Women and Health: The Growing Controversy

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Muerte, muerte y mas muerte, woodcut, Dianna S. Bain Bracker

La femme et la santé: controverse grandissante

Examen des limites et des dangers dans le domaine des soins de la santé tels qu'administrés aux femmes canadiennes.

This article was prepared for publication in the Toronto Globe and Mail, August, 1978. Although it was accepted by a senior editor, his superiors decided that the subject matter was not timely and that women readers would be unable to comprehend the statistical data.

In Ontario hospitals, student interns and residents routinely practise internal pelvic examinations on anaesthetized women patients. These patients, who are in hospital for gynecological operations, have not been informed of this practice, nor has the public at large.

The argument put forth by the medical community to justify this procedure is that it is necessary in order to train students. It is difficult to find unanaesthetized female patients who would willingly consent to have students practise pelvic examinations on them. Since the anaesthetized woman is unaware of what is occurring, the medical profession believes that there is nothing improper about the procedure.

This and other issues concerning the delivery of medical services to women are becoming points of controversy. At a time when health costs are soaring, grave concern has been expressed that the quality of health care provided to women may be questionable.

Over-Medication of Women

Why do doctors prescribe more mood-altering drugs for women than for men? A recent Canadian study on the psychotropic drug use among women demonstrated that women exceed men in their consumption of psychotropic drugs in a consistent ratio of 2:1. One explanation is that the doctor misinterprets his female patient's symptoms as imaginary because she speaks in a cultural language that he does not understand.

A 1966 study on the way in which patients from two cultures describe their ailments suggests this possibility. While the study concerned the Irish and the Italian, medical researchers concluded it was also relevant to all males and females.

This study, published in the *American Sociological Review,* indicated that at the Eye, Ear, Nose and Throat Clinic of Massachusetts General Hospital, the Irish patients presented few symptoms and refused to admit pain to doctors. Italians with comparable ailments gave more symptoms, acknowledged their illnesses and complained of pain. Doctors concluded that the Irish needed medical help more urgently than the Italians, even though the two groups had been matched for seriousness of illness.

The study suggests that the more stoical the patient, the more seriously the doctor tends to regard him or her. The more expansive the patient, the less seriously the physician takes him or her. In an update of the study, it was discovered that if no organic basis for the disease existed, doctors tended to describe an Italian as having emotional problems, but described an Irish patient in more neutral terms.

Dr. Linda Fidell, the author of a 1975 California drug-usage study, pointed out that in North American culture men generally act like the stoic Irish and women like the expansive Italians.

From childhood, Dr. Fidell observes, a female is encouraged to admit her pain and to ask for help freely. As a male (92% of all doctors are male), the doctor is programmed to endure hardship rather than ask for help immediately. When confronted with a female who describes vague symptoms at length, the doctor already assuming that women's ailments are often psycho-

somatic, may consider her problem an emotional one. So, Dr. Fidell concludes, the doctor prescribes a tranquillizer.

Drug advertisements also tend to foster such sexist assumptions she maintains. A five year study of leading medical journals concluded that medical advertising gives this message to physicians: Men have 'real illness'; women have mental problems.

In numerous surveys of mental health practitioners who were asked to describe a healthy, mature, socially competent man, woman, and adult, the results have indicated that regardless of the sex of the practitioner, traits of a healthy adult were significantly less likely to be attributed to a woman than to a man. The studies indicated that many mental health practitioners believe a healthy woman differs from a healthy man by being 'more submissive, less independent, less adventurous, less aggressive, more excitable in minor crises, less objective, disliking math and science.' This analysis of a healthy woman, the surveys conclude, is not simply mere stereotyping, but rather suggestive of a powerful negative assessment of women.

Gena Corea, author of *The Hidden Malpractice: How American Medicine Treats Women as Patients and Professionals,* says there is the danger that doctors programmed to expect psychosomatic afflictions in all women may overlook a critical condition.

Dr. W.H. Allemang, Senior Gynecologist and Obstetrician at Toronto General Hospital, believes that women are the recipients of mood-altering drugs more often than men, due to their emotional make-up. 'Women tend to react emotionally—it is part of the component of being a woman. Women are a little more feminine than men. Men are more rational.'

Dr. Allemang has assessed that women are greater users of the health care system than men. They go to a General Practitioner who is busy and has only approximately ten minutes to give to each patient. As a result, the reasons for anxiety are not discussed and women are often given tranquillizers. However, he feels this is not a serious problem.

