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HEALTHSHARING
COLLECTIVE NOTES

The right to abortion is an ongoing struggle, one that we have been waging with varying degrees of energy for decades. We have become weary with the seemingly never-ending series of protests, lobbying and marches which seem to "lead nowhere. We are tired. Suddenly there is a new wave of energy and a new optimism; the abortion issue is a top priority; witness the announced opening of free-standing abortion clinics in Winnipeg and Toronto and the promise of more to come throughout Canada.

Since the limited legalization of abortion in 1969 which established the ambiguous criterion of "continuation of pregnancy being likely to endanger a woman's life or health", and saddled us with the great albatross, the therapeutic abortion committee, pro-choice groups have essentially been on the defensive.

With one stirring and notable exception, gains on the abortion front over the last 14 years have been nil. In fact, access to abortion across Canada has been deteriorating in recent years. The exception, of course, is Québec. After three refusals by Québec juries to convict Henry Morgentaler of performing illegal abortions, the Attorney General of Québec conceded the unenforceability of the abortion law. This paved the way for government-funded community health clinics to extend services to include abortion.

The battle which was fought and won in Québec six years ago is finally about to erupt across the rest of Canada. For the first time in years pro-choice is on a major offensive and it feels great! Women Healthsharing wholeheartedly supports those who are challenging the oppressive abortion law by establishing free-standing abortion clinics. We applaud their courage and commitment. We see no contradiction between this and our support of more humane birthing practices and universal access to quality day care. We are writing.

We face a ruthless enemy. Anti-choice groups continue to fight the abortion issue on all fronts:

- Joe Borowski, recently granted standing by the Supreme Court of Canada, will soon be arguing before the Saskatchewan courts that the foetus should be accorded human rights.
- A law suit is underway against a B.C. hospital, alleging that their therapeutic abortion committee applies an unacceptably broad definition of health.
- Anti-choice hospital workers are being encouraged to steal operating room sheets and publicize the names of doctors who perform abortions.
- Hospital boards continue to be taken over by single-issue anti-abortionists — witness the recent activity on this front in New Brunswick.
- Pro-choice articles appearing in newspapers and magazines have triggered an onslaught of hate mail to the author, editor, and advertisers.

But currently, the primary target of anti-choice activity is the abortion clinics. Time, energy and money, of which the anti-choice folks have plenty, are being channeled toward an all-out campaign to stop abortion clinics. They have vowed that if the government does not close down free-standing clinics, they will — an ominous threat in light of the anti-clinic violence in the United States. A Clinic can prepare itself to deal with picketers, hate mail and harassment. But how does one protect against fire bombs, acid thrown in the faces of employees, destruction of property, these tactics of the so-called pro-life? As in the U.S., we will fight back and rebuild; we will not be threatened or intimidated away from our rights.

In Canada today, many congregations are being exhorted from the pulpit to send letters to their members of Parliament. The Toronto branch of the Right to Life is distributing a booklet with the catchy title, The Facts vs. Morgentaler, which has already been received by all Ontario M.P.P.'s. The "facts" as outlined lead to the inevitable conclusion that Morgentaler is incompetent, dishonest and motivated exclusively by the promise of financial gain. In light of this kind of personal attack, the anti-Semitic cartoon of Morgentaler in a Winnipeg newspaper, only the most blatant in a series of such racist attacks against Morgentaler, was not surprising.

Nothing escapes the attention of the anti-choice. They announce proudly that they know our every move, that they attend our meetings and have infiltrated our organizations. We hope that they are learning from the experience. We are pleased that they are so concerned about our activities and our strategies, that they recognize us for the threat that we are and fear the victory that will be ours. The establishment of free-standing abortion clinics will not silence the anti-choice, but it will change the whole nature of the struggle. We will no longer be struggling to attain our right to freedom of choice, but to maintain that right.

Madeline Boscoe Betty Burcher Anne Rochon Ford
Connie Clement Diana Majury Lisa McCaskell
Jennifer Penney Susan Wortman

FEATURES

8 The Radical Orthodoxy of Naturopathic Medicine
A medical anthropologist proposes naturopathy as an alternative to the invasive system of drugs and surgery by Carole Yawney

12 Not a Medical Emergency
A not so imaginary piece of fiction about a nurse’s efforts to meet the desires of a patient when faced with hospital bureaucracy by Phyllis Jensen

17 Mitral Valve Prolapse — A Benign Syndrome?
A personal account illustrating medicine’s failure to treat seriously a heart condition experienced by 20% of women by Sharon Anderson

NEWS

4 Newsfronts
25 Regional Reports

OUR READERS WRITE

21 My Story, Our Story
Sex gadgets, the new tupperware

27 Letters

ETCETERA

3 Collective Notes
6 Healthy
A doctor and a chiropractor look at complementary ways of dealing with low back pain

22 Reviews
28 Resources

HEALTHSHARING SPRING, 1983
Three Nova Scotia midwives have been charged with criminal negligence causing bodily harm as a result of a Halifax homebirth which they attended last November. A 10 pound baby born to a 22 year old woman is reported to have had a problem-free birth, but suffered a cardiac arrest following the birth. The baby was rushed by ambulance to the Isaac Walton Killam Hospital in Halifax where it was placed on a life-support system. Latest reports indicate that the baby is still on it. After the head of the Neonatal Unit at the hospital issued a complaint, the Crown Prosecutor pressed charges against the midwives, one of whom is a registered nurse as well as being trained in midwifery. Legal counsel acting on the midwives' behalf say that they risk a minimum sentence of 10 years in prison and possibly life imprisonment if the baby dies.

As a result of the incident, the Nova Scotia Medical Society has launched an all-out campaign against midwifery and homebirth in Nova Scotia. Currently, no Nova Scotia doctors support and donations would be greatly appreciated. Send c/o NAPSAC, 19 Fairmount Road, Halifax, Nova Scotia B3H 1H5.
DES Daughters in Canada

In the Fall '82 issue of *Healthsharing*, we printed a call to Canadian women whose mothers had been prescribed DES (diethylstilbestrol) during pregnancy. This synthetic estrogen (coined the "Wonder Drug" in its heyday) was prescribed heavily between 1940 and 1971 as a means of preventing miscarriage. This drug has had a series of harmful effects on the daughters of some of the women who were prescribed it. Harriet Simand of Montréal, herself a DES daughter who at the age of 21 had to undergo a total hysterectomy and removal of the vagina thanks to the Wonder Drug, has established the first DES Action group in Canada. Twenty-nine such groups exist across the United States. With a grant from Health and Welfare Canada, Simand, with the help of her mother, has undertaken the translation and production of two information brochures as well as posters on DES. The information will be distributed in community health centres, hospitals, women's health centres and schools and will be available to anyone requesting it.

To date, 3 cases of vaginal cancer directly linked to DES have been uncovered in Québec and six such cases have been verified in Ontario. 150 cases of "structural anomalies" have also been identified in young women exposed to DES in Ontario.

Harriet Simand can be contacted by writing to Box 223, Snowdon, P.O., Montréal, P.Q. H3X 3T4.

Claims for Spermicide Misleading

Although it generally looks favourably upon barrier methods of birth control, la Fédération du Québec pour le planning familial has come down hard on the makers of the vaginal spermicidal suppository, Pharmatex. Head of the Fédération, Ms. Fernande Ménard in an article in *Le Devoir*, reported that the effectiveness of the contraceptive has yet to be accurately determined. The Fédération expressed deep concern over the Canadian government's lack of intervention when the manufacturers of the spermicide, Interpharm, claimed in a press conference that their product is as effective in preventing pregnancy as the Pill or sterilization.

Ms. Ménard pointed out in an interview that the effectiveness of such a contraceptive is highly dependent on proper use. She noted that if the product could be purchased freely in drug stores, there is no guarantee that all women would read fully the accompanying instructions. She commented that the instructions were hard to understand and written in a manner not easily comprehended by all women. Comprehension of the instructions is vital since the suppository should be used in conjunction with a diaphragm or condom and it should also be noted that the use of soap can cancel out the effectiveness of the spermicide.

Shock Anew

In our last issue (Winter, 1982), we reported that electroshock therapy was banned in Berkeley, California following a public referendum on the issue. Well, the ban was short-lived thanks to a County Superior Court judge who held that it was not constitutional to ban a legal treatment undertaken voluntarily, electroshock has been resumed in Berkeley.

AIDS Reports in Canada

At a conference on sexually transmitted diseases held in Toronto this past Fall, Dr. Gordon Jessamine of the Laboratory Centre of Disease Control in Ottawa reported that six cases of acquired immunodeficiency syndrome (AIDS) had been reported in the previous month. Prior to this, a total of only fourteen cases of AIDS had been confirmed in Canada. The term AIDS covers a number of diseases including *Pneumocystis carinii* pneumonia, *Toxoplasma gondii* infections and Kaposi's sarcoma. The diseases are usually contacted because a person's immune system has broken down. The popular media has dwelled on the fact that a high proportion of AIDS victims to date have been gay men, with one theory stating that repeated bouts of sexually transmitted diseases have weakened their immune systems. In fact, a number of AIDS cases have surfaced in heterosexuals as well.

What was pointed out as noteworthy about the six Canadian cases reported recently (all in Ontario) was that three of these new cases were said to involve hemophilics. This is considered a disproportionately high percentage given that only four of the 625 AIDS cases on file in the United States involve hemophilics.

Cough It Up

A University of British Columbia study indicates that pulmonary infections in elders might be attributed to the fact that coughing does not clear their lungs as well as it should. Dr. J.A. Fleetham of U.B.C. tested the coughing power of 50 individuals in good health of various ages. Each person was asked to inhale acid compounds of varying concentrations after which time they were monitored to see how soon they responded with a cough. The oldest age group proved to take the longest to respond to the inhalations.

Bee Propolis and Antibiotics

Propolis is the glue-like resin which the bee produces and uses for tightening and protecting the hive. Research in France has demonstrated that the bee, unlike any other insect, carries no virus or bacteria because it secretes an antibiotic which makes it immune to such invasions.

Two independent studies, one conducted at the University of Western Australia and the other by Russian doctors Tichonov and Salo, have found that propolis carries properties which can strengthen the bacteriostatic activity of such antibiotics as tetracycline, neomycin, polymycin, streptomycin and penicillin.

The key to the antibiotic activity is flavonoids coming from plants which have a major part of their metabolism in common with human beings on the evolutionary ladder. By contrast, antibiotics like penicillin and tetracycline are produced by micro-organisms quite removed from humans on the evolutionary ladder. The result is that some infections are insensitive to these known antibiotics.

It may be years before the majority of the medical community accepts the value of bee propolis in fighting infection but research on the substance continues. In the meantime, many alternative practitioners are recommending it as a daily supplement to help build up resistance to infection and disease. Research is being done to determine the most effective way to encapsulate bee propolis and preserve all its natural qualities. It is currently available in most health food stores.
Sympto-thermal Questionnaire
Attention: Women who are using or have used the sympto-thermal method of birth control (also known as the co-operative method, the natural method, or just plain taking your temperature and checking your mucus), please send me your name and address in confidence, so that I can send you a questionnaire for some research I’m conducting on this topic. Send to: Bread and Roses Research for Women, att'n: Patti Schorn-Moffatt, 6285 Nelson St., West Vancouver, B.C. V7W 2A2.

Lesbian Anthology
Working class lesbians, please send oral history (interviews and tapes), personal narratives, journal excerpts, poetry, analyses or short fiction for consideration in an anthology of Canadian working class lesbians. I want to explore the experiences and perspectives of lesbians from working class backgrounds. Please forward your ideas, suggestions, work outlines and completed work to Cy-Thea Sand, P.O. Box 24953, Station C, Vancouver, B.C. V5T 4G3.

Post-Partum Depression
Beth Albright-Peakall of Ottawa would like to hear other women’s accounts of how they coped with post-partum depression. Send your accounts to Beth Albright-Peakall, 1122A-201 Bell St. North, Ottawa, Ont. K1R 7E2.

Health Items For Sale
Interested in obtaining such devices as stethoscopes, a radiation monitor or a breathalyzer? These items and more are available through the Edmund Scientific Health and Fitness mail order catalogue. To get the catalogue, phone toll-free: 1-800-257-6173 (U.S.).

