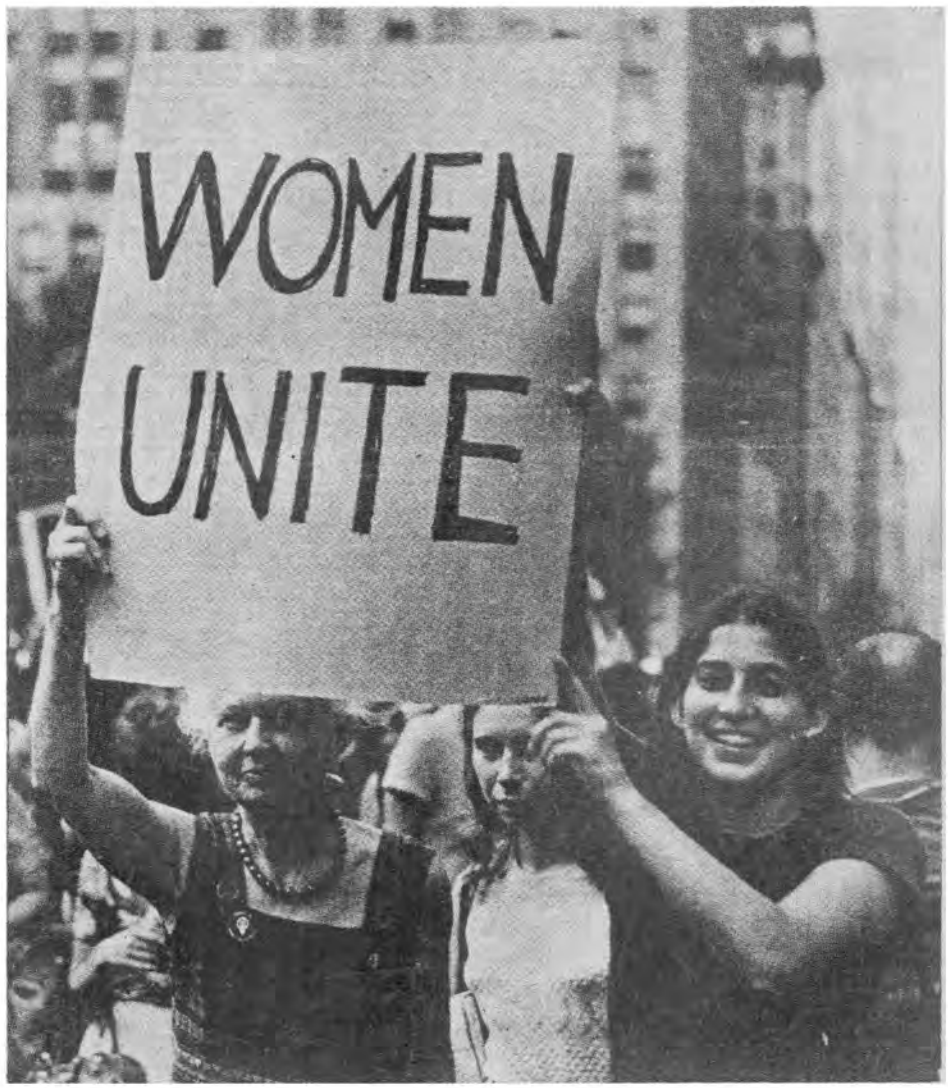
WOMEN
and
THEIR BODIES

a course



by

BOSTON WOMEN'S
HEALTH COLLECTIVE

75¢

General health and herbal medicine

COURSE INTRODUCTION

One year ago, a group of us who were then in women's liberation (now most of us consider ourselves members of Bread and Roses) got together to work on a laywoman's course on health, women and our bodies. The impetus for this course grew out of a workshop on "women and their bodies" at a women's conference at Emmanuel College in Boston, May 1969. After that, several of us developed a questionnaire about women's feelings about their bodies and their relationship to doctors. We discovered there were no "good" doctors and we had to learn for ourselves. We talked about our own experiences and we shared our own knowledge. We went to books and to medically trained people for more information. We decided on the topics collectively. (Originally, they included: Patient as Victim; Sexuality; Anatomy; Birth Control; Abortion; Pregnancy; Prepared Childbirth; Postpartum and Childcare; Medical Institutions; Medical Laws; and Organizing for Change.) We picked the one or ones we wanted to do and worked individually and in groups to write the papers. The process that developed in the group became as important as the material we were learning. For the first time, we were doing research and writing papers that were about us and for us. We were excited and our excitement was powerful. We wanted to share both the excitement and the material we were learning with our sisters. We saw ourselves differently and our lives began to change.

