The Inadequacy of Health Care of Women

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ABSTRACT/RESUME

Dans une première partie, nous décrivons les façons par lesquelles les hommes et les femmes reçoivent des traitements médicaux différents. Huit paramètres sont ensuite examinés en fonction de leurs conséquences sur les soins de santé offerts aux femmes. La situation actuelle est analysée à la lumière d'une perspective historique. Nous décrivons les causes de l'incidence plus élevée de visites médicales chez les femmes et nous faisons la relation entre cette incidence et les soins de santé de qualité inférieure offerts aux femmes. Les avantages psychologiques du médecin, une résultante de la relation médecin-patient traditionnelle, sont également traités.

> Many a young life is battered and forever crippled in the breakers of puberty; if it crosses these unharmed and is not dashed to pieces on the rock of childbirth, it may still ground on the ever-recurring shadows of menstruation, and lastly, upon the final bar of the menopause, ere protection is found in the unruffled waters of the harbor beyond the reach of the sexual storms.(1)

Women have had to live with myths and misconceptions about their bodies, whose function and feelings have traditionally been described for us by men. Not out of malice, not from weakness, but because of historical precedent, accepted shibboleths, folk

wisdom, and lack of empathy, men have never learned, consciously or unconsciously, to treat women's bodies as women's bodies. For example, Edward Tilt, a nineteenth century physician, while writing about the change of life, supported the popular conception of the day:

> Menstruation, 19th century physicians warned, could drive some women temporarily insane; menstruating women might go beserk, destroying furniture, attacking family and strangers alike and even killing their infants. Those 'unfortunate women,' subject to such excessive menstrual influence, Edward Tilt wrote, should for their own good and that of society be incarcerated for the length of their menstruating years.(2)

Doctor Tilt also wrote a lot about menopause. He knew that the menopausal woman characteristically had a "dull stupid look," was "pale or sallow," and "tended to grow a beard on her chin and upper lip."(3) Women have laboured under such misconceptions and untruths for many hundreds of years, the result of which leads to the hypothesis of this paper: Women do not get equal and/or adequate health care.

A historical perspective can, perhaps, offer some clues to today's situation. In the mid-1800s, it was culturally acceptable for women to be seen by women as well as by men as feeble: ill health was fashionable, and often was used as an escape. Ann Wood, in her article "The Fashionable Diseases," has written that, "professional work, . . . was hardly a socially acceptable escape from a lady's situation, but sickness, that very nervous condition brought on by the frustration of her life, was."(4) It is also the case that throughout the ages, doctors have tended to use the cause of the woman's illness as the cure. A stereotypical example of this is the kindly looking male doctor telling the harried mother with her toddlers in tow: "What you really need, my dear, is to have another child."

In the 1870s, Dr. Clark of Harvard Medical School believed girls were ill because they were quite literally destroying their wombs and their childbearing potential by pursuing a course of higher education intended by nature, only for the male sex.(5) He felt that women were so ill that soon they would not be able to reproduce at all and North American mothers would have to be imported from across the Atlantic. This attitude was typical. A New Haven professor, explained, while speaking to a medical society in 1870, that it seemed "as if the Almighty, in creating the female sex, had taken a uterus and built up a woman around it."(6)

For some women, like Catherine Esther Beecher in the mid-1880s, and her grand niece, Charlotte Perkins Gilman, "current medical treatment was patently not science for which they professed respect, but a part of the male dominated culture, for which they had both fear and contempt. They saw it a as a form of rape, designed to keep women prostrate, a perpetual patient dependent on a doctor's supposed professional expertise."(7)

Harriet Hunt, one of the first female physicians in North America, wrote her autobiography, Glances and Glimpses, in 1856. Explaining why she became a doctor, she related her absolute horror upon discovering how ignorant the doctors were about women's health. She insinuates in her book that a male physician's training led him actually to want his patients to be sick so that he would have someone on whom to practice the skills that he had learned. "Man, man alone," she stated, "has had the care of us and I would ask how our health stands now. Does it do credit to his skill?"(8) Over a century later, some residency training programmes are being criticized for performing therapeutic abortions on the basis that they subsequently lower the birth rate in that hospital, thereby denying residents adequate experience in difficult forceps deliveries or preinatal complications.