Also, the Sears Home Health Care catalogue contains useful implements for the temporarily or permanently disabled or bedridden: sick room commodities, incontinence gear, hearing improvers, walkers, exersice gear, arthritis implements and easy-to-put-on clothes. For a free copy of the catalogue, write: Sears Catalogue Department, Los Angeles, California 90051.

Drugless Treatment of Low Back Pain
by Drs. Zoltan Rona and Deborah Golledge

It is 1982 and chronic low back pain is still one of the commonest symptoms presented by patients to their M.D.’s. The usual medical approach is to examine the patient, perform X-rays which usually show no bony abnormalities, and then prescribe either muscle relaxants, pain-killers or tranquilizers and possibly physiotherapy. In most low back pain cases, this approach has little success. The main reasons being the neglect of the discipline of nutrition and chiropractic.

Since most cases of low back pain originate from damaged or weakened muscles and ligaments, it is wise to determine the nutritional status of these structures. Muscle metabolism and repair depend heavily on nutrients such as calcium, magnesium, phosphorus, copper, zinc, manganese and selenium.

A nutritionally oriented doctor can do a nutritional evaluation not only of the muscles and ligaments, but also the entire body. The evaluation includes:

- **A Physical Examination** — An examination of the hair, skin, nails, and mucous membranes (tongue, gums, lips, mouth, nose, etc.) provides clues about certain vitamin or mineral deficiencies. For example, transverse ridges on the nails may be a sign of a zinc deficiency. Easy pluckability of the hair may be a sign of a Vitamin A deficiency, some B vitamin deficiencies (choline, biotin, inositol) or a zinc deficiency. Periodontal problems may indicate a potential calcium and magnesium deficiency.

- **Blood and Urine Tests** — These can determine levels of some vitamins (Vitamin A, Vitamin B12, folic acid) and can also show whether or not an underlying biochemical imbalance exists.

- **Hair Mineral Analysis** — A lab test on a sample of hair can determine deficiencies in calcium, magnesium, copper, zinc, chromium or manganese, all of which affect muscle function. For example, a deficiency in calcium and magnesium can cause muscle cramps. The analysis can also determine toxic levels of lead, mercury, cadmium, arsenic or nickel.

- **A Computerized Dietary Survey** — The patient fills out a detailed questionnaire on her diet. From this information, a computer determines the current intake of protein, carbohydrate, fat, vitamins, minerals and fibre. This is correlated with the physical signs and symptoms, blood and urine test results and the hair mineral analysis to give a complete picture of the patient’s nutritional-biochemical status.

Once a complete nutritional evaluation is done, the patient can be counselled on dietary changes as well as vitamin and mineral supplementation. From our experience, it is extremely rare that a patient complaining of low back pain has no nutritional imbalances present.

Once nutritional balancing has been accomplished, or concurrently with it, chiropractic evaluation and treatment can begin. Chiropractic evaluation includes a full examination of the spine to check for mobility of the vertebrae, muscle tone, or spasms and neurological symptoms such as abnormal sensations, loss of sensation, ability of the muscles to function in the spinal areas and also in the limbs. Such a co-operative approach is not only highly effective but rapidly becoming a workable new trend in holistic health for many other problem areas as well. Let us illustrate with one example.

Dr. Rona: Lisa came to me in July 1981 complaining of chronic fatigue, headaches, anxiety, low back pain and painful menstruation. She had consulted other M.D.’s in the recent past but was told that she had no medical problems other than allergies for which she was receiving weekly allergy injections. My physical examination of her revealed no abnormalities other than a mild acne
and low back muscle tightness. Routine blood and urine tests also failed to reveal any abnormalities.

Computerized dietary survey, however, indicated that her diet was too high in fat, sodium, refined carbohydrates (sugar, white flour products), cholesterol, protein and Vitamin D (from a heavy dairy product consumption). She consumed the equivalent of 19.4 teaspoons of sugar a day. Such a high refined carbohydrate intake indicates a high phosphorus intake because most refined carbohydrate contains high levels of various phosphates. An excess of phosphorus stimulates the bones to demineralize, to lose calcium. Calcium deficiency may lead to muscle spasms, periodontal problems and a host of symptoms related to the nervous system (anxiety, insomnia, irritability, headaches, etc.). When bone demineralizes an excess of calcium goes into the bloodstream and is then deposited in soft tissues such as kidneys, joints, or hair. A high calcium level did show up in Lisa's hair analysis. She also had low levels of manganese and chromium.

Based on these results, I advised Lisa to make radical changes in her diet. She was advised to follow a high complex carbohydrate, high fibre diet which relies heavily on fresh fruits, vegetables and whole grains. This diet also restricts the amount of protein and fat intake, keeps refined carbohydrates to a bare minimum, and helps balance the calcium to phosphorus ratio. Lisa was also advised to take a host of vitamin and mineral supplements. Those which had particular importance to her low back pain included the following: chelated manganese to improve muscle contraction, chelated zinc to improve muscle tissue repair, chelated chromium to improve carbohydrate metabolism, vitamin B6, necessary for zinc to be absorbed, vitamin C with bioflavonoids and vitamin A, important in all body repair processes, and vitamin E for better oxygen uptake and improved muscle function.

**Dr. Golledge:** Lisa was referred to me for consultation on her low back pain. She explained that she had suffered from this pain on and off for 10 years. It was decidedly worse during her menstrual period. She experienced low back pain and uterine cramps 1 or 2 days just before her period and on the first day.

Her low back examination revealed that the muscles on either side of her spine were severely contracted. The motion in the area was restricted and some of the vertebrae were nearly immobile. Vertebrae higher on the spine had to make up for this lack of motion.

This increased motion in the compensating vertebrae causes an excess of friction and irritation at the nerve root which exits from the spinal column.

The nervous input or control of the uterus comes from this area of the spine. When nerve roots at a particular spinal level are compromised, the organ supplied by those nerve roots can suffer. An organ is controlled by its nerves; some are responsible for sensations and some for motor functions. Abnormal impulses can travel down the nerves and cause spasms in the uterus. These may be a result of pressure exerted by erratically moving vertebrae or contracted muscles around the spine. Inappropriate mineral levels can chemically irritate the nerves and/or muscles causing the same effect. This results in “referred” pain, where a problem in one location creates symptoms in a more distant area.

In Lisa's case, it appeared that her uterus was undergoing an abnormal amount of spasm at the time of her period and the low back problem would also become more painful at that time. In addition, her nutritional evaluation had indicated a negative calcium balance, something which I find common in women with painful periods.

We started a programme of chiropractic adjustments and muscle therapy, re-instituting the normal low-back movement. I suggested she take a mild calcium-magnesium supplement, increasing the dosage ten days before her period. Both these minerals are important to normal muscle functioning.

It has been three months now and Lisa has had one period with much less pain and one completely pain-free period. Her low back doesn’t bother her at all.

Although we must be careful not to generalize from one successful case to all other cases of low back pain, there can be no harm in attempting this approach with similar cases. In our experience, the results have been rewarding.

Deborah Golledge is a chiropractor practising in Toronto with Zoltan Rona, a physician. Together they run a holistic health centre.
When you first visit a naturopathic physician, she might look deep into your eyes and say you ought to be in pictures. But don’t worry, it’s not a come-on. She is simply practising iridology as a diagnostic technique and recommending a shot of your iris through a high-powered microscopic camera. On the other hand, she might want to send you to the lab for a battery of tests. Depending on what ails you, therapy might consist of a vitamin regimen to build up your resources, or physical manipulation to promote circulation, a good chat to help you recognize some of your own patterns that help perpetuate your condition, or even colonic irrigation to assist the process of detoxification. Naturopathic medicine is characterized by a high degree of eclecticism in both diagnosis and therapy. You could go to a dozen different naturopathic doctors and have a dozen different experiences. What naturopathic physicians share is their commitment to a common philosophy and principles. In their efforts to restore health, naturopathic doctors work in harmony with the natural tendency of the organism to re-balance structure and function when something is out of kilter. This principle is known as the *vis medicatrix naturae* or the “healing power of nature.”

Naturopathic medicine has a number of implications for women. In talking about improving women’s healthcare, we have to keep in mind two objectives. First, we need diagnostic and treatment procedures which are effective but are not in themselves dangerous to health. Second, the social organization and delivery of healthcare should encourage a sense of autonomy and responsibility in women as patients. The philosophy, theory and history of naturopathic medicine give it the potential to meet these two conditions. But because of the social context in which it is practiced, there are limits to how fully this potential is realized.

**Conventional Medicine — Allopathy**

As with medical doctors, naturopathic physicians are expected to have a firm grounding in the medical sciences. The difference between the two lies in their understanding of health and illness, and treatment strategies. Allopathy (conventional medicine) regards disease as an entity which can be effectively eliminated by producing physical states incompatible with the problem being treated. This results in an antagonistic attitude and confrontational dynamics on the part of allopaths. It can lead directly to iatrogenic (doctor-produced) side-effects because, in focusing on the local problem, the doctor often overlooks the whole person.

Naturopathic practitioners, on the other hand, assume that illness results when some basic natural or biological understanding is violated. Naturopathic medicine regards health and illness, not as relative states, but as dynamic processes and expressions of the life force of the individual organism. Illness then is treated as an attempt on the part of the individual to become well. The naturopathic physician must decide to what extent s/he should facilitate this process.

**Principles**

One fundamental principle is that no therapy should impede the natural healing process or do violence to the individual on any level whatsoever. Consequently naturopathic practitioners use techniques which are primarily non-suppressive and non-invasive. This contrasts sharply with the heroic and often excessive interventions of allopaths, such as surgery, drugs and radiation. Naturopathic therapies are designed to build up the individual’s resources — such as through nutrition or herbal remedies — and to assist the process of detoxification and elimination — such as fasting or hydrotherapy.

Naturopathic medicine recognizes, in principle, that individuals are enmeshed in a web of social and environmental relationships which affect their general level of health and well-being. This is the true sense of “holistic,” which not only considers the individual as a “whole” human being, but also acknowledges that s/he exists...
in a complex milieu. Naturopathic practitioners are encouraged to take seriously the literal meaning of the word “doctor,” from the Latin root “to teach.” This implies that ideally the patient should become aware of her own role in health and illness.

One naturopathic practitioner said to me that in thinking about what her profession had to offer women, she always came back to the theme of women as victims in the allopathic healthcare system. She felt that naturopathic medicine helped women to obtain power, both through gaining knowledge about their own health and by realizing that they have the ability with support to make their own changes. When I asked her to give me one example of how naturopathic medicine would go about dealing with a complaint that women commonly have, she cautioned me that I was still thinking allopathically, because she treated people, not diseases.

Another naturopathic physician outlined for me the procedure that he would follow in the case of a vaginal infection. He would first try to determine the degree of acidity or alkalinity locally and then possibly recommend the use of some physical agent, such as yogurt, golden seal, myrrh, or vinegar, to rebalance the condition. He might suggest changes in her normal diet which may predispose her to the particular problem she is experiencing. If she had a structural imbalance in the lower lumbar area, he might do some adjunctive procedures to help replenish the neurological and vascular supply. He would inquire about the kind of contraception she was using and counsel alternatives if it seemed related to the infection. Finally, he would move beyond the realm of the immediate cause and effect and look at the problem from the point of view of that individual’s personal expression. For example, how does she feel about herself, her body, her sexuality, her relationships with people?

Holistic Allopathy?

In the past several years there has been a great deal of discussion in the popular media about alternative healthcare, holistic medicine, and natural healing. Many of these terms are ambiguous and misleading. While there are no generally agreed upon definitions, there is some sense that these approaches have greater integrity than medical science. It is not uncommon for allopathic doctors to call themselves holistic healthcare practitioners because they offer alternative therapies based upon natural techniques. Massage, health food, exercise, reflexology — how do you know what is best for you or appropriate for what you are experiencing? All these and more, which are viewed by the public as alternatives, are really techniques which have their origin historically in a naturopathic system of healing. Although these techniques can be presented in an allopathic context as a means to the end of symptom relief, this will not necessarily get at the real source of the problem. Naturopathic medicine represents a healing system in that it is characterized by both a distinct theory of health and illness, as well as appropriate diagnostic and therapeutic modalities. Like other healing systems, naturopathic medicine is not an arbitrary collection of ideas and techniques which can be assimilated holus bolus into some other medical system without doing violence to its basic tenets.

