IS MEDICINE INHERENTLY SEXIST ?

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During the last twenty years, many feminists, activists and researchers have been taking a closer look at medicine. There is voluminous and irrefutable evidence that the medicine of the 19th and early 20th centuries incorporated and reinforced the sexist ideology in society. But does sexism operate in and through current medical practice in India? The author argues, that the teaching and practice of medicine here is strongly influenced by what happens in the West With extensive illustrations from popular textbooks and journals she shows how sexism in medicine operates just as strongly now as it did a hundred years ago. Additionally, campaigns such as the one promoting breast feeding continue to use outmoded and demeaning stereotype for women. This article is based on a paper written for the Medico Friend Circle's Annual Conference held in 1983, which focussed on 'Prejudice against women in the medical system.'

Medicine has played and continues to play a powerful role as a reinforcer and perpetuator of sexist ideology. It has the dubious distinction of shifting justification for sexism from religion to bio-medicine, thereby taking it out of the realm of prejudice and putting it within the confines of 'scientific' objectivity. The interpretations medicine offers are basically to legitimise the discrimination of women and their continued oppression under the guise of biological determinism.

The period of rapid industrialisation in the West witnessed the growth of the monopoly of the white middle-class male over medicine. This period also saw the emergence of new social norms which specified roles on the basis of sex and class. The upper-class women were expected to lead a sedentary life of enforced leisure with nothing more taxing than embroidery to keep them occupied, whereas the working-class women were forced to lead a life of hard physical labour. Although it was the working class women who were subjected to a host of illnesses, (a result of nutritional deficiencies and poor working and living conditions,) it was the upper-class women whom medicine considered as inherently sick. "It was the wealth extracted in that harsh outside world that enabled a man to afford a totally leisured wife. She was the social ornament that proved a man's success, her idleness, her delicacy, her child-like ignorance of 'reality' gave a man the 'class' that money alone could not provide". (Ehrenreich and English, 1973).

The combined effects of enforced leisure, confinement and boredom led to the emergence of the cult of 'female invalidism' among the upper class women. To the medical men the 'sick' women of the upper classes were a godsend. Here was a patient, who was ill without being 'diseased', in obvious need of the ministrations of a medical man (like himself), compliant enough to obey every one of the doctor's demands, and wealthy enough to afford the prolonged treatment --- an ideal patient as it were. "As a businessman, the doctor had a direct interest in a social role for women that encouraged them to be sick; as a doctor he had an obligation to find the causes of female complaints. The result was that as a scientist he ended up proposing medical theories that were actually justifications of women's social roles". (Ehrenreich and English, 1973). The popular medical theory proposed was that women's inherent weakness rested on the physiological law of 'conservation of energy'. Each person had a fixed supply of vital energy and the different organs had to compete with each other for their share. Since a woman's life was centred around her reproductive organs it meant that these organs developed at the expense of all the other organs. The result of such distribution of energy left the woman strong enough to bear children, but weak in every other way. This theory implied that the woman could never be physically or intellectually superior to a man who did not lose out his energy on reproductive functions. As a further development of the theory, it was postulated that the ovaries were central to the woman's being. The ovaries determined the personality traits of the woman and these could range from irritability to insanity. In textbooks and in actual medical practice, doctors found uterine and ovarian problems behind every female complaint be they headaches, sore throat or tuberculosis.

Although all these could be dismissed as part of the deep medical ignorance of the times, it did not prevent the medical profession from carrying out treatment which were specifically designed to alter female behaviour. Treatment for female invalidism included isolation, prolonged rest, clitorectomy and ovariotomy. Ehrenreich and English point out that this was in effect a surveillance system through

which the doctors could detect the first signs of rebelliousness and could interpret them as symptoms of disease, and hence, curable.

But the theories and medications could not be applied to working-class women. They had neither the time nor the money to indulge in female invalidism and their labour was essential for the growth of capital. Medical theory came up with an explanation based on racial differences : These women (mostly blacks and immigrants from Europe) were congenitally inferior to the white Anglo-Saxon protestants in that they had smaller brains, larger muscles and a host of inherited social traits. They were considered to be free from uterine diseases and were supposed to have robust healthy babies. Although these working-class women were not 'sick' they were 'sickening' to other classes. They bred disease and were the reservoir of infection. The danger of coming in contact with working-class women was especially great for upper classes for they often worked as maids in the homes of the upper class and as prostitutes. Thus medical theory proposed two seperate biological reasons to explain and justify the social roles of these two classes.

