yes 30 - No
If YES, was your doctor: a) sensitive to your concerns b) not interested c) helpful	1 - (a) 1 - (b) 4 - did not talk to Dr. about it 1 - not ascertained
9. Some women have definite ideas about their preference for breast or bottle feeding their babies, and some are uncertain. (There are many arguments for and against each.) Regarding the two possibilites, was your doctor: a) informative b) helpful c) rigidly "for" one way d) other	13 - (a) 7 - (b) 6 - (a) & (b) 4 - (c) 6 - decided without doctor's advice 1 - not ascertained
10. Many women who experience a miscarriage, especially with their first pregnancy, feel discouraged and fearful of their ability to bear children. If you have had a miscarriage, was this your reaction? Yes___ No___	6 - Yes 4 - No
If YES, was your doctor sensitive to this concern? Did he encourage you to discuss your fears? Since 1 in 10 women miscarry, did she/he inform you that it is not necessarily an indication of problems with your reproductive system? Did he investigate to your satisfaction the possible reasons for the miscarriage?	9 - helpful 1 - not applicable

Finally, 70% of the women interviewed recommended the doctors who had helped them deliver their children. The highest dissatisfaction came from women between the ages of 26 and 30, 36 and 40, and the lowest above the age 40 and below age 25.

Although one woman in every 10 miscarries, 60% of the women in our survey who had miscarriages were fearful that it meant an inability to bear children and all these felt their doctors were sensitive to their concerns.



"Listen - these people are all professional. If we'd had a baby they would have brought us a baby."

There were many criticisms made by women regarding their childbirth experience:

"You certainly learn more from experience than from doctors."

"The o.b. nurse told me to shut up and do what the doctor tells you."

"The doctor was only interested in the state of my uterus."

"I didn't even know the doctor who delivered me; it could have been the janitor."

These are all reflections of a prevalent attitude that pregnancy is a disease and the woman is patient. Hopefully things will change so that women will gain the knowledge and hence the confidence to know what they want and need and can live and own and take joy in their pregnancies.

WHAT DO WOMEN WANT ANYWAY?

At the end of our questionnaire there was a space where women were invited to share their ideas, experiences and opinions on doctors and the health system in general. It is from these comments that we are able to find the clearest and most thought-provoking insights into inadequacies in doctor-patient relationships as women see them.

From 250 questionnaires, approximately 40 contained comments ranging from mildly critical to grounds for a malpractice suit. These comments seem to document charges often laid against the "healers" of our society, not only by women, but also by all poor and minority groups. Medical care, it is said, can be obtained only in an atmosphere of mystery and unaccountability, and at the price of humiliation, dependence, and bodily insult.

Women, especially, often feel powerless and unhappy with their doctors. They see getting good medical care as a matter of luck.

"It is vitally important that this kind of research (Our survey) be done so that women are able to have some knowledge of the calibre of doctor that they consult. Going to an unknown doctor can be compared wtih playing Russian roulette."

It is the opinion of some people that if a woman is dissatisfied with her doctor it is the women's fault. This attitude can be seen in the following quotes:

"I am extremely interested in receiving a copy of the report which I assume is the only result of this study ... Frankly, I didn't realize, or am not sure in believing, that many females actually do experience tension or problems with their doctors. Is this not a problem on the woman's part?

I believe every female can be comfortable with her doctor. She may have to experiment with different doc- doctors ... ultimately it is easily possible to find a doctor she is at ease with and who is easily interested in discussing female problems with patients. After all, a doctor is a doctor!"

"If a woman does not approve of her doctor, she should not visit him but go to another. These questions seem to encourage bad feelings between doctor and patients. I firmly believe that a good diet would solve a lot of the problems you are investigating.

Contrast the attitudes above, with those below.

"I don't generally see doctors as I have little faith in modern medicine."

"I am mistrustful of modern medicine in general and therefore of all doctors."

The issue here seems to be faith. The patient "should" have complete faith in the doctor and assume that he "always knows best". This almost mystical view of the doctor as superhuman is reflected in both the accolades and the anger expressed when the "faith" is betrayed. There does, however, seem to be a realistic basis for the mistrust expressed in the two latter quotes - as we will attempt to show.

> "I've always been basically healthy and feel I know pretty well what's happening with my body. If I didn't have this knowledge and were more dependent on the doctor, I would be much more insecure about my health."

This woman sees that the information she possesses - information usually reserved solely for doctors - gives her more power. The first two women quoted would not concede that the extent of a woman's freedom of choice can be limited. The last quote points to the idea that women with knowledge of their own bodies may have a head start in terms of having information as to health possibilities.

Women of privileged social status may also have a head start - money, time, cultural orientation the same as doctor's.

> "Have you ever experienced discrimination?"
> "Yes - because I am dressed in jeans, etc. I am on welfare and an unwed mother."

The problem factors in a relationship between a woman and her doctor seem to fall under several main categories.

"I FEEL LIKE A SYMPTOM TO BE CURED"

> "Any comments on other experiences you have had as a patient?"
>
> "You are usually not asked what you would like."
> "You are not informed of all the possibilities."
> "You are usually treated as a nonentity."
>
> "They were rough and seemed not to care about me as a person, or my feelings, or thought I was imagining my sickness. If I could find a good doctor I would go."

These negative comments seem to very strongly express the feeling that the patient does not feel treated as an individual - a person.

> "I experienced a breast operation where a tumour was removed. I was 20 at the time and extremely sensitive and depressed about the biopsy. I got no psychological help at all. A breast operation should be accompanied by some sort of psychological help as well as the surgical routine."
>
> "In X hospital - respondent was young at the time of stay, had breast abcesses and was embarassed to have 4 or 5 MD's standing around her every morning."

The woman feels treated as a "thing". There is no sensitivity to her needs as an individual - especially when used as teaching material.

"Would you recommend this doctor?" -

"Yes, I would. He is very kind and interested in each person as an individual."

"The reason I would recommend this doctor is that he's open to each person's wants, needs, desires - and he chooses his treatment with the patient and finds the right method for them, rather than sticking rigidly to one method."

These comments give the feeling of being treated as an individual as the major factor in recommending the doctor.

"QUALITY OF TIME"

There were a few comments where the element of dissatisfaction had to do with wasting time.

"Dr. G does seem very knowing and understanding but the long waiting in his office (sometimes 2 hours) seems unnecessary. Also, after a visit tests in a lab are taken - then return in 2 weeks time. This seems too long when a diagnosis is concerned."

However, it seemed that a more important problem factor was the quality of the actual session with the doctor, rather than the length of it or the wait before.

"I know he is busy, but I don't feel rushed."

Informativeness and a show of sympathy on the doctor's part, be the session but 2 minutes long, can make a woman feel "unhurried". The opposite, for ten minutes to an hour, may still leave her feeling "rushed".

"Doctor was always rushed. Did not explain what was happening, why certain drugs were used. Was arrogant and know-it-all and did not refer to specialists."

Another motive for mistrust was expressed. Some women had the temerity to believe that a concern for profits might have crept to the top of the doctor's list of priorities.

"Sometimes I feel that the doctor calls me back to the office just so he can get the coverage from MSA."

"We've got to get into People's medicine. More knowledge of our bodies - free medical assistance - free drugs, free vitamins, etc. - midwives, home deliveries. Medicine should not be a money-making machine."

INTERFERING ASSUMPTIONS

Often a doctor's own personal moral code dictates how he sees and treats a woman's physical condition.

> "Doctor who delivered the kids is Roman Catholic. Wouldn't give me birth control information when I asked - finally - so I changed doctors."

> "he always asks me why I'm not working."

> "Dr. M's attitude when he discovered that I was unmarried and unattached (no boyfriends) was that I was probably a sex-starved female with deep psychological problems that were in turn causing my internal distress. But, just in case, he took tests to make sure there was nothing physically wrong. Imagine his distress when he discovered that his instant diagnosis (she's just another neurotic female) was incorrect and that I was suffering from a lovely oriental disease - flukes of the blood."

The latter quote illustrates the problem of a doctor allowing his preconceived notions of women as neurotic females to influence proper care. Surprise, surprise!! Sexism rears its ugly head.

> "Bit by bit the mass of Canadian women are starting to question everything, every aspect of their lives, through feminist eyes. All preconceived ideas are examined. And medicine is a field loaded with preconceived ideas."
>
> Kirsten Emmott

There is a connected issue indicated here of the tendency to attribute all ills to psychosomatic causes. For example an interviewer recorded the following:

> "Doctor who treated her for an ear infection with so many antibiotics that it caused a serious bowel condition claimed all the while that they tested for cancer that it was nerves. Finally they discovered his prescriptions were the cause."

It is well for a doctor to bear in mind that to attribute an illness to psychosomatic or sociosomatic causes " it would be necessary to ascertain and assess the part that each patient's past experience, learned behaviour, selective perception, and adaptive capacity play in designating certain stimuli as particularly stress-inducing."

Dodge, David I., Martin, Walter T., Social Stress and Chronic Illness (Illinois: Univ. of Notre Dame Press, 1970) p.59.

Conversely, a doctor's perception may be inadequate when he fails to recognize social stress underlying the symptom he treats. In such a case, tranquilizers will not touch the root cause of the problem. Making a woman feel that she alone is to blame for her ill-health is unwarranted and unjust.

'So you're anxious and depressed, hassled by your children, feeling unattractive and insecure. Your life seems meaningless, your energies absorbed totally in caring for the needs of other people. Somehow you just can't accept it; you become irritable and 'unreasonable'. You're freaking out, you think maybe you're going crazy.

You go to the only person you know to talk to about this - your family doctor. He listens, then writes you out a prescription and pats you on the head and says, "this will take care of that nervousness of yours."
And it does - in a way - by masking your problems from you in a chemical haze, by making you dependent on a drug for any sense of personal worth and well-being and thus preventing you from confronting your situation and seeing it as something which is not your 'personal; problem but the result of societal, political conditions."

'How To Get Hooked:
Your Family Doctor As Pusher'
Mother Lode,, Spring p.12
San Fancisco 1972

The above quoted Mother Lode article was written primarily on data from a McCall's magazine article, "The Over-Medicated Woman." It blamed the huge consumption of mood-altering drugs on "physicians... brainwashed by drug manufacturers into beleiving that the routine anxieties of daily life may be symptoms of mental illness that demand treatment with powerful drugs and pills." It states that twice as many American women as men take such drugs - 220 million prescriptions in 1970!!!

"This doctor is strongly not recommended. He fouled up several diagnoses, prescribed tranquilizers and bladder infection cures for everything - and neither helped my husband's ulcer, for example."

Although the correlation cannot be proven, there is certainly reason to believe that a doctor's lack of thoroughness and inattention to pertinent facts in the medical history are caused by his 'assumptions' - cultural and otherwise - about the woman patient.

The doctor's lack of understanding, or blindness to feelings (his professional blinkers) cause much anguish.

"If doctors and nurses were more informative re diagnosis type of medication, etc., it would prevent a lot of psychological problems."

"I had two miscarriages. Doctors are not very sympathetic; usually they seem to assume that you really didn't want the child or even tried to get rid of it."

"I feel that most doctors do not realize that a woman cannot go home after surgery and simply sit. Men and children cnnot cope without women and demand your attention when you get home. Therefore doctors should leave young mothers and housewives in the hospital a few days longer so that they can cope."

Doctors assume a lot of things, one of which is that many problems have emotional / psychological causes.

"Concerning sexual problems I've encountered, my doctor has attempted to be helpful. His inadequate answers were perhaps the result of mutual embarrassment. However I was left with the feeling that he attributed my difficulty (specifically dyspareuria) to emotional or psychological problems. Regardless of the cause, he offered no information as to how to deal with the problem other then lending me his copy of Masters and Jonson."

Even if the problem were psychological is it any excuse for the doctor not referring the patient to someone who could perhaps be more helpful?

THE CRAZY LADY SYNDROME

Interviewer's report:
Woman went into hospital to have ovarian cyst removed. When she woke up she found that a hysterectomy had been done. Was discharged and went home. A stitch came out and she began bleeding. Phoned her surgeon who said to tape it up; bleeding so badly she had to use a sanitary napkin on her stomach. Finally went to her GP who took care of her (saw her daily) and told her it was a mistake in the operating room.

Interviewer's report from our door-to-door interviewing. In this particular EA we found several women who had had hysterectomies. In several cases the woman told us the operation had been done to "cure their menstrual pain" or to "cure their menopausal difficulties". All these operations were done by one particular doctor!

One woman said,"he does hysterectomies on every woman over 40 - for everything". We are not claiming that all doctors treat women in this way... but we know that there is at least one doctor in Vancouver who is doing a lot of surgery.

Interviewer's report:
Womanwas spotting. Went to the doctor who inserted 'something' into uterus to correct problem. He told her to leave - blood streaming down legs. She had pain at home, phoned to tell him off,found out then that she had cancer. He hadn't done a Pap smear.

Interviewer's report:
Woman went into hospital for hysterectomy. She woke up groggy and was informed that incision was made but uterus not removed because staff doctor (not in Van.) decided she was two weeks pregnant. In fact her uterus was just swollen because her period was due. Woman was more worried about cancer (biopsy showed malignancy) than assumed pregnancy. Staff nurses nasty to her because they thought she was trying for a free abortion. Subsequent tests showed she was not pregnant and uterus finally removed. Very harrowing experience.

"My baby had not been near me since I left the hospital; I was too weak to care for her. At eight weeks I was up, no fever, but a bad smell was still there. A shooting pain gripped me at the base of my spine and I couldn't walk....I took a mirror, squatted down, and looked between my legs. A grey sac-like thing hung resting in the opening to my vagina. I thought my uterus had prolapsed. The next day my doctor removed a sanitary napkin from my canal. It had been forgotten; they had sutured it inside me. They had not counted as they cleaned me after delivery and they had sutured it inside me. They stole my health, my energy, and nearly my life and they didn't let my baby get the right food and all the food she needed. The psychological repercussions are horrible. Goddamn. Goddamn....Thank-you for letting me express this. Please tell other women. Someone must help. We must help each other."

"A woman who goes to a doctor must turn over her body to him and at the end of the treatment she gets it back; she is entitled to no explanations, she must not ask questions nor make suggestions."
K. Emmott

"I discovered my ovarian cysts through pain in intercourse. I wondered a lot why my tangerine-sized cysts had not been found sooner. There were LOTS of questions about what happened, especially after the operation. I still have a very foggy idea of what they did in there and what it looked like. I have fantasies about acupuncture so I would feel more involved with decisions made. I came to one ovary less. They told me I was a 'lucky girl'. The gynecologist was nice but not really hearing the feeling level of my words. I told M. (surgeon) about my anger at him for hurting me. He just couldn't understand. Told me I was 'oversensitive'.

If I make the fuss I would like and feel and need to, demanding their time in this unconventional way - I am a 'crazy lady', oversensitive. I still wonder if I was put back together right and nothing will cure me of that fear except a successful pregnancy."

Why is a woman asking for reassurance and explanations before and after a traumatic operation 'crazy'? This 'crazy lady syndrome' is perhaps our most serious charge against doctors. A woman runs the risk of neglect and poor treatment if she does not demand what she feels is best for her. And she is ignored as a 'neurotic female' when she does.

"LEAVE IT UP TO ME, DEAR"

At this point it may be wise to point out why we feel that these little anecdotes would be of any interest to doctors. Of course, there is the simple humanitarian reason - no one should have to be treated in a callous and insensitive manner. Also, perhaps doctors are simply unaware that some of them treat women patients as 'feeble-minded'. This view of women is, after all, fairly widespread in our society.

There are a few more practical reasons. The doctor's purpose is to deliver health care. Idealistically, the doctor's

purpose is to make his patient as healthy as possible, using his skills and knowledge to do so. As mentioned earlier, studies have been done pointing out that there is a direct correlation between a patient's satisfaction with the doctor and the "depth" of the relationship, with the success of the health care attempted (eg. if you like your doctor, you will be more likely to do as he says - take your pills or whatever).

This means that doctors cannot seperate strict medical care from the personal relationship. If the 'personal competence' is low, the medical competence will likely be low also.

In this survey we have not judged and are not qualified to judge the medical skill or competence of a doctor - except in the way that competence relates to the way the woman feels toward him. We have attempted to judge (and the directory is based on these criteria) whether the doctor is 'personally competent' - whether he is able to relate to his patients on a human level, as a

technician with skill and knowledge which he is making freely available to the patient - without any moral judgements attached. Any doctor who sees himself as 'superior' as a human being (both by right of his 'profession' and his 'maleness') cannot, in our opinion, give adequate medical care to women.

What do women want?

"The quality I most admire about my doctor is that he loves to learn from his patients. He does not consider himself a 'professional' and so does not frighten you off."

HEALTH IS NOT A COMMODITY - IT IS A RIGHT

1. Medical knowledge is not a magic charm. Its potency will not be diffused by sharing the secrets.

2. Medical practice is not a 'free-fire' zone in which the doctor may unload personal moralism on patients.

3. Health is not separate from life, nor is it to be equated with 'competence in approved social roles'. Rather, it is a person's total physical, mental and social well-being. A person searching for better health physically should not have to obtain it at the cost of humiliation or anguish.

4. The law of supply and demand does not hold in the present monopoly situation. Accountability is not preserved either by watch-dogs of 'professional ethics'. Opportunity to get redress must be made a less scarce and expensive process.

No - all doctors are not bad. We talked here primarily about our painful experiences - most of us have never had a chance to express this anger before. Now we're directing our energies towards helping doctors and ourselves reach an understanding together that will give us better care.

CHILDBIRTH PRACTICES STUDY GROUP

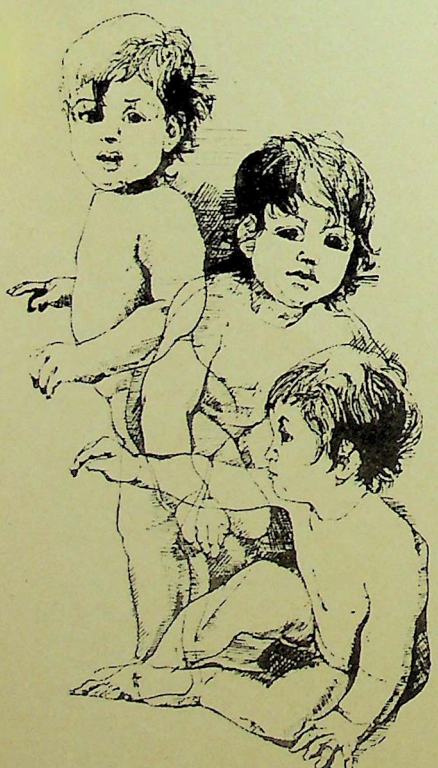
The Childbirth Practices Study Group was originally an outgrowth of the women's health group. At that time, a need was felt to assess the demand for home deliveries in the Vancouver area and the proposed project was conceived with this objective in mind. Shortly thereafter, certain members of this proposed group attended a meeting of the Vancouver Childbirth Association at which two Vancouver physicians spoke out against home deliveries, stressing that the current emphasis should be to improve hospitals so that people would not undertake the risks involved in home deliveries. From this time on, the proposed project's orientation was to assess satisfaction with medical care and more specifically, to assess a couple's satisfaction with maternity care received in various Vancouver hospitals. The idea of a fact sheet to coordinate local information resources concerning prenatal, maternal and childcare facilities originated at this time, along with the method of assessment to be used - an interview administered in the hospitals to women who had recently given birth. Vancouver General Hospital was approached and was asked for permission to do the study in their hospital. Their refusal necessitated the consideration of interviewing women in their homes. It was decided to use a questionnaire via a home interview which would be administered twice, once prior to the actual hospital experience, and again after, to determine whether or not the couple's expectations met up with what actually happened. At this time, the number of hospitals to be considered was augmented to include two other large hospitals in Vancouver, St. Paul's and Grace Hospital. In view of the project's other objectives, our interview schedule has since made it necessary to cut back on the number of

interviews to one per respondent, bringing our total number of interviews to 100. The questionnaire has been administered once after the woman has delivered, and within one month of her delivery to ensure maximum recall time.

