

SEXISM IN MEDICINE AND WOMEN'S RIGHTS

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The rights of women in the field of health should be viewed within the context of and as an extension to the rights of women in society. The authors elaborate this stance by dissecting women's poor health condition mired in their general, overall status in society. Any right to health as consumers must, therefore, contain within itself a right, to health, which in turn implies many other rights.

The rights of women as health consumers can be seen in the context of and as an extension to the rights of women in society. This may be elaborated in two ways. First, Women's health status is rooted in their socio-economic condition and is circumscribed by the political power they wield in society. Although there are only few systematic studies which relate women's morbidity patterns to their lifestyles that it is so cannot be doubted. Thus, any right to health as consumers must contain within itself a right to health, which in turn implies many others, such as the right to work, to food, to housing, to safe water and sanitation, to social security, to clean air and environment, to education, to form associations, etc.

Second, health care is provided in a setting, which is a microcosm of society and reflects, in an enhanced manner, the dominant prejudices and biases of society. This bias is so integral to the practice of medicine that even its recognition creates turmoil in the establishment and it is so hidden in the interstices of everyday practice, that even to trace it is a complex exercise. There is today enough literature to show why and how the biases grew. The removal of biases then involves a radical overhaul, which will inevitably mean a transformation of society. Women's rights as health consumers can only be seen as an extension of their rights in society and in consonance with their rights as health care providers.

However, it is important to recognise that when women come to the health system, they are in, what may be termed, an 'ill state' which has added to their vulnerability. In a sense women who come to the health system are survivors of socio-economic injuries. And this is why it is necessary to elaborate on the specific rights of women health consumers.

Doctors in our society are predominantly male and come largely from middle class backgrounds and respected professions. Their patients differ in that they are mostly from working class background and are non-professionals. Their women patients differ in gender, which adds another dimension to the social distance between them. This distance decreases when the patient is from the middle class and/or is a professional. The situation is no different for the women patient if the doctor is a woman. The women doctor graduation from a male dominated school has to, in order to survive imbibe and integrate the dominant value system, whether it be about women or about the poor. This process is facilitated by the fact that they have, because of their location in society, already internalised many of these values, including those of woman's place in society.

This distance between the doctor and the patient is evident in the manner the health care system, which is largely urban and capital intensive, operates. How are women patients treated by the medical establishment? Women patients come to medical setups for treatment of illness or for obstetric help or as victims of violence. They also come to seek medical aid for their children. The medical system deals with women's illnesses in a special manner. While there are no Indian studies, a number of foreign authors have noted that some common and troublesome conditions in women and children were dismissed as psychogenic. They document evidence for this in the case of dysmenorrhea, nausea during pregnancy, labour pains and infantile colic. Specific ways in which both doctors and patients accept stereotyped definitions of social as well as psychological causes of the problems of women patients have also been documented. A study revealed that male physicians take medical illness more seriously in men than in women.

Women patients are often seen as hysterical, irrational and incapable of making decisions. Following traditional linguistic convention, patients in most medical school lectures are referred to exclusively by the male pronoun 'he'. There is, however, a notable exception. In discussion of a hypothetical patient whose disease is of psychogenic origin, the lecturer automatically uses 'she'. Majority of women in our country are housewives. In most other countries women do as much office work as men and in addition do duties of housewives. Thus Indian women have more spare time. Since a majority of them have no other activities or hobbies and they do no reading they spend most of their spare time concentrating on their vaginal discharge.

This bias against women is seen not in attitudes, but manifests in the physical facilities available to them. For instance, the number of beds allotted to women patients in various wards of hospitals is much lower than the number of beds available to male patients. In fact, the diet given to women patients is much lower in calories than that given to men patients because it is assumed that women need less food than men.

We need to stress the fact that women in our society approach the medical facility only if their illness interfered with their daily routine. It is well known that they do not recognise their illness as such until it hampers their work. Also they do not want to deplete their family's meagre resources by spending it on their health care. So when they do approach medical facilities, it is imperative that they are treated with attention and sensitivity.

Veena Shatrugna's analysis 'of bed' strengths in a teaching hospital in Hyderabad reveals that burns are high among women patients between ages of 15 and 45, but more beds are allotted for men in the plastic surgery wards.