As we worked, we met weekly to discuss what we were learning about ourselves, our bodies, health and women. We presented each topic to the group, gave support and helpful criticisms to each other and rewrote the papers. By the fall, we were ready to share our collective knowledge with other sisters. Excited and nervous (we were <u>just</u> women; what authority did we have in matters of medicine and health?), we offered a course to sisters in women's liberation. Singularly and in groups, we presented the topics and discussed the material; sometimes in one large group, often in smaller groups. Sisters added their experiences, questions, fears, feelings, excitement. It was dynamic! We all learned together.

One original version of the course was that we as a group would give the course to a group of women who could then go out and give it to other women. To some extent, that is what happened. After the first time around, those of us who had worked out the course originally, plus women who had taken the course, got together in an enlarged group to rewrite the papers so they could be printed and shared, not only with women in Boston, but with women across the country. Other women wanted to learn, other women's health groups wanted to compare and combine our work and theirs.

So after a year and much enthusiasm and hard individual and collective thinking and working, we're publishing these papers. They are not final. They are not static. They are meant to be used by our sisters to increase consciousness about ourselves as women, to build our movement, to begin to struggle collectively for adequate health care, and in many other ways they can be useful to you. One suggestion to those of you who will use the papers to teach others: the papers in and of themselves are not very important. They should be viewed as a tool which stimulates discussion and action, which allows for new ideas and for change. Often, our best presentations of the course were done by a group of women (we could see a collective at work--in harmony, sharing, arguing, disagreeing) with questions throughout, and then splitting the larger group into smaller groups to continue talking about whatever part of the topic that was especially relevant to the women in that group. It was more important that we talked about our experiences, were challenged by others' experiences, (often we came from very different situations), raised our questions, expressed our feelings, were challenged to act, than that we learned any specific body of material.

It was exciting to learn new facts about our bodies, but it was even more exciting to talk about how we felt about our bodies, how we felt about ourselves, how we could become more autonomous human beings, how we could act together on our collective knowledge to change the health care system for women and for all people. We hope this will be true for you, too.

This course should grow and include other topics, such as menopause, divorce, childcare, strengthening our bodies (diet, exercise, karate, etc.) -- topics important to the group of women giving and taking the course. The material has been and should be used in ways other than a course. A course is only one way of spreading the word.

We want all your ideas, comments, suggestions, criticisms, etc.

Power to our sisters!!

Nancy Hawley, Wilma Diskin, Jane Pincus, Abby Schwarz, Esther Rome, Betsy Sable, Paula Doress, Jane de Long, Ginger Goldner, Nancy London , Barbara Perkins, Ruth Bell, Wendy Sanford, Pam Berger, Wendy Martz, Lucy Candib, Joan Ditzion, Carol Driscoll, Nancy Mann, and all the other women who took the course and read the papers.

In reading or teaching this course you may need additional information, pictures, or charts and models. There are bibliographies in several papers and most public libraries carry illustrated books in sections like Sex Education and Young Adults. You can probably avoid spending money on them.The following three books, not in most libraries, have some of the best illustrations and information:
A CHILD IS BORN, THE DRAMA OF LIFE BEFORE BIRTH IN UNPRECEDENTED PHOTOGRAPHS, A PRACTICAL GUIDE FOR THE EXPECTANT MOTHER, Dell Publishing Co. N.Y.
BIRTH CONTROL HANDBOOK, McGill Students Society, 3480 McTavish St, Montreal, Quebec (25¢) or from New England Free Press, 791 Tremont St, Boston, Mass, 02118 (10¢)
UNDERSTANDING, Ortho Pharmaceutical Corporation, Raritan, New Jersey

You can get more information, posters or plastic models from:
the nearest Planned Parenthood office
International Planned Parenthood Federation, 111 4th Ave, N.Y. N.Y.
Ortho Pharmaceutical Corporation, Raritan, New Jersey
Educational Department, Tampax Incorporated, N.Y N.Y.10017
Health Pac, 17 Murray St, N.Y N.Y.
Women's Abortion Project, 36 W. 22nd St N.Y. N.Y.