It has become increasingly apparent in large urban areas that in the area of health care, some people are seeking alternatives to the established institutions and professions. In view of this current trend, an evaluation of the expectations of parents who have recently delivered, their satisfactions and dissatisfactions with the maternity care they received, would be highly useful not only to the parents involved, but also to those doctors, hospitals and maternity organizations which would be interested in knowing their patients' reactions to the type of maternity care they received and in ultimately providing optimal maternity care. Although it was not within the scope of the project to

critically evaluate the type of medical care received, it was felt that in a country which operates under a type of socialized medical plan, various lay groups, such as ours, are in a position to assess and expose a family's satisfaction or dissatisfaction with the facilities as they presently exist. In view of the limited scope and resources of our project, we are unable to point out the details of this satisfaction or dissatisfaction, but we are in a position of saying to doctors and hospitals that if they wish to provide optimal maternity care, evaluation of maternity care from the patient's point of view is an area and an approach which could use further investigation on their part.

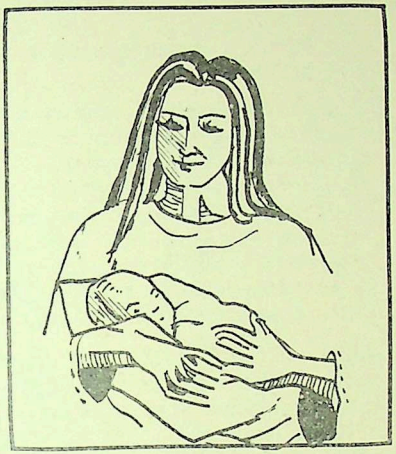
In view of current practices of birth control, most babies now are wanted babies and increasingly, women want to make the most of their childbirth experience. We hope that this project, by coordinating the information concerning various maternal resources and making them widely available will provide both a stimulus and an aid towards making childbirth a profitable experience. We also hope that the results of our questionnaire will foster some consideration and improvement by doctors and hospitals in the type of maternity care they provide.



Throughout the evolution of this project, three primary objectives have been maintained: an informative function, a research-oriented study, and an educative goal encompassing all aspects of the project's activities. The informative objective has centred mainly on the compilation and publication of a fact sheet coordinating information on the various obstetric facilities available in hospitals in Vancouver. Further aspects of maternity care, such as information on prenatal education, breastfeeding, family-centred maternity care, care of the newborn, welfare, medical insurance and resources for needy mothers is in handbook form (see Appendix), along with the hospital fact sheet.

The research aspect of the project centred mainly on a questionnaire drafted by the members of this project and which has been administered to over one hundred new mothers in the Vancouver area. This questionnaire aims at assessing the degree of satisfaction and dissatisfaction with the prenatal, childbirth and postpartum care they received in the various hospitals.

The educative function of the project, which for its participants has been the most outstanding benefit, has been two-fold: one of information dissemination to women



and other groups interested in the present resources of maternity care in Vancouver, and self-education for the project participants in the areas of pregnancy and childbirth. From the start of the project, the participants have immersed themselves through reading, lectures and meetings with professional people involved in health care, in all aspects of pregnancy and childbirth. In addition, a nurse gave two intensive weeks of lectures on the anatomy and physiology of pregnancy and childbirth, several meetings were held with individual obstetricians, nurses, sociologists and hospital adminstrators at which the project was discussed and recommendations were made which proved highly valuable. In addition, individual readings have been assigned to project participants throughout the summer and a critical bibliography has been compiled to further aid research in this area.

In our questionnaire, we had originally hoped to assess not only the mother butalso the father's satisfaction with the maternity care she received, in the form of a separate questionnaire directed at fathers only. This separate father questionnaire was found to be impossible due to our limited time schedule and the bureaucratic difficulties we encountered in obtaining, from the hospitals, the names of women who had recently delivered. We found ourselves spending a lot of time obtaining names of new mothers through birth announcements in the local newspapers. Had we been able to secure the cooperation of the hospitals in this respect, this step could have been eliminated thus making more time available for administering a father questionnaire. However, we did include in our mother questionnaire, several questions aimed at the father's involvement in his wife's pregnancy and childbirth and we feel that the most important aspects of his participation have been covered.

Hospitals interested in the project's results would be in a position to provide even a more detailed evaluation of the benefits and deficiencies of their facilities. However, the project feels that the lay approach which the project assumed was highly successful in enabling women to speak freely on their childbirth experience. We would like to see other lay groups such as ours work in conjunction with doctors and hospitals to further explore the area of satisfaction and dissatisfaction with maternity care provided in Vancouver. In addition, we feel that there is a need for an assessment of the demand for home deliveries, particularly among the immigrant and low-income groups in Vancouver. It is our suspicion that these groups are the most short-changed in regards to medical care in general and further exploration of this area would be highly profitable.

HOME DELIVERIES

There are no laws against having your baby at home. In the event that a planned home delivery jeopardizes the health of either mother or newborn, there is cause for a legal suit. All births must be registered with the Bureau of Vital Statisics.

There are certain risks which a woman should be aware of in making her decision as to have or not to have a home birth. The city of Vancouver is not set up for home deliveries and there are few doctors who are willing to be in attendance at a home delivery. There are no provisions for immediate medical aid to be rushed to the home in case of emergency, as is the case in England where home deliveries are backed up by flying squads for emergency treatment. The complications that may arise are beyond the scope of this handbook and it must be added that only 60% of complicaions that could arise are predictable.

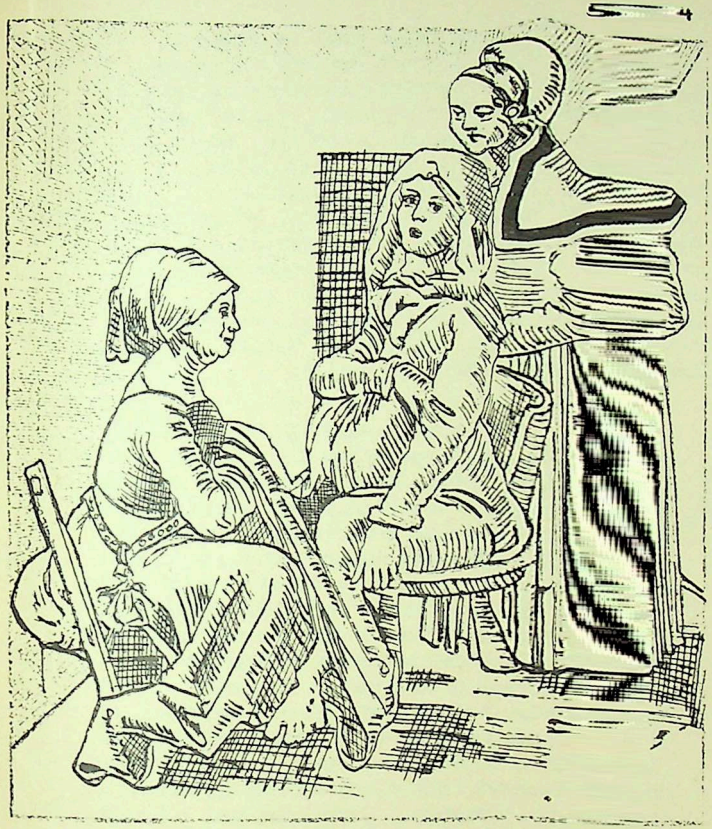
Since much of the impetus for the Childbirth Practices Study Group's Handbook and the study of women's childbirth experiences in the city of Vancouver (1972) came from an awareness of a growing consciousness that some women were dissatisfied with their hospital experience in labour, delivery and postpartum and some were looking for alternatives in home deliveries, we felt it would be of interest to present one woman's personal view on why she would prefer a home delivery or on how she sees the hospitals' need to change in order to meet the needs of many new mothers and fathers. The following is a letter from a young mother.

What makes a woman choose a home birth?

"I have considered having a home delivery as an alternative to delivering in the hospital. One thing worries me though; emergencies can happen so fast. In the hospital where the doctor has the most up-to-date equipment at his disposal there is little risk to mothers and babies.

Although chances of bleeding to death or having a retarded child through oxygen starvation are slight, what would the effects of such an event be on my family were I to run the risk and err in having a home delivery?

I have been in the hospital for the delivery of my first child. There I had an unpleasant experience that disturbed me for months afterwards. A small thing one might think - I was unlucky enough to get a nasty nurse on one of her bad days, apparently. Instead of helping me she snapped and criticized throughout the delivery and labour, and immediately following delivery she came to the recovery room and continued her little tirade about women who demanded too much time and patience, and thought they knew more than they, the professionals. My misfortune, a bit of bad luck to have to deal with this crotchety individual, no doubt one of 100,000 nurses. But a maternity 'patient' is vulnerable. In my weakened condition her words burnt like brands into my mind. I lost sleep, I wept. I fumed bitterly against the injustice that would allow such a woman to deal with any patient, and the cold organization of hospitals that achieve technical efficiency at the expense of spiritual and emotional support.



There is the undignified, but I suppose necessary enema and pubic shave and the lonely hours of pain which not even the best pre-natal course could prepare everyone for if one is unlucky enough to have a difficult labour. There are the bare white walls and staring clock of the labour ward, the white-gowned staff, the glaring lights of the delivery room , the armstraps and stirrups of the narrow hard delivery room bed - these are all things that are designed for superefficiency but not for creature comfort. Memories of these things and that one cold, unsympathetic nurse encountered by sheer chance have nonetheless caused me to have a bias against hospitals.

I am very sensitive to my environment. Knowing what I do now about my reactions during childbirth, I would want, in pain or fear, familiar surroundings. My own homey and colourful bedroom, the comfortable face of my husband, and the competent yet gently aid of a midwife or doctor who was friend as well as professional. In happiness, I would want to share immediately in the joy of the new baby with my husband, to nurse the baby right away and to have my older child join us and share in the wonder of the great event. If I could have all this and the assurance of maximum safety — but we can't. Not now, not in this society. So for now I would grudgingly choose hospital over home.

But not without careful consideration. We have, even when when placing ourselves under hospital care, many options—I would choose a hospital which allows husbands in labor and delivery, and which had rooming-in. I'd prepare myself with pre-natal classes and be sure of my doctor. I might even enlist the aid of a private nurse or midwife to help with the labor and be a buffer between me and anyone who might interfere with my plans for handling contractions. And meanwhile, I would keep faith that someday we'll have hospital care that puts the individual above the institition.

the beginning of the end

The Childbirth Practices Study Group have just begun to look at the information from interviews with women who had babies in hospitals in the Greater Vancouver area during June and July of this year. Here we present some preliminary results which we feel have interesting implications for women in this city.

A general theme implied by the results is that women have a better probability of receving the kind of medical service they desire if they ask for the things that are important to them, including asking for answers to questions that interest them. In our opinion, maternity patients should take as active role in choosing the kind of care they want. Patients who communicate their wishes can hope to make possible for themselves a rewarding and comfortable childbirth experience.

We were able to speak to 98 women. Forty of the deliveries were at Grace Hospital, twenty at Vancouver General, twelve at Lion's Gate, and the remaining twenty-four at St. Paul's, Richmond General, Royal Columbian, Burnaby General, or St. Vincent's. For 46 of the women this was their first pregnancy, for 31 their second, and for 14 women their third.

We have found that we spoke to women with a great variety of experiences and personal characteristics: women who were married, single, and in common-law relationships; women from age 16 to their late 30's; women with grade 10 education to women with graduate school education; women who saw a doctor prenatally and women who did not; women whose labour was induced; women whose babies were delivered by Caesarian section and women whose babies were delivered vaginally.

We found a variety of experiences in preparation for childbirth. 66% of the women chose a general practitioner for prenatal care and 24% went to an obstetrician. Usually women went to a doctor because they were already patients of these doctors. Some made a specific choice based on the recommendation of others or personal preference. We were interested in women's perceptions of the contact with these doctors. They seemed to value most highly open and honest communication with these doctors. Some resented difficulty in phoning their doctor. Some, particularly first mothers, felt that the instructions given to them concerning departure for the hospital were inadequate.

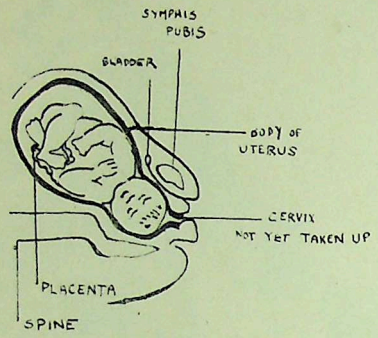
75% of the women said they took better care of themselves during their pregnancy. Over half of them did exercises in preparation for labour and delivery, and read extensively about the total pregnancy and childbirth experience. 60% of the women attended prenatal classes given by various organizations in the Greater Vancouver area. All of the women who attended Vancouver Childbirth Assoc. or Childbirth Education classes found them very beneficial.

Almost all of the women who toured hospital maternity facilities found the tour helpful. However, a number of women commented that they did not go on the tour because the time was inconvenient and some suggested that more convenient times be arranged both for working women and for men who are working but would also like to go on the tour. We recommend that women ask the hospitals to schedule some tours at different times than are presently offered, recognizing that daytime tours are inconvenient for many working people.

Turning to the hospital experience, we asked women how often procedures were explained to them during the prep, during labour, and during the time they were in the case room. We also asked if they received reports on the progress of their labour and delivery and if they received information on the baby's physical conditions immediately after birth. We further inquired, for all of these topics, whether or not they would have liked more information. Our results seem to indicate that, for most of the women we spoke to, explanations and information, when given, were usually adequate for them. Therefore, we urge mothers and fathers, together, to ask for information when they want it and nurses and doctors do not volunteer the information.

A large part of the interview focused on labour and delivery. During labour, women felt the most warmly about the presence of their husbands or friends. Although hospitals permit fathers in the labour room, individual nurses still seem to discourage the father's presence. In all hospitals, it was exceptional for fathers to be permitted to remain with the mothers throughout the entire labour. 68% of the women whose husbands or friends were asked to leave indicated that they were disturbed when he left. If fathers and mothers prefer to remain together at all times during labour, we urge that they make this clear to all medical personnel, including the doctor whom the mother sees prenatally, the nurse taking the mother to the labour room and the nurse in the labour and delivery area.

In delivery, about half of the women were accompanied by fathers. All of these women found the fathers helpful and, for many of them, his presence was the best part of delivery for them. One woman said that her husband was unsure of going into the case room; but, after being asked by the hospital staff to come in, he really enjoyed the experience. Some women who were fluent in only Japanese or Chinese were especially glad that their husbands were present to translate what the nurses said.



BEFORE LABOUR BEGINS

Most of the women who were not permitted to have anyone accompany them had complications during the delivery. However, in a few cases, fathers had difficulty getting into the delivery and the mothers involved felt that the reason for the difficulty was that the nurse did not want him included.

Concerning "pain killers" in labour, we found a general tendency among the women we interviewed to receive medication for pain, if they wanted it during their labour, and not to receive it if they did not want it at the time. The same was true for vaginal deliveries. 25% of the deliveries were done without any anesthetic.

It is interesting to note that of the women who received pain medication during labour and did not want it, only 13% found it very helpful but 56% said that it did not help them at all. In contrast, among the women who wanted something and received it, equal numbers said that it was very helpful, somewhat helpful, and not helpful. Several of the women explained that they had not requested medication but that a nurse came in, told them that they needed it, and the women unquestioningly accepted it. Some regretted this, remarking that demerol made them groggy or put them to sleep, making it difficult to handle labour as they had planned.

We have also noticed that many of the women said that the most negative aspect of their labour was pain. We would suggest, since demerol is not usually given until the cervix is well dilated because it tends to retard early dilation, that prospective maternity patients plan to handle discomfort during labour with a thorough knowledge of labour methods and the help of husbands, nurses or doctors.

In both labour and delivery, the feelings of the women about doctors and nurses ranged from finding them very helpful and supportive through their explanations and active involvement and coaching, to very negative feelings about their abruptness and medical discussion of labour and delivery without including the woman or considering her as a listener.

As a group, the mothers had more vivid memories of their postpartum stay than of any other aspect of their hospital experience, and these memories are accompanied by strong suggestions for the kind of postpartum stay that they would prefer.

Most of the women felt that the feeding instructions they received while in the hospital were adequate; however, more of the breast-feeding mothers than of the bottle-feeding mothers felt that they did not receive adequate information. A few of the women commented that one of the worst things in their post-partum experience was contradictory feeding instructions received from different nurses.

Some of the breast-feeding mothers expressed difficulties. Many had sore nipples and felt that they were not given sufficient information on how to care for them. One woman was told that her "breasts were not the right shape" and therefore that the baby wasn't getting enough milk. Another woman had inverted nipples and became so discouraged that she stopped breast-feeding. We strongly suggest that women who intend to breast-feed gather as much information on breast-feeding as possible before entering the hospital in order to guard against an encounter with a nurse who doesn't understand breast-feeding. The La Leche League is an excellent source of information.

Women who had rooming-in, in all hospitals but Vancouver General, felt that they could return the their babies to the nursery - in contrast to the preference expressed by most hospitals that rooming-in babies remain in the mother's room for 24 hours a day. Our suggestion is that women who want rooming-in first attempt to choose a hospital with a rooming-in policy that suits their needs; but, failing this, they should explore the flexibility of other hospitals and obtain the support of their doctors in attempting to create a suitable rooming-in situation for themselves.

An overall complaint for the women was a feeling of alientation of the mother and father from the baby and from each other. 65% of the women wanted to see their babies more than they did and many would have liked to have fed their babies on demand and to have bathed their own babies. 82% of the women who did not spend time with their husband and baby, together, would have liked to.

When asked which hospital policies would be important to them in another pregnancy, there was again an emphasis among the 98 women on "family-centred" care. 82 women felt it would be important to them that husbands be permitted in both the labour and delivery rooms. 82 women would like fathers with them when feeding the baby. 62 women would like modified rooming-in (a situation in which the mother can return the baby to the nursery when she wishes) and 60 women felt that rooming-in should be available without having to pay extra for a private room. As well, 18 women said the availability of 24 hour rooming-in was important to them.

The women also supported other policies. 64 women would like children allowed to visit. 25 women wanted longer visiting hours with 18 of these stating that they would should be unlimited. An additional 17 qualified their response by saying that only husbands should be given longer visiting privileges, with 13 of these saying his visiting should be unrestricted.

75 women wanted wards no larger than 4 beds, and 73 wanted private labour rooms. Several women remarked that they felt uncomfortable with another person in the same labour room or if they were placed in the postpartum area during early labour.

Some mothers specified that rooming-in mothers should be in an area separated from mothers who are not rooming-in.