Dr. Harding LeRiche, a Professor of Epidemiology at the University of Toronto Faculty of Medicine believes that over-medication is one of the worst things that is happening at the present time. However, studies that he has done indicate that women have more psychiatric problems than men.

In Dr. LeRiche's view, women are generally 'more timid, less aggressive, more sensitive, and more perceptive than men.' He suggests that this is somewhat related to social conditioning. However, the net result is that women tend to go to doctors more easily than men and hence are the recipients of more medication. 'Not only do they get treatment they need, but they probably also get treatment that is not needed'.

Today in Canada 78% of physicians prescribe more mood-altering drugs for women than for men. According to Jessica Hill, the Acting Director of Non-Medical Use of Drugs in Toronto, 70% of all tranquillizers are prescribed by GP's. These GP's, she claims, are more likely to prescribe tranquillizers to women than to men presenting the same complaints.

Although this data surfaced as early as 1971, Ruth Cooperstock, a Scientist at the Addiction Research Foundation in Toronto, maintains that there has been little response or change. 'Doctors', she says, 'have the role of confidant forced on them. Their education is geared to action. They generally won't say "I don't know" or refer the patient to an agency outside the health care system.'

'If a woman comes to a doctor describing anxiety and emotional problems and asking for help, the doctor is not trained as a marriage counsellor or housing expert and finds it difficult to take the time to allow the patient to ventilate. But the doctor does know that drugs diminish anxiety for short periods of time and often thinks that prescribing a drug is the humane thing to do. Current medical education devotes little time to training doctors in pharmacology or the problems of addiction.'

Dr. Eugene Vayda, in a February, 1976 article in the Canadian Medical Association Journal, states: 'Physicians need continuing training in clinical pharmacology . . . including teaching the properties of individual drugs and an understanding of the measures used to determine therapeutic effectiveness.'

The problem is further exacerbated, Ruth Cooperstock observes, by the growing phenomenon of cross-addiction of alcohol and mood-altering drugs – the effect of which is synergistic – meaning that the same amount of alcohol and valium, for example, has a more than doubling effect. In fact, Ontario statistics show 36% of recovered women alcoholics were cross-addicted, usually with tranquillizers.

What happens, Ms. Cooperstock says, is that doctors are aware that the prognosis for alcoholism is poor, so they try to stay away from it. Doctors are given so little training in alcohol addiction that they do not know much about the process. Furthermore, there is a great stigma attached to the female alcoholic. 'Women in our society are supposed to be the nurturing force and the bedrock of society', she says. 'A drunk female is terribly threatening – there is no dinner, the house is dirty, and the children are neglected.'

As a result, doctors do not generally ask their female patients about their rate of alcohol consumption. If they do, there is a generally-held misconception that if the doctor can reduce tension with mood-altering drugs, alcohol consumption will diminish. But Ms. Cooperstock's research indicates that the drugs can become addictive in themselves. The woman may be told to cut her drinking, to take valium and if she fails to comply, is sent on to a psychiatrist.

Ms. Cooperstock believes that until we see a critical mass of women in the medical profession, very little will change. It is interesting to note, she adds, with women's new wave of feminism, female doctors are being rushed off their feet by female patients.

'More women have tried tranquillizers and are not pleased with the results', she concludes. 'Younger women especially are seeking coping skills and life changes as opposed to solutions via a mood-altering drug.'

Unnecessary Surgery

I. *Hysterectomies*

Although discussion about the prevalence and perils of unnecessary surgery is a recent pheonomenon, the historical background indicates that this was a problem of serious proportion for 19th century women.

The commonly-held 19th century view was that women had no capacity for sexual feeling of any kind. If a woman did develop the illness of sexuality – called 'nymphomania' – physicians cured her with a variety of techniques. Many doctors cauterized (burned) the clitoris, or removed it surgically.

Removal of both ovaries was another operation frequently performed in the 19th century to cure female sexuality and nonconformity. American historian G.J. Barker-Benfield reports in his book, *The Horrors of the Half-Known Life: Male Attitudes Toward Women and Sexuality in Nineteenth-Century America,* that the medical symptoms for ovariotomy included 'neurosis, insanity, troublesomeness, eating like a ploughman, masturbation, attempted suicide, erotic tendencies, persecution mania, and anything untoward in female behavior'.