Practice of Naturopathic Medicine

Based upon an understanding of the philosophy and principles of practice of naturopathic medicine, we can recognize the potential which this system offers. Now we need to turn to an
Currently naturopathic physicians function primarily as general practitioners capable of dealing with a wide range of problems. In general they focus on prevention and health maintenance, especially in relation to chronic and degenerative disorders. There is even a small but growing number of dentists who have obtained naturopathic graduate standing. In medical emergencies, such as accidents, or when the natural vitality of the individual is so depressed that their life is threatened, naturopathic doctors (ND) may recommend the use of allopathic techniques, such as drugs or surgery, in order to save the life of a patient. Such heroic measures, though, are cushioned by the understanding that much more must be done in order to deal with the underlying source of the problem. There are remedies and procedures, for example, which can assist the patient to minimize the shock and trauma of surgery and to recover more speedily. On a less drastic level, several ND's routinely offer short courses on naturopathic first aid to help their patients cope with minor accidents.

Both a strength and a weakness of naturopathic medicine is its eclectic orientation. This heterogeneity is a source of creativity and open-endedness which functions in the best interest of the patient. Unlike allopathic medicine, the naturopathic profession has not legislated conformity. The principles underlying naturopathic medicine represent the common theme which connects this network of healers. Unfortunately, this diversity has often resulted in a certain amount of sectarianism and cultism which weakens the tight social organization that naturopaths need in order to protect their professional interests.

**Constraints**

There are a number of constraints which prevent naturopathic medicine from reaching its full potential. In the first place, in a society which is allopathically conditioned, it takes a certain amount of effort to make the cognitive leap into naturopathic thinking. We know that traditionally allopathic medicine has been hostile to their approaches to healing. The participation of allopaths in naturopathic medicine opens up the possibility of the cooption of naturopathic techniques which can be assimilated into other healing systems without regard to their conceptual basis.

In the second place, naturopathic physicians are highly desirous of professional recognition and social legitimacy. To what extent will they make an effort to present themselves in terms of an acceptable medical image? Their quest for credibility may affect the kinds of diagnostic and therapeutic choices they make on behalf of their patients. For example, we know that medical doctors are trained in the routine use of laboratory testing facilities and other kinds of medical technology such as x-ray, regardless of the benefit to the patient or the cost. Some naturopaths may fall back upon this model because they think it is expected of them.

A third factor which affects the scope of naturopathic practice is cost. While some private health insurance plans do cover naturopathic physicians, most provincial health insurance plans do not. Generally speaking, naturopathic patients must be willing to bear the cost of treatment and supplementary therapies such as vitamins, massage, etc.

There is a fourth factor which may limit the range of naturopathic medicine. While theoretically naturopathic medicine recognizes that an individual is part of her environment, in practical terms many environmental factors are not considered manageable by therapy. In this regard we could say that naturopathic medicine tends to be apolitical in that it emphasizes the role of individual responsibility in healthcare to the exclusion of broader social and political factors.

Lacking a suitable political language, naturopathic doctors sometimes find themselves categorizing complex social behaviour in terms of disease processes and their remedies. For example, if a naturopathic physician did not wish to see problematic behaviour as a social issue, s/he might refer to such behaviour as a release, as a manifestation of symptoms, or metaphorically as vomit. This labeling does not address the causes of the behaviour, nor provide an approach to deal with it. Alter-
natively, characteristic behaviour patterns can be reduced to those remedies which are used to treat them. Thus a naturopathic physician can distance themselves from a patient by referring to her for example as “someone needing a good dose of Sepia.” While the effectiveness of these remedies is not being questioned, some of their descriptions in textbooks, which date from an earlier age, convey definite moral and social implications. Sepia or cuttlefish is considered the Washerwoman’s Remedy:

Picture her — the sallow, tired mother of a big family, on “washing day”. She is perspiring profusely: pouring under the arms... Her back aches fearfully. She wants to press it — to support it. She feels she MUST sit down, or cross her legs, as her whole inside seems to be dragging down, and coming out of her. She simply must sit down to keep it in. The worry of the children is more than she can bear. Her baby wants to be picked up and carried, and walls and screams. The quarrels of the penultimate babies engaged in scratching out each other’s eyes are more than she can bear.... Oh! How she wants to run away and leave it all, and have a little peace. Her head aches. The pain is left-sided today: last time it was on the right side, as she remembers dully.

She is so nervous and jumpy, she has to hold on to the edge of the washtub to prevent herself from screaming. If she could only go away from everybody and everything, and lie down, alone, in the dark, and close her eyes!

Her husband comes in: she has no smile to greet his. Nothing but dull indifference, and weariness, and suffering. He must leave her alone. She has her work to do....

He looks at her sadly. Her dull face has lost its contour —its bloom — its pleasing lines. Browny bands or blotches are on forehead, and saddishly across nose and cheekbones.

She was a bright and bonny girl when he married her — and now she is SEPIA. (From: M.L. Tylor, Homeopathic Drug Pictures, The Homeopathic Research and Educational Trust, Devon, 1942 (original printing); this edition 1975, pp. 738-739.)

This is a particularly observant and sensitive account of women’s work. It reflects the kind of compassion naturopathic physicians are encouraged to develop. However to characterize such situations only in terms of their remedies is a gross simplification of the contributing social and economic factors. It must be emphasized that such dismissive tactics are only negative possibilities amongst a very alert and struggling body of practitioners. But there is some risk that this tendency could become more common if naturopathic medicine does not pursue its ability to broaden the frame of reference to include the social and political influences on illness.

Women and Naturopathic Medicine

How then is naturopathic medicine relevant to women? Women need healthcare which is both safe and effective, as well as being capable of helping women exercise autonomy over their lives. Naturopathic medicine clearly meets the first condition and has the potential to meet the second. However, because of the social and ideological contradictions within naturopathic medicine which stem from its position as a marginal healing system, both doctors and patients will have to engage in a protracted struggle to bring to fruition the promise of naturopathic medicine.

While there is nothing inherently sexist about naturopathic philosophy (in fact, the contrary is true), we have observed that the social organization of naturopathic medicine reflects some of the tendencies of the larger society. In particular, it is a field dominated by men. While naturopaths are well aware of the non-iatrogenic possibilities that they offer women in terms of therapy, there is very little conscious concern about helping women deal with their social role in a sexist society and how this might affect their need to express themselves through the mediums of illness and their bodies. Sharing the same sexist assumptions about women as other unenlightened members of society, some naturopaths are as benevolently paternalistic or as chauvinistic as medical doctors. Genuine concern for a woman’s well-being can take on moral and evaluative overtones.

For women who are disenfranchised from their traditional role as healers by the rise to power of allopathic doctors, naturopathic medicine offers an opportunity to reclaim a place in a healing profession which is humanly oriented. Women are in the forefront of the campaign for medical reform because of the ways in which allopathic medicine exploits them. Both individually and collectively they are in a position to encourage the development of naturopathic medicine. As naturopathic patients they can help sensitize their doctors to the social issues surrounding women’s expression of illness. Collectively they can organize as pressure groups to promote the legitimization of naturopathic medicine as an effective and humane healing system.

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I would like to thank Women Healthsharing for all the feedback and assistance they gave me during the collective editing process for this article. It was a good experience in finding better ways to express particular thoughts as well as in collaborating in a philosophical sense.

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just came in from Emerg," Karen reported to the evening staff who had come on duty. "You shouldn't have any trouble with her. She's not a medical emergency."

"Why's she here on the intensive care unit if she isn't critical?" demanded one of the nurses. The head nurse responded, reminding them of the new bed policy which had started another power struggle among the doctors. The nurses' experience of it was having critical care beds filled over the weekends with patients who were not seriously ill. On Monday morning they would be shipped out to ordinary wards to make room for new surgery patients of the same doctor.

"It's Dr. Herman's bed," Karen remarked. "He's got extra surgery booked for Monday and needs the beds, I bet," one of the staff nurses commented. Another nurse groaned in response, anticipating Monday's workload.

"Can I finish my report?" Karen asked in a tired voice. "I want to get home some time today." The head nurse nodded and Karen continued. "Mrs. Martin, 76 years old, just admitted from Emerg where she was treated for a severe allergic reaction to a bee sting while working in her garden." A nervous giggle broke the mood and Karen held silent for a moment waiting for attention. "Fortunately a neighbour saw her distress and called the ambulance. She was blue on admission, in extreme respiratory distress and given adrenalin. She has an intravenous running in case she gets into trouble, but it can probably be discontinued this evening if her vital signs remain stable. She has a history of asthma and is allergic to a lot of things. One of these is orange juice. We put a sign above her bed listing all of them. The respiratory technicians have been notified of her arrival and there is a treatment booked for tomorrow... Saturday," she added, remembering she was on duty for the weekend.

"The O.R. won't like that," someone interjected. This time Karen gave the guilty party a dirty look and tried to quickly conclude the report.

"Right now Mrs. Martin is resting quietly after what she calls 'the big fuss'. Seems a bit embarrassed about it. Her vital signs have been stable for several hours. She is not in any apparent distress although she has an occasional wheezy respiration. Are there any questions?" Karen asked more out of habit than interest, hoping there weren't any. The evening nurses shook their heads and almost in unison they got up and reached for the charts.

Karen waved at Mrs. Martin as she passed the bed on her way off duty. She threw the old lady a kiss thinking she looked so cute in the blue hospital gown with the sleeves rolled up. The patient was sipping a cup of tea and turned to look out of the window.

Karen was annoyed to find out that Mrs. Martin was already being called "Granny" even though she had no grandchildren.

"Granny had a quiet night. No changes in her condition," yawned the night nurse almost ready for bed herself. "We should try and get her out of the unit today."

Quiet, my eye, protested Karen to herself. With the death of the patient in the next bed the old lady obviously did not have a quiet night. Karen wondered why the nurses seemed to forget that the intensive care unit was terribly noisy with respirators wheezing, monitors beeping, people moving about, clanging equipment, conversations, whisperings, and telephones ringing. Karen was waiting for the day that nurses would tell it like it is without resorting to clichés like 'quiet night'. Suddenly she was pulled from her reverie, hearing that Granny had refused to sign a consent form for the scheduled bronchoscopy.
“Maybe you can convince her,” the night nurse directed Karen. “She’s due in the O.R. at 11 a.m. so if she won’t cooperate by 10 o’clock, I guess you will have to page Dr. Wilson, the resident on duty, to talk to her. He won’t be at all happy about that. He was in a real foul mood when the heart patient arrested.”

“Wilson,” moaned the nurses. “Why do I always end up on the same weekends as that jerk?” Karen’s friend Julie complained.

“Maybe,” Karen teased, “he goes to nursing service to find out your hours and pleads to be on the same shifts.” The two nurses bantered back and forth about the unpopular resident doctor and a couple of others added their own opinions. One of the new graduates looked askance at the laughing nurses mocking the doctors again. She, a new graduate, was dismayed at their unprofessional behavior, but assumed it was due to the fact that they didn’t have degrees.

“Palmer’s coming.” The warning rang out too late. The nurses swore that old nurse Palmer could hear through walls each time they began to enjoy themselves.

“Nurses,” Mrs. Palmer addressed them in her imperious manner. “You cheapen yourselves with all this prattling. You have patients to care for. They are your first and foremost responsibility. Dr. Wilson is a fine physician. He deserves your total respect and compliance with his orders.” The nurses drifted away in response to the ongoing lecture.

“Good morning,” Karen greeted her patient. “I thought I’d let you sleep in. It’s difficult to get enough rest on the unit with all of the things going on.” Mrs. Martin turned to Karen and she was surprised at how much older and more tired the woman looked.

“He died, didn’t he?” Mrs. Martin squeaked out in a little girl voice. Karen looked at her with a quizzical gaze not wanting to confirm the question.