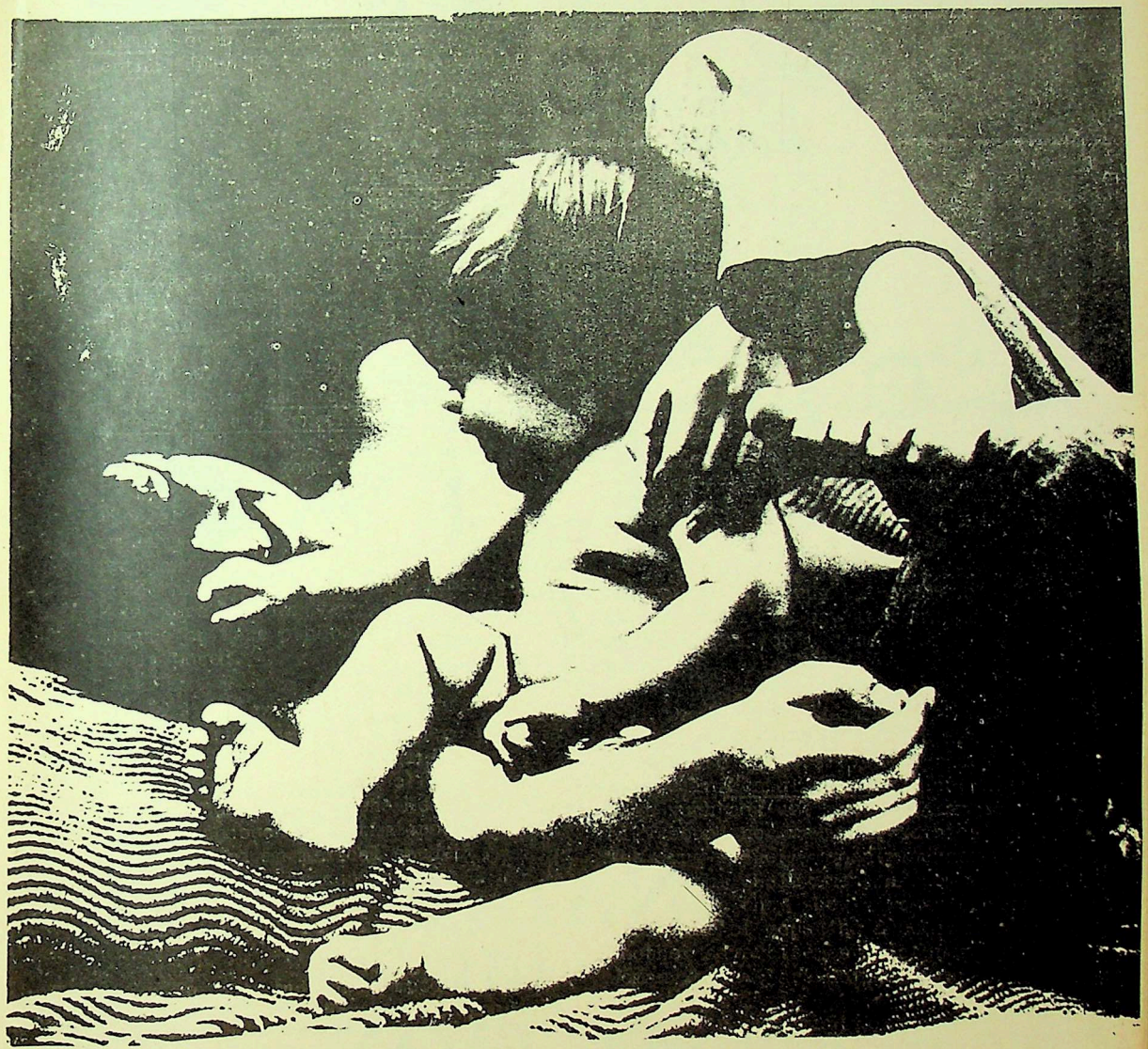
An interesting suggestion by one mother was that a communal dining area be provided for maternity patients.

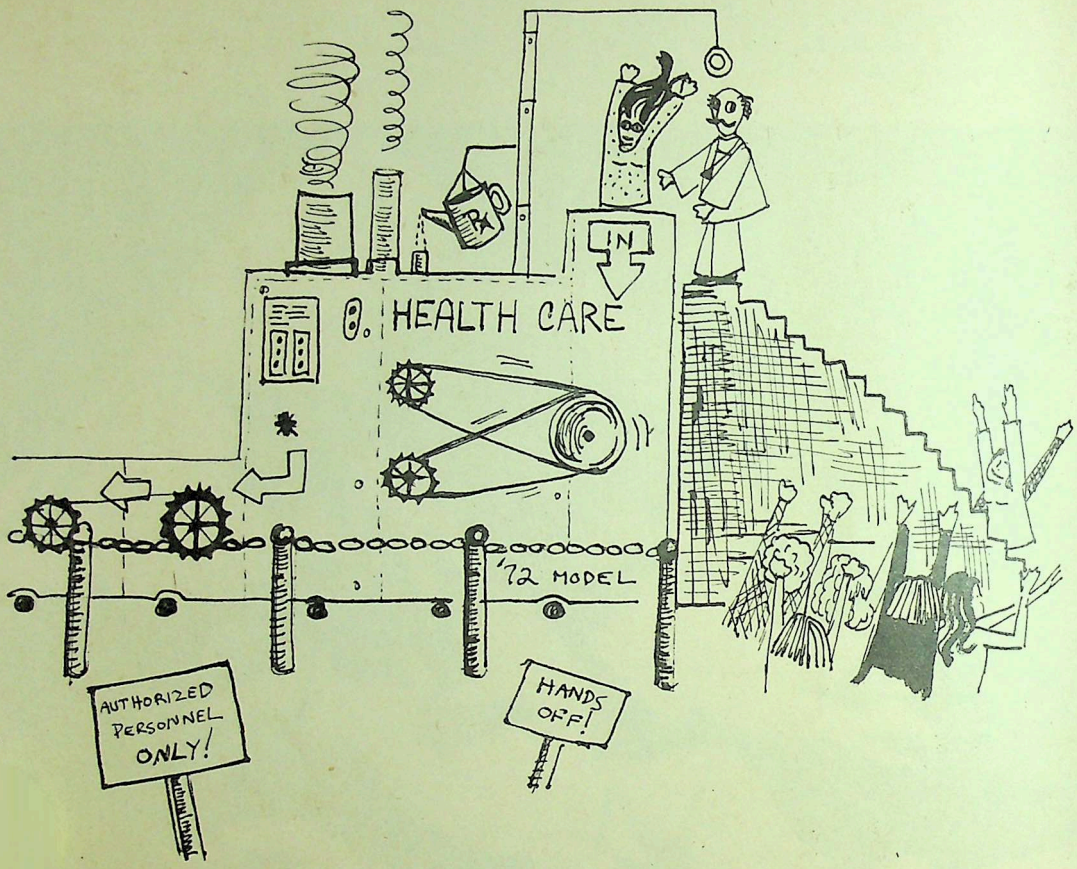
When asked why most of these policies do not exist in hospitals, hospital administrators and obstetrical supervisory staff usually respond that they are already short staffed and that many of these practices would require more staff and new facilities. However, many changes in maternity care could be made at little or no expense, as suggested by Haire and Haire in "Implementing Family-Centered Maternity Care with a Central Nursery".

If you want changes made in maternity care, please write to or speak to hospital administrators, nurses, doctors, prenatal class instructors and others providing care for expectant women or mothers of new-borns. The main concerns of our study is to communicate to medical personnel the feelings and experiences of the 98 women we spoke to. Our final report will reflect this emphasis, but the support of other concerned women in the Greater Vancouver area is vital.

Action is also needed in contacting M.L.A.'s and the provincial Minister of Health to request that more funds be provided for maternity care facilities.

If you wish to receive a copy of our final report, please phone The Women's Referral Bureau, 738-8471 between 12 noon and 8 pm. and request a copy of the "Childbirth Practices Study Group" report or write to Andria Wilkinson, #1 - 445 W. 10th Ave., Vancouver 10.





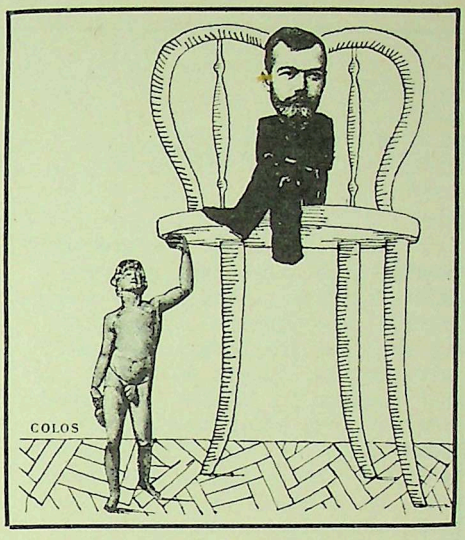
ANALYSIS and ACTION

We have probed into the question of what is a woman's medical experience now? Questions arise from the sketch of results above; for ourselves, for doctors, for medical institutions, etc. Despite an entrenched respect for the goal of good health, and the years of the struggle to actualize that goal, tales of bad experiences run rampant.

WHY IS THIS SO?

When you start considering health, you cannot stop with the study of medicine or of practitioners. Already, the women who have shared with us their vast information have shown it necessary to look further and deeper. Analysis focussing solely on doctor-patient communication is too shallow, for freedom of choice is limited for both parties. The doctor is hemmed in by the larger factors of structure and process of the medical corps, the woman by the system of society. Indeed, it seems that those who give good health care and those who get it do so in spite of organization and socialization.

Some indications of this: MSA does not cover the basic preventative tool of medicine--the physical checkup--why? Drug prices are often prohibitive--why? There are proportionately fewer doctors in "primary care" (G. P.) field now than ten years ago--why? They are often distributed far from the people who most need them--why? We must look for answers to such questions, for we are no longer in the mood where the "doctor" image still "commands a certain degree of awe and forgiveness."



While bad health care on the individual level may be attributed to ignorance, egotism, or greed, these can only be understood in terms of supporting factors (on the systematic level).

Is the proper study that of individual doctors and hospitals? Rather we must turn to a study of the nature of medical institutions, the cultural matrix, the legal and social structures, for a deeper understanding. First and foremost we must recognize that "the factors in our society which produce a great amount of sickness are not dealt with by the medical establishment: e.g., bad housing, poor nutrition, poor sanitation, pollution, and dangerous working conditions." (Our Bodies, Our Selves)

This is a hint of how broad our inquiry must be. The following papers will serve as examples, we hope, of the kind of investigation that needs to be done before a thorough understanding of an overall strategy for change can be formulated.

I. socialized sexism

Articles in the "underground" media, demonstrations, surveys, women's clinics, rebellions among health care workers--all testify to the disillusionment of women with the health system. What are the reasons for callous treatment, neglect, and indifference to our complaints? It seems that this attitude can be partly accounted for, as is shown below, by direct indoctrination of doctors in moralism and sexism. We are not suggesting, of course, that doctors and hospitals deliberately treat women in a way they know to be bad. Rather, the training doctors receive reflects the sexism of this society in general, and that bias shows itself in innumerable and often destructive ways.

Much of this section comes from a research paper entitled "Women and the Health System", written by Kirsten Emmott, a third year medical student at the University of B. C. The paper covers many aspects of discrimination against professional women health workers and sexist indoctrination of medical students. Some of the highlights are reviewed below. (The paper is available to read at A Woman's Place.)

GYNECOLOGY TEXTBOOKS

One would think that gynecology textbooks, not to mention the lectures of individual professors, would provide a calm, unprejudiced view of women patients. This is unfortunately not the case: authors of medical textbooks are as likely as anyone else to include their personal biases as if they were scientific truths. A random sampling of available textbooks from the Biomedical Branch Library at Vancouver General Hospital revealed the following shortcomings;

1) It is assumed that all gynecologists are men.
2) There is little or no mention of how to put a patient at her ease.
3) Women are attacked for being uncontrollably emotional and most complaints are assumed to have strongly psychogenic overtones.
4) Women are attacked for being foolish, undependable and untrustworthy.
5) Women are attacked for being dirty and immoral.
6) Dysmenorrhea is simultaneously described as a widespread, troublesome problem and as a neurosis which deserves no treatment.
7) Menopause is similarly treated.
8) Discussions about sex reveal ignorance, discredited anatomical and psychological ideas, and weird moralisms.
9) Women are attacked for being masochists.
10) Women are attacked for wanting abortions.

A large component of the above attitudes is the women's guilt.

"If every husband were a gynecologist in the widest sense we should see fewer clinical problems, and if every gynecologist were a husband and a father of girls he might be better fitted for his work."

from a gynecology textbook, 1967

"Perhaps it is not too ridiculous a quibble to suggest that if every woman were a gynecologist in the widest sense, and if every gynecologist were a woman and a mother, the situation might be even better."

Kirsten Emmott

Women are made to feel guilty, not only for having cramps or pregnancies but even for wanting regular checkups!

"a patient, either out of curiosity or because she is a nymphomaniac, comes in for gynecological examination."
from a gynecology textbook 1952

While the occasional gynecology text emphasizes kindness to patients, few mention such courtesies as warming the speculum, and most ignore such topics entirely. Any women who has felt embarassed and humiliated lying on the examination table knows what help a little kindness and gentleness can be sometimes.

Women are assumed in these textbooks to be neurotic individuals, always complaining about pain or tension for no reason. Dysmenorrhea (painful periods) is especially bothersome to the gynecologist as is premenstrual or menopausal tension. One text even suggests that "Most gynecologists consider that there is a strong emotional component in the genesis of trichomoniasis, but this has not yet been clarified". If it ever is clarified, it is certain to revolutionize the thinking of those who used to think spontaneous generation was impossible!

One text, however, warns against a diagnosis of psychogenic illness until all organic causes have been ruled out. It relates the story of a woman who had unusual pain and tachycardia, which the G.P. attributed to neurosis. The relatives insisted on a second opinion and the consulting doctor recognized the symptons of ectopic pregnancy. By the time they reached the patient's home, the tube containing the pregnancy had ruptured.

Women are portrayed as ignorant and foolish. One text says, "Many are extraordinarily careless about the dates of menstruation and keep no records. If reliable information on these matters is wanted, ask the husband." (!) Anyone who had ever actually had a menstrual period would know the pointlessness of keeping 'truly accurate records'. The only reason to do so would be to avoid the scorn of a gynecologist, and it simply isn't worth the trouble. And anyone who actually had a husband would know how reliable his information on 'these matters' is.

When it comes to a discussion of sex, these textbook writers reveal ignorance of female genitalia and their functions, pass on outdated information on female sexuality, and make moralistic judgements about women.

> "An important feature of sex desire in the man is the urge to dominate the woman, subjugate her to his will: in the women acquiescence to the masterful takes a high place."
> from a gynecology textbook, 1967

In for a particularly bad time are prostitutes and women who want abortions; also in trouble are women who masturbate or high school women who want birth control -- they may instead be given drugs or other treatment to 'cure' them of these desires.

Doctors are not unaware that a poor doctor-patient relationship may contribute to poor success in treatment. Yet they seem to be even more concerned about annoyances for doctors caused by unhappy patients. One book written "to guide physicians in their management of the doctor-patient relationship" refers in the forward to patients as behaving "stupidly, childishly, mean - always ready to put the doctor in a bad spot." It explains that with better patient management (sic)"patients will behave more maturely and will be more appreciative and cooperative" and there will be a reduction in "the unearned incidence of dissatisfied patients quitting the doctor, failing to pay his fees, bringing malpractice suits, and generally gossiping and causing trouble".

MEDICAL JOURNAL ADVERTISING

Doctors are constantly receiving publications, samples, even free gifts from companies engaged in selling medicines and medical equipment. A tremendous amount of space in medical journals is devoted to such advertising, mainly from the large Pharmeceutical firms. If one looks through recent issues of medical journals with special attention to how women are portrayed in drug company advertising, one will come away with the following general impressions:

1. Women are portrayed as patients more often than men are.
2. Women are often portrayed with hostility or contempt.
3. Advertisements for psychotropic drugs usually portray women, not men.
4. Women's problems, especially as portrayed in psychotropic drug advertisements, are shown as neuroses rather than as problems amenable to social solutions.
5. Women's bodies, nude or partly clothed, are used to decorate advertisements.
6. All doctors portrayed in advertisements are men.
7. Advertisements are aimed at men, especially those inviting the reader to respond to sexual innuendo.

One advertisement shows a woman in her mid-thirties, arms akimbo, a glum, somewhat defiant look on her face. The copy, in bold headlines, proclaims:

> A COLLECTOR. AT 35 SHE'S COLLECTED, AMONG OTHER THINGS, A COLLEGE DEGREE SHE'S NEVER USED, A HUSBAND WHOSE CAREER TAKES HIM AWAY MOST OF THE TIME, A FOLDER OF UNPAID BILLS, AND VARIOUS SYMPTONS — REAL OR IMAGINED.

The pitch is for a tranquilizer.

Another well-circulated ad pictures a nail-chewing young housewife gazing apprehensively through prison bars of mops, scrubbing brushes and brooms. The clarion message to physicians announces:

> YOU CAN"T SET HER FREE. BUT YOU CAN HELP HER FEEL LESS ANXIOUS. YOU KNOW THIS WOMAN. SHE'S BESET BY THE SEEMINGLY INSURMOUNTABLE PROBLEMS OF RAISING A YOUNG FAMILY, AND CONFINED TO THE HOME MOST OF THE TIME. HER SYMPTONS REFLECT A SENSE OF INADEQUACY AND ISOLATION.

The pitch is for another tranquilizer.

A third advertisement shows a series of snapshots, covering a period of 15 years, of a young woman posing with different men, including her father. In the final shot, she is standing alone on the deck of a ship. The copy reads:

> 35, SINGLE, AND PSYCHONEUROTIC. THE PURSER ON HER CRUISE SHIP TOOK THE LAST SNAPSHOT OF JAN. YOU PROBABLY SEE MANY SUCH JANS IN YOUR PRACTICE. THE UNMARRIEDS WITH LOW SELF-ESTEEM. JAN NEVER FOUND A MAN TO MEASURE UP TO HER FATHER. NOW SHE REALIZES SHE'S IN A LOSING PATTERN — AND THAT SHE MAY NEVER MARRY.

The solution? The company's unique anti-depressant for this "tense, overanxious patient who has a neurotic sense of failure, guilt or loss."

- examples of medical journal advertising from McCalls', September 1971, "The Over-Medicated Woman".

For a quick impression of the sexism behind drug company advertisements, here are the partial results of a survey of the advertisements in the Canadian Medical Association Journal over a period of six months (July 18 - December 5, 1971):

	Ads Showing	
	Females Only	Males Only
Total	72	42
-anxious or depressed	19	2
-bitchy, dullwitted	5	1
-nude or in underwear	13	0

A survey of eight consecutive issues of the American Journal of Obstetrics and Gynecology (Sept. - Dec., 1971) showed that about a quarter of the women were portrayed in a distinctly unfavorable light. The large number of women shown smiling were nearly all in advanced pregnancy, and were advertising such things as vitamin supplements. Most were wearing very short skirts or were otherwise seductively posed.

(In the same survey there were 18 advertisements for vaginitis cures. Of these, seven offered the drugs recommended in the Medical Letter handbook of antimicrobial therapy, and in medical student lectures, for the conditions described. The rest offered ineffective and obsolete remedies.)

The consumption of mood-changing drugs by North Americans is extremely high, and they are taken by twice as many women as men. In advertisements in medical journals, doctors are told that the answer to the "tired housewife"

Orifer* is the other pill. The one most women take after discovering they have one of the pills left over. Orifer is the most widely-prescribed prenatal supplement in Canada. And one of the least expensive. Full information is available on request.

syndrome is to drug the patient -- her problems may not lessen, but at least she won't come back so often.

Dr. Robert Sidenberg, clinical professor of psychiatry, at New York State University at Syracuse, states in Mental Hygiene (Jan. 1971) that such ads are not psychiatrically sound nor medically ethical. The drug industry openly acknowledges the enslavement of women, he says, when they show a woman behind bars made of mops and brooms. Another advertisement pictures a woman who, we are told, has an M.A. degree but who must now be content with the PTA and housework. This, we are advised, contributes to her gynecological complaints, and she should be given mood-altering drugs.

an oral contraceptive to make a doctor happier

When his "pill" patient has problems, you can be sure he'll be one of the first to hear about them. And hear about them. And hear about them...

If her problem is breakthrough bleeding or excessive menstrual flow—either of which may occur on low-dosage regimens—one thing to do is switch her to Ortho-Novum 2 mg. Because it provides greater hormonal content, this widely prescribed oral contraceptive may be especially helpful in these situations. Naturally, other side effects, common to all oral contraceptives, are possible and are fully discussed on the following page.

Next time you see a patient who isn't doing as well as she'd like on a low-dosage oral contraceptive, consider switching her to Ortho-Novum 2 mg. You could be preventing a "pill" failure or dropout. And you'll be cutting down on your "phone time" too.

Ortho-Novum 2 mg
TRADEMARK

Each tablet contains 2 mg norethindrone and 0.10 mg mestranol

Surely the doctor could "set her free" by, say, getting her a day care centre and a job. He could get the father of these troublesome children to look after them, or to do some of the housework. He could stop thinking that all single women are psychoneurotic failures, and that marriage is the only goal in life for women. He could agitate for better career opportunities for women and better pay for the jobs they do, so that they could find satisfaction there. He could stop drugging women into adjusting to a bad deal.

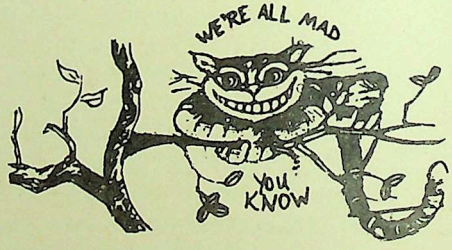
Even worse are the advertisements in which doctors are invited to drug women simply because they are bothersome. A distraught, angry man exclaims: "Women are impossible!". The copy explains that his wife is suffering from premenstrual tension and needs meprobamate. An insomniac in curlers keeps her husband awake. "How can this shrew be tamed?" Why, with sleeping pills. Another must be tranquilized because she demands too much of the doctor's time.

