

PART I - Why Study Women's Health?



Please Read: Munch, Shari. "Gender-based Diagnosing of Women's Medical Complaints: Contributions of Feminist Thought, 1970-1995."

This section of the Unit will examine why it is necessary to study women's health separate from men's health. Several points will be considered. Women make up more than half the population and they have health problems that are gender specific, reproductive health is simply the most obvious. However, beyond reproductive issues researchers ignored women's specific health issues. In fact, as will be seen later in this Unit, there are certain diseases (such as breast cancer, rheumatoid arthritis and lupus) that are more prevalent among women than among men. This is particularly noticeable as women age. In Western society, women outlive men. However, the fact that women live longer than men does not mean that have better health. In other words *quantify* of life does not guarantee *quality* of life. Women, more so than men, are more likely to be incapacitated due to mental or physical problems during their later years and generally suffer more chronic ill health. Then again, compared to elderly men, elderly women are less likely to have a spouse or a partner to take care of them. Too often the medical research that is done has used male subjects and the research then has been generalized to women. As well, the lack of protection given to women as consumers of medical products and the general bias and stereotyping of women has also worked against women in terms of obtaining appropriate health care.

Women's experiences with the health care system have often been undertaken in a climate that is androcentric, that is, in an atmosphere that suggests that the male body is the normal body. In such an environment female characteristics constitute deviations from the norm. That which is male is strong; that which is female is weak. Western thinkers such as Aristotle saw the male sperm as lively and energetic acting on the passive and virtually inert matter that is the female egg. Women, regardless of what they had achieved in life have, from the ancient Greeks been viewed as being less well developed both mentally and morally than their male counterparts. Because of this thinking women were denied the right to vote, the right to serve on a jury, denied entrance to institutions of higher education and prevented from practicing the professions, including law and medicine. Of course, women of colour and Aboriginal women have been even less valued and have been denied even more rights and for a longer time than women of European descent.

The term "women's health" is often used synonymously with women's reproductive capacity. But even here research priorities neglected some of the most common aspects of women's ability to procreate. For example, menstruation and menopause, were, until lately, given little attention as health issues. At the turn of the twentieth century women's life expectancy was approximately sixty years; today women can expect to live into their eighties and many women are living beyond ninety. This demographic change has revolutionized the way that we think about women's lives. The need to increase our understanding of postmenopausal health issues such as osteoporosis, dementia and heart disease is increasingly evident.

While awareness of the health problems that women face is increasing, attention given to women's health is still in its infancy. Nowhere is this more evident than in the case of heart disease, a condition that affects both women and men. Usually research on heart disease has focused on men and the findings generalized to women. Heart disease is the leading cause of death for Canadian women: 41 per cent of all deaths of Canadian women are heart related

compared to 37 per cent for men (Heart and Stroke, 1997). It is now more than ten years since Dr. Bernadine Healy in an editorial in the *New England Journal of Medicine* wrote that women's heart health was an understudied and poorly known research area. Indeed, scientific investigations addressing coronary heart disease in women before the 1980s were rare. Recent research tells us that the development of heart disease, its symptoms, treatment and recovery are very different for women than for men and yet studies done today still indicate that women are not diagnosed and treated as aggressively as men.

Another problem that has drawn attention to the neglect of women's health and thus the need to study women's health is the failure to ensure the safety of medical products and treatments that women as consumers of such products routinely use. There are numerous examples that could be cited here but the discussion will be limited to five examples: thalidomide, diethylstilbestrol (DES), the Dalkon Shield, the exclusion of women from drug trials and psychologisation.

THALIDOMIDE

Thalidomide was manufactured in West Germany in 1953 and quickly spread to many countries around the world. It became available to Canadians for prescription use on April 1, 1961. Although thalidomide was withdrawn from the West German and the British markets by December 1961, it remained legally available in Canada until March 1962, a full three months later. Incredulously the drug was still sold in some Canadian pharmacies until mid-May 1962. Thalidomide was sold as a wonder drug, that is, as a sedative that would provide pregnant women with a safe, sound sleep. It was also intended to combat many of the symptoms associated with morning sickness. However, what drug manufacturers did not realize was that the drug could cross the placental wall affecting the foetus. In fact, thalidomide was a catastrophic drug with tragic side effects. For example, a percentage of the women taking the drug experienced peripheral neuritis, which is the inflammation of nerves in the legs and arms that can have devastating and sometimes irreversible side effects. As well, when thalidomide was taken by pregnant women, particularly during the first trimester it caused birth defects, and infant deaths. Any part of the foetus that was in development at the time the drug was ingested could result in birth defects including deafness, blindness and/or a cleft palate. The most common deformity was disfigurement of the limbs. Babies were born with stubby hands or feet attached close to the body. No one knows the number of babies affected by the drug or the misery and guilt this caused thousands of women who trusted medical practitioners who prescribed thalidomide and the drug companies who manufactured it (www.thalidomide.ca).

DIETHYLSTILBESTROL (DES)

The next example of the lack of attention given to drug therapies prescribed for women is diethylstilbestrol (DES). DES is a synthetic estrogen that was given to millions of pregnant women between 1938 and 1971. The drug was thought to prevent miscarriage and advertisements for the drug promised "bigger and stronger babies" and "no gastric or other side effects...in either high or low dosage". Not only was DES not effective in preventing pregnancy complications, but if taken during the first five months of pregnancy, DES had the potential to interfere with the development of their reproductive system in a foetus. Thus daughters of women who took DES have higher rates of vaginal cancer. The sons of women who took the drug are prone to testicular abnormalities. The women who actually took DES while pregnant are at greater risk of breast cancer. (www.desaction.org)

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