“That man... over there... last night,” Mrs. Martin tested Karen. “I know you can’t tell me for sure but he...” Tears formed on the edges of her eyelids. “I know he died,” Mrs. Martin almost sobbed. “They took him out in the empty stretcher with the curtains around the bottom. That’s so they can hide the body. Isn’t it?” she asked rhetorically. Karen looked startled at the news that the secret stretcher was a known fact with the patients.

“Everyone knows it is a death stretcher,” Mrs. Martin whimpered. “Now I’m in the bed where he was yesterday.”

“Don’t be superstitious, Mrs. Martin,” Karen scolded. “I’m sure you are just tuckered out and over-reacting to everything.” The patient shook her head and tears flew off her eyelids.

“You’re right,” Karen replied, trying another tactic to reassure the old lady. “It’s silly to think that people don’t know about the curtained stretcher. But don’t you think it’s nicer for everyone that way?” Mrs. Martin shook her head.

“No, you shouldn’t hide death that way. After all people do come to the hospital to die,” the patient told her nurse. Karen tried to change the subject and apologized for not bringing breakfast.

“After your tests we’ll give you some tea and jello. Maybe you can have a light dinner tonight,” Karen cheerfully suggested. “The tests won’t take long and it will help the doctors find out why you have trouble breathing.”

“I know why I get wheezy,” Mrs. Martin told Karen. “It’s from ragweed and cats but I love the dear things. I shouldn’t eat chocolate either. That does it too. No, I don’t need tests done. I need to go home.”

“Well,” Karen sighed deeply thinking of the mass of work she had to do. Here she was pampering the old lady but she had to admit it was nice for a change to have a patient you could talk to.

“I know what’s the trouble,” the old lady beamed at Karen. “I’m an old woman. That’s all that’s wrong.”

“No, you’re not,” Karen protested. “I am too. That’s why they call me ‘Granny’,” Mrs. Martin replied looking like she was going to cry again.

“You’re not all that old and they shouldn’t call you ‘Granny’,” Karen said. Once again she was annoyed at the hospital habit.

“Seventy-six last month,” the patient boasted. “Bring in the curtained stretcher.”

“Ah, you’re just teasing me,” Karen laughed trying to get away. “Look, I’ve gotta go. I’ll leave this consent form for the exam with you and when you’ve signed it... just wave at me and I will come and get it.” She laid the consent form on the overbed table with an opened pen.

“No,” Mrs. Martin objected. “Bring me my breakfast... and my clothes. I’m gettin’ outta here. If that bee hadn’t stung me I wouldn’t be here. Now you want to experiment on..."
an old lady. Do fancy tests. Well, I don’t want it. I won’t sign. Just go off... take care of all the sick people.”

Just as Karen was about to get away Dr. Herman, who was assigned to Mrs. Martin in emergency the day before, breezed into the cubicle with the head nurse.

“How are we today Granny? You’re looking chipper,” he said to the bedstead pulling out his stethoscope and not waiting for a reply. “The girls tell me you don’t want to sign the consent. Here it is,” he said reaching out to Karen to produce the forms instantly and not noticing that they were sitting in front of the patient. “Now just be a good girl and sign where the big X is marked.”

“Nope!” Mrs. Martin said quickly as she drew herself up in bed to gain a better position of power with the doctor. “I don’t need it. You want a bronch — whatever it is — do one on yourself.” She giggled at her own joke.

“Now, Mrs. Martin,” the head nurse broke in. “Be reasonable and do as the doctor says. He knows what is best for you.”

“He doesn’t know me from Adam,” the old lady protested.

“No need to get snippy Granny,” the doctor chastised. “We just want to take a look down your breathing tubes to make sure nothing is wrong down there.”

“Nope!” Mrs. Martin repeated folding her arms in front of herself for emphasis. “I don’t want it. I don’t want anyone looking inside of me. I’ve had a good life. If there is anything wrong now it’s okay with me. I’m an old lady.”

“We’ll see about that,” the doctor warned. “You better cooperate with the girls here.” He turned to the head nurse saying “Have her in the O.R. by 11 a.m.”

“Please Mrs. Martin,” the head nurse pleaded. “Just sign the consent and everything will be over in a few hours and you can go home.”

“Nope! I told you once. I’ve told you twice. I don’t want any test. I want to go home.” Mrs. Martin glared at the nurses.

“Stupid jerk,” Julie interjected. “He’s so clumsy he’ll probably mess up and end up doing a tracheotomy. You know old lady Martin is right. I wouldn’t let those pigs near me either!” Julie spluttered with anger.

“Listen Julie,” Karen almost whispered. “I’ll just tell her she can sign herself out.” Julie laughed in relief.

“Every hear of anyone signing herself out of the intensive care unit? It’s wonderful. I love it. Can’t you see the headlines: ‘PATIENT SIGNS SELF OUT TO AVOID DR.’S EXPERIMENTS’. I love it!”

morning Karen was not as confident as she had been at lunch the previous day. She was almost late for work. She told herself it was because she was trying to avoid going to work. She worried about a confrontation with Wilson over her refusal to give the heavy sedative. She even prayed on the way to work for her assignment to be changed so she wouldn’t have to face it. Her heart sank when she saw the same names. She found it difficult to listen to the monotone of the night nurse’s reports but sat up when she heard the nurse mention Mrs. Martin.

“Granny was given some orange juice last night and had a reaction.”

“I hope you filled out the accident form,” the head nurse commented to Karen. “Booked for tomorrow. She can have her lunch. An accident just came in and the O.R.’s are full. The resident has ordered a sedative one hour before the bronchoscopy if she is restless.”

“Damn!” Karen spat out to her friend Julie over lunch.

“Nurse! Watch your language,” the doctor chastised. “We just want to know how you feel.”

“I know,” Karen sighed with a worried voice. Suddenly she sat up. “I’ve got it. The sedative is ordered ‘only as necessary’ for restlessness.”

“Right,” Julie piped up supporting the plan. “If they ask you can always say that with the best of your ability you decided it wasn’t necessary.”

“But what if Palmer... it’d be just like her... or the new graduate decided to get rigid about doctors’ orders and gave it?” Karen worried out loud.

“You’ll just have to watch closely to make sure they don’t,” Julie advised.

“I don’t have time to watch them,” Karen complained. “Because Martin doesn’t need more than routine care, they gave me an extra patient. I’m already behind today.” Suddenly she flashed a smile. “I know. I’ll wait until tomorrow. If Dr. Wilson insists on doing the bronchoscopy — I know Dr. Herman doesn’t care. I bet Wilson will insist ‘cause I heard him tell Herman that he was excited about doing his first bronchoscopy alone. . . .”

“Cancelled today,” the head nurse called to Karen. “Booked for tomorrow. She can have her lunch. An accident just came in and the O.R.’s are full. The resident has ordered a sedative one hour before the bronchoscopy if she is restless.”

“Granny is still drowsy,” the night nurse reported. “She’s been on the unit two nights now and that is enough to bring on confusion.”
“Good morning, Mrs. Martin,” Karen greeted the sleeping patient. “I hear you had a bit of an accident last night.”

“I didn’t have an accident,” she slurred like a drunk.

“At least you don’t have to worry about it happening again,” Karen reassured the patient. “You don’t get breakfast so you won’t be sick after your tests.”

“I won’t sign,” Mrs. Martin croaked and struggled to sit up. “I just want to go home.” Karen leaned over to the old woman and almost whispered in her ear.

“It’s okay. You don’t have to sign for the tests. You can go home right now if you want to,” Karen told her.

“I want to go home,” Mrs. Martin repeated in a tired voice. “I want to go home now. They don’t feed you here with anything good. Just a lot of bread and crackers. Sugar this and sugar that and soda pop. I want to go home. I’m so tired.” Karen patted the old lady’s hand to reassure her.

“It’s alright. You can go home right now if you want to. I’ll help you but first you have to sign yourself out.” Karen explained.

“Nope! I won’t sign. No tests.” The old woman shook her head.

“But Mrs. Martin it’s not the tests I’m talking about. It’s signing yourself out of the hospital. It’s the only way you can go unless your doctor gives you permission,” Karen tried to tell her.

“Nope! I won’t sign,” the old lady repeated.

“Look, Mrs. Martin,” Karen tried again. “You want to go home. Right?” The old lady shook her head in response. “Okay, you want to go home, you have to first tell the head nurse. Then she will give you a release paper to sign. It says the doctors aren’t responsible for what may happen to you when you leave. After you sign, I’ll get your clothes and you can go.”

“Nope! I won’t sign,” Mrs. Martin shook her head.

“Code 1, Code 1, Code 1.” Karen heard the announcement and saw Julie frantically working on one of her patients. Karen’s heart always did a momentary stop before she quickly moved to help. It was a horrible thing to lose a patient and especially one you had worked with all week. Just before your day off was even worse.

“Nurse,” Palmer came up behind Karen who was still helping Julie with the emergency. “Dr. Wilson called to find out if Granny’s sedative has been given. He’s quite anxious about it and is going into the O.R. to scrub on another operation.”

“No, I haven’t given it,” Karen explained in an exasperated voice waving at the flurry in front of them.

“Well if you are too busy, I guess I will have to do it,” Mrs. Palmer threatened.

“No, no,” Karen protested. “I can handle it.”

“You are going to give it?” Mrs. Palmer lowered her voice demandingly. Karen did not answer but walked over, checking the intravenous on her patients. Then she milked a chest tube while Mrs. Palmer hovered nearby. Karen took a blood pressure.

“Nurse, I’m waiting for an answer,” Mrs. Palmer said in an insistent voice.

“What?” Karen asked feigning innocence.

“I want to know if you have given Granny her pre-operative sedation. That’s what I want to know.”

“She doesn’t need it,” Karen iced at her.
"But Dr. Wilson ordered it," the older nurse protested.

"Yes, I'm aware of that, Mrs. Palmer. Mrs. Martin is my patient," Karen answered.

"Dr. Wilson ordered it so you have to give it... and now, Mrs. Palmer directed.

"Mrs. Palmer," Karen said quietly and stopped for emphasis. "I'm very busy as I am certain you are too. Now if you don't mind... if you would leave me to do my work, I am sure you must have a lot to do too." She turned right in front of the older nurse and walked past her.

"I must report you!" Palmer shouted after Karen. "For not following doctor's orders." She stomped over to the head nurse's office.

"Karen," said the head nurse patiently. "Mrs. Palmer is quite upset and says you have failed to follow doctor's orders. Now would you like to talk about this?"

"She's not correct," Karen defended herself. "Dr. Wilson ordered a very heavy dose of sedative for Mrs. Martin prior to a scheduled bronchoscopy. The way the order is written it says 'if necessary for restlessness'. Mrs. Martin is not restless. As a matter of fact she is still sleeping as an after-effect from the antihistamine. So while Mrs. Palmer feels I am not following orders, the real problem is that Mrs. Palmer is not reading orders correctly."

"But apparently Dr. Wilson called to find out if it had been given," the head nurse commented. "That sounds like he wants it given now."

"Don't you think you are being a bit picky?" the head nurse asked, cocking her head to one side. "I think Dr. Wilson's intention — and this is not only Mrs. Palmer's idea — is that Granny was to get the injection before the test — for which I might mention we do not have her consent anyway. If she has not signed permission, there are ways around that. It is important that they take a look. She does have a history of bronchial problems and may even have a growth. The bronchoscopy may save her life."

"Yes, and it might kill her too," Karen remarked in parting. She was surprised at her own nerve. As Karen and Julie left for lunch they both noticed Mrs. Palmer on the phone waiting for a response from someone at the other end. The new graduate was standing beside her, waiting too.

Karen tried to get Julie over the Code 1 Blues. It was particularly tough when the patient was young. There never was any time to deal with one's own emotions about it. They had to be locked inside especially if one had to immediately switch over and console the family. Suddenly Karen dropped her fork.

"What's wrong?" Julie asked.

"Wasn't that Mrs. Martin's chart that Palmer had?" Karen demanded.

"What? What are you talking about?" Julie asked with wide eyes.

"When we left," Karen insisted. "Wasn't that Mrs. Martin's chart they had?"