Worst of all are ads for estrogen replacement. Copywriters really go to town on the supposed "witches' curse" (an actual phrase used) of the menopause. An ad for Premarin shows a longsuffering bus driver with the caption "he is suffering from estrogen deficiency". We turn the page to see "she is the reason why" under a picture of a harrassing menopausal bus passenger who "makes life miserable for everyone she comes in contact with."

Another Premarin ad shows a kindly gentleman interrupted at his morning paper. This time "the reason why" is his wife, whom we see on the next page, in curlers and robe, teeth gritted, finger pointed, and glaring at her husband.

In contrast, a quite unusual advertisement, from an eight-page supplement about men and their chances of getting coronary heart disease, shows a man being obnoxious and troublesome in a restaurant. The copy says, "Pattern Type A is an aggressive individual who must assert himself as one who deserves recognition and good service, whether from fellow-workers or a waiter. Pattern Type A has been associated with a significantly higher incidence of CHD as compared to other patients with the same coronary risk factors". His behaviour is not offered as sufficient cause for treatment with hormones or psychotropic drugs, as is so often the case where women are portrayed in this way.

Needless to say, drug companies do not much care how women feel about their advertisements so long as doctors keep prescribing what is offered. The situation will change only when women force doctors to supply safe, effective treatment based on verifiable evidence and not advertising innuendo.

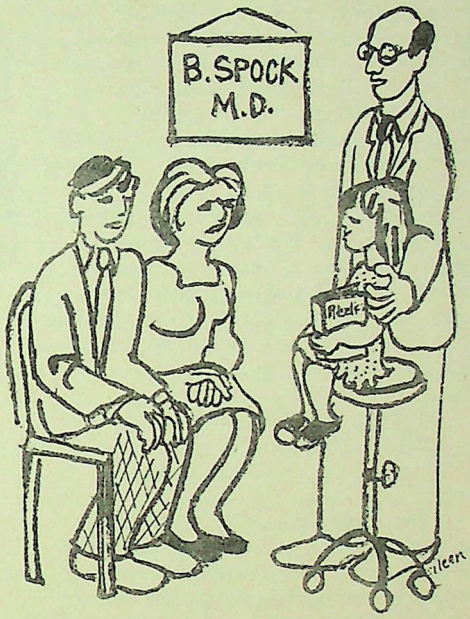


PSYCHIATRY

Few doctors excite so much ire among today's feminists as psychiatrists. Psychiatry, they say, is a modern religion whose heretics are labelled "crazy". It makes the basic assumption that women are inferior, then says that only inferior people would quarrel with that. The more you resist the diagnosis, the sicker you must be.

Freud was a sexist. His famous confession that he could not understand what it was that woman wants did not prevent him and his followers from applying psychotherapy to women. Sexist psychiatrists are even worse than sexist medical doctors, because they judge a woman's normality by how well she conforms to sexist prejudices.

A 1970 study, "Sex role stereotypes and Clinical Psychology, 34, 1 - 7), reveals that clinicians define "healthy woman" as different from "healthy man", and that the traits considered normal for a woman include behaviour generally regarded as less socially desireable. The feminine behaviour identified by the clinicians suggested that "'healthy' women differ from 'healthy' men in being more submissive, less independent, less competitive, more excitable in minor crises, having their feelings more easily hurt, being more emotional, more conceited about their appearance, less objective, and by disliking math and science." (quoted from a review paper by Joan Gardner). In other words, the essential feminine traits are seen to be passivity, masochism and narcissism. Gardner concludes, "Acceptance of an adjustment notion of health places women in the conflictual position of having to decide whether to exhibit those positive characteristics considered desirable for men and thus have their 'femininity' questioned (i.e., be deviant in terms of being a woman); or to behave in the prescribed feminine manner, accept second-class adult status and possibly live a lie as well."



"If you follow my advice we may have caught it in time. Teach her to cook and clean..."

Doctors use sexist counselling to make women "adjust" to their problems rather than face and perhaps change them. Many women who are just becoming aware of their oppression become depressed or anxious about their situation and seek psychiatric help, only to be told that their troubles stem from their refusal to accept their assigned role as women. Some psychiatrists even take advantage of power relationships vis-a-vis female patients to abuse them sexually, especially when the patient is a prostitute, lesbian, or other sexual nonconformist.

The media and the general public uncritically accept and apply the sexist doctrines of Freudianism. The classical example of course, is the myth of the vaginal orgasm. One marriage manual, written by a woman, states, "Women ... who have vaginal anesthesia may be fortunate in being able freely to achieve an outside clitoral climax provided their husbands are competent to help them. Usually this will go a long way to compensate for having no internal orgasm. Indeed, many women who depend upon clitoral orgasm for their enjoyment do not even realize that their vaginal capacity is lacking in some way. (!)"

"A real man has his orgasm in his kneecap."
Graffitum

The fact is, of course, that the presence or absence of a penis makes a considerable difference in one's emotional attitude to sex, but to say that it is the difference between mental health and mental illness is a long jump.

CONTRACEPTIVES AND ABORTION

The history of contraception is the history of a huge centuries-old underground of women, struggling with the problem of unwanted pregnancies, usually either ignored or harshly condemned by male religious leaders and doctors. While wealthy women have had access to contraceptive information through private doctors, there has until recently been no help at all for the poor women. Thousands continue to die annually from illegal abortion attempts. And still the control of research and access to safe birth control and

safe abortions is in the hands of male-controlled drug companies, hospitals, and the medical profession. Is it too much to suggest that if men had to bear unwanted children, there would be a quick upsurge in contraceptives research and availability of safe abortions?

It is ironic that the Pill, which seemed to promise as easy (and profitable) answer to the need for birth control, was rushed onto the market after improper testing and was only called into question after millions of women had been exposed to its possible dangers. After the January 1970 hearings before a U.S.Senate Committee, a warning (written by men) was to be included in Pill packages. The warning was later cut from 700 to 90 words becasue, as Health Education and Welfare Secretary Robert Finch later told D.C. women's liberation workers, "We wouldn't want to put an undue burden on the medical profession".

Recently abortions have been made more available through liberalization of anti-abortion laws and/or through relaxation of hospital requirements for therapeutic abortions. In Vancouver, pressure from women wanting abortions has forced the Vancouver General Hospital to relax its abortion rules.

Women are still campaigning, however, for complete repeal of the abortion law as part of the Criminal Code: abortion is a medical and social question and should be decided by the woman in consultation with her family and her doctor, and not by the state. Numerous polls of magazine readership, college students, and political ridings show overwhelming votes in favour of repeal, yet in most provinces and in all but the largest cities, abortions are still expensive, dangerous, and illegal.

The newer, experimental contraceptive devices include injections, more pills, and mechanical devices for the woman -- the research on contraceptives for men continues to move at a snail's pace. However, women are forcing the issue by refusing the Pill and using abortion as a back-up to contraceptive failure.

While vasectomy is promising as a simple sterilizing operation (much safer than the usual methods of female sterilization), it is still frowned upon except where the couple is "absolutely sure" that the husband will not want any more children and where they are unwilling for the wife to be the one to be sterilized! (Look during the next few years for either a completely reversable vasectomy technique or, more likely, a tremendous increase in the sperm bank business.)

WOMEN AS PHYSICIANS

Only 7% of Canada's doctors are women. In the United States the percentage is 9%; in India, 12%; Phillipines, 25%; Western Europe, 13 to 20%; Eastern Europe, 30%; Soviet Union, 65%. Medical schools have historically discriminated against women. An article by Harold Kaplan, M.D., in the New Physician described a study of attitudes in North American medical schools to women. Over 95% of the schools in the U.S. and Canada responded to this survey. As his first conclusion, Kaplan states that a significant number of schools were very negative about single or married women (what other kinds are there?) in medicine: "... while no school in the United States overtly or officially refuses to accept women, prejudice does seem to manifest itself by refusing medical school admission to married women with or without children, schools being very unimpressed with single women as medical students, or simply by the administration of a school being uninterested in adapting to the unique problems women have."

"I confess myself puzzled as to how the act of standing before the priest and saying "I do" can drastically alter one's intellectual abilities. Are not many of the male students married? Would it be better for the women simply to live common law? To have separate apartments? To be required to remain virgin? Why don't committees make a special effort to recruit lesbians?"

—K.E.

Kaplan found that some schools are ambivalent in their attitudes toward women, pregnancy and medicine; while they deny any problem exists, or avoid facing it, they make special provisions for this "nonexistent" problem when it occurs. He describes the University of B.C. as a classical example of avoiding facing the conflict they themselves describe.

"...we would not admit students where there is likely to be a conflict between two jobs; that is, the academic pursuit and the responsibility of looking after a family ... there is no discrimination against women students, there are certainly no special privileges for them. We have several women medical students who have children but they carry on exactly the same as any other medical student."

> "Let me say here that I consider this absolutely wrong. Where marriage and childbirth are concerned, women (especially young women) are special and deserve not rigid equality but special privileges. We demand this in the same spirit that black people have demanded special financial terms to build up their businesses, improve their ghettos, and desegregate their schools: to equalize opportunity."
>
> —K.E.

Some medical schools allow schedules to be juggled somewhat to suit the students. While this makes it slightly easier for a woman medical student to have children while in school, in many schools such women return to the full academic schedule in from three days to two weeks -- too short a recovery period, and potentially dangerous to the woman's health. The reason they return so soon is that "there has been no provision made for their absence and they fear that they will lose the academic year's credit if they stay out longer".

In fact, female medical students do quite well. In 1970, 19.7% of women students were in the top 10% of their classes. While 15% of women in U.S. schools in recent years dropped out, as compared to about 8% of men, only 19% of those leaving for non-academic reasons had children.

Often women interested in a career in medicine are shuffled into "light" (read: low-pay, low-prestige) work to become paramedics, such as dental assistants and contraceptive technologists. Women doctors are heavily concentrated in pediatrics, obstetrics, radiology, and general practice. Rarely do women enter such high-prestige fields as neurosurgery. It is open to question whether these jobs are considered "more suitable for women" because thay are lower in prestige, or vice-versa.

In spite of the lack of arrangements for childbirth or childcare, women medical school graduates manage to do quite well in their practice. In a survey of the graduates of seven medical schools between 1945 and 1951, 91% of the respondents (all women) were practising. Ninety percent of the married women were practising. All the single women practised full time.

A 1967 survey reported that 38% of the 17,000 women doctors in the U.S. took off an average of four years from practice because

of pregnancy and motherhood. They calculated that the nation therefore lost 25,440 years of practice.(!) By this logic, since women live an average of 7 years longer than men, the U.S. would gain 119,000 extra years of practice just from these women physicians -- at that rate, why not have all doctors women?

Medical school prof: "So how do you like medical school?"

Female med student: "I love it."

Prof: "Are you going to practise?"

WOMEN IN NURSING

The discontents of women in nursing today might be summed up as follows:

1. Nurses are treated with overtly chauvinistic, patronizing attitudes by male doctors.
2. Nurses are badly paid and overworked, and are paid less than men who do the same work.
3. Nurses are taught to think of themselves as angels of mercy, as selfless adminstrators of womanly comfort, rather than as workers. This results in:
   a) poorly organized unions which fail to protect them.
   b) failure to improve working conditions and salaries.
   c) advertisements for nursing positions which offer fraudulent, sexist incentives such as hope of matrimonial success, rather than decent salaries.
4. Nurses resent being held up as examples of "failure" by feminists. In other words, being told that if there were no sex discrimination, they would all be doctors.
5. Nurses are used as part of a health team, but their administrators are powerless.

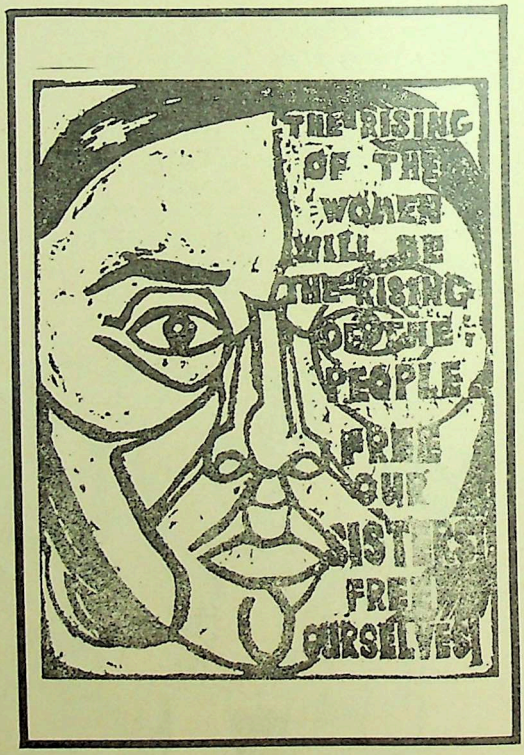
Most women in medicine are nurses. Most doctors are males. Nurses are subjected to both subtle and obvious attempts on the part of male doctors to make sure they are constantly reminded of their "place" that is, behind the man, as usual. These range from petty rebuffs to practices endangering the health of patients, such as "forgetting" to write an order or not reading the nurses' notes. Male nurses, however, are in most cases treated with greatest respect by most male doctors, regardless of ability.

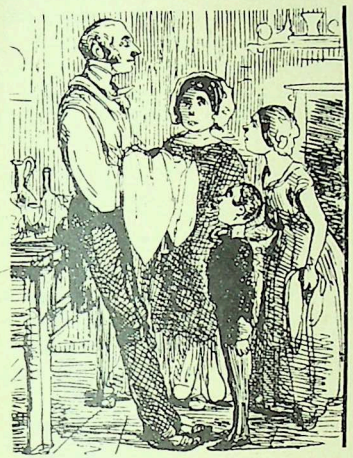
In B.C. in 1970, a practical nurse earned a monthly average of $444. An inexperienced orderly earned $501. Similar discrepancies are found throughout the hospital hierarchy -- women are nearly always paid less than men doing equivalent jobs, and often less than men in jobs of lower responsibility and training. The unions which are supposed to be protecting nurse employees are often lax; some prefer to support established hospital policy rather than investigate complaints from nurses. And, in a typical example of the powerlessness of women workers, the "leaders" of these unions are often males.

Nurses are sometimes attacked by so-called "feminists" for not being doctors (in other words, for not having good salaries, prestige, and a good union). The assumption is that if a nurse is intelligent, educated, and capable, she is a nurse instead of a physician only because of sex discrimination. It is true that early socialization (that doctors are men and nurses are women) has caused many a girl with an interest in medicine to aim for nursing instead of medical school. However, many nurses are so by choice and trying to upgrade a job which involves a closer, more direct relationship to patient care than does that of the doctor.

Women interested in organizing women workers prefer to try for better pay and working conditions for the jobs women do now, rather than try to move them out of those jobs. They see that nursing is thought to be a dead-end job, and so on, ad infinitum. Now that women are changing, the nursing profession must certainly change.

Possible avenues for change include the suggestion of discriminating in favour of women, to allow for pregnancy and motherhood; better organizing as workers; carrying on the daily struggle against the elitism and chauvinism of male doctors; and making nursing a proper part of the health care team, with strong leadership. Indeed, some suggest that the nurse should be the principal member of the health team, since it is she who has the closest and most knowledgeable contact with the patient, and that doctors as well as paramedics should be used as consultants and technicians with special training in specific areas.





II. health organization vs. health ethics

Much of this section comes from a sociology research paper written in Toronto in 1971. The complete paper can be read at A Woman's Place.

"Medical ethics" is the code governing a powerful group from within. Medical values are among the most idealistic, humanitarian and highminded in the world. There are good structural reasons for this:

1. Medicine is an extremely powerful profession since it quite literally decides questions of life and death for the people.

2. More significantly, medicine exercises enormous control over the conditions and organization of medical practice.

Any group with that much power is in need of very high standards. The problem is that the people most intimately affected have very little direct control to make sure these standards are systematically met.

It is my contention that the priorities of the organization of medical care make it quite difficult for the average physician to live up to the ethics. Major structural aspects are in direct contradiction to the most essential axioms of medical ethics.

For example: Control of medicine lies totally outside the collective power of the poor. Medicine, all values aside, is run as a business. This is not to say that all doctors are in it for the money; this clearly is not the case. The ethical value behind the practice of medicine is the care of the sick and the good of the patient; the organizational principle is the free enterprise system. While its goals are that of service, its structure is that of business. This is the ethical contradiction at the heart of medicine, and it proves Friedson's thesis that no value system can transcend the structure out of which those values arise.

The organizational priorities of medicine are not comprehensive community care. When the practice of medicine is organized around the principle of the physician's right to practice where he wishes in a fee-for-service system, is it really such a surprise that for all the ethical discussions of equal care for all, the affluent get better care? This is not a question of greed: it is the result of social organization.

Why is it ethical for doctors to retain control over medical remuneration? If the priority of medical organization were community service, what would be ethically illogical in allowing the community for whom medical care is a right rather than a privilege to determine physicians' fees? In the present system, if a doctor chooses to be altruistic and maintain ethical standards, he can, but whether he does this or not is up to him, not the community. The profession, ethically speaking, has no right to so control the health care system, simply because it alone has the means to provide that care. [This is illustrated with extended examples of the profession's clinging to this monopoly of control over issues—e.g., Medicare in Saskatchewan, the abortion question.]

Respect for another physician's monopoly over his patient is very subtly inculcated. [The paper goes into this in great and convincing detail.]

Physicians present a conspiracy of silence and a "united front." If there is uncertainty, tentativeness, and disagreement, why not be more honest about it? (Worry about losing the confidence of the "consumers", perhaps?) If mistakes are made or a diagnosis is not forthcoming after a reasonable length of time, the patient has a right to make further medical decisions about his own life based on adequate knowledge of what is occurring inside his own body. The professional "conspiracy of silence" denies to patients this basic right.

An example of how values can change with organizational change is the Fritzi Englestein Free People's Health Center in Chicago. Patients at this clinic are told as clearly as possible everything they want to know about their illness, including the doctor's confusion about it (if it exists). If a doctor makes a mistake, he is criticized and admits it. This policy, far from undermining the community's confidence in the clinic, has fostered it. After years of mystification and uncertainty, people are beginning to understand how their own bodies work and how the doctor is trying to help them, rather than turning to a mystified individual with something resembling blind faith. This model of the doctor-patient relationship, omitting of course such tenuous issues as informing the patient of a terminal disease, opens up much more ethical avenues of medical realism, forthrightness, demystification, and honesty than the "conspiracy of silence."

Of course, this change in values springs out of structural changes. The Fritzi Englestein Clinic is free; doctors either volunteer their services or are paid the same wages; they are not particularly worried about taking away each other's patients, since this is a working class neighborhood and many more doctors are needed to see all those who need medical care. Clearly this clinic has been founded upon different organizational priorities than the rest of the profession; that is why its values have changed.

Towards a Strategy

The preceding two articles show how the structural organization of medical care operates to prevent the implementation of essentially valid ethical goals. It follows that the goal of total health care for everyone can only be achieved by a radical restructuring of the health system.

It is time to develop a new theory of health, expressed in terms of structural goals. By this redefinition health would not involve a body of magical knowledge and skill reserved to a few, but would become a daily aspect of our lives. Health care would be in large part preventative, and would be free to all at the point of delivery. The organization of health care delivery would be non-sexist, non-hierarchical, decentralized, and community controlled. This can only be achieved within the context of a feminist restructuring of society.

Thus, the role of the health movement in terms of overall strategy has four aspects:

1. To share information.
2. To create alternatives.
3. To make specific institutional demands.
4. To expose the nature of the health system.

As individuals, we can work on any or all of these levels to raise women's consciousness about health care and to demand good health care from our individual doctors. Women in groups can not only share experiences and support individual struggles, but also become involved in referral services, clinics, and other alternatives. As a movement we must work to understand the interlocking facets of the medical system and how we can most effectively challenge and change that system.