The modern controversy over unnecessary surgery rages about hysterectomy – the surgical removal of the uterus. The medical reasons for performing such a procedure are said to be uterine cancer, inexplicable menstrual bleeding, small non-malignant tumors, menstrual cramps, and vaginal laxness (a condition in which the vaginal walls lose their firmness, often as a result of childbearing).

Other doctors are not convinced and claim that for most of these symptoms, rest, relaxation, hormones, or scraping of the uterus (D&C) are all treatments that should be considered before major surgery. Despite this more cautious sector of opinion, hysterectomies have become the second most frequently performed operation on females in the USA. Further, the number of hysterectomies performed in the USA increased approximately 60% between 1965 and 1973, far in excess of population growth.

Numerous American studies, including one by the University of Michigan Department of Obstetrics and Gynecology, have concluded that at least one-third of the hysterectomies performed are completely unwarranted, exposing women unnecessarily to the risks of anaesthesia reactions and post-operative complications such as pneumonia, blood clots and infection.

The Canadian pattern of surgery is similar. Dr. Eugene Vayda, Chairman of the Department of Health Administration, University of Toronto Faculty of Medicine, recently wrote in the *Canadian Journal of Surgery* that hysterectomy, which is done twice as frequently in Canada as in England and Wales, increased by 40% between 1968 and 1972.

Vayda concluded: 'It seems unlikely that these increases were due to changes in the prevalence of associated diseases'. Instead he accounted for some of the increase by correlating it to such factors as the number of surgical personnel and bed:patient ratio. (The frequency of the procedure increased when more physicians and beds were available.)

The 40% increase in Canadian hysterectomies evidenced between 1968 and 1972 seems to have levelled off, but except for a minor decrease, the rate has remained at the controversially high level. In 1971, there were 23,635 hysterectomies done in Ontario, compared to 23,197 in 1975. Across Canada the hysterectomy rate per 100,000 female population was 622 in 1971, and 572 in 1975.

When questioned about whether unnecessary hysterectomies are being done in Canada, Dr. W.H. LeRiche, Professor of Epidemiology, University of Toronto Faculty of Medicine, said: 'A few years ago there were too many hysterectomies being done in Saskatchewan, but that has been stopped. As far as Ontario is concerned, when I studied it a few year ago, I found no unnecessary surgery in university centres.'

'In smaller centres and medium-sized towns where there aren't any university medical schools, there may be some unnecessary hysterectomies.' Despite the similarity of Canadian and American data, LeRiche said that 'on the whole, it is not a problem in Canada as it is in the U.S. Discipline on the medical profession is of a higher standard in Canada.'

The Saskatchewan incident referred to is notorious among members of the medical profession. In Saskatchewan an increase of 75% between 1964 and 1971 in the rate of hysterectomies was brought to the attention of the Saskatchewan College of Physicians and Surgeons.

The College appointed a special committee which identified indications for hysterectomy and classified hysterectomies in 1970 and 1973 at selected hospitals as 'justified' or 'unjustified'. Unjustified hysterectomy rates ranged from 1.7 to 58.6%. Hospitals with low rates of unjustified hysterectomies were 'commended' and those with high rates were sent five recommendations which included the statements that 'unnecessary surgery should cease' and 'Tissue Committees (which examine all tissues removed by physicians) should take a renewed interest in their responsibility'. The committee reported a 50% reduction in the rate of hysterectomy in the one Saskatchewan city with the highest 'unjustified' hysterectomy rate, and an overall provincial reduction of 13% , which they attributed in part to the review.

Dr. Eugene Vayda has recently suggested that perhaps the next step after criteria for 'justified' and 'unjustified' elective surgery are developed and agreed upon would be to allow hospital surgical utilization committees 'to act prospectively to screen candidates for elective surgery and to pre-authorize elective operations.' The most serious obstacle to this approach is that the medical profession cannot agree on the criteria indicating hysterectomy.

One of the reasons why hysterectomy rates are so high is that physicians not only remove the uterus once they discover uterine cancer, but increasingly remove it to prevent any possibility of future cancer. Hysterectomy will, of course, prevent cancer. If you don't have a uterus, you can't get uterine cancer. Medical journalists bear witness to the current debate over whether gynecologists should remove the healthy reproductive organs of *all* women who reach a certain age to prevent development of cancer in the uterus and ovaries. *(Audio Digest of Obstetrics/Gynecology*, 1973).