Sexism in Current Medical Practice

It could be argued that all this took place in the distant past at a time when the scientific foundation of medicine was still being laid and that the content of medicine itself has changed since then. Such an argument would be valid only if it was possible to prove that the later devlopments in medicine were not influenced by sexist prejudices. But a review of medical literature reveals that sexism is still dominant in the interaction between 'medicine' women, and medicine still continues to rationalise and to dictate social norms to women.

It would have been difficult to substantiate these statements had they been made say, twenty years ago, because then the ultimate pronouncements on woman's 'nature' still came from the doctors. But the militant feminist movement in the west has been powerful enough to draw the attention of academicians to provide the much-needed data. The following quotes are taken from studies conducted in US and in England and are relevant to India as well. for the teaching and practice of medicine is not very different and students follow the same textbooks. Doctors continue to view women patients as hysterical, irrational and incapable of making decisions. ". . . . . women's illnesses are psychosomatic until proven otherwise".

"Following traditional linguistic convention, patients in most medical school lectures are referred

> *"Primary dysmenorrhoea is dismissed as being psychogenic, although it affects 50 percent of women"*

to exclusively by the male pronoun 'he'. There is, however a notable exception: in discussing a hypothetical patient whose disease is of psychogenic origin, the lecturer often automatically uses 'she'. For it is widely taught, both explicitly and implicitly, that women patients (when they receive notice at all) have uninteresting illnesses are unreliable historians and are beset by sucn emotionality that their symptoms are unlikely to reflect 'real' disease."

" Women as compared to men are more likely to have their depression treated by drugs than to be helped to overcome the causes of their distress". (Howell, 1974)

Work up by physicians in response to five common complaints in a sample of 104 men and women - 52 married couples— were evaluated by chart audit. For the total group of complaints, back pain, headache, dizziness, chest pain and fatigue, the physicians' work ups were significantly more extensive for men than they were for women. These data tend to support the argument that male physicians take medical illness more seriously in men than in women. (Armitage et al, 1979)

Most complaints which are termed women's complaints (because they refer to their reproductive tracts) are often dismissed as being of purely psychogenic origin. Primary dysmenorrhoea is one such gynaecological complaint which though it affects about 50 per cent of women, is considered partly or wholly psychogenic. This is inspite of the fact that the origin of pain is still unknown.

"One gains little conviction in relation to most of the literature (regarding dysmenorrhoea) especially in respect of management. To illustrate an extreme, one recent study advises physicians not to trust empiric diagnoses of dysfunctional dysmenorrhoea, but to inspect the peritoneal cavity by culdoscope and to expect often to find free (menstrual ?) blood as the cause of the pain. Actually, one is finally driven to the conclusion that theories concerning intrinsic dysmenorrhoea in early menstruation are as conflicting as are countless methods and medications which are claimed as being helpful. Hardly, a day or a medical journal, goes by which does not offer a new near-panacea whose rationale conflicts with many

others. It reflects more essentially the psychosomatic ineffectiveness of the proscribing physician, and in general the results are not superior to our sage advices at the beginning of the century" (Jones).

The psychogenic theory of primary dysmenorrhoea however is very definite : "It is generally acknowledged that this condition, is much more frequent in the highstrung, nervous or neurotic female than in her stabler sister." (Lennane and Lennane 1973).

"Faulty outlook leading to an exaggeration of minor discomfort.... may even be an excuse to avoid doing something that is disliked". Or more simply, "The pain is always secondary to an emotional problem." (Lennane and Lennane 1973).

In refuting these theories Jean Lennane and John Lennane have this to say : "There is no valid basis for this attitude. These authors are not referring merely to the effect that the personality of the patient may have on the amount of suffering or complaints occurring in any organic illness, but are implying or directly stating, that the patients' faulty outlook is causing the condition.