I. TO SHARE INFORMATION

One of the first steps toward ridding oneself of sexist oppression is to get together with other women. The very fact of coming together to talk about health care and share our ideas serves to "de-isolate" women. Because we "all have a story to tell", we can support and strengthen each other, and discover that we have the collective knowledge and strength to change the system. Women in consciousness-raising health groups have shared personal experiences and learned from each other. We have learned to examine each other and have become more familiar with our bodies than the "experts" on whom we formerly depended. When forced to seek medical care, we have gone in

pairs or in groups to demand proper treatment. Gr ps of women meeting together to talk about their health form the source and the basis for the women's health movement.

We have seen that information about our bodies is not automatically given to us by the doctors who treat us. We want that information and mean to obtain it in order to educate ourselves and pratise preventative health care. We want to gather information on health priorities across Canada and in other countries. We want to understand the power structure and financing of health institutions and their implications for the treatment of female patients. This information will give us ammunition with which to pressure institutions like hospitals to change in order to meet women's real needs.

The objectives of information sharing can be seen as the demystification and deprofessionalization of health care. By this we mean that medical care must be delivered in a respectful and educational manner, and that health "skills" must be taught to all. Both of these objectives are linked to changes in both sex roles and authority roles. Both will be accomplished, not for narrow reasons of efficiency and economics, but because they are absolutely necessary to the development of a rational, humanistic health system.

II. TO CREATE ALTERNATIVES

Alternative health care delivery systems serve both to reflect the value system of the new concept of health and also as bases for community education. By involving

By "Putting women's liberation into practice" women's clinics attempt to give substance to the right of women to control their own lives and bodies. The substance consists of the destruction of the psychological and biological myths which are used to oppress women; the demystifycation of male-monopolized knowledge and skills; and the development of self-sufficiency, self-control and self-confidence. Add to this the ethic of leaderlessness and sisterliness which has characterized consciousness raising groups and it is not difficult to see why women's free clinics have done more to demystify, democratize and deprofessionalize health care than other free clinics. Everyone who works in women's clinics (including male doctors) keeps returning to the same point: "You have to be here on women's night to sense the difference — I can't explain it — it's just the entire atmosphere".

Health - Pac Oct. '71.

the patient in her own health care, such alternatives as free clinics become vehicles for the demystification of medicine.

Demystification of health care is first attacked through education. In many free women's clinics, both patients and paramedical workers attend regular "educationals" designed to impart both practical knowledge and an enthusiasm for personal involvement in one's own health care. Authority roles may begin to be broken down through the "patient advocate" system, in which the role of the advocate is "to (1) help the patient understand the procedures, assure follow-up and referral if necessary, and protect the patient from medical abuse, (2) challenge the professionalism of the rest of the staff, (3) raise the political consciousness of patients and staff alike". (Health/PAC, October 1971) Democratization is accomplished by rotation of role-positions and by the apprentice method of teaching: this type of skill transfer allows the individual to go as far as she wishes toward becoming a skilled paramedic herself.

Serving as an example, however, is not enough for alternative health services. The opening of a free clinic, per se, is not a threat to any doctor's practice or health institution. In fact, "there is a fine line between challenging the health system and actually doing its work". (Health/PAC) The idea of withdrawing "patronage" from establishment institutions doesn't work: there is no economic challenge because of the overburden of patients waiting to fill those spaces, and ultimately the free clinic is dependent upon establishment health services for medicines, for money, and for back-up care of patients.

The alternative clinic really begins to challenge the health system when it acts as an instrument of change. The most significant changes have come about when free clinics have supported community struggles against the health system. These struggles include demands for free health care for low-income groups, union organization for health workers, mass screening for environmental illness, and free transportation and child care for patients. Some groups have even refused to establish their own clinics, seeking rather to force existing health institutions to perform their stated functions.

III. TO MAKE SPECIFIC INSITUTIONAL DEMANDS

While learning about the health care system and analyzing its structure and performance, we see the need in many specific instances for immediate progressive reforms. We demand these reforms not as superficialities but because of the anguish caused to our sisters by the lack of them. Thus the fight for abortion is an effort to end the horror of backstreet abortions and to eliminate unreasonable restrictions on a woman's private life.

Kaethe Kollwitz

Further progress may result in such demands as licensing of paramedics, unionization of nurses, incorporation of nutritional and other information in health education courses, restructuring of medical insurance schemes, the institution of group practices, and so on. However, the medical industry, as the crisis in health care availability and the demands for institutional reform increase, will be able to adopt a more liberal, accomodating posture, and will institute reforms as a means of maintaining control over the system rather than as prelude to the complete overhaul of it. We must parry these tactics and keep in mind our image of a humane, comprehensive and consistent service.

IV. TO EXPOSE THE NATURE OF THE HEALTH SYSTEM

We rocognize that what we propose is not an easy or an easily-focused task. We must simultaneously treat the symptoms and cure the root causes of our sick health care system. We must expose the factors which are blocking good health care -- the drug industries, hospital supply and equipment companies, elite medical schools, nursing homes, urban hospital complexes, the CMA, profit-oriented private practitioners -- in order to see how and where restructuring of the system is necessary.

Both doctors and lay people must recognize that we can't eliminate the "dis-eases" caused basically by social problems (sexism,poverty, pollution).

We must begin attacking the inner structure of this corrupt system, and not just its outer irregularities. Whether we are providing alternative services or engaging in institutional confrontations, the real problem is that of changing traditional, automatic processes of thinking and the concretized moulds that have grown up around them.

Health care is no longer a privilege, to be obtained only by the wealthy. Nor is it a commodity to be streamlined and bargained off. (Consumerism in health is in the final sense reactionary: it wields no power and causes no change.) Complete health care is a right to which we are born.

Physical health is indivisible from personal and social health. We see the women's health movement as part of the greater struggle for the liberation of women and of all people from oppression. In the health movement we are learning to share our skills, attacking the sources of our oppression, and gaining the confidence which comes from building the means to meet our own needs.

"The hospital workers, mothers and young women consumers who have begun to challenge health care institutions know that health is only one among many issues that women must face in their struggle for equality and self-determination. Male supremacism runs as deep in our society as racism, governing the way we are educated, entertained, employed, and ultimately determining the ways we see ourselves and other people. It cannot be uprooted from the health system without changes in every social institution which now oppresses women — from the family to the major corporate bureaucracy. If so many women are turning first to health institutions, it is because that is where they are — as workers, as patients, as mothers.

— Health/PAC
March 1970

What are Health Groups?

Many of us first became interested in women's health issues through participation in consciousness-raising health groups. In Vancouver a weekly health group began meeting last January. We came together for various reasons: some of us had backgrounds in medicine or biological sciences and were concerned about the quality of care women receive; some of us were laywomen who were interested in meeting other women and finding out how to obtain better health care; some of us came because of specific experiences which angered and radicalized us; some of us had special interests in particular kinds of treatment, such as acupuncture or herbal medicine.

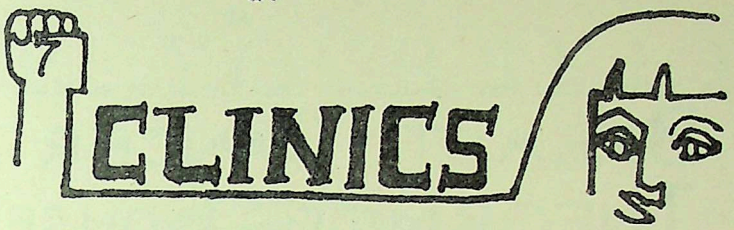
At our first meeting we talked about what each of us wanted from the group. We developed an agenda, including every subject any woman was interested in discussing or finding out about. We agreed to intersperse discussions with practical sessions (such as speculum examinations), and to attempt to include topics which would enlarge our perspective of the health care system in Vancouver, British Columbia, Canada, and elsewhere.

Our information came from a variety of sources. Among our own members were a medical student, two nurses, a nutritionist, and several women with other technical training who could point out sources and help us find up-to-date data. We also had several "consultants"--friends who were doctors, psychiatrists, social workers, etc., and who were willing to help us in their particular fields. We also derived much practical help, ideas and inspiration from talking to women who had been involved with women's health groups in other cities.

Some of the subjects we have covered are: female hormones, birth control, sexuality, using specula for vaginal examinations, body image, homosexuality, vaginitis, psychiatry, midwifery, nutrition, pregnancy and childbirth, rape, women's clinics, breast self-examinations, menopause acupuncture, cervical and bi-manual examinations, yoga, herbal medicine, and political aspects of the health system. We have alternated "discussion" and "practical" subjects as much as possible, and have included several evaluation sessions.

In our group of women there is an incredible assortment of experiences, talents and perceptions. The discussions have therefore been stimulating and emotionally binding. We have shared our own experiences and those of other women. We have found that women everywhere, not just in Vancouver, are beginning to take the care of their bodies into their own hands. We have learned about treatments not accepted by Western medicine. We have learned what we look like and feel like inside. We have explored our feelings about ourselves and our friends and our lovers. Through getting to know each other, we have gathered energy to do more.

There are several health groups of woman of all ages now meeting at A Woman's Place and in people's homes. If you are interested in becoming involved, call Melanie at 733-9377 or A Woman's Place (731-9619).



From the time when our health group meetings began, we had the idea of a woman's self-help clinic. This would be a paramedical clinic with an emphasis on involving the woman in her own health care and on breaking down the professionalism surrounding doctor-patient relationships.

In May, 1972 about twelve women decided to begin preparing in a more formal way for the future clinic. About half of the twelve had had training in the medical or biological sciences, and they devised a basic course for the rest of us covering physiology and anatomy, with special emphasis on the reproductive system.

In addition, a number of women in the group succeeded in apprenticing themselves to various clinics in Vancouver in order to gain practical experience and knowledge of medical procedures. This prepared us with a solid factual and practical base from which to deal with the common problems seen in women's clinics: VD and vaginal detection, birth control, pregnancy detection, pelvic and breast examinations, and sexuality problem counselling.

There is now a self-help Women's Clinic on Friday evenings from 6 to 9 pm at 1952 West 4th Avenue. Women from the health group, including a woman who is a doctor, operate this clinic.

"In recent months the idea of women's free clinics has swept the women's movement ... In a number of cases women's clinics are in part a reaction to the overt sexist treatment women were receiving at regular free clinics. 'The doctors were saying that they were tired of looking at vaginas. They would do crude pelvics and make insensitive and moralistic comments to the women'."

-- Health/PAC
Oct. 1971

Our energy is derived from two basic assumptions:

1. Knowledge of our bodies in sickness and in health (and in childbirth and birth control ...) is a profoundly vital part of our perception of ourselves as whole, strong, responsible people.

2. As 'lay' people we have essential ingredients to add to the health care of other women.

We are in the midst of a process of demystifying medicine via self-educational sessions, intensive studies, and practical training. Our vision is to extend our knowledge and experience to many other women, at the same time inviting their involvement in a process of expanding their own self-knowledge.

A contribution from a woman who read the first edition:

BREAST CANCER AND INFORMED CONSENT

Few women realize the choices that are open to them with regard to growths in the breasts. Lumps are common, and in 80% of cases, the lumps are not malignant but benign cysts. In women under 30, only 2% of lumps are malignant. When a woman goes to a doctor with a lump, she can always ask about the possibility of having the lump aspirated, a simple process of removing the fluid from a cyst. If there is no fluid, the doctor will likely then advise a biopsy and removal of the lump. This is a simple operation and leaves only minor scars. From that point on, medical authorities differ on subsequent treatment, and in North America radical surgery (mastectomy - removal of the breast) is still frequent. Dr. Ray Lawson of Montreal has pioneered new techniques of diagnosis called mammography and thermography, and methods of treatment using radiation therapy. Dr. Lawson states unequivocally, "Radical operations for breast cancer are completely unjustified". He maintains the survival rate from the simple operation (lumpectomy) is as good as those from the radical surgery.

All this I found out when I was a patient of Dr. Lawson's in Montreal in October, 1972. Up til that time I had had 5 biopsies, surgery to remove lumps, all of which had been benign. Dr. Lawson aspirated several lumps, took numerous X-rays, and gave me a clean bill of health with regard to my chest condition!

It was then that I questioned him about the failure of many physicians to inform patients about aspirating, to discuss data on patients who have had mastectomies, and to encourage patients to be informed enough to make decisions about their preferred treatment.

Dr. Lawson stated there are no clinics in B.C. like his, but there is one in Edmonton. A recent article in the Vancouver Sun (p45, Oct. 31,'72) indicates the American Cancer Society and the National Cancer Institute are setting up 20 such clinics in the United States, using X-ray techniques of mammography and thermography. If cancerous growths are detected early while the cancer is still localized to the breasts, the 5 year survival rate is 80-85%.

My advice to all women with lumps, based on my experience:

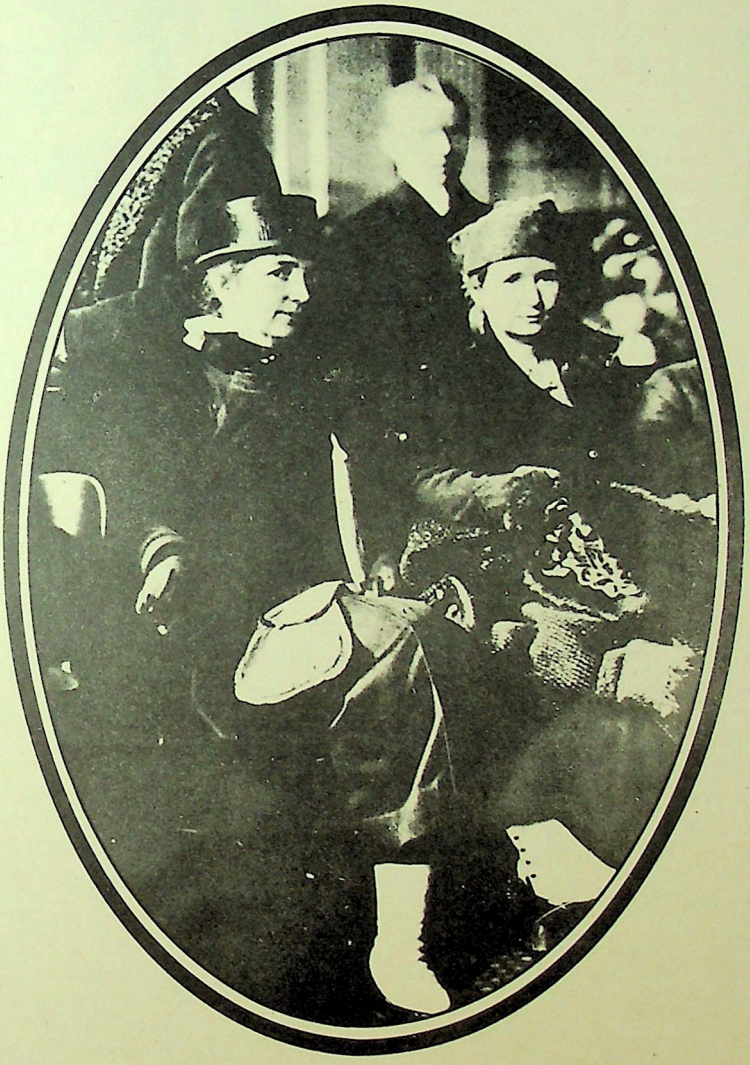
1. Ask about aspirating.
2. Ask for alternatives to mastectomies.
3. Ask why we don't have better diagnostic and treatment facilities in B.C.

I would be happy to supply written medical material to anyone interested. Dr. Lawson gave me plenty!

Sheilah Thompson

WRITE US WITH YOUR CONCERNS - WE'LL BE PUTTING OUT A THIRD EDITION.

HELP YOURSELF



Margaret Sanger and sister, Ethel Byrne, in court, 1917

Free Clinics

There are several free clinics now in existence in Vancouver. These have come into being in the last few years because of the need for alternatives to the present medical system. There are many people who rarely, if ever, go to private doctors or regular clinics for various reasons such as cost, personal lifestyle, dislike of bureaucracy. Patients at free clinics are often freaks, transients, young teenagers, and generally poor people.

Even though the B.C. Medical Plan provides inexpensive and good coverage for most people, one has to have lived in B.C. for one year in order to qualify for low-cost premium assistance. This requirement completely eliminates the transient people who flood into B.C. every summer, usually with very little money and looking for work. Also, many people are unaware that this plan exists, or unwilling, afraid, or unable to deal with the bureaucracy of obtaining coverage.

Many young people cannot go to their family doctors for problems such as V.D. or birth control. Young women, in particular, often get moral lectures and risk having their situation exposed to their parents, in contrast to the medical agreement of confidentiality.

Free clinics provide a friendly and relaxed atmosphere. The traditional doctor-patient relationship does not hold - there are just people serving people, and no moral judgements are made, only medical ones. Attempts are made to teach people more about their bodies, and the care and treatment of their own bodies. The clinics are clean and well kept up, confidentiality is observed, and the medical personnel, though very often warm and human, are well-trained and efficient.

Pine Street Clinic	2333 Pine St. (at 8th) 738-6622	Mon. 10-12 1- 4 Tues. 10:30-1 1- 4	Nurse Nurse and Doctor Nurse and Doctor Personal Counselling
	General Practice Pap Smears V.D. tests Pregnancy tests Referrals Prescriptions for birth control pills	Wed. 10-12 1- 4 Thur. 10-12 1- 4 Fri. 10-12 1- 4 Sat. 10 -1 All times	Nurse Nurse and Doctor Nurse and VD Nurse Nurse and Doctor Nurse Gestalt Therapist Nurse and Doctor Nurse and Doctor Personal Counselling
Vancouver Free Clinic	1952 West 4th 731-6929	Mon. 7 - 9pm Tues. 2 - 4 7 - 9 Wed. 11:30-3 7 - 9 Thur. 2 - 4 7 - 9 Fri. 6:30-9	General Medicine Well People's Clinic Pediatrician VD Control Prenatal, Natural Childbirth General Medicine VD Control Prenatal Care Nutrition Gynecologist VD Control Women's Self-Help Clinic
Downtown Community Health Society	373 E. Cordova 685-2744 685-3624	Weekdays: 9 - 5 Mon, Wed, Fri; 7 - 9pm	General Practice including VD tests and treatment, Pregnancy Tests, Birth Control
Reach Clinic	1144 Commercial 254-1354 684-2474	Weekdays: 1 - 4 Thursday: 7 - 9pm	General Practice Full-time nutritionist Licensed laboratory Pregnancy tests Pap Smears $2.00 for membership
The House	1040 West 7th 732-3301	24 hours	Generally for dope problems - soft drugs. Medical care included

INSURANCE for HEALTH

The benefits of B.C. Medical Services are available to all individuals who have resided in B.C. over 60 days. Application should be made 60 days from the end of the month in which you arrived in B.C. This coverage provides for payment of doctors' service. If you need to see a specialist, you need a referral from a general practitioner in order to have the specialist's fees covered. After 12 months residency, you are automatically eligible for hospitalization benefits. During the 60 plus days of waiting contact your previous plan requesting coverage for the waiting period.

If you have resided in B.C. for twelve months, you are eligible for premium assistance, if during that time you had no taxable income. If you fall into category A (see the B.C. Medical brochure) there is coverage for prescriptions also. Students from out of the province may continue on their medical plan from their home province if they are returning to their home for some part of each consecutive 12 months.

If you have no taxable income in the 12 months ending December 31st of the last year, monthly premium payable is as follows:

One person - $ .50
Family of 2 - 1.00
Family of 3 - 1.25

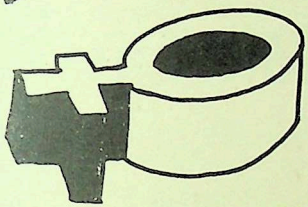
If your taxable income is between $1,000 and $10,000 annually, monthly payment is as follows:

One person - $ 5.00
Family of 2 - $10.00
Family of 3 - $12.50

For more information, phone 683-0211 in Vancouver.

If you are not eligible for any coverage or not able to make payments to any insurance policy, then consult our listing of free clinics in this booklet.

VENEREAL DISEASE CLINICS



V.D. TESTS

The procedure of doing a V.D. test for women involves an internal examination of the vagina. A smear is taken and examined under a microscope or a culture test is run to determine whether a venereal disease is present. The examination and smear (which is gently scraping some cells off the cervix) are painless procedures, only sometimes involving a small amount of discomfort if a woman is tense. It is much more comfortable, however, than having V.D. For syphilis, usually a blood test is required; that just involves having a small sample of blood taken from the arm. Only a pinprick is felt. The treatment for both gonorrhea and syphilis is anitbiotics, taken orally or by injecion.