"I didn't see. I'm sorry. I wasn't really with it," Julie apologized.

"I bet they got a 'stat' order for the sedative. Damn! She'll go into respiratory distress if they give her anything else," Karen sighed with anger.

"But isn't that what they want to do so they can call her a medical emergency and do the tests and save her? All without her permission," Julie sarcastically noted. Karen put down her fork.

"I think I am going to be sick," she said to Julie.

"That's the last thing you should do," Julie teased. "You might end up on intensive care. Not as a medical emergency and Palmer would be your nurse."

"Yeah, and she'd follow doctor's orders to save my life," Karen returned mimicking her friend's voice.

On the way back from the cafeteria they saw Mrs. Palmer and the new graduate heading over for lunch.

"There's one who will rise fast," Julie sneered at the new graduate in step with Mrs. Palmer.

"Nurse," Mrs. Palmer called Karen. "Your patient just left for the O.R. Dr. Wilson wasn't upset about the delay in her sedation. They weren't quite ready for her anyway." Then Palmer turned and beamed at the new graduate. All Karen and Julie could do was glare at them.

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The majority of practising physicians are woefully uninformed about mitral valve prolapse which they summarily dismiss as “a woman’s disorder”. Others ridicule this abnormality with smart-alecky epithets like “the slick chick syndrome”, so-called because mitral valve prolapse (MVP) women are usually slender and tall.

MVP is a cardiac abnormality affecting up to 20% of the adult population. One study showed a 17% incidence in women alone, confirming what doctors tell me of the startling ratio of one in five women for one in 20 men. However, the overall incidence may be vastly underrated as I have heard one cardiologist remark that his practice consisted chiefly of MVP patients and another that “half the people walking around have MVP”.

I developed heart complications that threatened my health and even my life. But, to get adequate medical care, I had to battle what seemed like the entire medical profession, which strove with mafia-like force to prevent me from knowing anything about my health.

As far as is known, the alterations in the mitral valve, located between the upper and lower chambers of the left side of the heart (atrium and ventricle respectively) are due to connective tissue disease. The softer mucinous components of the valvular tissue proliferate replacing the sturdier, fibrous elements, causing the valve to stretch, balloon or prolapse into the atrium during systole (the ejection of blood via the aorta to all parts of the body). For many years, this condition was thought to be benign, but, for the last twenty years, researchers have warned of the necessity of antibiotic protection during certain surgical procedures to prevent bacterial infection.

My GP first sent me to a cardiologist, designated A in this article, after I had experienced two frightening episodes of partial loss of consciousness with a rapid, fluttering heartbeat, unrecordable pulse and cold, numb extremities. Cardiologist A, curt and very conscious of maintaining the professional image of distance between doctor and patient, referred to me indifferently as a “mitral valve prolaper”, while he lectured to his students on the MVP syndrome. Never having heard of MVP, I attempted to ask questions, but he cut me off with “The syndrome is completely benign. You’ve nothing to worry about.” He could not explain my episodes of near-fainting, but said they were unimportant. He did not suggest any precautions, but instead sent me away with a prescription for an anti-arrhythmic drug, propranolol.

Several months later, I consulted another cardiologist, “B”. I had been contemplating a first child, and had learned that propranolol could cause intrauterine growth retardation, chiefly in the size of the baby’s head, thus raising the question of mental retardation. I did enough reading, including a paper by cardiologist B and his colleagues describing the parts of the mitral valve, to clarify questions concerning my basic fears. After asking him some of the questions I had prepared, cardiologist B immediately interrupted me: “Why are you going into all of this? I don’t have time. MVP is nothing more than a curiosity.” He was scornful of my attempts to read the medical literature and incensed that I had invading his privacy by reading his article. “A little learning is a dangerous thing,” he finished with a snicker. He then appealed to my husband’s authority to silence his hysterical, tongue-wagging wife, as though she were an embarrassing drunk at a cocktail party. “Was she like this before you married her? She must have been!”

As if this were not enough, I suffered sexual harassment during an echocardiogram (the video screen presentation of the movement of the heart and its valves by means of ultrasound). A doctor learning the ultrasound technique made certain improper gestures.
in the darkened room, while reassuring me that he was trying, by palpation, to locate the aorta. Furthermore, when he indicated for me to dress, he remained in the room, rudely staring at me. I reported the incident to cardiologist B, as it took place in his hospital, and received a formal apology from the offending doctor. However, this event, plus cardiologist B's behaviour, dissuaded me from returning to that centre.

Time was important with respect to the pregnancy. (I was thirty-four at the time) and consequently I was anxious to secure a contact with a cardiologist and a gynecologist at the same hospital. At my GP's advice, I chose to return to cardiologist A. Unfortunately, my choice was a grave error. Cardiologist A and B differed on one very important point. B recommended the use of antibiotics during childbirth and dental work. A never mentioned antibiotics and wrote to my GP, "I do not believe the risks of infective endocarditis in these mild mitral prolapsers is really significant." Endocarditis is inflammation of the lining of the heart. It wasn't until a year and a half later, when I developed complications, that I realized B supported antibiotics to protect against bacterial or infective endocarditis, caused by bacteria entering the bloodstream and settling on damaged valves and other organs of the body such as the kidney, liver and spleen. The most common route, accounting for up to 50% of cases, is dental manipulation, cleaning, filling, extraction of teeth or any infection of the gums (periodontal) or roots of teeth (endodontal). Unless treated, the disease, whether acute or subacute (chronic) has a uniformly fatal outcome as it did before the introduction of antibiotics in 1944. Even with treatment, four to six weeks of intravenous antibiotics, there is a 30% failure rate.

The use of antibiotics was never made clear to me and, therefore, it would have been easy for a layman to assume, as dentists did for 20 years after the connection between the teeth and the heart was made, that such medication was to prevent local infection in the mouth or, as in the case of childbirth, the uterus.

When I saw cardiologist A for the yearly check-up, he repeated that the syndrome was benign, that propranolol could not harm the fetus and that I should have a "four-plus reassurance" of a long life. Nothing happened until six months later, when I suffered a severe tooth infection. A fever developed which did not register on the basal thermometer because it exceeded 41°C. I managed to get the fever down with a pain killer and afterwards went straight to my dentist. Although aware of my murmur, my dentist did not consult my cardiologist and did not mention antibiotics. Instead, I was sent on to an endodontist who, likewise, saw no connection between the teeth and the heart. My unfortunate luck was to have seen three practitioners, none of whom was familiar with the previous 20 years of research or with the latest recommendations of the American Heart Association with respect to antibiotic protection against endocarditis for MVP patients.

During the root canal therapy, I had continuous fever, pain and excessively rapid heart action. When I complained of the latter to cardiologist A, he simply instructed me to increase the propranolol. These events culminated in a one inch increase in the transverse diameter of my heart over the following year.

An alert doctor would have suspected infective endocarditis for several reasons. First of all, I complained that I was feeling unwell because of mild fever and prolonged pain from my tooth. He ignored this signal and didn't even take my temperature. Secondly, there was a possible explanation for the increased heart size. Standard textbooks point out that pericarditis (inflammation of the membranous sac surrounding the heart) occurs in one fifth of the cases of bacterial endocarditis and would account for sudden cardiomegaly (heart enlargement). And, thirdly, cardiologist A told me himself that he noticed a change in my murmur which he regarded as insignificant in this benign syndrome. The classic change in murmur is the most suspicious sign of bacterial endocarditis and has been recognized for many, many years.

Before I was to see cardiologist A, he consented, contrary to the whole canon of medical research and in spite of my enlarged heart, to periodontal surgery on the infected tooth without antibiotics, which would in all likelihood spread the infection. The surgery, I was told could save the tooth. I was very upset at the time because of the enlarged heart, and asked the periodontist to contact my cardiologist. Presumably, the contact was made. He then went ahead with the surgery telling me I'd be all right if I took ampicillin after the surgery and even though this is not the drug of choice of the American Heart Association. Furthermore, in order for these antibiotics to be effective, they must be taken one hour prior to the procedure in order to assure optimum blood level.

When I finally saw cardiologist A, he denied speaking with the periodontist or prescribing ampicillin. In fact, he was totally unfamiliar with the dental problem, showed no interest and offered no advice about antibiotic protection. He looked at my heart under the fluoroscope and pronounced that the cardiomegaly had miraculously disappeared. I found this difficult to believe since the fluoroscope machine, by means of X-ray, shows only the moving heart and provides no permanent record to compare with a previous X-ray. Cardiologist A attributed the cardiomegaly to the fever.

From then on the tooth continued to abscess. Several doctors and dentists I saw prescribed short courses of antibiotics which would suppress rather than eradicate the organisms responsible for endocarditis. After a year of dealing with this infection, I was finally admitted to hospital for extraction of the
A's hospital a clerk told me that my entire file had disappeared. The clerk showed me a binder with the written reports of the radiologists and ultrasound technicians on these tests. A photocopied handwritten note signed by cardiologist A, attached to these reports, stated that nothing further was to be released except by legal intervention. A typed file card indicated that my documents had been sent to a nonexistent doctor at another hospital in the city.

In the summer of '81 I visited the American doctor, only to be again disappointed. When I discussed the link between the dental infection, cardiomegaly and my deteriorized condition, he refused to make a statement of cause and effect, responding very coldly, “This is what happens when patients read. You've read the literature, haven’t you?”

I discussed the whole matter with my GP who reluctantly permitted me to view the letters from the cardiologists describing my condition. From these letters I learned that my murmur had, indeed, worsened, become longer and louder, and that there was increasing regurgitation. I also learned that cardiologist C would be willing to give me an answer if he had permission to view all my previous records from cardiologist A.

I, therefore, signed a requisition ordering cardiologist A to release all my records to cardiologist C. A month later at my appointment, cardiologist C told me he had not received records and he was no longer prepared to discuss my past treatment. In fact, he was angry that I had returned to him and confessed to a long telephone conversation with cardiologist A, the substance of which remains a mystery. When I attempted to ask about the deterioration in my murmur, C flew into a rage and behaved in a frightening and unprofessional manner. “I don’t need this aggravation,” he shouted, and escorted me to the door.

I determined to consult a doctor in the United States who was currently doing research in MVP. From my reading, I was able to choose a specialist whose research directly related to the problem of infection and endocarditis in the MVP syndrome. Naturally, he asked for all medical records as C had. The day I arrived to collect them from the Medical Record's Department at A's hospital a clerk told me that my entire file had disappeared. The clerk showed me a binder with the written reports of the radiologists and ultrasound technicians on these tests. A photocopied handwritten note signed by cardiologist A, attached to these reports, stated that nothing further was to be released except by legal intervention. A typed file card indicated that my documents had been sent to a nonexistent doctor at another hospital in the city.

When I returned to Canada, I was once again without a cardiologist which left me feeling desperate. Two doctors I consulted did not believe that I had ever had cardiomegaly and repeated that the syndrome was benign. I no longer had the records to convince them. By now I had completely abandoned the idea of pregnancy and was only concerned with being tested for subacute bacterial endocarditis. Incentively, I wrote to the Ontario Medical Association telling them the whole story and asking for a cardiologist. I was sent to a young doctor who, I was told, did not take patients on a regular basis. He did no tests and described my murmur as cardiologist A had described it before my illness. Furthermore, he parroted the same nonsense that the syndrome was benign, that I could have a child with no risks and even cast doubt on the use of antibiotics.

From this point on, my health declined. Twice I have been hospitalized for enlargement of my spleen, a primary sign of subacute or chronic endocarditis, as is clubbing of the fingernails, which I am told I have. The sudden appearance of nodules on the tricuspid valve on the right side of my heart may point to healed endocarditis vegetations. I now have a completely pansystolic murmur heard when flat on my back. My GP has recommended diuretics to relieve excess fluids in the tissues as I have considerable swelling in my abdomen and legs. Obviously, these are early signs of congestive heart failure which pushes me closer to death or to replacement of my natural valve with an artificial device which carries, according to some reports, a failure rate as high as 52%. It is known that only 10% of MVP patients have a pansystolic murmur since the severe regurgitation it represents develops only late in life. Doctors tell me the deterioration in my murmur is due to soft tissue changes in the valves. Yet the bulk of research shows that tissue deterioration develops very slowly, is found mostly in the elderly and never in a patient under age fifty. Early rapid deterioration in this syndrome, according to the majority of research, can only be due to a bacterial infection. Though I have an internist looking after me, he has still not given me a diagnosis or treatment, largely because the fever is low grade and the cultures are negative, a not uncommon entity in approximately 30% of long-standing cases.