Another point of women's contact with medical facilities is at the time of pregnancy and childbirth. A woman's ability to give birth unaided is no longer an accepted activity and is taken over as a medical or surgical emergency. In general, there has been an increase in the

rate of Caesarians and hysterectomies over a period of time. Various sophisticated labour induction techniques are introduced and routine episiotomies are performed. The cost of childbirth is on a rapid increase. In public hospitals women report rude behaviour on the part of the staff, thus increasing the trauma of the woman who is undergoing labour. There is no provision made for a significant other woman to stay with her to help reduce the alienation of the hospital setting.

Another point of contact is when the woman is approached for routine antenatal care, family planning, immunisation and illnesses of family members. While on the one hand, the hospital setting is extremely alienating, depersonalised, inattentive towards women, in the case of the family planning programme, on the other hand, women are made the prime targets. Women are seen as reproductive machines to be controlled if one has to solve the 'population problem'. Women in reproductive age groups fall under the category of 'eligible couples'. They are encouraged to adopt family planning methods like tubectomy, IUD insertions, injectables, etc. Very little information is given to them about the risks involved. Women often become targets for testing of new devices and contraceptives, most often without consent.

Sterilisation as a procedure is often offered to women only as a condition for conducting abortion on an unwanted conception. Very little attention is paid to post-operative complaints or those by current contraceptive use. Most research concentrates on developing female contraceptive as opposed to male contraceptive. An interesting paradox here is that, on the one hand, there is a lot of investment in controlling the female reproductive capabilities, while on the other, there is an emphasis laid on offering test-tube babies for those unable to bear a child. Women are also tapped for immunization campaigns, but while administering these almost no information is given about side effects or possible complications. Although women routinely accompany children when they are admitted to paediatric wards, there is no provision for them to stay. They are often treated rudely and end up performing the nurse's duty towards the patient they have accompanied.

Women also approach the medical establishment as victims of violence and when they do very little sensitivity or sympathy is shown to them. This is even more damaging, because, often women are not willing to talk about the circumstances which have caused the injury. In fact, in cases of rape women go to doctors on an associated complaint, often not revealing that a rape has occurred. Doctors, in assessing the injury, inadvertently or otherwise deflect attention from the criminal act by seeking unnecessary information about the sexual history of the women.

Modi's Textbook of Medical Jurisprudence and Toxicology (21st edition, 1988) has cautioned the doctors to 'beware' of women. It states that many complaints of rape are false since the women must have consented. It says, it is very difficult to rape single-handedly a grown up and experienced woman without the stiffest possible resistance from her. It instructs doctors to note the previous character of the girl and warns doctors that they may be charged with rape because of the nature of medical examination involved, and suggests they conduct the examination in the presence of female staff.

Keith Simpson's Forensic Medicine says it is very common, in instances of rape, for the girl to lie. According to Krishnan's Handbook of Forensic Medicine and Toxicology. "As far as the women from the low class is concerned, it is impossible to rape her because she is stronger".

The case of Narasamma, a middle aged slum resident who was gang raped is instructive. She was rushed to a public hospital soon after the rape occurred. She had a lump on her head; her blouse was torn, revealing scratch marks on her breasts. The medical officer who was approached barely looked at her and gave her paracetamol and sedative. The next day she approached the same medical officer, this time accompanied by a social worker who informed the doctor that the women had been raped. The doctor maintained that the onus of saying that she was raped is on her. In a society where the distance between a woman, especially a poor woman, and a doctor is so great and the woman is in a state of shock, it is hardly likely that the woman will tell the doctor of the event. It is for the doctor to elicit the information, even if not by direct questioning but by putting the patient at ease and recognising her state of mind. This failure is not that of an individual doctor, but a characteristic of the medical establishment, which because of its bias against women does injustice to them.

WOMEN'S RIGHTS

In the earlier pages we have discussed the status of women in Indian society and the reproduction in the medical system of the sexist bias which operates to the detriment of women when they interact with the medical system. In this section we discuss the rights of women as consumers of health care.