As Dr. LeRiche says: 'You can't have it both ways. While unnecessary hysterectomies may be alleged, cervical cancer is quite serious.' However, according to Ralph Nader's Washington, D.C.'s Health Research Group, the death rate for hysterectomy itself (1,000 out of every 1 million women annually) is, in fact, higher than the death rate for uterine/cervical cancer (100 out of every 1 million women each year).

In *Seizing Our Bodies: The Politics of Women's Health*, Claudia Dreifus reports that the American Planned Parenthood Federation is taking issue with what they call 'hacking preventively' at future possibly offending flesh. 'Preventive lobotomies', says Planned Parenthood in an effort to point out the absurdity of the argument, 'for young people at statistically high risk of developing violent psychoses at some future time have not been suggested by physicians writing in psychiatric journals'.

Recently, some physicians have abandoned the question of which medical symptoms warrant surgical removal of the uterus, and have wholeheartedly endorsed this operation for the sole purpose of sterilization. Dr. W.H. Allemang, Senior Gynecologist and Obstetrician at Toronto General Hospital, accounts for the 'popularity' of hysterectomy because it is 'a reasonable form of sterilization. The alternative of the sterilization procedure just leaves a useless uterus, except to get cancer. With a hysterectomy you prevent menstruation, which for a woman in her 40's may be a bit out of control. It's that easy. It's an attractive package in this day and age both for the patient and the doctor.'

When asked whether he felt too many hysterectomies were being done in Canada, Dr. Allemang said: 'What is too much operating? No doubt there is an increasing trend in the area of hysterectomy, but these things become fetishes of the time. Which one is today's, which one will be next year's, I don't know. Surgery has in a sense become safer. Most physicians want to contribute the best they can. They develop theories that a certain procedure will solve the patient's problem. There is not very much risk associated with it.'

In an environment where 92% of all physicians are male, the type of reasoning which predominates was identified in a 1970 issue of *Medical World News.* This journal reported on a cancer conference where surgeons had agreed that they rarely hesitate to remove an ovary but think twice about removing a testicle. 'The doctors readily admitted that such a sex-oriented viewpoint arises from the fact that most surgeons are male', the *News* reported. 'Said one of them wryly, "No ovary is good enough to leave in, and no testicle is bad enough to take out!"'

II. *Breast Surgery*

The unresolved controversy over the various methods of treatment for breast cancer is more publicly-visible than the issue of hysterectomy. A range of surgical procedures are used – from a radical mastectomy in which the breast, underlying lymph nodes, and the pectoral muscles are removed, through less drastic surgery such as the partial, modified, simple or subcutaneous mastectomy.

The radical mastectomy was first devised by William Stewart Halsted in 1882, when according to Gena Corea in *The Hidden Malpractice,* due to late diagnosis, tumors were much more massive by the time they were treated than they are now. His radical mastectomy quickly became the standard operation for breast cancer in USA and Canada. Corea reports that even though there has been no proof that the Halsted radical is a superior treatment to more moderate procedures, no controlled study of the various procedures was undertaken until 1970.

At that point, the National Cancer Institute, on a test of 1,700 women, compared three treatments: the radical mastectomy, simple mastectomy, and simple mastectomy followed by radiation therapy. After two years, all three treatments had approximately the same 15% recurrence rates of disease.

'It's a very sad business because there's no proof whatever surgery is done makes any difference – no proof that radical mastectomy does any more good than just taking out a lump. The evidence is that we don't really know what treatments are most effective', says Dr. LeRiche.

Dr. George Crile, Jr., author of *What Women Should Know About Breast Cancer,* takes a more extreme view. He reported in his book that many surgeons in North America and most of those in England now agree that there is no longer any place for the mutilating radical operation. 'If the cancer is so advanced that it cannot be removed by an operation less than radical mastectomy, it has already spread through the system and is incurable by surgery'.

Gena Corea reports that when American physicians detect a cancerous tumor in the breast, 90% of them perform a Halsted radical mastectomy. British surgeons perform half as many radical mastectomies per 100,000 population as American surgeons. Dr. Crile noted in his book that Canadian surgeons appear to be abandoning radical mastectomy more rapidly than American surgeons. However, Dr. Eugene Vayda has reported that: 'The rates in Canada for the period from 1968–1972 for radical mastectomy have remained essentially the same'.

After this period, the number of radical and extended radical mastectomies done in Ontario and Canada began to decline. In 1973, of the 3,574 mastectomies done in Ontario, there were 744 radical and extended radical; in 1976, of 4,523 mastectomies in Ontario, there were 595 radical and extended radical. The Canadian figures indicate that in 1971 there were 28 radical mastectomies per 100,000 female population; in 1975, there were 15.