If MVP is so benign, why are doctors so hostile to the patient who acquires knowledge about this condition? There are many good reasons. A great many doctors, even specialists, unfamiliar with medical research believe infective endocarditis is a rare disease, in general belonging to the pre-antibiotic era. This is the same as believing leprosy belongs only in biblical times. Doctors think endocarditis is rarer still in the MVP syndrome, yet
researchers consider it a major complication. Most startling are the studies that show no decline in the number of cases of endocarditis since the introduction of antibiotics in 1944. One study in particular found that the number of fatal cases has averaged eighty-eight percent a year since 1941. This is inexcusable when antibiotics can prevent this disease.

What accounts for these disturbing facts? Misdiagnosis, according to many prominent researchers. Although the knowledge of what to look for and what to test has increased, careless doctors are still overlooking a disease that shares many of the characteristics of far less fatal illnesses such as flu. It has been known since the classic studies of Emanuel Libman in 1912 that a patient can have endocarditis yet not be sick enough to consult a physician or to have a clinical picture so nonspecific, with negative blood cultures, as to deceive the examiner. Such patients appear to heal spontaneously, but, invariably, they die three to four years later with congestive heart failure, renal failure or cerebral embolism (lodging of a clot, probably containing bacteria, in the brain) an event which occurs in 50% of endocarditis cases.

Because MVP is found in more women than men, it is just possible that this is another reason the male-dominated medical profession is not giving the condition the attention it deserves. In fact, doctors hastily attribute complaints to neurosis. Several times my search for an explanation of my unusual symptoms was interpreted as a neurotic obsession with my health; psychiatric counselling was even suggested. Incredible as it may seem, when I complained only once in three years of atypical chest pain, cardiologist A wrote to my GP saying I showed "a labile mentality" (psychological instability). He justified his opinion by pointing out that, as a creative writing teacher I was inclined to have an overactive, hypochondriacal imagination. When I pressed for action after a year of oral infection, he said "Oh you want me to play Daddy," as though all I needed was psychological reassurance. Such attitudes must be fairly common or researchers would not state so emphatically that MVP patients are far from neurotic. One group of researchers showed that symptoms of lightheadedness, dizziness, fainting, palpitation, lethargy and reduced exercise tolerance can be caused by a fall in blood pressure in a standing position.

Unfortunately, like many illnesses, MVP becomes interesting to the doctor only when the patient is near death and requires replacement of her natural valve with a prosthetic device, as surely she will if she contacts endocarditis. One major study showed that mitral valve prolapse was the underlying cause for valve replacement in 50% of patients. But prevention is not profitable. The current trend in this glamorous technological age is towards surgery, not prevention or medication; towards artificial devices, not repair or maintenance of natural parts. Researchers lament that the popularity of plastic valves, which are easier and faster to insert and hence more profitable, has lead to the failure of young surgeons to learn the more tedious techniques of repairing or reconstructing the natural valve. And yet, artificial valves are known to have a high failure rate with many complications including increased risk of endocarditis.

To attribute complaints to neurosis is not good preventative medicine. Furthermore, it is a deliberate attempt to discourage the patient from discovering the truth that the deterioration in her health is due to doctor incompetence. The Ontario Medical Association doctor doubted the use of antibiotics for MVP patients, claiming confusion in the medical literature. "That's the state of the art," he said smartly. In fact, there has been no confusion for almost 20 years. Standard heart textbooks such as J.W. Hurst's The Heart, 1974 edition, clearly state it is a medical error not to provide antibiotic prophylaxis for MVP patients. The only confused persons were the doctors caring for me. It is safe for them to let the patient think research, not the doctor, does not have the answer.

It is up to us as citizens to try to separate fact from fiction, to educate ourselves to be enlightened critics of our health care system. This means recognizing that we are not always benefiting from medical research conducted with our funds and that the doctor is only as good as his or her clinical experience. This way we can hope to avoid being guinea pigs, as I have been. After my experience, cardiologist A told me he would remind medical and dental students, whom he taught, of the association between MVP and endocarditis. The policy at his hospital has since changed dramatically. One woman I know who has MVP was examined there and prescribed antibiotics for dental work, and my sister who has no murmur, was allowed extraction of her teeth in hospital under antibiotic coverage. My family pharmacist, who received no prescriptions for antibiotics with dental work for eight years, has now received three in six months. Obviously, someone is recognizing the error of his ways.

A little learning may be a dangerous thing, and yet if I had known a lot more I might have been spared the deterioration in my health and changes in the quality and possible duration of my life.

Sharon Anderson lives in Central Ontario. She has a Master's degree in English and has written considerable poetry and prose.

As part of my research for a book on a critique of the health care system, I would appreciate hearing the personal experiences of people with Mitral Valve Prolapse, including, if possible, answers to the following questions:

1. Have you ever been diagnosed as having a murmur?
2. If you have MVP with symptoms, what is your doctor's attitude?
3. Do you have what is known as a "click" or a "click" and a murmur?
4. Have you ever been prescribed antibiotics for dental work or other situations?
5. Does your past history include chronic sore throat, especially tonsillitis, or frequent dental problems?
6. Have you ever had tonsils or teeth removed after 1962? Did you have antibiotics?
7. Have you ever had a fever related to dental work or the above procedures, or a fever of unknown origin?
8. Did your health deteriorate afterwards?
9. Have you ever been told you have a change in your murmur, an enlarged heart or spleen, clubbing of the fingernails, congestive heart failure or any kind of kidney failure with or without symptoms?

PLEASE ADDRESS ALL CORRESPONDENCE C/O HEALTHSHARING
My Story, Our Story

My story, our story, is every woman's experience — our collective experience — with health.

Things That Go Buzz In The Night

by Shari Levine

The invitation shows pictures of women from family-style magazines of the fifties. The women are dressed in tasteful, stylish clothing of that era. One caresses a long, tapered candlestick. Another holds a toolbox. The third grins widely.

The invitation bears this message: “Have you ever wanted to purchase a particular sexual pleasure aid and been too embarrassed to walk into the appropriate store? Or, once you finally made it into the store, bought an item as quickly as you could, only to realize when you got it home that it wasn’t what you wanted anyway? A Pleasure Party will give you the opportunity to look at a wide variety of sexual and sensual pleasure aids and discuss their uses with a professionally trained distributor. . . . Women only, please!”

I told one friend about the party. “Oh, Fuckerware,” she said. “Are you going?”

“I don’t know.” I had to admit to being drawn to the idea and at the same time having serious misgivings. Were sex toys the logical outcome of learning to be more relaxed about one’s own body and less resistant to its potential pleasures? Or was the Pleasure Party just another scheme to part an insecure but highly sex-conscious culture from its dollars in the possible hope that the use of these gadgets would make one a better lover? Would a good lover need this kind of thing? Was this the kind of thing that helped to make a good lover? Pleasure Party offered a chance to examine further some of my questions. I decided to go.

My own experience in the use of things not attached to my body by virtue of birth and development was minimal. When I was married the fourteen-year-old daughter of a friend gave me a vibrator. “This is what I use,” she informed me. “It’s the best I’ve found.” I thanked her uncertainly, wishing I had such savvy. Except for a few experimental weeks, the vibrator has spent its time in a box.

The party. Fifty invitations had been sent. Seven women have arrived and are munching guacamole and chips and drinking a cool punch of triple sec, fruit juices and tequila. The hostess, who gets a discount on her own purchases based upon the amount her guests spend, does not understand the turnout. Apparently there is plenty of reticence even among the so-called sexually “free” generation.

The theme of the evening is good taste. The Pleasure Party distributor, a mid-thirtyish woman with softly curled blond hair and a smooth honey voice, is tastefully dressed in a ruffled apricot blouse and co-ordinated pants. The products are tastefully stored in wicker boxes and baskets.

We sit in a circle. The guests are in their late twenties and early thirties. We all know each other and because of this are less reserved than another gathering might be. We giggle like teenagers at a slumber party when the subject turned — as it inevitably did — to boys.

The distributor whose name is Terry (she hands out her card — it reads “Terry’s Tantalizers”) is running her hands over a pair of rabbit fur gloves. Her hands move back and forth, back and forth, her fingers digging into, then smoothing the fur. She begins, languorously, to speak. I cannot take my eyes off those hands. The combination of her voice and her movements is lulling, soothing and faintly erotic.

“Pleasure Party was started,” she says, “to give people a chance to buy sex products in a sex-positive environment. We have found there is a real lack of information about sex toys and how to use them to achieve maximum benefits. We want people like your own experience — our collective experience — with health.

So far, so good. Nothing as yet is unfamiliar. We lean forward expectantly, hushed. What are we waiting for? As I look around the room, I wonder to what extent this evening is, for some a gathering of light-hearted fun, for others an unstated hope against private pain.

“Please stop eating now,” Terry says. “We have plenty of items here for you to taste.”

She brings out an assortment of little boxes in different sizes and shapes. They bear names like Emotion Lotion and RSVP — Female Response Lotion. They are for massage and lubrication.

“I like to use this when pleasuring my partner,” Terry says. “After a long day, we take a shower together, turn on some soft music and light candles. I rub this oil gently over my partner’s body.” Terry’s voice sounds like oil — smooth and soft and slick. “They come in flavors too, so I can lick them off with my tongue.”

We pass the bottles around, rub some oil onto our hands and dutifully lick. The flavor is strawberry, syrupy and sweet, like children’s candy.

Terry is full of ideas for the use of these products and not shy about “sharing” personal anecdotes. Again I wonder if this “openness” is really the result of greater ease and comfort. She looks relaxed, surrounded by oils and perfumes and as-yet-unopened scarlet silk bags. But I cannot write her off as a dim-witted sex-kitten; her job with Pleasure Party is putting her through an MBA program.
Next we pass around the hardware, the vibrators. Terry shows us a series of vibrators — ones that actually look like penises; highly effective vibrators that don’t even remotely resemble penises; and one particular model, with a protrusion designed to rub against the clitoris, that several women said they wished a penis looked like.

Even Terry’s words are tasteful. She speaks of “pleasuring” and “lovemaking” and “sensual touching” as in: “When I’m in the mood for lovemaking and am pleasuring my partner, I often use this cream for sensual touching.” Clearly one of the important features of marketing these products is to take them out of the realm of the porno book store, to make them respectable. Terry’s tone is soft and prettified.

The talk among my friends, though, is raunchier: “Here’s my new best friend,” holding up a vibrator.

“Hey, will this stuff blow my diet?”

“Honey, that’s not all that’ll get blown!”

And even: “My mother would love this!”

The presentation takes about an hour. At the end I survey the carpeted landscape, now littered with potions, lotions and plastics. Now we eye the products in earnest. To protect the privacy of each individual woman (or couple — parties can also be co-ed, and some, though more rarely, are with men only) Terry takes and fills orders in a separate room. There is no waiting for delivery; she has everything shown tonight on hand in good supply.

I clutch with apprehension. Persuasively I want everything (having been sold on the ideas presented) and nothing at all (still retaining some resistance). At my one and only Tupperware party (San Francisco style, thrown by two gay men) I couldn’t decide between the jello mould, sandwich holders or juice container. I bought the jello mould and have never used it. I think I have it stored in the same closet as my vibrator.

My friends emerge. Defying their right to privacy, each opens her brown paper bag and reveals its contents. The non-penis shaped vibrator is a big seller. I think that its shape won’t be upsetting to the partners waiting at home. Oils are also in big demand.

I go in to see Terry near the end of the evening. I have been captivated by her presentation and now think sex toys are the greatest invention since sliced bread. But I am not impulsive; I stay within my budget. I think that maybe I’ll host my own Pleasure Party later that summer, and invite both men and women. I wonder about doing that kind of work myself. Could I achieve the ease and comfort that Terry has so aptly demonstrated tonight?

