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Women in transition

Presidential address

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In 1938, the founding fellows of this association came together to establish a new institution; an institution of study, of teaching, and of collegial discourse to improve the practice of obstetrics and gynecology. To these founders we acknowledge our appreciation for their part in the advances in medicine we see today and from them we accept the responsibilities that we shall carry on in the future.

From the mountaintop of five decades we look down on advances in medical care that only the clairvoyant could have foreseen or predicted. Infant mortality has decreased from 47 per 1000 live births in 1940 to 11.9 per 1000 live births in 1981. Simultaneously maternal mortality has dropped from 37.5 per 100,000 live births in 1940 to 8.5 per 100,000 live births in 1981.[1] Other changes that have saved lives are the widespread use of the Papanicolaou smear, the virtual conquering of infectious diseases by antibiotics, and the prevention of hemorrhagic death by the availability of blood banks. These routinely accepted methods of treatment were not available to our founding fellows. Additionally, the rapid expanse of medical knowledge in recent years has given us the ability to control Rh sensitization, to essentially eradicate rubella, and to cure many of the sexually transmitted diseases, some of which were not even known when this organization was founded. Advances in knowledge and in technology have made possible in vitro fertilization, intrauterine surgical procedures, ultrasound, endoscopy, laser surgical procedures, and gene splicing.

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This catalogue lists only the advances in medical science that have affected the practice of our profession. It is not enough to marvel at them. It is not enough to settle back in comfortable satisfaction and proclaim what we have done. Beyond them are profound changes in life-style, in economic consequences, in political alignment, in family structure, and in the very lives of the patients whom we serve. The woman is the consumer of our services. How has she changed?

First to be considered is the economic sector. Women in dramatic numbers have entered the work force. In 1975 39% of all women worked. This increased to 51% in 1984.[2] In the professions—medicine, law and theology—and in the business world the number of women is increasing rapidly. In the past women have not been expected to have a career or acquire great wealth or even support themselves. What they have been expected to do is to marry, have children, and care for the family. Now women are entering the work force either because they choose to or because they must work to support themselves or to supplement income for their families. While more women are working, figures from the Bureau of Census belie the conclusion that women in general are improving their position in the economic world. Women earn considerably less than men. In 1955 the full-time working woman earned 64¢ for every dollar a man made. In 1983 the figure was the same—64¢ versus $1.[3] The wage gap has not changed in three decades. A major reason for this disparity is that women are concentrated in twenty of the 420 occupations listed by the United States Department of Labor—mainly jobs in retail sales, clerical work, low-skill manual labor, and services that typically have low wages and are dead-ended.[4] Women's work has historically been characterized by its low pay, interruptability,

monotony, and repetition. One article reports that 46% of all working women can be found in four occupations: clerks, saleswomen, waitresses, and hairdressers.[5]

Even more discouraging is the growing number of women whose income falls below the poverty line—a direct result of the breakup of marriages and the rapid rise in the number of single-parent families. A 1984 Census Bureau statistic indicated that single-parent households represent 26% of all families with children under 18 years of age and that 90% of these households are headed by women.[6] Economic hardships that these women encounter while trying to raise a family alone have led to a new trend that social scientists have labeled "the feminization of poverty." Another large segment of poverty includes the female head of household over 65 years of age. Sadly, the number of women and children in poverty has increased in recent times. Without assistance, hundreds of thousands of women in our country can expect to live out a grim scenario. They can expect to grow up as a member of a poor family, secure a job that will keep them a member of the working poor, raise children alone in poverty, and finally join the majority of the population of female aged poor. On the positive side, many economists predict that the overall earning power of women will increase. They attribute this to the approaching seniority of the wave of women who came into the work force in the 1970s.[7] Hopefully, with more training and higher levels of education and with attitudinal changes of the public, the gap will narrow significantly in the next decade.

On the political front women have had some headline successes: mayors of major cities, United States senators and representatives in congress, cabinet officers, and even a candidacy for vice-president on a national ticket. In Great Britain, Israel, and India the government itself has been headed by women. With women making up 53% of the voting age population and the number of women elected to state legislatures more than tripling in the past fifteen years, there is reason to look for further participation in the political process.[7] Polls indicate that women are more likely to support funds for social progress, peace initiatives, and programs with emphasis on education, environment, and health.[7] With their enormous voting power women have the power to make things happen if they choose to use it.

Nowhere has the change in women's status been more pronounced than in the institution of the family. In the 1980s, according to the Census Bureau, in more than 60% of families both husband and wife work and only 12% have a working father, a full-time homemaking mother, and a number of children. Sixty-six percent of women as single parents are in the work force.[7] The traditional family is in a state of flux. The personal dilemma of the woman of the 1980s is how to balance demands of a career with the responsibility of being a wife and mother. As a result, marriage roles have changed. Women are getting married later and having fewer children. For many working mothers the myth of superwoman has given way to the reality that working in the marketplace and raising children is a difficult and sometimes overpowering task. Family structure itself has changed dramatically with one divorce in six marriages in 1940 and one divorce in two marriages in 1980. Three fourths of all divorced persons remarry, which suggests that the family as an institution is not being rejected.[8] The traditional family unit no longer exemplifies two-parent families, lifetime marital commitment, marriage with children, and a family circle that extends from young adult to postretirement stages. Alternatives to the traditional family style are growing and becoming more diversified and I expect that every family here is in some way experiencing these changes.