Many doctors in Canada criticize the findings of the National Cancer Institute, pointing out that the women tested must be followed for a number of years before any firm conclusions can be drawn. Author Dr. Crile, however, argues that for too long surgeons have assumed the entire burden of deciding how their patients with breast cancer should be treated.

He states: 'Today there is no agreement on treatment, and the surgeon, therefore, has an obligation to inform the patient of the facts. Only when the patient is allowed to participate in the decision can she accept an operation on her breast with what can be known ethically as "informed consent" '.

Cancer of the breast is by far the most common malignant tumor in women. Health and Welfare Canada reports that it is the third leading cause of death in all Canadian women. For women aged 40–49, it is the leading cause of death.

Estrogen Replacement Therapy for Menopausal Women

In her recently published book, *The Hidden Malpractice,* Gena Corea has reported that every woman reacts to the change of life differently. 'But doctors tend to assume that all menopausal women will be psychologically and physically at risk. They are expected to have emotional breakdowns, lose their sexual appetites, experience hot flashes and sprout little moustaches. Their breasts and vaginas are supposed to shrivel up'.

Dr. David Reuben asserted in his widely read book, *Everything You Always Wanted to Know About Sex,* that a menopausal woman was, 'not really a man, but no longer a functional woman (living) in the world of intersex . . . . Having outlived their ovaries, menopausal women may have outlived their usefulness as human beings'.

A 1966 book entitled, *Feminine Forever,* written by a respected American gynecologist, Dr. Robert A. Wilson, went one step further, referring to menopausal women as 'living decay', 'the death of womanhood' and 'an individual who can't be entrusted with decision-making jobs'.

According to Elaine Vayda, an Assistant Professor at York University's School of Social Work who developed a course in the Social Aspects of Health and Disease, 'most women expect something horrific to take place at menopause, but in fact, the majority of women continue to produce sufficient amounts of the female hormone estrogen, to be well and functioning'.

Professor Vayda says 'the belief that menopause is a period of decay and an end usually coincides with a time when children leave home and husbands and wives experience life crises which often result in separation, divorce and a sense of failure'.

All of this, she goes on to say, gets medicalized as menopause – a disease, and is then often treated with drugs, commonly known as Estrogen Replacement Therapy. Menopause is a normal, physical occurrence in most women, Professor Vayda concludes, but the whole social structure has made it into a far more significant event than it is.

The Consequences of treating menopausal women with ERT became apparent in 1975 when Dr. Donald F. Austin, the Chief of the California Tumor Registry, reported 'that from 1969–1973, the rate of invasive uterine cancer in California rose 80% among white women 50 years and older. He linked the rise in cancer to the increased use of ERT. (The USA estrogen drug market had grown from $17M. in 1962 to $69M. in 1973.)

Concern was also recently expressed in the prestigious *New England Journal of Medicine* which published two studies which showed that post-menopausal women who take estrogen are 5 to 14 times more likely to get cancer of the uterine lining than women who do not use the estrogens.

Dr. Allemang claims that the reports are difficult to analyze. He goes on to say, 'If I were a woman, I would use ERT if I had

menopausal symptoms.' He claims that 20–25% of the women he sees are so symptomatic that ERT is indicated. He believes that the benefit is greater than the risk.

Professor Harding LeRiche flatly asserts, 'menopause is not a disease . . . . The physical symptoms are not that common. Most responsible gynecologists will say "no" to ERT'. He concludes that, 'there are tremendous changes in attitudes about menopause and that the trend is definitely against the use of ERT'.

Dr. Sheila Cohen, a prominent Toronto Gynecologist at Sick Children's Hospital, believes that there should be considerable re-evaluation about ERT. 'Gynecologists', she says, 'are not adaquately trained in endocrinology. If a woman comes in depressed or melancholic, it should not necessarily be attributed to menopause. You don't just hand out a hormonal pill'. 'Besides', she says, 'there is no evidence to suggest that ERT retards the aging process. Estrogens have been proven to be harmful and if prescribed, at all, should only be used in low dosages and in a sequential manner, and really for specific *uses* – hot flashes, estrogen deprivation of the vagina'.