Weeks pass. I am back to feeling skeptical. My discreet brown paper bag sits unopened. My partner has made noises about being taken for a sex object. I don’t believe I’ve been taken, but I do feel I’ve been caught up in something to which I don’t yet understand my responses. I think some more and think, finally, that I am still confused.

Shari Levine is a Canadian who has lived in the San Francisco Bay area for the last seven years. She is a graduate student at San Francisco State University in the Masters of Science in Counselling program. She writes fiction and non-fiction and is seriously contemplating returning to Canada.

### Decoding The Anorexic’s Message

**Reviewed by Layne Melanby**


Few items on anorexia nervosa could move me to write about this disorder. Having been in various stages of anorexia for half of my lifetime, I know the subject well. I have read the books and lived the life. It was with this somewhat jaded perspective that I approached Sheila MacLeod’s book, The Art of Starvation.

No stranger to the disease herself, MacLeod is forty-three years old and suffered from it first in 1955 when little was known and most certainly less mentioned about anorexia nervosa. She embraces the adolescent that she was at that time with such tenderness and respectful intelligence that we cannot help but gain expanded insight and understanding. MacLeod divides her book into the stages of her own experience with anorexia: Onset, Euphoria, Depression, Recovery and Prognosis. She explores and describes these stages from the inside.

Anorexia nervosa is a complex and eloquent metaphor with an intricate root system; Sheila MacLeod deals with it as such. She knows that it is not a dieter’s disease, a quest for perfection, a fear of growing up or any number of the definitions it has been given. A novelist and a playwright with political consciousness, she brings her acute intelligence and knowledge to her analysis and assessment of anorexia. She draws from William Blake and Samuel Coleridge as well as Eric Erikson, R.D. Laing, Thomas Szasz and others. She is thoroughly familiar with the work of Hilde Bruch, Peter Dally, Minuchin, and Mara Selvini Palazzoli — all of whom work with anorexics — and expands, personalises and questions their approaches. She addresses forms of treatment anorexics receive including feminist therapy and feminist analysis.

MacLeod refers carefully to her recovery from anorexia nervosa, never to her cure. This assessment is realistic and thus hopeful. There are patterns of thinking, feeling and eating that remain, and most likely will remain, which can only be described as anorexic. She describes her two
I'm Okay, You're Okay Approach to Rape

Reviewed by Gilbert Bélisle


The author of this book, who "in no way aspires to be objective or scientific" has set out to "think hard about the assumptions" that support "men's consciousness of rape". This book was excerpted in the July 1982 issue of Mother Jones. The illustrations which accompanied it left me with the impression that it would be worth reading.

All of the important books on rape have been written by women. The works of Brownmiller, Griffin, Lederer and Dworkin, to name but a few Americans, have given us a sickeningly-clear picture of male violence. Yet none of these authors are read by men in any significant number. Men, as a whole, prefer to continue thinking that when a woman says no, she means yes. It is conceivable that men will feel less threatened by a book on rape if it is written by a man, and if it has a "male point of view".

This, however, is not the book that will achieve that goal. It consists of 28 interviews, the last of which is with an advocate for rape victims. As well, it contains a 35-page introduction, which discusses rape metaphors and the perception of women by men. Save for a few sketchy references, it does not analyze the interviews. There is also an 86-line conclusion and a list of addresses of men's groups.

The author seems to be of the opinion that if men see how misguided their attitudes are, they will reform. This kind of lazy, simplistic thinking is what ensures the survival of rape myths. Beneke has given us "an I'm okay, you're okay manual for rapists, male professionals, lovers and friends," to quote from the interview with the advocate.

The interviews, which should more properly be called conversations, since Beneke has not bothered to ask the same questions — in some cases, there are no questions — vary in length from 6 lines to 11 pages. They are grouped by profession: Lawyers, Doctors, Policemen; affection: Husbands, Lovers, Friends; conviction: Rapist; and a miscellaneous group of others. None of the interviews are commented upon, nor are any of the assertions which are made by the men challenged.

The interviews are very disturbing, and not only because of what the men have to say. Beneke's failure to give any explanation on what he is attempting to do leaves us to wonder about his motivations. For example, he identifies all of the "interviewees" with only a first name except for Andrea Rechtin, the advocate, and Dr. Alfred Messer, a psychoanalyst. It is legitimate to assume that Rechtin is identified because Beneke wants to add to the credibility of what she is saying. It would follow that Messer is identified for the same reason. However, Messer is given to saying things like, "What I want to focus on here, though, is something that isn't talked about: there are

Layne Mellanby is a psychologist living in Toronto. She is a member of the collective which publishes Broadside: a Feminist Review.
and was under the influence of drugs and alcohol when he committed his first rape. Why doesn't Beneke call the freshman who says the following a rapist: "I used a bit of force once where I overpowered a woman. She didn't mind it after it was over. If she'd started crying or something, I would've stopped."? Does Beneke want us to think that you have to be convicted to be a rapist?

Perhaps the following can give us an insight into Beneke's consciousness of rape. On page 66, he asks a man who is about to boast of raping a "radical feminist" "who wanted me to rape her to prove a point" (sic), "Has something gone wrong in a culture when sensitive men of good conscience can be turned on by rape?" That Beneke thinks that "a sensitive man of good conscience" can be turned on by rape indicates that he just doesn't have much of a handle on the issue.

But his most offensive gesture is his cop-out at the end of the book. After 27 interviews in which men have spouted all the prevalent nonsense about rape, all he can find to say is: "If attitudes toward rape are to change, we must have a clear sense of what attitudes exist. The foregoing interviews have been presented to reveal some prevalent attitudes. But to present a variety of male perspectives on rape, so many of which are misguided, without at the same time presenting an informed woman's perspective on the men, would also be misguided." And having so relieved himself of any responsibility he might have in commenting on the interviews, he gives us the interview with Rechtin, who is left with the task of refuting all that has preceded.

This book is useless. Beneke can't even be bothered to provide a bibliography. Did we really need another book which doesn't explain male violence? By serving as a soapbox for rape culture, Beneke pushes back men's understanding of rape. His book adds nothing new, clarifies nothing, analyzes nothing. It does however raise the question of whether it is possible for a man to explore men's consciousness of rape.

**Gilbert Bélisle is a translator at Canadian Tire who dreams of the day when he won't be.**

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**No Guilt Junk Food**

**Reviewed by Phyllis Jensen**


This book has the wrong title. It should be called "How to Eat Junk-Food and Not Feel Guilty." There are several sections on bad habits, like using caffeine, cigarettes, alcohol and over-the-counter-drugs. No popular illegal ones are mentioned. A page or two outlines the health dangers of these substances but it is left up to the reader to make her own decisions. If the reader chooses to use these substances (after all, the message is, it's her right in a liberated society) this book offers a prescription on what foods to eat to avoid the worst effects.

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**The same kind of information goes for women on birth control pills. The authors note 50 metabolic disorders which have been associated with the use of the Pill. But they tell you if you take the Pill with orange juice that will make a difference. Now if you gain weight on the Pill, their solution is to cut calories, exercise more, or see your doctor about getting a different Pill. Vitamin B6 to relieve depression caused by the Pill is not advised because it is a controversial treatment.

Anything controversial in the area of health or nutrition is rejected by these authors. This fact demonstrates more the conservatism of their training in nutrition and medicine than an updating of knowledge in the area — an up-dating the book pretends to do.

The book is written in sections designed to relate to women's changing roles and ages. It is not meant to be an old-fashioned book but a very modern one, like today's woman, supposedly liberated from traditional roles. Rather than plowing through the entire text, the reader is advised to look only at those sections which apply to her situation. However there is a predominance of mother/wife sections and many incorrect assumptions about women's participation in the labour force.

Taking the authors' advice, I decided to check out the relevant sections. I also decided to look up their suggestions for my digestive problems: hypoglycemia and lactose intolerance. Using their categories, "career woman" seemed the most appropriate.

Imagine my surprise to find that career woman means executive, and the picture painted is of the old stereotype of the powerful executive (man) under a great deal of stress, making the important decisions in the world. However, recent studies on work stress show that workers in secondary positions experience more stress in their jobs than do executives. In the medical setting the most stressful job is not that of the heart surgeon (rarely a woman) but the nursing aid who is caught betwixt and between. This is the more common position of the working woman.

Forget that Hope and Bright-See have inaccurately portrayed the working woman. What do they have to say? They explain that the single woman has less risk of a heart attack than the married woman (usually a homemaker). So do they talk about men's understanding of rape. His book adds nothing new, clarifies nothing, analyzes nothing. It does however raise the question of whether it is possible for a man to explore men's consciousness of rape.
calories. This doesn’t sound like the working women I know.

The section on hypoglycemia is frightening in its inaccuracies and shows the limitations of present medical practice to deal with nutritionally-related disorders. “Hypoglycemia,” they claim, “is a very popular and socially accepted disorder — just the thing to discuss at cocktail parties.” Further, “doctors are reluctant to diagnose this condition because it’s overly self-diagnosed.” Should doctors be reluctant to diagnose any disorder?

I resent the flippant attitude the authors have about something which has been a real problem for me, including getting it diagnosed. Quite rightly they say hypoglycemia is not curable but able to be controlled. But it is not controlled with the diet they suggest.

Do they do any better with lactose intolerance? No! There are only two brief references to it. Their approach does not differ from the repeated message in the book. If you have this problem, don’t worry, just do this. They tell lactose intolerant people that they can still drink milk, just take enzymes. Switch to cheeses and fermented milk products. But it’s not true! Ask anyone with lactose intolerance.

Just a glance at other sections in the book show the repeated argument: no physical or mental disorder can be traced to diet. Not even acne. There are many things that aren’t good for you to ingest but go ahead; you can counter the effects if you eat in a certain way. They are trying not to alienate readers, but if one knows anything about nutrition the contradictions in the book are glaring.

If disease is not caused through bad nutrition, then how can these authors suggest that disease may be side-stepped with “good” nutrition?

Phyllis Jensen worked as a nurse for many years. Presently she is completing a Ph.D and is employed as a researcher in Toronto.

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Regional Reports

**NOVA SCOTIA**

**Susan Hower**

**Winnifred McCarthy**

SAW — A Program in Bloom: The Supportive Action for Women (SAW) program of the Bedford-Sackville area began in June, 1981. According to coordinator Hazel Hemeon, SAW was established to set up a support system for women, to link women to community services, and to bring together professionals in the health and social fields to develop cooperative preventative approaches to women’s problems. Since then, SAW has blossomed into an extensive program which provides counselling services, a broad range of education and skill development courses, a toy-lending library and a resource centre. SAW has even initiated spin-off groups such as Health, Education and Recreation (HER) which is funded by Secretary of State.

Support Proposal: Personal experience motivated A. Marsha Manett to develop an exhaustive proposal to evaluate and improve existing support systems for families who have experienced pregnancy loss or neonatal death. Developed for the Halifax Metro area, the proposal can be used as a model for other urban centres and even rural communities. Direct inquiries to: Manett Proposal, 1225 Barrington Street, Halifax, Nova Scotia B3J 1Y2.

New Women’s Centre: Lunenburg County Women’s Group members are busy establishing a resource centre for women on the South Shore. Operating initially with grants from Secretary of State and OXFAM-Canada, the new centre will emphasize wide community appeal and outreach to rural women.

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**ONTARIO**

**Toronto Women’s Health Network**

Midwives’ Co-operative: A group of midwives in Toronto have established a co-operative to provide prenatal care, prenatal classes, counselling, birth assistants and back-up. The co-operative will emphasize continuity of care and team work in supporting the child-bearing family. For more information, call 416-686-2111.

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**MANITOBA**

**Lissa Donner**

**Morgentaler Moves West:** Dr. Henry Morgentaler has announced his intention to open a clinic to provide therapeutic abortions for Manitoba women on March first. Currently, it is estimated that 60% of Manitoba women must leave the province in order to obtain therapeutic abortions. Many of these women now travel to Dr. Morgentaler’s clinic in Montreal. Prompted by the plight of these women and hoping that the Manitoba NDP government would be sympathetic to the establishment of such a clinic, Dr. Morgentaler has chosen to open now in Winnipeg.