"If the pain is the result of 'faulty outlook' one would expect it to start at the time of the initial psychic shock (menarche), and not two to four years later. The pain is dependent on the occurrence of ovulation and is reliably and usually completely removed by suppression of ovulation (92 per cent of severe cases in one study) Perhaps the few who do not respond to ovulation suppression might be psychologically disturbed, but in practice, psychosomatic study and psychometric tests do not confirm this hypothesis. Scientific supporting evidence is completely absent e. g. a prospective study of pubescent girls, or of menstruating girls who were not yet ovulating. Evidence when offered, is scanty. **'A dysmenorrhoic mother usually has a dysmenorrhoic daughter'** which, if true (no statistical confirmation is offered), would more usually be taken to indicate a hereditary factor.

"The attitude to treatment may also be unusual.. very little can be done for the patient who prefers to use menstrual symptoms as a monthly refuge from responsibility and effort'. The patient with visceral colic is treated with rest and relief of pain; the patient who persists in having severe dysmenorrhoea may be denied both." (Lennane and Lennane, 1973).

The following quote also shows how women's gynaecological complaints are seen as unimportant and not worthy of medical attention. "Majority of the women in our country are housewives. In most

"Mistaken and misleading beliefs about female sexuality continued to dominate medical theories until the late 70s."

of the other countries women do as much office work as men and in addition do the duties of housewives. Thus Indian women have more 'spare time'. Since majority of them have no other activities or hobbies and do not do any reading (being uneducated) **they spend most of their spare time concentrating on their vaginal discharge".** (emphasis ours) (Kapoor, 1976). The underlying attitude that will be encouraged in general practitioners is self-evident. It is also significant that leucorrhoea (vaginal white discharge) is the only common gynec problem discussed in the book.

In fact, it is not too farfetched to say that almost every second gynaecological complaint is viewed with suspicion as being fictitious and just a figment of the imagination. Here is what Lennane and Lennane say with regard to nausea of pregnancy : "A well-defined clinical entity occurring in 75 to 88 per cent of pregnant women. The exact cause remains unknown. The condition is nevertheless commonly held to be partly or wholly psychogenic again without any scientific supporting evidence. Few will deny that the psychogenic factor is of prime importance, and it is probable that many adjustments demanded of the newly-pregnant woman impose a mild condition of stress coupled with an irrationally exaggerated fear of the obstetric hazards confronting her, especially that of producing an abnormal child. Classified with the neuroses, (nausea of pregnancy) may indicate resentment, ambivalence and inadequacy in women ill-prepared for motherhood" ..... " Nearly all pregnant women see a doctor and to classify up to 88 per cent of patients with a particular organic condition (pregnancy) as neurotic is unusual in the extreme" ... "its severity in multiple pregnancy and hydatidiform mole contradict the neurosis theory. unless it is postulated that the patient can subconsciously and definitely diagnose these conditions as early as the fourth week" (Lennane and Lennane, 1973).

Female sexuality has always been a source of concern in all patriarchal societies. Medical theories of the late 19th and early 20th century drew a rigid distinction between reproductivity and sexuality. It was believed that the development of reproductive powers and of the maternal instincts could only take place when sexuality itself was suppressed. Women

were told (by medical theoreticians), that sexual feelings were "unnatural, unwomanly pathological and probably detrimental to the supreme function of reproduction". These beliefs continued to dominate medical theories till as late as the 'seventies, even after Master's and Johnson's findings had revolutionised the understanding of female sexuality. According to Scully and Bart (1973) who reviewed 27 general gynaecological textbooks published in the US from 1943 to 1972: "... examination of gynaecological textbooks, one of the primary professional socialisation agents for practitioners in the field, revealed a persistent bias towards a greater concern with the patient's husband than with the patient herself. Women are consistently described as anatomically destined to be happy. So gynaecology appears to be another of the forces committed to maintaining traditional sex role stereotypes, in the interest of men and from a male perspective."