According to Dr. Cynthia Carver, a Toronto General Practitioner whose practice is primarily female, women are still requesting ERT even when they are advised of the risks. She says, 'women are conditioned to the notion that as they age, they will be less desirable. In our society, you have to be young and beautiful to be desirable'.

Natural Childbirth and Home Births

Attitudes on the part of pregnant women and their spouses influenced by the new wave of natural childbirth proponents, are definitely changing, says Terri Brown, an instructor at the Childbirth Educational Association of Toronto. 'More women', she claims, 'are preparing for childbirth in the sense that they are aware of the alternatives'.

'Women', she continues, 'are becoming cautious about drugs that cross the placenta. They are asking about side effects to the baby and to themselves. They are less willing to accept that a medicated birth is the only alternative'.

Gena Corea in *The Hidden Malpractice,* compares Dutch women who usually give birth with the emotional support of their husbands and midwives as their only (and very effective) form of pain relief, to North American women who are often frightened into believing that they could not possibly endure childbirth without some drug or anaesthesia. Ms. Corea has researched the routine use of anaesthesia by American obstetricians, leading, she observes, to other interventions in childbirth, including the following common ones:

- placing the mother in the more dangerous lithotomy position (on her back), as opposed to semi-sitting, sideways, or squatting, because it is convenient, not for a medically-valid reason;
- delivering by forceps and performing an episiotomy (an incision to enlarge the vaginal opening) because the numbed, drugged mother has lost her bearing-down reflex and becomes incapable of participating in the delivery;
- elective labour induction which can lead to cord compression, premature separation of the placenta and narrowly spaced contractions;
- chemical stimulation of labour;
- tranquillizers – almost all of which enter the fetus' blood stream shortly after administration to the mother and tend to depress the fetal respiratory system;
- analgesics (pain killers) which tend to inhibit a newborn's efforts to breath;
- anaesthesia which can reduce the mother's blood pressure;
- early clamping of the umbilical cord which reduces the newborn's blood supply.

Despite these and other hazards, Ms. Corea's research indicates doctors sometimes prefer a drugged mother because it is easier to work on an inanimate object than on a responsive person.

A more disconcerting statistic is cited by Dr. Eugene Vayda of the University of Toronto's Faculty of Medicine in the May, 1976 edition of the *Canadian Journal of Surgery,* in relation to intervention by caesarian section. According to Dr. Vayda, 'the caesarian section rate increased approximately 30% between 1968–1972 and the inter-provincial variation was greater than 200%, between 1968–1972'. Dr. Vayda maintains in his article that 'the 30% increase was due to closer fetal monitoring (a device strapped to the woman's abdomen, tracing fetal heart rate and uterine contractions) and more liberal use of caesarian section'.

Terri Brown of the Childbirth Education Association of Toronto believes the increased use of caesarian section in birth is the result of doctors trying to make the birth process easier for women who do not necessarily want it so. In her work she observes that doctors intervene too quickly. The decision to do a caesarian section can influence the birthing process for the next twelve years, because the first caesarian precludes a normal delivery in future pregnancies.

Ms. Brown's organization encourages women to go 'doctor-shopping' if they do not like the answers they receive from their doctor. She fears that many doctors view birth as a disease, not a natural event.

Phyllis Curry, the Director of CARES, a Toronto pregnancy and abortion referral centre, believes that birth should be a family event where the father is encouraged to participate.

Recently she has noticed increased interest in home deliveries. She concedes, however, that home births in Canada are a middle class phenomenon. In Metropolitan Toronto fifty-seven home birth took place in 1977, an increase of 44% in the last five years. Home births focus in on the needs of the baby –i.e., born without trauma in the family setting. Home births, says Ms. Curry, encourage 'an immediate and natural bonding with both parents'. This concept, Ms. Curry maintains, is very appealing to mothers concerned about medicalization of the birth process.

Abortion

Phyllis Curry, the Director of CARES, a Toronto pregnancy and abortion referral centre, says she often hears from women who have been misinformed about the legality of abortion by physicians. 'Some are told abortion is not legal after twelve weeks. We had a call the other day from a woman who told us her physician said he could not get the consent of the therapeutic abortion committee unless the patient could demonstrate there would definitely be a marriage breakdown and divorce if she didn't get the abortion'. Ms. Curry attributes some of this misinformation to the fact that 'doctors themselves are confused about the law'.

