DALKON SHIELD

A number of other examples could be used to support the charge that drug companies, the medical community and the state have failed to demand adequate testing of drugs before they reach the consumers. The last example to be used here is the Dalkon Shield. The Dalkon Shield was an intrauterine device (IUD) that was inserted into the uterus to prevent pregnancy. IUDs were popular in the United States during the 1970s when about two million women were using the device. However, infections and mid-trimester spontaneous abortion were reported in women who had conceived while using the shield and who had attempted to carry the pregnancy to term (Oberman 270). In fact, some women died as a result of using this device. The problems were related to one specific IUD, the Dalkon Shield. At the time the Dalkon Shield came on the market it was not subject to rigorous clinical testing because under the terms of the USA's Federal Food, Drug and Cosmetic Act it was not classified as a drug. The device was finally removed from the U.S. market but it continued to be marketed overseas, particularly in Third World Countries. http://en.wikipedia.org/wiki/Dalkon_Shield

Excluding women from drug trials: A problem that has plagued women's health for decades is their exclusion from drug trials that was commonplace in North America until well into the 1990s. Most drug manufacturers argued that it was simply too costly to include women, especially fertile women in such trials. Women's hormone cycle, their use of contraception, the chances of the women becoming pregnant while in the trial were factors, they argued, that added to the study's complexity and cost (Oberman 272). Prior to 1996 Health Canada "encouraged" drug manufacturers to include women as subjects in clinical trials but it was not until 1996 that Health Canada requested that a policy be formalized, made mandatory and integrated into the Drug Directorate's regulatory guidelines that would include women in clinical drug trials. The Minister of Health at that time, the Honourable David Dingwall stated that "this policy is an important step that will help safeguard the health of Canadian women…it will provide further assurance that the drugs women may use meet the highest possible standards of safety and efficacy." The question remains "why did it take so long" (Jeffery 2001)? (for a more nuanced perspective and up-to-date analysis see http://www.whp-apsf.ca/pdf/clinicalTrialsEN.pdf).

Psychologisation: The final point that I want to make in this section on the need to study women's health is raised by Ellen Goudsmit (1994)* in an article "All in Her Mind! Stereotypic Views and Psychologisation of Women's Illness: Sex Bias in Medicine" wherein she argues that one of the more serious and pervasive problems that women face is what Goudsmit refers to as "psychologisation." Goudsmith defines "psychologisation" as placing an "emphasis on psychological factors in illness where there is little or no evidence to justify it"(7). Shari Munch, in the reading assigned for this section also deals with this issue when she refers to gender-biased diagnosing "a tendency for physicians and other health care professionals to mislabel women's somatic complaints", (complaint that have no medical explanation) as non-serious and/or psychosomatic** (102) Goudsmit describes several instances of women attending a physician expecting to receive a diagnosis for relief from their symptoms only to be sent home with a mood altering drug or even worse, sent to a psychiatrist because it was thought that they had a mental illness (7). Women's complaints are too often dismissed as psychological. While psychologisation, can happen to men, it is more prevalent among women (8). According to Goudsmit there is good evidence to show that being a woman can impact many practitioners' clinical judgment. Stereotypical notions about women as being weak, suggestible, emotionally unbalanced, irrational, manipulative and unable to cope with even relatively minor stress can act as a source of bias both in the way they are diagnosed and in their eventual treatment (7). The

overemphasis of psychological factors in illness can lead to diagnostic errors, and to inappropriate treatment, and thus to a great deal of unnecessary suffering.

This is also the essence of the article by Shari Munch. Munch argues that with the rise of the second wave of the women's movement which emerged in Canada in the late 1960s and the introduction of the Royal Commission on the Status of Women, sexist practices in the treatment of women by medical practitioners, particularly male doctors, was widely discussed. The argument was that doctors' diagnosis was often gender-biased, that is, based on the fact that the patient was female. Instead getting to the bottom of somatic complaints medical professionals would label them as psychosomatic. Women would then be prescribed drugs and the real cause of the health problems, which was very real to the person experiencing it, would go undiagnosed and thus untreated.

Both Goudsmit and Munch acknowledge that this happened to both men and women, but it occurs far more often to women and was based on stereotypical notions of women being "naturally" weak and suggestible. Medical texts of the early twentieth century are replete with comments about the inherent delicate nature of women's physical constitution, or at least middle class and especially affluent women whose husbands' income supported the physicians' careers (Munch 111). Poor women and women of colour was justified on a belief that they had "coarser" natures and "medical racism overshadowed medical sexism for black women" (113). Munch cites comments from medical literature such as the "traits that compose the core of female personality are feminine narcissism, masochism and passivity" and "many women, wittingly or unwittingly, exaggerate the severity of their complaints to gratify neurotic desires" (Munch 110). As you read the article by Munch, which can be challenging, note the following points made by the author:

Stop and Think

- Note the examples provided by the Munch (p. 102) to support her statement that women's medical conditions go untreated;
- Munch claims that gender-biased notions of women by physicians was first challenged in 1973 in an article published in the *New England Journal of Medicine* by two psychiatrists K. Jean Lennane and R. John Lennane who raised concerns about possible "sexual prejudice" in the treatment of female conditions such as morning sickness in early pregnancy, dysmenorrhoea and infertility argument that these conditions may not be women's rejection of her feminine role as mother, but may be a real physical problem in need of treatment (Munch 105).
- Note the three points on which gender bias rested: the Greeks believed that women's womb caused them to have an emotional "nature"; women's physical complains were attempts to reject their "feminine role"; women were "naturally" weak and were "more ladylike if they were pale and faint in appearance" (106).
- The author also shows that at the same time as middle and upper class white women were seen as weak and vulnerable, working class women and those from minority groups were employed as domestics, factory workers and agricultural field hands and were never allowed the "luxury" of idleness or viewed as feminine (113). As the author states the "medical neglect of poor women… was justified by the belief that poor women had "coarser" natures"(113).