The Attorney General of Manitoba, Roland Penner, has stated that, although he personally favours the removal of therapeutic abortion from the Criminal Code, he cannot interfere to stop the laying of charges against Dr. Morgentaler without extending the bounds of his authority. It appears that a legal confrontation is inevitable. One wonders why, when abortion is governed by a federal law intended to be applied uniformly across Canada, it was within the authority of the Attorney General of Quebec in 1976 to provide Quebec doctors with an undertaking that...
no charges would be laid in Quebec in connection with abortions competently performed by qualified physicians, but it is not now within Penner’s authority. Or is Penner implying that the Quebec Attorney General acted improperly?

A coalition of women’s groups has been formed to pressure the province to provide adequate reproductive health care for women. Events can be expected to heat up, with the right of women to therapeutic abortion again becoming a major arena of political struggle.

ALBERTA

Government Funds Schafly: Courtesy of the Alberta government, Edmonton women had the opportunity to listen to the views of right-wing activist Phyllis Schafly last November. Schafly was brought to Alberta by a group known as Women United for the Family (or AFWUF as it is fondly called by friend and foe alike). AFWUF was formed specifically as a pressure group to counter the pro-choice position of the Alberta Status of Women Action Committee. The provincial government donated $12,000 to cover the costs of the meeting at which Schafly and Canadian sex-education opponent Kathleen Gow were key speakers.

Confidential Records Exposed: Abortion-by-Choice, a Calgary group, has obtained and circulated a Campaign Life newsletter (mailed out of Toronto) which advocates and gives explicit instructions for the stealing of operating room sheets by hospital personnel for the purpose of exposing doctors who perform therapeutic abortions. This tactic is tantamount to theft and places in jeopardy the confidentiality of patient and doctor. Campaign Life Edmonton has publicly admitted that they have obtained and utilized O.R. sheets.

BRITISH COLUMBIA

Fighting Back in Large Numbers: Pornography is the word of the day in B.C. thanks to a chain of franchises called Red Hot Video, to the Wimmin’s Fire Brigade, and to actions taken by the B.C. Federation of Women (BCFW). The Vancouver Women’s Health Collective is one of 34 feminist groups belonging to the BCFW. The Wimmin’s Fire Brigade firebombed several Red Hot Video outlets in late November, 1982 because, as they said in a press statement, all legal attempts to shut down these stores selling violent pornography had failed.

Several days prior to the firebombings, BCFW issued a press release stating that one of our goals for 1983 was to close down Red Hot Video. The media has been questioning B.C. feminists to find out what we know about the Wimmin’s Fire Brigade; we have been responding with our thoughts on pornography, censorship, and so on.

As feminists, we want to be clear about the issues:

- Red Hot Video distributes a catalogue listing over 400 tapes available at a mere $3.00 a day to anyone (oh yes, over 19) who has a home video recorder or would like to rent one from them. Many of the stores are open long hours, 7 days a week. There are 11 (there were 13 until the Wimmin’s Fire Brigade) convenient locations around the province.

- Many of the tapes contain scenes of rape or gang rape. They show women being beaten and degraded. Penises move freely from one female orifice to another, from one woman to another, provocatively advocating complete disregard for women’s health. It would be ludicrous to bring up the subject of birth control. All that the women’s health movement has worked toward in the last decade is trampled to death in these tapes.

- As well, they perpetrate the dangerous misconception that women are available for, and are craving, sex (with men) anytime, any place, with anyone and that when we say “no” we mean “try me.”

- Red Hot Video tapes equate pain, humiliation and coercion of women and children with men’s sexual pleasure. In short, Red Hot Video makes millions pushing hate propaganda about women. Red Hot Video is popularizing violent porn; there will be more to come — First Choice Pay TV, soon to be available in B.C., has signed a $30 million contract with Playboy Enterprises to show porn movies 3 nights a week.

This new availability of violent pornography is a vicious backlash against the women’s liberation movement. Although Red Hot Video is only one group, they must be stopped.

Feminists continue to discuss strategies; some exciting things are happening. Thousands of people joined a BCFW provincial picket of Red Hot Video outlets on December 11. Several owners of buildings leased to Red Hot Video are working to kick them out. A socialist group is circulating buttons saying “Keep The Heat On Red Hot Video.” Neighbourhood groups are circulating petitions.

We are planning further actions. BCFW is compiling information describing our activities and our analysis. If you would like to receive this or send us information, write to the Red Hot Video Action Committee, c/o BCFW, P.O. Box 24687, Station C, Vancouver, B.C.
We reserve the option to print letters to Healthsharing with minor editing for length, unless they are marked “not for publication”.

Graphics Offend
I am writing concerning the extremely inappropriate graphics that accompany my article, Lesbians in Therapy, in your feminist therapy issue (Winter 1982).

Have you not looked at these drawings? If you can see no problem, and ‘see’ is the operative word as much as is ‘problem’, substitute ‘woman’ or ‘black’ for ‘lesbian’ in the captions, and then see what you see. Lesbians are not dirty old men in raincoats exposing themselves to gawking strangers. We do not disappear — much less have a year’s periods all at once — when we put on a dress. Men don’t make us nervous. The power the world grants men simply because they are men, the power it denies women simply because we are not men, does make us very nervous. It should. (“I wonder why whites make me nervous . . .”) Lesbians are not a joke.

The graphics are subtle. Very subtle. I have heard repeatedly of women who did not read the article because the graphics led them to expect satire, and they needed serious information on the theme of the issue. When told that it was a serious piece they went back and read it. They came away asking, “Why does it have those graphics?”

To that, I add the question, “Why is this the only article accompanied by such inappropriate illustrations?” Intentional or not — and I can’t help but wonder — surely the difference in tone, the difference in seriousness given to this piece, is obvious to anyone. This kind of sabotage does less than nothing for lesbian invisibility, it interferes with the ability of what your own press release calls a “sensitive treatment” to communicate on its own terms, it makes that communication an uphill battle, and it certainly does not — as a collective member reminded me to do in the writing of the article — consider the audience. Said one of the women interviewed for the piece, “When I stopped being so angry that I couldn’t pick up the magazine, after a long time of reminding myself that I know your ethics and your commitment, I finally began to read it. It was very difficult to get past the pictures to what the article was actually saying. The two are so far apart that I had to go back and read the beginning several times before I could get past my confusion. The article would have been better off to have been published with no graphics.” I agree. When I asked her to tell you what she had told me, she replied, predictably, “I couldn’t sign my name. My job depends on staying closeted.”

She agreed to be quoted anonymously — as she had for the article.

Several people have been told that I saw and approved the graphics before the issue was published. Those who know me know that this could not possibly be true. For the record, I wish to state that I had approved the illustrator in theory only, prior to publication. I did so on the assumption, which ten years of magazine publishing had led me to consider a reasonable one, that standards of good taste, appropriateness and integrity would be applied to selection of the graphics. They were not. I did not see the graphics before publication. I had no say in their selection. I did not, and under no circumstances would I ever, approve those that appear with my article.

I was pleased by the step forward represented by the inclusion of this article in this issue of a magazine I had considered feminist. I am politically, professionally, and personally embarrassed and insulted by the two steps back of the presentation.

Frances Rooney
Toronto, Ontario

Collective Responds
All members of Women Healthsharing apologize for the serious lapse of judgement which gave rise to using the particular graphics chosen. We mistakenly mistook Frances’s knowledge of Dawna Gallagher’s style as an okay for taking a humorous approach in the drawings. We regret our error and have undertaken to correct the mistake by using new graphics obtained by Frances in a reprinting undertaken to fulfill outstanding orders for the therapy issue.

“Midwifery Update”
In the section of her article on the status of midwifery in British Columbia, Betty Burcher (“Midwifery Update”, Healthsharing, Fall 1982) refers to a birth centre project. Several of her statements relating to this proposed alternative birth centre are inaccurate. In particular it is not true, as she suggests, that the impetus for the proposal came from the publicity surrounding an inquest into the death of an infant born at home. The birth centre project proposed by a group of Vancouver women, of which I was a part, stemmed from an interest in testing an alternative model of maternity care utilizing nurse-midwives and work on the project preceded the inquest to which she referred.

Furthermore, the centre was not to be run independent of physicians. Rather a system of physician consultation, support and back-up was to be an inherent part of the program. Yet another inaccuracy in Burcher’s report was the proposed source of funding. The group sought funding from the Federal Government, Department of Health and Welfare, not from the provincial government. For projects such as this to be funded the provincial government must give an indication of support and this was not obtained.

For a further discussion of the obstacles which our group was unable to surmount in trying to obtain funding for the project I refer you to an article in The Canadian Nurse, “An Alternative Birth Centre Proposal”, Dec. 1981, pp. 34-36, written by Elaine M. Carty, Ilene Tanz Gordon and myself.

J. Alison Rice
Vancouver, B.C.

Fan Mail
Since the beginning of your magazine I have been very impressed with both the sensitivity and the practicality of it. The articles, relevant to today’s social and medical issues, are a useful tool to be used by women to increase their awareness and thus their personal strength both mental and physical.

Being a health professional myself (I teach nursing), I am constantly appalled at the lack of knowledge women have of their own bodies and environment. More importantly, I am shocked at the small amount of truly pertinent information available, especially to young women. In so many ways we still live in the dark ages! It is because I see your magazine as fulfilling a vital role that I am sending this donation with my admiration for your publication.

Jane E. Evans
Maitland, Ontario

APOLOGY
To Mary-Anne Kril for not crediting her contribution to the article “Women in Institutions” (Winter, 1982 issue). Her Research paper, “Women and mental Illness: The rigidity of gender stereotypes”, provided valuable material for the article.
Women in Science Conference
The Society for Canadian Women in Science and Technology (SCWIST) is hosting a conference with the aim of developing a national network for women in science and technology. Issues to be covered include: science and gender, science and math education for girls and women scientists re-entering the work force. The conference will be held from May 20 to 22, 1983 in Vancouver. For more information, write Dr. Hilda Lei Ching, SCWIST, P.O. Box 2184, Vancouver, B.C. V6B 3V7.

Immunization Information Pamphlet
This pamphlet concerns alternatives to immunization for children. It contains all the articles on this topic that have been printed in Mothering magazine up to the present publication. It is available for $4 (American funds) by writing Mothering, P.O. Box 2208, Albuquerque, New Mexico, 87103.

Women and the Law
The Legal Services Society has produced several resources for use in schools, libraries and women's groups. The Women and the Law kit contains three film strips exploring the lives of women of different ethnic backgrounds, a 1982 updated teachers' guide and a student comic book "Our Grannies and the Law" (also available individually). There is an optional 10 minute 16 mm film which dramatizes contemporary legal dilemmas.

Fair Ball: Towards Sex Equality in Canadian Sport
This recent publication of the Canadian Advisory Council on the Status of Women is an inquiry into questions of discrimination in sport. It examines women's sport, considering how human rights legislation, government initiatives, educational institutions and sporting organizations might more effectively promote full participation of women in Canadian athletics. Available free of charge in English or French from the Canadian Advisory Council on the Status of Women, 66 Slater St., 18th floor. Ottawa, Ont. K1P 5H1.

Working Women
This educational kit contains five programs for use with unions and women's organizations. Each program contains an outline, background articles and a bibliography. Topics covered: women and the Canadian economy, third world women, the double day, the impact of technological change on women's jobs and history of working women's struggles. Kits are available for $10 from CUSO-OXFAM Labour Project, 136 Avenue F South, Saskatoon, Sask. S7M 1S8.

Parental Rights & Daycare: A Bargaining Guide for Unions
This new booklet, published by the Ontario Federation of Labour, is designed to provide guidance to unions in formulating their bargaining demands on parental rights and daycare. It contains contract clauses already achieved, benefits provided by law, arguments to use at the negotiating table, background facts and considerations and model clauses. The price for orders of less than 100 is $2 each; for 100 or more, $1.75. Order from Elizabeth Smith, Ontario Federation of Labour, 15 Gervais Dr., Suite 202, Don Mills, Ont. M3C 1Y8.