Among a group of women surveyed who were carrying their pregnancies to term, the Report of the Committee on the Operation of the Abortion Law (the Badgley Report), commissioned by the Canadian federal government in 1976, stated a number indicated they had at one time considered having an abortion, but had not because of a lack of access to services for therapeutic abortion, or because of delays which had been involved in applications submitted on their behalf to hospitals.


Jean Raisler

One out of five of these women thought that getting an abortion was illegal under any circumstances.

The Criminal Code provides that therapeutic abortion may be performed when, in the opinion of a hospital therapeutic abortion committee composed of three doctors, the continuation of a pregnancy 'would or would be likely to endanger the patient's life or health'.

The Badgley Report concluded that accessibility to the abortion procedure is unequal across Canada, stating: 'What this means is that the procedure provided in the Criminal Code for obtaining therapeutic abortion is in practice illusory for many Canadian women'.

The inaccessibility is attributed to the small number of hospitals and doctors doing the procedure, and quotas set by each hospital on the number of abortions per week.

Dr. Sheila Cohen, says in her opinion the problems are caused because 'patients are being shunted from doctor to doctor, there are hospital-imposed limits on the number of abortions each doctor can do in a week, and because of the large numbers in demand – Toronto has to service a large region of northern Ontario where the procedure is unavailable. If every hospital and every doctor able to do abortions accepted their responsibility in that regard, no one facility would be overburdened'.

The hospital quotas are in many cases very low. Sherran Ridgley, a member of the Women's Health Organization, who works as a family planning counsellor in Toronto, points out as an example, that Women's College has a clinic quota of two patients per week.

Delay is also a major factor. Abortions can be done in the first trimester of pregnancy (up to twelve weeks) by a safe, relatively simple procedure. When the pregnancy has advanced to the second trimester (thirteen weeks to twenty-four weeks), the procedure is more complex and the possibility of complications is much higher.

Sherran Ridgley says: 'Although there is no legal limit before which time the procedure must be done, hospitals set a policy fixing a cut-off time. In Canada, some hospitals used to do the procedure up to twenty weeks'.

'But both hospitals and doctors are cutting back in terms of time limits. Getting a second trimester abortion in Canada is always a problem. But more and more doctors are no longer doing the full range of first trimester procedures – they're cutting off at ten weeks'.

This cutting-back of time limits has grave implications for women seeking therapeutic abortion. The most common pregnancy tests are not effective before forty-two days from the date of the last menstrual period (at which point the pregnancy has already advanced to six weeks).

On the average, the manner in which doctors and hospitals now process requests for abortion creates an eight week delay between a pregnant woman's first visit to a doctor and eventual performance of an abortion, according to the Badgley Report.

The Report noted that while many attributed this delay to the socially-irresponsible behaviour of women seeking abortions, 'the findings were unmistakeable' that the factors which accounted for most of the delay were the attitudes of physicians and hospital personnel.

Dr. Cynthia Carver, a Toronto General Practitioner, states that 'it is tragic that due to unnecessary delays, many women are pushed into the second trimester of pregnancy before they can obtain an abortion. The system in Ontario that causes this delay increases the risk of complications beyond what it should be'.

'Physicians in Toronto are finding that a woman who is seeking an abortion at six weeks, must wait until the eleventh or twelfth week before the procedure can be obtained'. The solution, as she sees it, is 'to set up an out-patient clinic where the therapeutic abortion committee meets frequently, and appointments are set up on the basis of need'.

Due to many of these roadblocks, pregnancy counselling and referral agencies admit that many Canadian patients are forced to turn to the US for assistance. The Badgley Report determined that a number of the women going to the US to obtain an abortion said they did so because their doctors would not

do the procedure and would not refer them to other doctors or hospitals. In a number of cases, they had been told by physicians that getting an abortion in Canada was illegal.

Rape Examination

While not all rape victims are willing to report their assault to the police or to participate in the criminal justice process, those who are must go to a hospital emergency ward immediately after the rape for a medical examination.

Concern has recently been voiced over their treatment, especially in light of the rising numbers of reported rapes. (In Metropolitan Toronto, there were 189 reported incidents of rape and attempted rape in 1976. In 1977, this number rose to 263.)

Ilene Bell of the Toronto Rape Crisis Centre says there are still some hospitals which will not do the required examinations for rape victims.

'Queensway General Hospital, for example', she says, 'will not take rape victims. If the woman has knife wounds from the rape, they'll treat those, but will send her to another hospital for the medical examination. Although we've asked this hospital why it has adopted this policy, they refuse to talk to anyone about it'.