The above are very different kinds of people. Don't forget that Ortho and Tampax are capitalist organizationsp, pushing their own products for profit; nevetheless, their educational departments put out some excellent stuff. Planned Parenthood pushes population control and birth control pills.

The local Planned Parenthood can give you the name of the local Ortho representative from whom you can try to get birth control kits (with Ortho contraceptive products). It helps to have a physician call for you. P.P. can also give you the names of gynecologists who may give or sell you different IUD's. It is also good to have the names of doctors to whom you can refer women.

It took a long time to put together this course, but we don't consider it a finished product. As more women use, teach, and learn from the course, it must be expanded and revised to meet our needs. We plan to continue our work and want to have a second edition ready to be printed in 6 months to a year. The course will be best changed by the corrections and additions sent by those who useit. So send them in:
Boston Women's Health Collective, c/o New England Free Press, 791 Tremont St. Boston, Mass, 02118.

WOMEN, MEDICINE AND CAPITALISM

Marcuse says that "health is a state defined by an elite." A year ago few of us understood that statement. What does he mean? We believed that all people want to be healthy and that some of us are more fortunate than others because we have more competent doctors. "Now you should go to Dr. A. Man. He's my doctor and he's just great!"

Today we understand the stark truth of Marcuse's statement. We have not only started to look at health differently, but have found that health is one more example of the many problems we as people, especially as women, face in this society. We have not had power to determine medical priorities; they are determined by the corporate medical industry (including drug companies, Blue Cross, the AMA and other profit-making groups) and academic research. We have learned that we are not to blame for choosing a bad doctor or not having the money to even choose. Certainly, some doctors have learned medical skills better than others, but how good are technical skills if they are not practiced in a human way?

We as women are redefining competence: a doctor who behaves in a male chauvinist way is not competent, even if he has medical skills. We have decided that health can no longer be defined by an elite group of white, upper middle class men. It must be defined by us, the women who need the most health care, in a way that meets the needs of all our sisters and brothers--poor, black, brown, red, yellow and pink.

I. The ideology of control and submission

Perhaps the most obvious indication of this ideology is the way that doctors treat us as women patients. We are considered stupid, mindless creatures, unable to follow instructions (known as orders). While men patients may also be treated this way, we fare worse because women are thought to be incapable of understanding or dealing with our own situation. Health is not something which belongs to a person, but is rather a precious item that the doctor doles out from his stores. Thus, the doctor preserves his expertise and powers for himself. He controls the knowledge and thereby controls the patient. He maintains his status in a number of ways: First, he and his colleagues make it very difficult for more people to become doctors. (For instance, for thirty years, the AMA opposed the expansion of the existing medical schools, primarily to protect their entrepreneurial economic privilege.) Second, he sets himself off from other people in a number of ways, including dressing in whites. (In fact, in most hospitals there is a rigid hierarchy which is demarcated according to dress: doctors wear whites, nurses wear white with a cap denoting what school they attended, nurses' aides wear another color uniform, and housekeeping women still another color. The implication being, of course, that it is very important not to confuse one group with another.) Another much more important way doctors set themselves off from other people is through their language. Pseudoscientific jargon is the immense wall which doctors have built around their feudal (private) property, i.e. around that body of information, experience, etc. which they consider as medical knowledge. (epistaxis=nosebleed, thrombosis=blood clot, scleral icterus=yellow eyeballs, etc.)

Thirdly, doctors insulate themselves from the rest of society by making the education process (indoctrination) so long, tedious, and grueling that the public has come to believe that one must be superhuman to survive it. (Actually, it is like one long fraternity "rush" after which you've made it and can do what you like. Only members of the club get to learn the secret, which is that doctors don't know much to begin with and are bluffing a good deal of time.) Thus, a small medical elite preserves its own position through mystification, butressed by symbolic by symbolic dress, language, and education.