- Considerable research was needed to show that gender-biased diagnosis was a problem. The women's health movement which emerged from the women's movement in the late 1960s and early 1970s.

PART II – The Need for A Feminist Model of Practice

Those who agree that there are problems with the treatment of women within the health care system argue that a new model for caring for women is necessary. Linda Andrist in an article entitled "A Feminist Model for Women's Health Care," (1997)* argues that we can look to feminist theories when seeking for new ways to treat women's health needs. She identified four themes within a feminist model of practice that will be briefly discussed here. The first is symmetry in provider-patient relationships, second, access to information, third, shared decision-making and finally social change.

Symmetry in provider-patient relationships: Andrist argues that symmetry is the attempt on the part of the medical professional to reduce the inequalities that often exist between the medical "expert" and the patient. She suggests that in order to bring about more egalitarian relationships, medical professionals should take on the role of teacher who shares information with the patient therefore creating an atmosphere for an open, give-and-take discussion. Andrist feels that in a space where the professional and the patient meet as equals the physical, social and personal barriers can be eliminated (270).

Access to information: Andrist feels that access to information is a major component of feminist practice. "The assess-disclose-assess model is a useful guide to teaching. This occurs when the provider finds out what the patient knows or does not know, provides some information, and then assesses the patient's reaction before going further" (270). In this way the provider can find out how well the patient is taking in the information and can judge how much detail to present in one session (270).

Participation in decision-making: As teachers and co-participants, feminist practitioners expect patients to be interested in knowing and participating in their health care. As patients are given access to information they become empowered. Feminist practitioners also acknowledge the limitations of medical science and this too must be shared with patients. Patients need to know what they can and cannot expect from treatments. Establishing mutual trust is an important component of the feminist model.

Social Change: Activism to bring about societal change is an essential part of the feminist model (272). Although being patient-centers is essential to the feminist model of care medical professionals must also strive for change in the larger social context. In other words, providers must keep abreast of, and critically assess the research emerging with respect to women's health care. Andrist points out that both providers and patients have a right to be suspicious of the treatment of women within the health care system. In the last century they have seen the medicalization (a concept to be discussed below) of childbirth, menstruation and women's sexual health, the "discovery" of premenstrual syndrome, which threatens to become a psychiatric designation, and an epidemic of hysterectomies and cesarean births (all of these will be discussed in this course).

PART III – Toward a Sex- and Gender-Specific Focus on Women's Health

Please Read: Bren, "Does Sex Make a Difference?" See also 10 Differences Between Men and Women that Make a Difference in Women's Health.

A feminist model of practice would encourage continuing research on women's health issues but just how to go about doing this is controversial. There are those who argue that a specialization in women's health is vital, other reject the idea They argue that the creation of a primary care specialty (or general practitioner) who has trained in women's health will lead to 'ghettoization' of women's health. They feel that once a women's health specialization has been established other specialists will then feel it is not necessary for them to consider women's needs within their own specialties (Wallis 107).

Then there are those who feel that a specialty in women's health is less important than the idea of including information on women's health in the curriculum of medical schools and training programs in order to educate all doctors. These people argue that women's health must be legitimized as a body of knowledge required of all physicians before graduation and certification by any medical board. As Wallis points out "we cannot afford for the health needs of more than half of the population to be ignored by health professionals" (107). All specialists, Wallis argues, need to undergo a bi-gender education and acquire bi-gender insights into health and disease (107).

The argument over whether a specialty in women's health is needed or not arises from the fact that women and men are biologically different and thus diagnosis and treatments prescribed must take gender differences into account (Gesensway (2001)* states that "whether it is deciding which antidepressant or painkiller to prescribe, which angina treatment or heart attack intervention to order, or even how to urge someone to begin an exercise regimen, sex and gender differences in health and medicine appear to be more pervasive and than ever imagined" (935).

The author goes on to argue that now that there is a recognition and understanding of sex differences, it is time to ask some of the important questions that this raises. For example How do sex and gender matter to health and medicine? When do sex and gender matter and when might they be irrelevant? The answers could potentially change medical practice.

What health professionals are increasingly aware of in medical research and in medical practice is that being female does make a difference when it comes to the health of either women or men. The article "Does Sex Make a Difference? the author deals with a number of gender differences that exist. As the author, Linda Bren, states "When it comes to health risks, sex does matter (53). The short statement from the Canadian Women's Health Network points to ten differences between women and men of which should be aware.
http://www.cwhn.ca/resources/sexual_diff/index.html