The turn of the century heralded the transformation to modern day medicine. The American Medical Association founded the Council on Medical Education in 1906. In 1910, Abraham Flexner sparked the reform movement in medicine, attacking in his report of that year, the incredibly bad privately owned medical schools. At that time, less than one-third of medical schools were associated with a university.(9) Conditions and facilities were appalling and the training was less than adequate. A student who graduated from any 'medical school' was automatically granted a license to practise. The reform movement sparked a stiffening of requirements by licensing boards and higher standards for practicing physicians. Unfortunately, even with reform in medical education, male doctors, prisoners of their own theoretical constructs, are still ignorant of the concerns of women.(10)

Barriers to women's equality, and how they affect the health care of women can be examined using eight different parameters:(11)

1) Procreation--"The status of women may be seen as both a determinant and a consequence of variations of reproductive behavior. A woman's health, educational opportunities, employment, political rights and role in marriage and the family may all af-

fect, and in turn be affected by, the timing and number of her children, and her knowledge of how to plan births."(12)

There are many implications in that statement, not the least of which is that, by teaching women how not to procreate, or when to procreate, we are opening up more choices. "Should I go back to school next year or have a baby?" now becomes a realistic and manageable query for the informed woman.

2) Domestic Responsibilities--The sharing of domestic responsibilities in the home increases in direct proportion to the woman's educational and employment status. This also means that less educated people spend more time involved in domestic chores because they may be unaware that other alternatives exist.

3) Cultural Labels--The traditional definition of a woman's role as a mother and housemaker persists in society. This role definition is supported by both sexes in spite of the fact that, increasingly, the modern woman is moving away from traditional life styles.

4) Institutional Definitions--Over the years, institutions have been changing, so that now, traditional definitions no longer fit. Some examples of traditional institutions: marriage (in Alberta, the divorce rate is higher than the marriage rate); the family (consider the increase and acceptability of single parent or childless families); the church (a restrictive stand on abortion and birth control no longer acceptable to many women); legal institutions (matrimonial property laws, ERA in the USA, equal pay for equal work, maternity leave laws, etc. when not enforced, serve to discredit a fair and just system); government and politics (it is only within this century that women could vote or run for office).

5) Social Customs--Social barriers create inequalities in social amenities and dating customs. With the advent of mass media, manufacturers have been able to manipulate and dictate 'proper social roles' for their own profits and people who choose to lead lives of independence find themselves sometimes to their dismay, totally outside "sociological norms."

6) Education--Next to age, the educational level of women appears to be one of the strongest factors affecting fertility. Marriage and childbearing in North America have a greater negative affect on women's education than on men's. The illiteracy rate in most countries is much higher among women

than men. Women are usually less than one half of the school population, with even lower proportions at higher levels of training.

7) Labour--Work opportunities or the lack of them for females, have great impact for women's mental and physical health. Women in high power jobs tend, on the whole to be healthier than their homemaker counterparts. Women who work in personally gratifying jobs have smaller families and this in turn affects the economic status of the family. Major declines in the birth rate have often preceded an increase in women's participation in the work force. The increase in the number of women in the labour force has been influenced by education, inflationary pressures, smaller families, increased divorce rate and the feminist movement. Despite this increase, women have typically participated in economic activity which has supplemented their primary status in the home so that there is a differential in the work experience: for example, in the U. S. in 1973, nearly one-half of the female workforce worked fewer than 35 hours per week. Social problems encountered by women in the labour force include: inequity of pay; lack of facilities for childcare; increased workload and decreased leisure time; expanded demand for women's services dependent upon high rates of economic growth. In periods of recession, women are among the first to lose their jobs.

8) Medical Knowledge and Facilities--"Both opponents and proponents of women's emancipation make themselves known through medical knowledge and facilities. The opponents burden women with unwanted pregnancies and frustrated lives. The proponents provide good medical facilities, the knowledge and opportunities to plan pregnancies or postpone fertility, and an opportunity for the female to seek her goal as a person."(13) Restrictive legislation concerning abortion laws, sex and family life education, are not conducive to promoting total health care and wellbeing in women.

The above eight parameters well illustrate how women are treated as distinct from men. Considering the fact that so far most physicians are males and most physicians unwittingly subscribe to the inherent discriminations that are made, it is easy to infer how the health care of women can be compromised.

It is well know that women average more doctor visits than men. There

are several reasons for this, women being more neurotic than men NOT being one of them. It is part of a woman's career as a wife and homemaker to take her children to the doctor; hence, women become accustomed to being in a doctor's presence and become more dependent upon a doctor, not just because of themselves, but because of their children. As well, a woman's dependence on her doctor is fostered, as will be discussed shortly.

Doctors seem to have more trouble diagnosing "women's diseases." There is an economic basis for this: it is more expensive to have men sick in terms of the GNP. Therefore, large amounts of money are poured into research of 'men's diseases,' for example, myocardial infarcts, while less research money is available for 'women's diseases.'

Doctors are not listening to patients. In a study done in Calgary in 1974 of 498 Rheumatoid Arthritis patients (female), who had presented symptoms to their physicians, 87% had gone twelve years or longer without a diagnosis and most of those were told they were neurotic.(14) It is also well known that women take more tranquillizers than men. I propose that doctors are not prepared to deal with women's problems and it is often more expedient for a physician to prescribe drugs. The capitalist theory of disease or the fee-for-service system does not encourage preventative medicine; the emphasis is on treatment of the symptoms, isolated both from the rest of the mind and body, and from the social context of the illness.

