WOMEN & CHILDREN FIRST

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To Ruth Lockshin
With best regards.
Michele Landsberg

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OUR BODIES, MEN'S RULES

SEVERAL YEARS AGO, WHEN THE ONTARIO STATUS OF WOMEN COUNCIL produced a research report on women's health, it ended up asking some acerbic questions that women don't ask for themselves. Why is it, asked the report, that no sooner did the hysterectomy rate level off, after it was shown how many of these operations were unnecessary, than the Caesarian rate shot up to a horrifying fifty per cent in some hospitals? Why, in 1982, are there only 38 beds for women addicts in Ontario's detoxification centres, compared to 313 beds for men, even though female alcoholism is rising and women are twice as susceptible as men to cirrhosis of the liver? Why do unnecessary operations on women seem to go so faithfully hand in hand with changes in health insurance coverage, or the special equipment or training of the doctor in question?

What the Council didn't spell out was its clear conviction that women often receive inadequate or inappropriate medical care because most doctors are men. Medicine, of course, is no more exempt from popular culture than any other discipline. Doctors are bombarded with ads in medical journals convincing them that every known mood and phase of a woman's life, from childhood fears to adult anger, is a cranky neurosis that should be kept under control by mood-altering drugs. Gynaecology textbooks still peddle the most medieval nonsense about "hysterical" female emotions. Medical and surgical equipment has a high-tech glamour for many of the mechanical whiz-kids who become doctors: those who have access to electronic foetal monitoring, for example, insist on using this dangerous and sometimes lethal new system on every woman in labour, regardless of whether or not there are any indications that it may be needed—just as an earlier generation of doctors recklessly damaged babies with newfangled forceps.

Worst of all, as Dr. Robert Mendelsohn points out in his book *Male Practice*, it is the sheer *otherness* of women that make them particularly prey to what he calls "medical and surgical overkill".

Doctors who would go to any lengths to save a male patient's genital functions and organs will slice out a woman's womb or cut off a breast almost without a second thought. One small example he uses is the episiotomy operation, the cutting open of the woman's perineum during labour in order to widen the vaginal opening for the baby to emerge. North American doctors perform this surgical routine almost universally, with the excuse that "surgical cutting will prevent accidental rips." Doctors in countries like Holland use an episiotomy in only about eight per cent of all childbirths. A normal woman, especially one who is not forced to lie unnaturally on her back during childbirth, doesn't necessarily need an episiotomy; the perineum is remarkably elastic. But surgeons are so anxious to practise their hard-earned skills that they do the episiotomy anyway, even knowing that it may cause post-partum infections. Episiotomies are responsible, says Mendelsohn, for about twenty per cent of maternal deaths; the anaesthetic needle has been known to pierce the baby's brain and kill him; botched episiotomies have later caused endless excretory and sexual problems for women; and, to top it all off, even a tear would rarely require as many stitches or risk as much damage as the episiotomy.

Is it only male doctors who intervene so gratuitously and sometimes ruinously? No, but women doctors, trained in all-male institutions, can hardly help blotting up the predominant male attitudes. Until a change in conventional thinking comes about, the male view of women will continue to rule the practice of medicine. Although more women are enrolling in medical schools (more than fifty per cent of McMaster University's medical students are female), male students still outnumber females by a daunting two to one across Canada, and three to one at the post-graduate level, so that the profession will be heavily male-dominated for years to come. Since physicians, as numerous studies have shown, are mostly drawn from a rather conservative middle-class background, they are rarely in the vanguard of social enlightenment. A nay-sayer like Dr. Mendelsohn is as rare a creature as the boy who saw that the Emperor had no clothes.

It would be wrong to imply that male doctors are evil necromancers, performing their wicked deeds on helpless victims. The passive female patient, conditioned to a proper state of humble deference in the doctor's office, is the other half of the equation. Very few ever question a diagnosis or prescription that doesn't seem right to them. As the Status of Women Council report stressed, women have agreed to be hypnotized by the snake-charmer's spell. Hence the need for a growing new field: female therapy.

"Female therapy recognizes the role of a woman's social and physical reality perhaps more than traditional psychiatry does. The female events, like rape or menstruation, *invade* us psychologically. Even the possibility of rape is a lifetime threat. So women are used to feelings of powerlessness, of chronic rage and dependency," explains Dr. Elaine Borins, director of the new Women's Clinic at Toronto Western Hospital. "Also, women are genuinely under-privileged. Female therapy takes into account the psychological realities of a woman who has to walk to the supermarket with two babies in tow and who does not have enough money to pay for the food."

The Women's Clinic has an all-female staff of five, ranging from social workers to psychiatric nurses. "It's a necessity. Women now prefer to be seen by women. In the U.S., male psychiatrists are looking for patients but women psychiatrists have long waiting lists," Dr. Borins says.

It's not a question of female chauvinism but of the almost inevitable dominance relationship when the doctor is male and the patient female: "Women spend most of their lives emotionally adapting to men. They don't want to do it any more when they come for help."

"There's an overwhelming pervasiveness of male attitudes in medicine," says Elaine Borins. "I really became aware of it when I went back to medical school to study psychiatry for four years. In several thousand hours of training, I had precisely four hours of supervision by a female." Fledgling psychiatrists may later decide to devote their attention to specialized corners of their territory (child psychiatry, sexual deviation) but only a page or two of their texts will refer to the emotional lives of women. And the same student psychiatrist may go right through his training without ever having to consider what specific traumas like incest might do to a woman.

This extraordinary gap in the doctors' and psychiatrists' training is all the more disturbing when you look at the facts of women's lives. As Margaret Mead demonstrated, marriage is demonstrably bad for women's health. The rates of mental illness and physical ailment skyrocket for married women, while married men benefit hugely on all scales of physical and emotional well-being. That, say some recent experts, is because when women enter marriage, they enter a legalized position of subordination, which is bad for one's health. "Conditions of subordination set the stage for extraordinary events that may heighten vulnerability to mental