V.D. CLINICS - (FREE)

Gov't V.D. Clinics:

Confidential for those over 12.
828 W. 10th Ave.
ph. 874-2331
Mon.-Fri. 8:30 - 1 pm., 2 - 4 pm.

537 Carnarvon, New Westminster
Mon.-Thurs. 9 - 11 am.
Mon.-Fri. 4 - 5 pm.

Abbot Clinic:

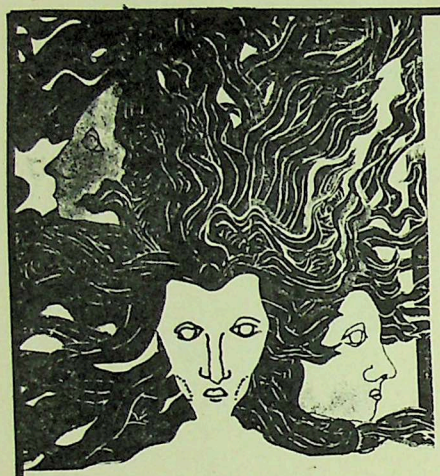
306 Abbot Street.
ph. 874-2331
Tues.-Fri. 2:30 pm.
V.D., birth control, gynecology

Downtown Community Health Society

(Gastown Clinic)
373 E. Cordova
ph. 685-2744
685-3624
Mon-Fri: 9 - 5 pm
Mon,Wed, & Fri: 7 - 9 pm

Gordon House Clinic:

1068 Davie Street.
ph. 683-2554
Wed. 7 - 9 pm.
2 nurses



Women's Referral Bureau

1776 W. Broadway
736-8471

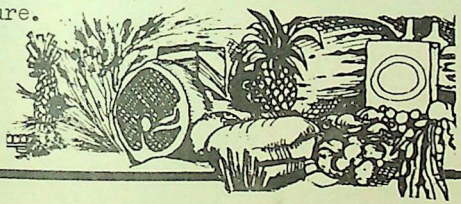
The Women's Referral Bureau is a telephone service operated by volunteers. Its purposes are to give women the information they need to obtain a legal abortion and also to provide information about facilities available in Vancouver for their general health care (clinics, recommended doctors, etc.) Callers seeking an abortion are provided with information concerning sympathetic doctors, costs and the type of operation performed. As well, the volunteers attempt to identify the callers's emotional condition and give any support necessary, eg. someone to listen to, a ride to the hospital, etc.

Our view of abortion is that it is not a suitable form of birth control. Abortions are unpleasant for both patient and doctor. However, abortion is still preferable to bringing an unwanted, unloved child into the world. Birth control information should be readily available to all, most importantly, high school students. Through a massive education program the need for abortion could be greatly reduced.

NUTRITION

As the concept of total health care through community health centres or other community facilities becomes a reality in Canada, greater emphasis and attention must be given to nutrition and the role it plays in health care. Since nutrition programmes are a necessary part of total health care the nutritionist would be an important member of an interprofessional team in any health centre.

Although the current emphasis is upon diagnostic and therapeutic nutritional care, which is usually given in the hospital setting, there is a great need for preventative nutrition care to improve the nutritional values of the population. As individuals, we can become more aware of nutrition as a preventative health measure.



The effect of good nutrition is exerted throughout your life span, but it plays a particularly significant role in pregnancy, infancy, childhood and adolescence. By being aware of your diet and determining your nutritional needs you can begin to be aware of the preventive measures an individual can take to promote good health. A great deal of knowledge can be gained by getting together with other individuals and discussing nutritional problems with a person who is qualified in this area.

Although it is beyond the scope of this booklet to discuss basic nutrition the following references are good and can be consulted. (If you are reading other books make sure their sources are reliable.) If you have additional questions or problems the following services are available in Vancouver: Dial-a-Dietitian (687-6439) and Community Nutrition Service, 1144 Commercial Dr., 254-1354.

Bowes and Church: Food Values of Portions Commonly Used. Toronto, J. B. Lippincott Co., 1970. (available at medical bookstores)

U. S. Dept. of Agriculture: Composition of Foods--Agricultural Handbook No. 8. 1963.

Dept. of Health and Welfare: Nutrient Value of Some Common Foods. Ottawa, 1971. (available at Information Canada)

The Vancouver Free Clinic: Home Health Almanac. Vancouver, 1972.

The Associated Milk Foundation of Canada: Handy Nutrition. 1970. (very traditional, but supplies good basic information)

Lappe, Francis Moore: Diet for a Small Planet. N.Y., Friends of the Earth/Ballantine Books, 1971. (deals specifically with vegetarianism; available from most health food stores)

GUIDE TO HAVING a BABY in VANCOUVER

This Booklet is in effect a "guide to having a baby in Vancouver". The topics in the booklet are organized in the order of most usefulness - chronological from prenatal information to care of the newborn. We suggest that expectant mothers consider all of these areas early in order to make decisions which can be acted upon early in order to make their childbirth experience all that they wish it to be.

All organizations which give prenatal care are listed, and we emphasize that women should choose that program which best suits their needs.

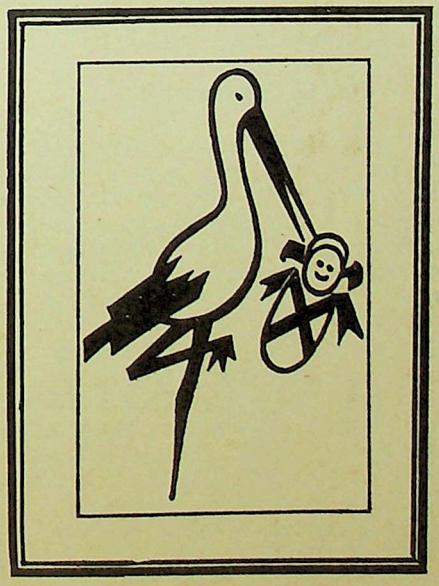
For women who plan to breast feed, we have described the La Leche League. This is an organization of women who help and encourage women with breast-feeding.

Information for the poor is given in the hopes that women on welfare can find stores that sell groceries, clothes, etc. at the most reasonable prices. To our knowledge, there is no store in Vancouver that sells inexpensive baby food and supplies.

The information on day care is brief. Unfortunately this is due to the great lack of such facilities in Vancouver. For many women, day care is an urgent necessity and there is little help for them at present. (A book on day care in British Columbia will be available in September at community information centres.)

To investigate the satisfaction of Vancouver women with the facilities and services in maternity wards at several major hospitals we conducted a short survey and the results will soon be printed.

Earlier in this booklet we presented a short discussion of our findings and their implications.



NUTRIENTS FOR NEW MOTHERS

The following excerpt from the B.C. Dietetic Association Position Paper on Nutrition in Pregnancy and Lactation:

"The following groups must be acknowledged to be nutritionally at risk during pregnancy and specific attention must be made to their unique nutritional needs.

1. Adolescents who are biologically immature at the time of pregnancy.
2. Women who are significantly underweight.
3. Women who have a history of an inadequate nutritional intake.
4. Women who are significantly overweight. This group is particularly vulnerable to unsound advice about excessive caloric restriction during pregnancy."

All mothers-to-be are anxious to insure that they have a healthy baby. The intake of healthy food should be attended to conscientiously as diet does affect both mother and child. With this in mind I went to visit Reach Clinic's Community Nutrition Service, 1114 Commercial Dr., and spoke to a nutritionist. The nutritionist is available for counselling individuals Monday, Wednesday, Thursday, and Friday. The first visit costs $10 and each visit thereafter is $2. She will help prepare a detailed personal diet which is right for you.

You may call a nutritionist at 254-1354.

Vegetarians will be interested in knowing that Reach has just printed a 15¢ manual entitled Vegetarianism and Pregnancy.

Single Mothers

Single mothers, especially those on welfare, will be faced with the decision whether or not to keep their child. This is a decision that is solely up to them. Many women in the past have had the experience in the hospital, after their baby's birth, of having social workers visit them to try and pressure then into giving up their baby for adoption. Single women, as with married women, have every right, legal and social, to keep their children if they so desire, unless extraordinary conditions exist, such as a woman having a baby while incarcerated in a mental asylum or prison, in which cases the child is usually taken away by the Children's Aid Society and placed in a foster home or put up for adoption. The chances of these women ever getting their children back if they are released are very slim. If a woman wishes to put her newborn child up for adoption she should make arrangements with the Children's Aid Society either before or after the birth and they will assume responsibility for finding good adoptive parents. Newborn children have a very good chance of being quickly adopted.

For more information on legal rights, see pamphlet:

Women and The Law

available from

Vancouver People's Law School
2426 York Ave., Vancouver 9.
732-0222.

Welfare Mothers

Welfare Offices are at:

North Unit 1530 West 8th Ave.
731-5727

West Unit 1530 West 8th Ave.
731-9155

South Unit 6445 Knight Road
321-3441

East Unit 2610 Victoia Dr.
872-7661

Applications for Social Assistance are made at these offices. The place to go for Health Care is the West Unit.

KEEPING IN SHAPE

We feel that prenatal education for parents is beneficial in increasing the understanding of childbirth as a natural physiological body process and in dispelling misunderstandings of pregnancy and childbirth. These classes offer an opportunity to acquire knowledge in pregnancy, labour and delivery and to learn techniques that may make these easier. The course topics usually include physiology of childbearing, hygiene including nutrition during pregnancy and lactation, breathing levels used for different stages of labour, relaxation techniques and the role of the father in labour and delivery. In addition, preparations for the baby, and care of the mother and baby after delivery are discussed. This is not a simple way to an easy birth with no pain or discomfort, but a means to enable a woman to gain more self-understanding to help herself in labour and to increase her self-confidence. Fathers are encouraged to attend, thereby providing an opportunity for both parents to participate in the birth of their child. We feel that these classes are an asset not only to new mothers but also to those who already have children.

We provide here a short description and fact sheet of the classes offered in the Lower Mainland.

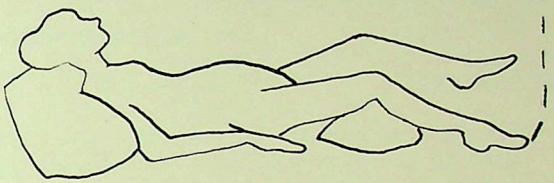
Metropolitan Health offers classes for expectant parents. The two hour classes focus on growth development, birth and care of the baby. Demonstration of exercises, relaxation and breathing techniques are included in the courses. Informal discussion is also an essential part of the program. These are taught by public health nurses.

Vancouver Childbirth Association has a very intense 9 week course. Each instructor is a mother herself and undergoes a very detailed educational program by the Association. Both parents together are taught the exercises with an emphasis on team cooperation. Open discussions, with films aid the teaching process. Some of the topics covered are breathing and relaxation techniques, coping with some of the emotional and physical changes of pregnancy, labour and delivery, family centred maternity care, characteristics and basic needs of the baby, infant care, breast and bottle feeding, postpartum care and exercises, and the beginning weeks together as a family.

In addition, there are Preview Nights for those enrolled in future classes or for those who wish to learn more about the classes before enrolliig. Topics discussed on Preview Night include: What is the Vancouver Childbirth Association? What is psychoprophylaxis? basic nutrition and family meal planning, husband's role in childbirth preparation, and primary relaxation exercises. There is no fee for the preview night session.

Periodically couples who have been through the classes come back with their newborn, to discuss and share their experiences. Also of

interest are the films shown that deal with conception and development of the baby during its intrauterine life, and another film showing actual deliveries with mothers using breathing techniques similar to those taught in the classes.



Childbirth Education divides their course into two parts. The first class, or "early bird" class, is for mothers in their 3 - 4 month. Some of the topics discussed are maternal nutrition, psychological and physical changes of pregnancy. Early exercises and relaxation techniques are also taught. The second part of the course is a set of 9 classes the mother attends from her 7th month on. The women are taught more details of the psychoprophylactic prepared childbirth, the theory and practical care of the breasts, explanation of the hospital stay, including the various medical techniques and procedures, roomin-in, why a baby cries, and adapting to life with a new baby. A very important lesson occurs in the last class which is a "rehearsal of labor".

Scholarships are available for those unable to pay for the full amount of $18. Library facilities are available on all aspects of childbirth, for those taking the course. Breast feeding counsellors teach a class and are also available for assistance 24 hours a day.

They also offer sets of 3 classes or Slimnastics for $1.00 for the new mother. These entail exercises and discussions of breast feeding, nutrition and role change for new parents.

The Parents Group is another possibility offered. For $2 per couple, the new parents receive a newsletter and may attend meetings with other parents and resource people to discuss a variety of topics such as infant diseases and home treatment, bringing up a preschool child, holidaying with a child, toys and books.

Mothers seeking assistance with nutritional problems related to their children are encouraged to speak with their former instructor and are often referred to a Nutrition Clinic and counselling at the Children's Hospital at 250 W. 59th.

The Free Clinic offers group discussions of the childbirth experience. There is no specified direction of these gatherings; the expectant couples are encouraged to simply discuss any relevant topic that they feel would be beneficial.

Service	Location of Classes	Cost	Month of Pregnancy	Course Length	Dads
*METROPOLITAN HEALTH SERVICES					
Health Unit 1 306 Abbott St. ph. 684-4191	Central Presbyterian Church 1100 Thurlow	$ 3	6 months	7 wks	Yes
(For Chinese mothers only - helps the adjustment to Canadian hospitals - no English)	Lions Hall 788 Commercial	$ 3	1-9 mos.	8 wks	Yes
Health Unit 2 2112 West 42nd Ave. ph. 261-6336	Education Center 5957 W. Blvd.	$ 3	6 months	7 wks	Yes
(For single mothers)	Education Center 5957 E. Blvd.	$ 3	anytime	3 wks	Yes
Health Unit 3 1530 West 8th Ave. ph. 736-9844	Canadian Memorial Church Hall 1811 West 16th	$ 3	6 months	7 wks	Yes
Health Unit 4 6405 Knight Rd. ph. 321-6151	at Unit 4	$ 3	6 months	7 wks	Yes
Health Unit 5 2610 Victoria Dr. ph. 872-2511	at Unit 5	$ 3	6 months	7 wks	Yes
Burnaby Health Unit 4949 Canada Way ph. 299-7211	Allesmere United Church 3505 Allesmere N. Burnaby	$ 3	6 months	7 wks	Yes
North Shore Health Unit 253 East 14th St. ph. 988-5231	St. Francis Church 6656 Balmoral North Vancouver	$ 3	6 months	7 wks	Yes
West Vancouver Office Municipal Office 750 17th ph. 922-9136	Municipal Hall	$ 3	6 months	7 wks	Yes

Service	Location of Classes	Cost	Month of Pregnancy	Course Length	Dads
Richmond Health Unit 691 3rd Rd. ph. 278-5511	At Richmond Health Unit	$ 3	6 months	7 wks	Yes
VANCOUVER CHILDBIRTH ASSOCIATION 444 Robson St. ph. 263-7910	B.C.I.T. 3700 Wellington Burnaby	$25	6 months	9 wks	Yes
	St. David's Church Taylor Way & Upper Levels West Vancouver	$25	6 months	9 wks	Yes
	Knox United Church 5600 Balaclava Vancouver	$25	6 months	9 wks	Yes
	Surrey Memorial Hospital Surrey, B.C.	$25	6 months	9 wks	Yes
CHILDBIRTH EDUCATION 676 W. 31st. ph. 872-7315	1st class - "Early Birds" 66 W. 31st	$18	3-4 mos.	10 classes	Yes
	Classes 2 through 10 St. Mary's Anglican Church 37th & Larch		7 months		
U.B.C. HEALTH SERVICES ph. 228-3149	Held according to need. Will be held in the new Health Science Center	$ 5	6 months	10 wks	Yes
FREE CLINIC 1952 W. 4th ph. 731-6929	At the clinic, Saturdays. Mainly open discussion. No formalized educational service.	free			Yes

*NOTE: All mothers must register with the Unit of their choice before attending the classes.
Mothers are encouraged to register as soon as pregnancy is noted for the introductory class.
Generally, new classes begin each month.
Afternoon and evening classes are held to enable all mothers to come to their nearest Unit.
Course fees are waived for those unable to pay.

MATERNITY CARE

In the following few pages we present information on all Vancouver hospital maternity wards. Before asking hospitals about the facilities for mother, father, and infant we looked for a description of what might be considered "ideal" to use as a guide for examining what "is". Below, we present an excerpt from a book by Doris and John Haire which deals entirely with the idea that hospitals should cater to the needs of each individual family. The book is well researched, organized and presented - enabling individuals to question some of the standard, acceptable patterns of service to maternity patients. Most Vancouver hospitals have now modified form of "rooming-in", which is one major aspect of family maternity care. The most complete adoption of this arrangement is available at St. Paul's Hospital.

Family centred-maternity care is a flexible concept of individualized maternity care which permits the parents to share the childbearing experiences and to have access to their baby during the postpartum period to the extent they desire. A complete family-centred program provides childbirth education which prepares the couple for childbearing experience. The prepared couple is then made to feel free to share the childbearing experience to the extent that they desire, if there are no medical contraindictions. During the labour the husband is not treated as a visitor, but as an integral part of the family unit. He is treated with courtesy and understanding. His questions, as well as his wife's, are answered, procedures are explained and the physician's technical statements are interpreted if necessary; for example, cervical dilation is explained with the aid of a demonstration chart.

While his wife is in labour the husband is offered coffee at intervals, encouraged not to go without eating for long periods of time, and is assured that someone will stay near his wife when he has to leave for a meal or for any other reason.

If there are no contraindictions, the couple wish to be together during the birth of their baby they may do so if they comply with certain requirements set by the medical and nursing staffs. These requirements usually follow a similar pattern.

** The couple to be together must have the permission of their attending physician.

** The husband and wife must have attended childbirth education classes or received some advance preparation.

** The husband must agree to leave the labour/delivery area if his wife receives medication which will make her unaware of his presence or if the delivery will require an operative procedure, other than an episiotomy.

** The husband must be aware of the importance of maintaining the privacy of other patients in the labour/delivery area and agree to stay in his wife's room or in a designated area while his wife or her room-mate (if she is sharing the labour room) is being examined.

Family-centred postpartum care makes it possible for both parents to get to know their baby during the hospital stay and to begin functioning as a family unit under the guidance of maternity nursing personnel. Each mother is made to feel free to have her baby cared for in the nursery or to have her baby at her bedside as little as she wishes, except during regular visiting hours, at which time all babies must be returned to the regular nursery.

If the mother wishes, she may undress her baby and check him over, diaper him, perform a baby bath demonstration and feed her baby on demand. The latter is especially important if the mother is breast-feeding.

During the postpartum stay the father is not considered a visitor. Except during regular visitor hours, when all babies are in a regular nursery, he may hold or feed his baby. He is made to feel free to ask questions, and watch a baby bath or diapering demonstration if he is in the department when the demonstration is being given. Giving the demonstrations around the lunch hour sometimes helps to make it possible for the father to be present.

It should be emphasized here that in a family-centred program parents are not pressured to take advantage of the services offered. In a family-centred program the couple may choose NOT to take classes or be together during labor and birth and the mother may prefer that her baby remain in the nursery most of the day. Family-centred maternity care is patient-centred care, pure and simple.

The goals of a family-centred maternity program are:

*To insure that the mother has a good experience during labor, birth and her post-partum stay.

*To enable the husband to share in this experience to whatever extent that he and his wife desire, if there are no contraindictions.

*To insure that every mother leaves the hospital confident in her ability to care for her baby.

*To accomplish these goals without jeopardizing the health and well-being of mother and child.

(P. 1 - 5, and 6)

(This is reprinted here with permission of the authors, Doris and John Haire.)

CHOOSING A HOSPITAL . . .

What alternatives are available in maternity policies and facilities in Vancouver? To provide a more adequate basis for choice for prospective parents the following "guide to maternity wards in greater Vancouver" has been prepared. We present below the commonalities and differences in hospitals. Information was gathered through personal tours and discussions with either the director of nursing or the supervisor of obstetrics at each hospital. Please keep in mind that we have not covered every aspect of maternity care in hospitals; in particular, we have not questioned the quality of medical care, but rather the physical amenities available and policies which affect one's stay in a hospital. We did not always ask exactly the same questions of each hospital, and the specific paragraphs which are given below are based on impressions we gathered while visiting the various hospitals. These descriptions may enable you to choose a hospital which best meets your needs and those of your family.