Instead of sharing its skills, the medical profession has kept its knowledge restricted. This means that women tend not to know about their health needs and so can not demand good care. Because of the authoritarian role of doctors, advice and guidance may be followed without anyone, least of all the doctor, realizing the impact on the woman. Often a woman ends up being totally dependent upon her doctor, and then is free from neither her problems nor her dependency.

In regard to sexual problems and interpersonal relationships, doctors are dangerously ignorant, even though the public continues to see them as knowledgeable. The medical profession has done little to contradict the public or turn its illusions into a reality. Many doctors make excessive use of psychological advantages to propagate the 'great white god' image, which brings to mind a picture of the all powerful bestower of health, enrobed in a white gown, enthroned behind a desk, with the tools of the trade jauntily peeking out of

pockets, surrounded by books containing the wonderous knowledge of the all-powerful. More commonly, many physicians fail to recognize their psychological advantages inherent in the unequal doctor-patient relationship. One can appreciate the fright a patient has when confronted by any of these inequalities. The doctor is in home territory, the patient on strange grounds. This tends to compound the patient's anxiety. The patient is often first seen when undressed, a situation which is often compromising to the patient. The doctor commonly wears a white coat symbolizing his/her position in the institutional structure of society. The doctor is usually busy, going from room to room, seeming many patients, whereby the patient is usually waiting, sitting and worrying about this one important event of the day. The doctor commonly sits across the desk from the patient, rather than sitting beside or across from the patient, thus intensifying the image of the authority figure. The doctor commonly will not say, "I don't know," thus appearing to be omniscient. The patient is usually concerned about a health problem and may not be functioning at his/her optimal level. Doctors commonly call patients, even people much older than they, by their first name, while patients commonly call doctors by their last name. Doctors commonly use terms of endearment like 'dear,' 'honey,' where the intention is good without realizing the condescending effect this has on the doctor-patient relationship. Doctors also can place distance between themselves and their patients by the use of unnecessary medical jargon.

While it is true that most doctors are unaware of the use of these advantages, it must be understood that by being unaware, one is more likely to exploit them rather than to do anything to compensate for them. Physicians should be able to overcome the doctor-patient barrier by being aware of the inherent psychological imbalances, eliminating some and compensating for others. For example, explaining a point of physiology may take only a few seconds, and yet can remove a concern or answer an unasked question. Developing the ability to admit we do not know everything would be most appropriate, and would acknowledge that we possess only a finite amount of knowledge as does the patient, bringing us more into a sharing than a power giver-taker role. By recognizing that patients are concerned about their health even if the reasons seem trivial to us, we will be able to allow the patient to work out anxieties in an intelligent and informed manner.

We, as physicians, have a responsibility to the community and country in which we work. We must reinforce the World Health Organization's definition of health: "Health is a state of complete

physical, mental, emotional and social well-being and not merely the absence of disease or infirmity." Only when physicians descend to the level of mere human beings, and women are elevated to that same level, can women receive comprehensive health care.

NOTES

1. A. Hamilton, "A Treatise on the Management of Female Complaints," quoted in Smith-Rosenberg, C., Puberty to Menopause: The Cycle of Femininity in the Nineteenth Century America; M. Hartman and L. Banner,eds., Clio's Consciousness Raised (New York: Harper & Row, 1974), p. 25.
2. Smith-Rosenberg, op cit., p. 29.
3. Ibid., p. 31
4. A. Wood, "The Fashionable Diseases": Women's Complaints and Their Treatment in Nineteenth Century America, Hartman and Banner, eds., Clio's Consciousness Raised, p. 7.
5. Ibid., p. 3.
6. Ibid., p. 3.
7. Ibid., p. 10.
8. H. Hunt, Glances and Glimpses: or Fifty Years Social, including Twenty Years Professional Life (Boston: John P. Jewitt, 1856), p. 414.
9. S. Flexner and J.T. Flexner, William Henry Welch and the Heroic Age of American Medicine (New York: Viking Press, 1941), p. 307.
10. R. Morantz, The Lady and Her Physician, cited in Hartman and Banner, eds., Clio's Consciousness Raised, p. 47.
11. C. Garcia and D. Rosenfeld, Human Fertility: The Regulation of Reproduction (Philadelphia: F.A. Davis Co., 1977), p. 39-45.
12. R.B. Dixon, Women's Rights and Fertility Reports on Pop Family Planning (1975), p. 2.
13. Garcia and Rosenfeld, op cit., p. 42.
14. M.K. Eriksen, Psychological Correlates of Rheumatoid Arthritis and Diabetes Mellitus. Unpublished study, 1974.