It is important for us to understand that mystification is the primary process here. It is mystification that makes us postpone going to the doctor for "that little pain," since he's such a "busy man." It is mystification that prevents us from demanding a precise explanation of what is the matter and how exactly he is going to treat it. It is mystification that causes us to become passive objects who submit to his control and supposed expertise.

II. Objectification

We know that we as women are objectified as sex objects in our society. Any woman who has walked alone at night knows the feeling of vulnerability and helplessness that accompanies our awareness that we are being perceived as pure sex objects. The medical setting further objectifies a person. The patient is assumed to be an object on which one can "objectively" and "scientifically" perform certain operations. The patient is merely the vehicle which brings the disease to the interventionist (instrumentalist). The outgrowth of these assumptions is that the best place for a doctor to act on a patient is in the hospital, i.e. when the patient is horizontal, passive, most like an object. Finally, that part of a person which is considered sick is further separated and removed. ("The ulcer in 417." or "We did a gall bladder today.") For us as women, the treatment of any gynecological or obstetrical problem thereby results in the alienation of us from our own body, from our own genitals.

III. Alienation

Naomi Weisstein, in her essay on women, Kinder, Kirche, Kuche, has outlined very well how the society has caused the alienation of a woman from her body. Freud's impact cannot be overestimated; we have internalized the notion that woman is incomplete, that something is missing. This alienation leads to a condition which is epitomized by the middle class woman, who, whenever she feels ill, goes to see her gynecologist. The implication: whatever is the matter with her has to do with her sexuality.

Alienation is also what makes it hard for us to talk about sex. Our sexual experience is so privatized that we never find out that other women have the same problems we do. We come to accept not having orgasm as our natural condition. We remain ignorant about our own sexuality and chalk it up to our own inadequacies. And if we should be so bold as to go to a doctor--and if we should summon up the courage to ask him about our common problem--chances are he will know nothing about it, although he will never or rarely admit this and will probably laughingly dismiss our questions. Doctors in general are as ignorant about sexuality as the rest of the men in society.

Doctors' blatant ignorance about sex stands in stark contradiction to the fact that they are considered the only legitimate person to consult about any sexual problem. Thus, we bring all our awkwardness and ignorance about sex to a doctor who cannot understand that his own ignorance and arrogance are the epitome of male chauvinism. (Add any man's standard portion of male chauvinism to the whole mind set and life style of the man who controls knowledge and thereby people "for their benefit" and we come up with the doctor of our society.)

Which brings us to preventative medicine. We as women are made to feel uncomfortable about going to a doctor in the first place. If we cannot feel comfortable going to our doctors normally, then to go for preventive reasons will be all the more difficult. Thus, while the medical profession has come out in favor of massive screening of women for cancer of the breast and cervix (the cervix is the neck of the uterus, or womb), their practice, their approach, their manner--that is to say, their ideology-- all works in the opposite direction. First, our complaints aren't important enough, since we think that we aren't important. (A man is made to feel uncomfortable in a different way; he is made to feel that it isn't masculine to admit to a minor ailment, since he should be tough and not feel it.) The net result is that both men and women postpone seeing a doctor, whom they regard as too important to be bothered. And when the visit involves a pelvic examination, it is even less likely a woman will go through with it. Small wonder that only 12% of the women in this country who ought to have "Pap" tests (short for Papinicolaou, the guy who invented it) for cervical cancer get them. This is one of the very concrete ways that male chauvinist medicine means poorer health care and health protection for us.

We cannot begin to write here about capitalist forms of medicine per se; that is to say, the prohibitive cost of medical care, the racist and inferior treatment of poor people and black people, the profit and prestige-making institutions of the "health industry" (hospitals, medical schools, drug companies, etc.), the total neglect of the public or preventive protection, or the fee-for-service, pay-as-you-die economic base upon which most medical practice is based. This is an important and extensive issue which must be dealt with elsewhere. Suffice it to say that capitalism is incapable of providing good health care, both curative and preventive, for all the people. Cost-benefit analysis trades off the benefit to the people of collective public health in favor of the cost to the people of private, patch-up medical care. The capitalist medical care system can be no more dedicated to improving the people's helath than can General Motors become dedicated to improving the people's public transportation. Our difficulty in perceiving the similarity between the health care system and any other corporate capitalist enterprise in the society results from our acceptance of the rhetoric that medicine helps people.