Maternity Tours

These tours are provided by each hospital in order to acquaint prospective parents with procedures and facilities in admission, labor, delivery and postpartum rooms. Tours are usually sponsored by the Women's Auxiliary and tea is served. The approximate length of a tour is 30 to 60 minutes. Fathers are generally encouraged to attend or you may bring a friend who might also accompany you when you enter labor. Tours are given monthly or bi-monthly.

Admission to Maternity

All hospitals have a pre-registration system. You can obtain a form from your doctor or from the hospital in which you choose to deliver your baby. By completing this form and mailing it in at least a month in advance you eliminate the need for much questioning and paper work on arrival at the hospital. This may help make admission more speedy and comfortable for you when you arrive in labor. Do mention whether or not you have attended prenatal classes as this lets nurses know how much preparation you have had and may help them to make you more comfortable and will enable them to judge how much more explanation of procedures you require. Upon arrival at the hospital, a friend or your husband may help speed things up by signing you in while you proceed to the labor area for a prep.

Maternity Prep

The prep in all hospitals consists of a shave, enema, examination and taking of blood pressure. The mini-prep is efficient and less bothersome than a full prep. While you are being prepped your husband may wait outside your room, in or near the labor area.

Labor

It is important that you have your husband or friend who is trained in psychoprophylaxis accompany you if you desire a controlled or "natural" childbirth. Nurses are usually trained in these methods but don't have the time to stay continuously with one woman in labor. All hospitals

allow at least one person to be with the mother in labor; it may be necessary for this person to gown first. Women are allowed to walk around in early labor and are free to shower where facilities are available.

If a woman is in labor for a long time, she may be given fluids or intravenous, but food is not given due to the possibility of vomiting and aspiration. All hospitals provide pillows, blankets, ice chips and powder for massage, but you may have to ask or have your husband ask, to have these things when you wish to have them.

False Labor

Expectant mothers often suffer from so-called "false labor", which the nurse should be able to distinguish from "effective uterine contractions". True labor contractions will produce a demonstrative dilation of the cervix in the course of a few hours. On the other hand, "false labor" contractions are painful but do not affect the cervix. (from Maternity Nursing, by Fitzpatrick, Nicholson, an Reeder).

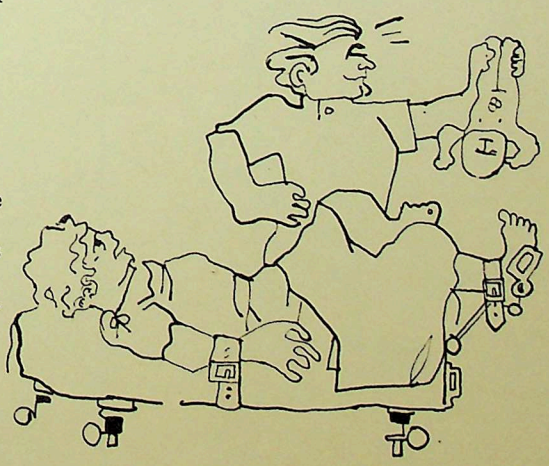
If you should happen to enter the hospital with "false labor" and are discharged as a result, do not be disheartened or embarrassed for this is a common occurence and is best diagnosed by medical staff.

Delivery

Fathers-to-be who desire to be present at the delivery of their child should have told their wife's doctor sometime early in the pregnancy. Usually the father will not be allowed in the delivery room until the doctor is present and permits him in. It is desirable that fathers have also attended prenatal classes. Fathers may be asked to leave if anything unusual or complicated does occur.

Most hospitals have the same delivery procedure - deliveries are done with the woman in prone position with legs in stirrups and her hands may be strapped in for her own security and to keep her arms out of the way when the child is born. If you do not wish to deliver in this position it is a must that you discuss your feelings with your doctor ahead of time. For instance, if you wish to have a pillow or prop in the delivery room or to deliver in an alternative position, your doctor should have prior knowledge of this; so choose a doctor who is amenable to your desires. Do ask nurses for blankets or pillows if it will make you more comfortable.

Episiotomies are standard procedure in most hospitals, unless of course, it is a very speedy delivery. Anesthetics are given at the doctor's discretion unless the mother expressly refuses to accept anesthetics; but it may be that her delivery expressly requires it. You should make your feelings on this matter clear prior to entering the hospital, or at least prior to the delivery stage.



Holding and Nursing in the Caseroom

Most hospitals allow the mother and/or father to hold their child immediately after birth once it is assured that the child is normal and healthy. If you wish to nurse your baby immediately after delivery it would be advisable to discuss this with your doctor ahead of time. It has happened in the exceptional case, but is not a general practice at any hospital. The y must be kept warm and observed be normal and healthy before is possible to allow a mother nurse immediately - some doctors will then allow it. The usual procedure is a 6 - 8 hour observation of newborns in the nursery, prior to the first feeding. Glucose and water may be given to infants by a nursery nurse during this time.

Health Care Instruction

Most postpartum nurses offer instruction in breast care, nursing, bottle feeding, and baby bathing. Some nurses may also be able to provide information on nutrition or you should ask to see a nutritionist. You may miss some of the above instruction in some hospitals if your stay is less than 5 days. Baby bathing is not generally done individually except for rooming-in mothers. Some of the advice you receive for nursing may be contradictory or inadequate, but do persist if you desire to nurse. If you need assistance, even while in the hospital, call the La Leche League which is listed in this booklet. You will also need to care for your episiotomy; therefore assure that you have adequate instruction and request additional help if you are uncomfortable.

Name, Location & Phone of Hospital	No. of Deliveries Per Month	Visiting Hours & Policies	Tour Schedule	Location of Admitting	No. of Labor Rooms & Beds
Burnaby General 3800 Ingleton 434-4211	120	2:30 - 5:00 7:00 - 8:00 2 visitors per time. No child. under 14	Every 2nd & 4th Wed. at 2:30 pm	Ground Fl. Admission. After 11 pm use Emergency	3 labor rooms. 2 beds in each.
Grace Hospital 26th & Heather 874-3454	210	3:00 - 4:00 7:00 - 8:00 2 visitors. Child. under 14: Sun. 3-4	Every 2nd & 4th Tuesday at 1:30 pm.	Ground floor.	2 - private
Lion's Gate 230 E. 13th North Vancouver 988-3131	125	3:00 - 5:00 7:00 - 8:00 2 visitors. No children under 16.	Arranged through prenatal classes.	Ground floor.	7 - private. 1 semi.
Richmond General 700 Westminster 278-9711	80	3:00 - 5:00 7:00 - 8:00 2 visitors. No children under 16.	Every 2nd Sunday at 2:30.	Ground floor.	3
Royal Colombian 330 E. Columbia New Westminster 522-2771	150	3:00 - 5:00 7:00 - 8:00 (Dads only) No children under 15.	Arranged through Public Health.	Ground floor.	4 labor beds.
Saint Mary's 220 Royal New Westminster 521-1881	47	3:00 - 5:00 7:00 - 8:00 No children under 14.	Arranged through prenatal classes.	Ground floor.	4 - private labor rooms.
Saint Paul's 1081 Burrard Vancouver 682-2344	110 - 120	Unlimited for Dad. 4 passes from 7-8 pm. No children under 16.	1st Tues. at 2:30 2nd Tues. at 7:30	Ground floor. After 8pm, go to Emergency.	1 priv. 1 semi. 1 triple
Saint Vincent's 749 W. 33rd Vancouver 876-7171	50 - 80	2:30 - 4:00 7:00 - 8:30 2 visitors. No children under 12.	Every Tuesday at 12:30	Ground floor.	1 labor room. 4 beds.
Vancouver General Willow Pavillion 12th & Willow 876-3211	180	2:30 - 4:30 6:30 - 8:00 Children allowed	Book through Ms. Lafek at Willow Pavillion.	Ground floor.	4 priv. labor rooms.

Hospital	Location of Labor Area	Location of Father's Waiting Room	No. of Delivery Rooms	Presence of Anesthetist	Alternate Delivery Positions	Who Delivers if Dr. is late?
Burnaby General	3rd floor	4th floor	3	On call.	On side if prearranged	Dr. on call.
Grace	3rd floor	3rd floor	4 - one has student viewing gallery	Present for all deliveries.	On side.	Dr. on call.
Lion's Gate	3rd floor	3rd floor	4	On call.	On side.	Dr. on call.
Richmond General	3 floor.	3 floor.	2	On call.	On side.	Dr. on call.
Royal Colombian	4th floor	Next to maternity ward.	3	On call.	On side.	Dr. on call.
Saint Mary's	2nd floor.		3	On call.	On side.	Dr. on call.
Saint Paul's	5th floor.	5th floor.	3	On call.	On side.	Dr. on call.
Saint Vincent's	3rd floor.	3rd floor.	3	On call.	On side.	Dr. on call.
Vancouver General	To post-partum then labor.	Waiting room on every floor.	4	On call.	On side.	Dr. on call.

Hospital	Nursery Curtains	No. of Postpartum Rooms & Beds	Availability of Bath & Toilet	Rooming-in Arrangement	Feeding Schedule
Burnaby General	Open	1 private 4 semi 5 4-bed wards.	1 toilet and shower per 9 - 10 patients	Modified for private room patients $7.50 - $10.	Every 4 hours and 2 am if desired
Grace Hospital	Open	7 private 4 2-bed 3 4-bed 1 10-bed	No information given.	24 hour rooming-in; $7.50 - $10. per day.	Every 4 hours.
Lion's Gate	Open	5 private 5 semi 4 4-bed	1 bath for every 8 patients.	Modified $11 / day	Every 4 hours & 2 am.
Richmond General	Open	2 private 2 semi 6 4-bed	Toilet & bath for each room.	24 hour $8 / day	Every 4 hours.
Royal Colombian	Open	2 private 2 semi 2 4-bed	1 toilet per 4 1 bath per 8-10	Modified	Every 4 hours.
Saint Mary's	Open	4 private 2 semi 7 4-bed	No information given.	24 hour	Every 4 hours.
Saint Paul's	Open	2 private 3 semi	1 for each room.	Modified.	On demand
Saint Vincent's	Open	5 private 4 semi 3 4-bed	1 toilet per 4 beds	Modified	Every 3-4 hours.
Vancouver General	Open	13 private 4 semi 2 4-bed 16 bed ward	Very limited.	24 hour.	Every 4 hours.

Hospital	Accessibility of Infant	Physiotherapist	Wards for Abortion & Sterilization	Average Length of Stay - Vaginal Delivery	Average Length of Stay - Caesarian Delivery
Burnaby General	Aside from rooming-in, at feedings only.	Every morning.	Separate from postpartum accommodation.	4-5 days	6-7 days
Grace Hospital	Feedings only.	3 days a week.	Separate wards.	6 days	8-10 days
Lion's Gate	Feedings and open nursery.	Twice a week.	Separate wards.	5-7 days	7-10 days
Richmond General	Feedings.	Every day.	Separate wards.	5 days	7 days
Royal Colombian	Feedings.	Every day.	Separate wards.	5 days	6 days
Saint Mary's	Feedings only.	Every morning.	No abortions or steriliz-ations.	5 days	8 days
Saint Paul's	As often or as seldom as you like.	Every morning.	No abortions or steriliz-ations.	5 days	10 days
Saint Vincent's	At feeding.	Every morning.	No abortions or steriliz-ations.	5-6 days	9-10 days
Vancouver General	At feeding.	Every evening.	Separate wards.	5-6 days	8-10 days

Vancouver General Hospital

VGH has a five-floor obstetrical pavillion. It was built in 1929 and, due to lack of funds, has had almost no structural changes made since that time. This has an influence on the type of care given - some things, such as an extensive rooming-in, are not possible because of lack of physical facilities for them. Still, it is probably the best technically equipped hospital in the Lower Mainland. This is a referral hospital for all of B.C.

There is a check-up for the baby at the out-patient department three weeks after the baby leaves the hospital, and the mother can also go back for her own check-up after six weeks.

The Grace Hospital

This hospital is for obstetrics and gynaecology only. Labor rooms are equipped with piped-in music; they are usually doubles. One delivery room has a viewing gallery for students. The delivery rooms (4) face out onto a common corridor so that a nurse could be of assistance in more than one room at a time if extra help were needed in one delivery room. If requested the mother may nurse her baby on the delivery table. There is a very pleasant atmosphere in both wards and private rooms. There is limited facility for rooming-in. Chapel services are held daily, for'patients' who request it.

Saint Mary's Hospital

This small hospital has all the charm lacking in a big hospital. The number of deliveries is going down yearly, but the maternity ward still functions with four labor rooms, and two delivery rooms. The atmosphere is bright and cheery. The hospital can handle all emergencies and rarely needs to refer infants for care elsewhere. Staff are particularly concerned with maternal instruction in the care of newborns, and provide individual help to mothers nursing or desiring to bathe their own babies.

Richmond General Hospital

Built in 1966, Richmond General Hospital is a highly modernized hospital. Rooms are large and bright with windows overlooking the rural scenery. There is a two-way intercom system between the "patients" rooms and the nursing desk, between the main desk and nursery, and between the labor rooms and the nursing desk. A patient lounge is also available for those women wanting use of a television, library, sun-deck or companionship outside the refuge of their rooms.

Each room is equipped with a supply cupboard containing all the necessities of the patients such as linen, creams, straws, etc., to facilitate quicker service for the patients.

St. Vincent's Hospital

The nursing staff at St. Vincent's is all trained in psycho - prophylaxis and attend in-service lectures throughout the year on all aspects of maternity care. This encourages the introduction of new ideas in obstetrics and a review of previous knowledge.

Another policy this hospital follows is that each mother, on

her third day postpartum, is visited by the physiotherapist to encourage and teach the value and techniques of postpartum exercises.

The obstetrical case load is fairly small and the women enjoy a more intimate type of hospital setting.

Lion's Gate

In addition to their regular rooming-in program which is available upon request to women in privat rooms, Lion's Gate offers a facility which they call "modified" rooming-in for all women having their babies at this hospital. This program of modified rooming-in is an intermediate step between total rooming-in as described elsewhere in this booklet and the more common type of maternity facility where mother and infant are separated except during feeding times. A special room opposite the regular newborn nursery is set aside and equipped to allow mothers to stay with their infant in addition to the regular feeding times. Mothers can go to this room and handle, feed, change or bathe their babies under the direction of a nurse.

Lion's Gate also has a T.V. lounge and a sun room where mothers can have visitors.

Royal Columbian

Because we came into contact with the Royal Colombian at a late date in our study, we were unable to tour this hospital's maternity facilities to obtain any further details.

Saint Paul's

Saint Paul's is the only hospital in the Lower Mainland offering an exclusive maternity program which they call Family-centred maternity care. This hospital tries to duplicate as much as possible the home environment that the mother and infant will return to upon leaving the hospital. While in the hospital, mothers can assume responsibility for the care of their infant at their own pace and can have the baby by their bedside for as little or as long as they choose. Fathers have unlimited visiting hours and are encouraged to participate in the care of their child. There are no routines imposed on the family and the nursing staff is very willing to assist the family in every way. The objective of the unit is to discharge a mother, father and baby who know, enjoy and are comfortable with each other in this new life situation. Nursing instruction is available in this hospital on breast-feeding, baby bathing, nutrition and postpartum exercises. In addition, there is a communal dining room in which mothers are encouraged to eat their meals, meet other new mothers and share experiences. Husbands are also welcome to eat with their wives for a nominal price. There are two T.V. lounges, a library and an outside deck which are available to maternity patients.

Burnaby General

There was no mention of any special facility or maternity program at this hospital. However, a modified program of rooming-in does exist.

CARE OF THE NEWBORN

For information on Post-partum counselling. See page 127.

La Leche League

This organization of La Leche League is a group of mothers who have joined together to help and encourage mothers in their attempts to breast feed their babies. They have literature and information available on almost all aspects of breast feeding.

They hold their meetings the first Tuesday of every month. Other breast-feeding mothers attend the meetings and there are always lively discussions about the problems and the successes of breast-feeding.

Information concerning the time and location of the meetings can be obtained from:
Jillian Russell 736-4713
or Norma Bedford 2668147.

Vancouver Area Parents Of Twins Club

The purpose of this club is to provide communication among parents of multiple births. This club is interested in sharing and exchanging ideas and information about the special joys and problems in raising twins and triplets.

During their first year they have enjoyed informative discussions, guest speakers and family social events. They attempt to provide information and material aid to needy families with twins. It is hoped that the social functions will be on a bigger scale next year.

The meetings are held on the fourth Monday of each month at
All Saints' Church
7405 Royal Oak Ave. (at Rumble)
Burnaby.
Meetings begin at 8:00 p.m.

Children's Hospital -- 250 West 59th 327-1101

The Children's Hospital has a nutrition clinic. This clinic is for bottle- and breast-feeding mothers and their babies. The clinic is geared towards teaching nutrition to mothers. An R.N. and a nutritionist are present to discuss the baby's developmental progress. They help mothers to deal with feeding problems and provide information on vegetarian diets. The clinic sees babies at one month, three months, six months, nine months, twelve months, and twelve and a half months, and again at two years in order to insure that the child is growing healthily. The clinic times are Tuesday 1 to 7 p.m.

Vancouver Free Youth Clinic -- 1932 West 4th 731-6929

This clinic holds a Well-Baby Clinic every Thursday morning from 11:00 a.m. to 1:00 p.m. Nutritionists are present to advise mothers on the health and care of their baby. Babies are weighed and measured, immunizations are available, and the progress of growth is charted. Doctors are available if necessary.

St. John's Ambulance -- 6111 Cambie
321-2651

There is a home nursing course taught by a registered nurse. This course teaches total home nursing. It covers such areas as care for elderly persons and prevention of home accidents, and includes a section on care of the newborn, care of the sick child, and management of emergency home delivery. These courses could be of help in the home throughout the year. The course costs $10.00. For more information call St. John's Ambulance.

Pine Street Clinic -- 2333 Pine
738-6622

The Pine Street health unit has no specific health care for the newborn, but it has a general practitioner available during the day if any medical care is needed. This is a free clinic.

Metropolitan Health

This organization is supported by the city and financed by local taxes. It is not necessary to be covered by B.C. Medical in order that your child receive the services available.

Metropolitan Health nurses visit every house with a newborn child. The mother is talked with and encouraged to ask questions about her health or the health of her baby.

Mothers are made aware of the public health unit centers and hours. These clinics weigh and measure infants, discuss nutrition, and do developmental tests at 9 months, 18 months, and three years. Immunizations are given as well as eye and hearing tests.

To find the unit in your area call the main office at 873-7393 or 873-7398.

Eating Well Without Wealth

Information on cheap shopping may help those on small budgets and with big appetites.

Everbest Cash Grocery
910 Commercial
Vegetables, fruit, other groceries.

Stong's - two stores
4326 Dunbar St; 3745 Rupert St.
General groceries; carry only union grapes and lettuces.

Woodward's Food Department
101 West Hastings (downtown br.)
Especially on $1.49 day, inexpensive groceries.

Solo Food Market
2520 Commercial
Groceries, Italian foods.

Sunrise Market
300 Powell Street
Inexpensive fruit, vegetables - sometimes slightly damaged, most in good quality. Some other goods too.

Buy-Low
3151 Arbutus
Inexpensive canned goods, still in cases. Other groceries, fruit vegetables, etc.

Famous Foods
1315 East Hastings
Canned goods, oil (cooking), staples, spices, etc.

Cheese

Apple Dairy
1864 West 4th Ave.
Inexpensive cheese, usually good condition. Looks like a warehouse but sells to individuals.

The Lido
518 East Broadway
Cheese in varying conditions, some good, some very moldy on the outside but good if mold is cut off - very inexpensive.
Also, sausages, some vegetables, other goods.

Bread

Crusty's Thrift Shop
1303 Commercial
Inexpensive bread.

Mother Hubbard's Bakery
2106 West Broadway
Store outlet sells inexpensive bread and baked goods.

Pacific Bakery
382 Powell Street
Day-old bread.

Meat

Best Bi Foods
633 E. Hastings
Government inspected horsemeat, low prices, other meats.