'Etobicoke General didn't use to take rape victims either. Now they tell us they will, but the police do not know this yet, so few rape victims are taken there', she added. 'When we asked them why they didn't let the police know their policy had changed, their reply was that if they advertised this, they would have every rape victim on their doorstep'.

Ms. Bell added that even in hospitals which do take rape victims, many doctors are reluctant to do the examination. 'They don't want to be required to go to court. It's time-consuming, and they make less money in court than they do in practice. Also they're often embarrassed on the witness stand because they made some mistake in the examination'.

'A lot of the problem is attitudinal. Many doctors have doubts about whether the patient has really been raped. When they feel it isn't a *bona fide* rape case, they feel the examination is a waste of their time'.

Questioned about this allegation, Dr. Allemang said: 'Whether doctors are as cooperative as they might be, in view of the legal involvement, I don't know. I don't think the onus is on the medical profession. There's a bit of a tendency to avoid involvement unless there's a good, legitimate *prima facie* case. You would want to avoid the drunk weekend rape complainant'.

Concern has also been expressed about the quality of the tests conducted. Ms. Bell says that although the examination takes about an hour, it is actually quite simple. 'But because it's so long and involved, and the doctor must do every step correctly, mistakes are often made. Many doctors haven't done the examination often and don't know all the details'.

Dr. Sheila Cohen says that in the teaching hospitals, the residents on call for emergencies are the ones who do these examinations. 'Whether a resident can handle this depends on the resident's training. I hope the training has improved from the time when I was a resident. I would say that there is not enough supervision at night, when many rape victims require examination'.

Mr. Elgin Brown, Head of Biology, Centre of Forensic Sciences, receives the rape evidentiary specimens collected by physicians. Providing the analysis services for police throughout the province, he sees 300–400 cases a year.

Problems with the quality and completeness of the tests done by the examining physicians have existed for the twenty years Mr. Brown has been working at the Centre.

'We sometimes get inadequate specimens, improperly packaged specimens, or the physician fails to get combings from the pubic area. When the specimens are inadequate, we can't do the range of tests we would normally do'.

'On occasion, in a province-wide operation, the police do get lack of cooperation from the medical profession. But most of the time it is due to a lack of complete understanding as to what is required both on the part of the police and the doctor'.

Mr. Brown does state, however, that the situation is improving. 'We have been working for the past two years with police, hospitals, the Rape Crisis Centre and the Crown's office to work up a protocol – a checklist of material we require, in the form of a sexual assault kit'.

The Provincial Secretariat of Justice did hold a two-day conference in Toronto to discuss rape – prevention, investigation, and the care and treatment of the complainant. A number of recommendations were made, including the need for a more uniform approach throughout the province in the use of sexual assault kits for emergency room examination of rape victims.

The Rape Crisis Centre also expresses concern that in many cases, physicians fail to discuss the problems of potential pregnancy and venereal disease with the patient. Ms. Bell recalls, 'I recently counselled a rape victim who had not been warned about V.D. – she ended up with secondary syphilis. In other cases, doctors will automatically give the victim penicillin – without even knowing whether she has been infected – that's no better'.

The psychological and emotional needs of the rape victim and how the medical examination affects her are other factors that concern the Rape Crisis Centre staff. They have developed a booklet, 'Emergency Room Care for Rape Victims', which recommends that the patient be seen without delay, and where a delay is unavoidable that she be placed in a private room but never left to wait alone.

They also recommend that the victim not be pressed to relate the entire story to medical personnel and that all examination procedures should be fully explained to the patient in advance.

Dr. Cohen shares some of their concerns: 'I know it's difficult in the emergency ward to give the required tender loving care. Ideally, the Rape Crisis Centre should have their own physicians on call who are trained to do the examination. Every hospital should have a protocol'.

'I don't know what it is about the medical profession that they don't take this as seriously as it should be taken. Once doctors are out of residency they don't see rape in the emergency wards and I guess they become over-complacent'.

Tip of the Iceberg

This shocking information was unearthed during one year's work in preparation to establish the Toronto Women's Health Clinic, a project which ultimately was rejected by the Ontario Ministry of Health. It is obvious that our findings constitute only the tip of the iceberg. Since the medical establishment appears to be indifferent to the crisis in women's health care, we as women must take the initiative. We must move on several fronts: exchanging information, making our concerns public, and organizing self help groups. Mysogynist health care endangers us all. By default the remedies for these abuses will have to come from us.