In the textbooks published between 1963-72: " Eight (of the textbooks) continued to state, contrary to Master's and Johnson's findings, that the male sex drive was stronger and six still maintained that procreation was the major function of sex for the female. Two said that most women were 'frigid' and another stated that one-third were sexually unresponsive. ..... when they (the book) deal with the subject (sex role) the traditional female sex role is preferred. Thus Jeffcoate states 'An important feature of sex desire in the man is the urge to dominate the women and subjugate her to his will; in the women, acquiescence to the masterful takes a high place'. In 1971 we read: 'the traits that compose the core of the female personality are feminine narcissism, masochism and passivity '... A 1970 text states, 'The frequency of intercourse depends entirely upon the male sex drive. The bride should be advised to allow her husband's sex drive to set their pace and she should attempt to gear hers satisfactorily to his. If she finds, after several months or years that this is not possible, she be advised to consult her physician as soon as she realises there is a real problem'. The gynaecologist's self-image as helpful to women combined with unbelievable condescension is epitomised in this remark: "If like all human beings he (the gynaecologist) is made in the image of the Almighty and if he is kind, then his kindness and concern for his patient may provide her with a glimpse of God's image."

Medical attitudes have changed little in spite of the criticisms which have been the outcome of the feminist movement. A recent example is the breast feeding campaign which has merely incorporated the new attitude of society towards women,

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but has not changed its fundamental sexist ideology.

For many years the infant formula companies had peddled breast milk substitutes as an expression of mother's love. They had played upon the image of women as sex objects who in order to be desirable had to be depilated, deodorised, and have well-shaped and firm breasts. The counter propoganda (of the breast feeding campaign) tries to allay the fears of the mother about the shape of her breast by reassuring her that breast feeding will, in fact, make her more shapely.

"Contrary to the old wives's tales that nursing makes breasts sag (age and gravity do that), breast feeding actually helps women to get their bodies back in shape after childbirth. It helps the uterus return to its pre-pregnancy condition and facilitates loss of excess weight gained during pregnancy. It promotes a deep feeling of warmth and attachment between mother and baby. and many women report the physical sensations of breast feeding are pleasurable" (UNICEF, 1981). The issue is not whether the technical content of the quote is correct or not, but that the images it uses and reinforces are as sexist as 'organised' commercial advertisement. The advocates of this campaign also reinforce the idea of the main role of women as being to reproduce and to nourish at the cost of self.

' Lactation offers the opportunity of giving 'self.' to feed an infant, instead of feeding through the medium of the substitute glass bottle, rubber nipple and compounded baby formula. To this end successful lactation is indeed, a worthy and noble goal for the physician to inspire" (Applebaum, 1970). And further,

"The remarkable ability of poor women to breast feed their babies for prolonged periods is the most redeeming feature in an otherwise bleak nutritional status of many developing countries" (Gopalan, quoted UNICEF)

Conclusions

A woman is by definition 'emotional'. For long it was believed that a woman's emotions were controlled by her womb and a disturbance in the womb

led to a hysterical state. Modern thinking has reversed this understanding. It is believed now that emotions acting through hypothalamus effect menstrual function considerably.

The process of professionalisation includes learning attitudes about work, about relations with colleagues and about patients or clients. In medicne these attituides are strongly coloured by a demeaning regard for women. For, after all, such attitudes about women are pervasive in society and moreover the medical profession has been virtually a male monopoly. This may be disputed in India since the majority of gynaecologists here are women. Unfortunately, they too have imbibed the sexist values in society. We are all products of our cultural expectations---- and our culture devalues women.

The answer does not lie in doing away with gynaecologists. The more mature way would be: (i) to recognise inadequacies that exist in our knowledge and be more open and receptive to women's personal experiences; (ii) to redirect research priorities and focus on problems that women consider as important; (iii) to end the medical monopoly of knowledge about women's physiology, their illnesses. Only then can we hope that medicine will serve those who need it most.

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does witch-hunting take place with greater frequency during certain seasons? There are no simple answers. This article looks at the entire complex fabric of the adivasi's way of life, the status of women, and how factors such as deforestation, modern diseases, increasing unemployment and impoverishment and a deterioration and disappearance of trbial knowledge of medicine may be generating a set of circumstances which could perpetuate and strengthen the belief in the bhutalis and thus lead to increasing persecution of women. We especially ask readers to respond to this article.

Our focus throughout the issue is on women as consumers of health care. Women also comprise a large proportion of the providers of health care and we hope to devote a seperate issue to the topic sometime. We hope you find this glimpse of the many health issues which concern women, insteresting.

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