Paul's Quality Meats
1535 Yew Street
Inexpensive meat, cheddar cheese.

Save-on Meat Market
43 West Hastings
Large assortment, inexpensive meats, fish, poultry, other goods, cheese, etc.

Clothing

Free Clinic
1952 West 4th
Free store in basement - used clothing in differing conditions, help yourself.

Happiness
229 Carrall Street
A barrel of free things.

Helpful Nieghbour Workshop
Church at 808 E. 50th, side door
For those in need.

Free Home Help Service
282 Powell St.
Free store.

Children's Aid Society
201 W. 6th
ph. 872-7711
Clothing voucher for under 18's

Salvation Army, Family Service Centre
319 E. Hastings
Clothing voucher for over 18's, except single men.

Free Home Help

FLIP - 872-7711
Children's Aid Society
Home help for those in need.

Home Help Service - 684-9615
Handicapped, elderly, and shut-in help.

K.I.N.D. - 733-4144
Free home help and maintenance, in-home care, babysitting, for those in need.

Holiday Handyman Services
435-2062
While you're away.

Vancouver Home Repair Center
1895 Venables
225-9012

HEAVY BARGAINS

Junior League Thrift Shop

260 E. Broadway, Vancouver 10
876-4921
Shops selling used goods, clothing, etc. which are donated by members of the Junior League. The profits are returned to the community through community services. Also consignment buying and selling on a 50-50 basis.

Good Will Industries Association

6416 Fraser St., Vancouver 15
Ms. M.L. Carson, Secretary
327-5818
Provide work for handicapped by processing and repairing discarded and used second hand goods or merchandise.

National Council of Jewish Women Thrift Shop

2331 Main St., Vancouver 10
Ms. Marie Doduck, Chairman
Thrift shop is maintained as a service to that section of the public who, because of financial deprivations, can only buy good used clothing at a modest price. Clothing is donated free to agencies who should request same through a letter to the President.

St. Vincent De Paul Salvage Bureau

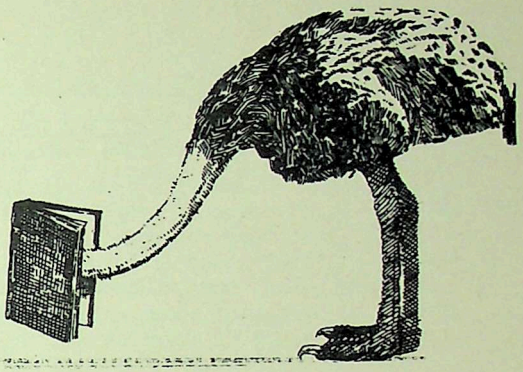
150 Robson St., Vancouver 3
682-3161
A non-profit organization which is a special work of the St. Vincent de Paul Society. Its aims are to assist poor people and those on marginal income by collecting used furniture, clothing, etc., and making it available to them at a price within their means, to provide jobs for the handicapped and disabled. Large donations of household essentials and clothing are given yearly to those who have no means.

The Salvation Army

Welfare Industries
111 Victoria Drive, Vancouver 6
253-1161
The sale of merchandise reconditioned in the Opportunity Rehabilitation Workshop, which provides assessment and training to handicapped individuals. Merchandise available at moderate prices in 7 retail stores in the Greater Vancouver Area. The Salvation Army has branch stores around town which sell furniture and clothing.
456 East Hastings.
1420 Commercial Dr.
1126 Robson St.
4191 Main St.
6669 Fraser St.
5650 Victoria Dr.
4220 East Hastings.

NOTE: These lists are not necessarily complete.

bibliography



Dick-Read, Grantly. Childbirth without Fear, Toronto, British Book Service, 1955 (orig. 1942)

Written by one of the first proponents of natural childbirth in the U.S., Dick-Read views childbirth as a natural and almost mystical experience. Interesting book, but outdated by such recent approaches as the Lamaze and Philip-Wright techniques.

Flanagan, Geraldine L. The First Nine Months of Life, New York, Pocket Books, 1969.

Very readable and scientifically accurate account of fetal development, illustrated with authentic photographs of the hour-by-hour, month-by-month development of the human embryo, from egg cell to birth. Available in paperback for 75¢.

Fitzpatrick, E., Eastman, N. and Reeder, S. Maternity Nursing, Toronto, J.B. Lippincott Co., 1966.

A revision of a well-known maternity textbook, Zabriskie's Obstetrics for Nurses, Maternity Nursing, is a comprehensive although readable treatment of maternity care from a nursing standpoint. It puts great emphasis on the family and the maternal-child continuum, physical and emotional considerations as well as the role of the nurse in maternity care. In addition to chapters on anatomy and physiology of childbirth and the conduct of normal labour, chapters are included on maternal disorders and abnormalities of the fetus and newborn.

Goodrich, F.W. Preparing for Childbirth: A Manual for Expectant Parents. Englewood Cliffs, N.J., Prentice-Hall, 1966.

Goodrich's popularly written book gives a general over-all coverage of pregnancy and childbirth starting with lectures on the anatomy and physiology of the reproductive system through breathing techniques to be used in labour and delivery. Written by a physician, the book emphasizes the obstetrical procedures which the pregnant woman will encounter in the hospital. Good coverage is given to exercise and relaxation techniques during pregnancy. The section on labour and delivery, however, seemed incomplete, dealing only with an ideal, normal birth and with no mention of any labour or delivery complications.

Guttmacher. Pregnancy and Birth

Good general coverage of pregnancy and childbirth by the well-known director of planned parenthood in the U.S.A. No mention of psychoprophylaxis or prepared childbirth.

Haire, John and Doris. Implementing Family-Centered Maternity Care With a Central Nursery.
available by writing to: The International Education Assoc., 208 Ditty Bldg., Bellevue, Wash. 98004

Excellent coverage of the following topics:
1) common questions on Family-Centered Maternity Care and their answers.
2) Parent education classes.
3) Labour, Delivery, and Recovery.
4) Family-Centered Postpartum care and its medical advisability.
5) Successful breastfeeding.
6) Staff orientation and guidelines for a family-centered program.
7) Suggested patient program.

Hazell, Lester. Common Sense Childbirth, New York, G.P. Putnam's, 1969.

Written by a mother, this anecdotal approach to childbirth advocates the "fun and satisfaction we can get through active participation in bringing forth our young". The two best chapters are "Breast-feeding successfully and joyfully" and "Home delivery".

Heardman, Helen. Ralaxation and Exercises for Natural Childbirth, Edinburgh, E.S. Livingstone Ltd., 1966.

This pamphlet is an excellent exercise manual for pregnant women. Includes general keep-fit exercises, breathing and relaxation techniques and postpartum exercises.

Lamaze, Fernand. Painless Childbirth, Chicago, Henry Regnevy Co., 1970.

Covers the physiology and psychology of pain in childbirth and advocates a method of painless childbirth based on breathing techniques, and neuro-muscular control.

Montague, Ashley. Life Before Birth.

Montague's provoking book begins with the thesis that life starts not at birth, but at conception and that what happens in the interval between conception and birth is critical, not only for fetal development but also for subsequent growth and development of the individual after birth. Montague's purpose is to show a prospective mother the various ways in which she can influence the physical and emotional development of her child before she is born. Among the topics covered are: nutrition, maternal age, drugs, smoking, infectious diseases, emotions and fatigue, radiation and X-rays.

Rubin, Riva. "Cognitive Style in Pregnancy", American Journal of Nursing, 1970, p. 502.

This article surveys the woman's perception during pregnancy: how she seems less predictable to others and herself. It studies the various stages by which a woman comes to accept her pregnancy, from resistance and surprise to acceptance and joy.

Rugh, Roberts and Shettles, Landrom. From Conception to Birth: The Drama of Life's Beginnings, New York, Harper Row, 1971.

This scientific and comprehensive treatment is dedicated to the idea that there is a need to improve the quality of human life through education of the prospective mother. Written in popular language and illustrated by color microscopic photography, the book traces the day by day progression of how an embryo becomes a fetus. There is also an excellent chapter on drugs, diseases, radiation and their effects on the fetus.

Thomas, Herbert. Childbirth With Understanding, 1962, Charles C. Thomas

Topics: Prepared Childbirth
Preparation for Parenthood
Support during Labour
Rooming-in
Nurse-midwife in hospital obstetrics Program and private practice.

Book puts forward a good case for all the above.

Thomas, Herbert. Understanding Natural Childbirth: A Book for the Expectant Mother, New York, McGraw-Hill, 1950.

This book contains a good discussion of rooming-in and pictures of labour but no vaginal views.

Wright, Erna. The New Childbirth, New York, Hart Publishing Co., 1966.

Erna Wright's book is based on the idea that learning how to give birth is like learning any other skill, and she advocates that it be done with control and dignity. Based on the psychoprophylactic method, the book is written as a substitute for actual psychoprophylactic classes and is organized as a series of 6 lessons to be followed as soon as the woman is 4 months pregnant. Exercises to tone up the muscles for labour are well illustrated and emphasized. Two of the most interesting chapters are "the necessary father", a discussion of the father's role in preparation for delivery, and a chapter called "What if it isn't like in the textbook?" which gives the reader supplementary aid techniques in the event of a long or complicated labour.

Directory of Doctors

I. MAKING UP THE DIRECTORY OF DOCTORS

At the end of each section of the medical questionnaire we asked the respondent whether or not she would recommend her doctor to another woman. They were requested to answer questions "according to the doctor you see most often for gynecological problems". We have taken these responses together with other facts about their doctors that the respondents gave us (if the doctor told them certain facts we think a patient should be told, if the doctor was sensitive to any pain involved, etc.) and recorded them in our file on doctors. The areas of practice we have recorded information on are:

- General Routine
- Menstrual Difficulties
- Vaginitis
- The Pill
- I.U.D.
- Diaphragm
- Tubal Ligation
- Abortion
- Other Methods of Birth Control
- Infertility
- Menopause
- Venereal Disease
- Pregnancy and Childbirth

We also recorded any general comments that help us know the overall tone of the relationship between the woman and her doctor.

There are over 300 general practitioners in Vancouver, and over 50 gynecologists. Unfortunately we have not been able to reach patients of every doctor with our questionnaires. The absence of a doctor's name from our office directory, therefore, is not necessarily an indication of a negative recommendation. We may, to date, have received no opinions of her/him at all. The doctors we do recommend have received more than one positive recommendation.

If you want to fill out a questionnaire about doctors you have seen, or know a group of women who would be able to fill them in, please contact us. We all benefit from sharing our experiences with each other.

II. OUR DIRECTORY

In our first edition, we printed a list of doctors that were recommended by the women completing the questionnaire. Because of limited space we were able to indicate only the specified areas (as listed on the previous page) for which we had received recommendations. We were not able to pass on any detailed information we have about a doctor's manner with patients. Since the quality of our relationship with a doctor is based on how she/he relates to us as individuals as well as her/his competence in treating a medical problem, not every one of us will feel comfortable with the same doctor. Instead of printing a list of doctors here we feel we would be better able to help you choose a doctor if you call us or drop in at the Women's Referral Bureau. We can then share more of our information with you.

DOCTOR DIRECTORY

AT

WOMEN'S REFERRAL BUREAU

1766 WEST BROADWAY

736-8471

Call or come in + talk to us if you need a doctor and want to go to one that other women have recommended.

IF YOU GO TO A DOCTOR ON OUR RECOMMENDATION, DON'T FORGET TO LET US KNOW IF YOU WOULD RECOMMEND THAT DOCTOR TO OTHER WOMEN. CALL US, OR EVEN BETTER, DROP IN AND FILL OUT A QUESTIONNAIRE.

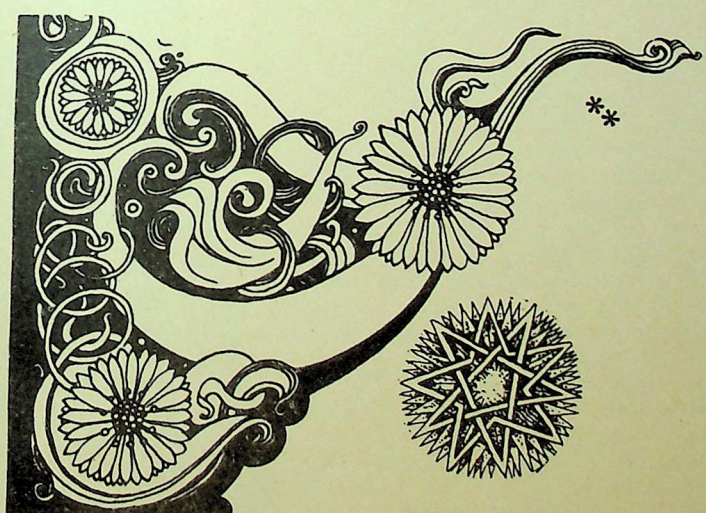
III. COMMUNICATING WITH DOCTORS

We want our doctors to give us better medical service. There are quite a few doctors in Vancouver who would be responsive to their patients' concerns about the quality of health care. But they can't make the changes we want unless they know what we want.

1. If we change doctors, we should give our reasons to the doctor we've decided to leave - in person, by phone, or in a letter. It is important to mention aspects of her/his practice that have satisfied us.

2. If we are basically satisfied with our doctor, but are uncomfortable or annoyed with some particular aspect of the experience, we can discuss it with her/him. It may be difficult to do - or it may not be. Again, let's let them know what we do like so they'll keep it up. Let's help the better doctors we know become the best.

3. If you would like to help us expand our list of doctors and help us develop communications between ourselves and our doctors, come by A Woman's Place.



Medical Her-stories

When we visit a doctor we are all familiar with the routine of The File, handed from nurse to doctor and then back to nurse - and never to us. Since the medical history recorded here is OURS, surely we deserve access to and participation in the writing of this our history - our HERstory.

In order to facilitate the process of making us participate in this part of our relationship with our doctors and to help us re-own this aspect of the care, we distributed along with the Questionnaire Medical Herstory Cards. These are intended to allow us women to keep our own records of major illnesses, drug sensitivities, current prescriptions (e.g. which brand of the Pill), blood type, innoculations, doctor's name etc.

It is only a start. Taking the responsibility for our own bodies, for our own health is a long process requiring knowledge, support, and courage.

SUGGESTIONS OF WHAT WOMEN EXPECT FROM THEIR DOCTOR'S "MEDICAL" EXAMINATION

THE SOCIAL HISTORY	INCLUDING:	WHEN:
	a)family background	
	b)financial problems	
	c)emotional problems related to: home, friends, work.	first visit
	d)past medical her-story	

This her-story could be taken by a specially-trained assistant. The best time to do it would be after the doctor has met the woman and explained the procedure to her and while the woman is waiting for the physical to begin. This report should be updated each year.

> "In private family practice
> I have found so many problems
> were socially related."
> - Dr. Helen Duffy

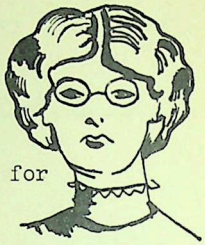
THE PHYSICAL EXAMINATION (Once a year)

1. Audiometry: visual examination of ears test hearing ability
2. Eyes: exam using an opthalmoscope.
3. Mouth and Throat
4. Glands: starting at the head, with the fingers, feeling glands of the neck, under the arms, breasts, abdomen, pelvic area, and legs
5. Blood pressure and pulse
6. Chest and heart: with stethoscope
7. Pelvic Examination:
   Internal -using a speculum and taking a PAP smear (cancer test) smear to test for V.D.
   External -bi-manual (in vagina and on pelvic area above)
8. Digital Examination of the rectum

"..... I feel strongly that if doctors know what we expect some of them and hopefully, all of them, will carry out a proper examination.

This examination by the doctor would require 20 to 30 minutes time, the social her-story by the nurse 45 to 60 minutes. This examination is not covered by any present medical plan, yet it is the SINGLE most important preventative measure available today. It should be covered by all the health plans."

- Mary M. White, R.N.



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A. GENERAL

McGill Birth Control Handbook. Single copies free (send 25¢ for mailing) from Birth Control Handbook, P.O.Box 1000, Station G, Montreal 112, Quebec.
A straight-forward comprehensive birth control guide. Includes a good bibliography.

Our Bodies, Our Selves: A Course by and for Women. Boston Women's Health Collective, c/o New England Free Press, 791 Tremont St., Boston, Mass. 02118
Highly recommended.

Davis, Adele. Let's Eat Right to Keep Fit, Signet (paperback)

Masters & Johnson. Human Sexual Response

Wright, Erna. Periods Without Pain, Tandem Books (paperback)

Health files at A Woman's Place, 1766 W. Broadway, Vancouver.
Collection of pamphlets, clippings, articles on all aspects of women's health.

B. CRITIQUES OF THE HEALTH SYSTEM

Dodge, David L. and Martin, Walter T. Social Stress and Chronic Illness: Mortality Patterns in Industrial Society, Illinois, U. of Notre Dame Press, 1970

Ehrenreich, Barabara and John. The American Health Empire: Power, Profits and Politics, (A Health-Pac Book), N.Y., Random House, 1970.

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Hardin, Garrett. "The History and Future of Birth Control", Perspectives in Biology and Medicine, Autumn, 1966.

Harris, Richard. The Real Voice, N.Y., Macmillan

"Caution: Health Care May be Hazardous to Your Health", Up From Under, Vol. I, No. 1

Health-PAC Bulletins. Available from Health-Pac, 17 Murray St., N.Y.
Subscriptions: students - $5.00, regular - $7.00
On-going discussions on the health system in monthly bulletins.


ILLEGAL ABORTIONS
KILL
12.000
QUACKS
KILL

Another contribution - this one from a group!

POST-PARTUM COUNSELLING

FOR WHOM?

Our group has been developed to help mothers who are experiencing any of the following:

1. Feelings of inadequacy or inability to cope as a mother and/or wife.
2. Feelings of depression that may range from sadness to thought of suicide.
3. Feelings or acts of aggression and/or overconcern towards the baby.
4. Feelings of guilt.
5. Sometimes a desire to give the baby away to someone who would be able to give more adequate care.

WHO WE ARE?

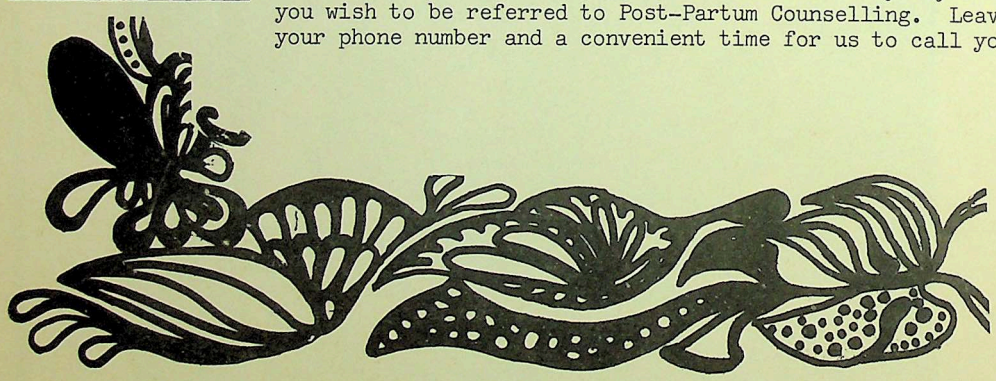
We are mothers who have experienced these feelings ourselves. We've stayed in the group to help other mothers feeling them now. The program is twofold:

1. A weekly group meeting provides contact with others who are or have been similarly distressed. We share our experience to help each other find alternate ways of coping.

2. One or more mothers who are in direct contact with the mother to give warmth and support when it is needed.

HOW TO GET IN TOUCH

Call the Crisis Centre - 733-4111. You need only say that you wish to be referred to Post-Partum Counselling. Leave your phone number and a convenient time for us to call you.



If you are interested in finding out about and buying herbs:

GOLDEN BOUGH,
1913 Yew St.
733-4724

The people there - Beth, Puck, and Suzanne - are really friendly.

In education, in marriage, in everything, disappointment is the lot of woman. It shall be the business of my life to deepen this disappointment in every woman's heart until she bows down to it no longer.

— Lucy Stone, 1855

The question is asked, What does woman want, more than she enjoys? I answer, she asks nothing as a favour but as a right.

— Lucretia Mott, 1849