The health rights of all patients irrespective of gender, social class and geographic location in India are fundamentally similar. Apart from these general rights, women have certain additional health rights on three grounds: 1) they are more socially disadvantaged 2) they are usually the procurers and providers of health care for their family members, particularly children and the elderly and 3) they require the services of health professionals for health procedures related to child bearing and contraception. In this context of the special needs of and demand made by women, the health rights to women are discussed.

Women's perspectives on the causes of ill health, the relationship of traditional beliefs to health status, family decision-making dynamics and the usual patterns of resort to health care must be understood and incorporated in the design of all health programmes. This calls for a restructuring of the educational and training programmes of health professionals at all levels: doctors, nurses, ward assistants, community level workers and those who constitute the interface between the medical establishment and people. Unless such a restructuring occurs, any other rights demanded by women become meaningless and ineffective. Thus the rights of women as consumers of health care must be seen in the context of the rights of women as seekers of training in providing equitable and unbiased health care.

All health care programmes must, as far as possible, be guided by women at the level of actual implementation. This is so as to ensure that programmes will take into account their multiple responsibilities and roles. In both community-based programmes and in hospitals women must be represented in all administrative bodies. That this representation must not be merely cosmetic is implicit.

Quality of care is intrinsically correlated to the utilisation and effectiveness of women's health services. Quality of care must take into account the process of service from the woman's perspective and must reflect/incorporate her cultural setting.

Elements, which determine the quality of care, include interpersonal relations between the woman and the provider. A woman's dignity and self-respect must never be abused, whether in the course of routine services or in a crisis situation. While privacy and confidentiality must be ensured during all interactions, a woman has a right to seek the attendance of another women during these interactions.

Complete and accurate information must be given to women about the medicare being provided, the investigations necessary, the risks involved, as well as about the diagnosis. This should be given in supportive and friendly environments. Also, an attempt must be to make the woman understand her ailment and the medicare must not be delivered as a mandatory act. This means that the health care providers must be trained to communicate in a manner, which the patient can understand. This is necessary especially in the case of women, where attitudes, prejudices and biases against women in society at large are reflected in the medical system.

Informed consent, whether for medical treatment, surgical procedure or experimentation, must not mean a shelving of responsibility on the part of the doctor. A patient must be encouraged to make an independent decision on the understanding that the doctor abides by that decision and will take responsibility for it within the constraints defined.

Health care providers should conceptualise female morbidities broadly, so as to include and recognise the full range of activities undertaken by a women, thus it is necessary to recognise that a woman has as much right to seek and receive help for disabling complaints, such as constant backache, as a man. These cannot be disregarded because a woman's work creates conditions for such a disability. It is as much the right of a woman to have the condition studied and treated, as a doctor's responsibility to link the medical condition with the social circumstances of women's lives and, therefore, attempt to empower women with the knowledge that their illnesses are often a consequence of their social location, and that the ultimate remedy comes with a change of the social situation.

This is also true of violence against women, which has taken many forms: rape, assault, wife battering, burning and incest. It must be demanded that the medical establishment recognise the social pathology of these medical conditions. Such women have the right to treatment, which enhances their coping and control of situations where they become the victims. This may be through specially trained personnel in departments, such as burns,

psychiatry or orthopaedics, or through the involvement of women's groups working with women survivors of domestic violence.

Although a woman's childbearing role is the most emphasised, women as mothers or as reproductive beings have few rights. For instance, she has little control over how many children she can bear or if at all she will bear children. The medical system plays a direct role in obstructing her right to appropriate contraception in various ways. It is important that the entire range of contraceptives must be available to her with complete information on their long and short-term effects and reliability. Women must also have the right to safe abortion for whatever reasons.

A woman must also have the right to choose where and how she will deliver her child. If she chooses to deliver children to home she must have the right to trained help, or specialist care in an emergency. Similarly, she must have the right in principle to choose whether or not she will breast-feed her child, whether or not she will seek particular immunisation. But this right, it must be underlined can be exercised only in the context of a society where unbiased information is available freely and there is no pressure on her to adopt a particular practice.

It is hardly necessary to point out that the ifs and buts that constrain these rights are many. But a beginning has to be made in defining these rights in individual locations so as to concretise them.

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