The fourth category for consideration is women's health. Probably the most important change of all is women's increased ability to control their reproductive lives with the advent of "the pill," along with improvements in other forms of contraception. This has enabled our patients to have a planned family with the average number of children being 3.6 in 1960 and 1.8 in 1984.[3] The pill had a stunning effect on American society. Beginning in the 1960s women could experience sex without fear of pregnancy and, for the first time, know the kind of sexual freedom that only men had known. From our vantage point in the 1980s it is difficult to imagine the beginning of the struggle to change laws and attitudes about contraception. As late as 1960, a couple using contraceptives in their own Connecticut bedroom was committing a felony. The last birth control laws were in effect in Massachusetts until 1972. The sexual revolution is not without a price. There is no social change that comes without new conflicts and emotional conflicts have been the most widespread side effect of the pill.[9] One woman's freedom may be another woman's license and another woman's insecurity. Also impacting women's health was the supreme court's ruling in 1973 making abortion legal. This decision, though controversial, did take abortion out of the back alleys and into a safe and sterile environment. Women are still in sexual transition.

Perhaps a symptom of women's and society's confusion over female sexuality is the high number of illegitimate births. Teenage pregnancy in this country is a growing health and sociologic problem. The Alan Guttmacher Institute reported that the rate of illegitimate teenage pregnancy in the United States was more than twice the rate of industrial European countries though sexual activity is said to be the same.[10] This problem has complex cultural roots but sex education and the availability of contraceptives to this large segment of females will be a start toward a solution. Dr.

Luella Klein, immediate past President of the American College of Obstetricians and Gynecologists, has been particularly effective in bringing this to the attention of physicians and the public in general.

A key factor in the focus on women's health is the dramatic increase in the number of female physicians. One third of medical students today are women. Dr. Keith Russell predicts that in the very near future our specialty will be equally divided between men and women.[7]

This focus on women's health has been significantly advanced by the insistence by women of better health care. Many of you remember that a typical labor in the 1940s was managed with "twilight sleep," a combination of morphine and scopolamine, and delivery was accomplished with drop ether or chloroform for anesthesia. Fortunately, this has been replaced, in part because of the demand of patients for alternatives such as the various programs on childbirth preparation, less depressive forms of anesthesia, and, more important, the cooperation of laboring women and support from their husbands. Little headway has been made in decreasing the mortality of breast cancer but alternative methods of therapy have made treatment more acceptable to some women. Unfortunately, lung cancer and chronic respiratory diseases have hung heavy over the smoking woman and more public awareness of our environmental danger may reverse this trend. Being female continues to offer some protection from heart disease though with an aging female population this area must be considered a high priority for further research.

One outstanding statistic in women's health care is that in a span of 32 years, from 1950 to 1982, the life expectancy of a female born in the United States increased from 71.1 to 78.2 years—more than 7 years of longevity[8] That this increase in longevity is due to medical science is only part of the answer. Improved nutrition, education, and environment have certainly been factors. Then that certain indefinable biologic advantage that has always made women live longer than men must be given credit.

All things considered, the female in the United States is healthier than she was in earlier years. An article in the *Ladies Home Journal* sums it up this way: "Women in the '80's are better educated, healthier, and live longer, fuller lives although their earning power is yet to reach that of men. Women have also stretched their adult years by postponing marriage and motherhood until they get an education and start a career. They have managed to combine work outside the home with family life; and as women have changed, society has had to respond. Day care centers have sprouted in suburbs and towns. Supermarkets are open 24 hours a day. Repairmen make evening calls. Best of all, husbands are helping out."[9]

Socially, economically, and physically women's options are expanding. A major factor in this expansion of opportunity is women's increasing willingness to vocalize their needs and wants. In 1969 in Boston a small group of women gathered to discuss women and their bodies. Out of that beginning grew The Boston Women's Health Collective. They have published a book by and for women now widely known as *Our Bodies Ourselves*. This is a quote from a paragraph in the preface of the book: "In the beginning we called ourselves the doctors' group. We had all experienced similar feelings of frustration and anger towards specific doctors and the medical maze in general and initially we wanted to do something about these doctors who were condescending, paternalistic, judgmental, and noninformative."[11] If only a small percentage of our patients feel this way about their physicians then we must look seriously at ourselves and the way we dispense our medical services. Each of us can be proud of the advances made in the health care of women during our personal careers but this is not enough. It no longer suffices to be a good technical surgeon or dispenser of the healing herbs or attendant at the birthing of the firstborn. We must concern ourselves with looking on our patients not as a disease entity or as a neurotic housewife, but as a whole person, one who has feelings and a thinking mind, one who is sensitive to her own wants and needs, and these wants and needs will not be the same with every patient. Many women, both as consumers and as health workers, are making a radical challenge to the medical care system as we have known it. We, as physicians, must respond to this challenge and be a part of a medical care system that will benefit all women.

In spite of the many changes in women's lives over the years, motherhood remains both an essential and a cherished role. All humanity reveres a mother. She nurtures and loves our children. She offers them succor when they are ill, frightened, or in pain. She comforts their father in times of stress and hardship. All of this and more does a mother give—but this mother represents many women who are frightened, who are poor, who are insecure, who have pain, who feel neglected, unwanted, and unloved. She is our patient also.

Ours is the only medical specialty that treats women exclusively. We must be her champion. We must listen to her needs and help provide for them. No longer can we be content to treat a disease and neglect to listen to our patient when she is crying out to be recognized as a human being. We must be women's advocates in health matters—yes, but more than that, we must be women's advocates in all that effects her, whether it be in the marketplace, in her political life, or in the family.

We must support her as she seeks equality in the work force and fairness in pension systems and social security. We must support her when she seeks to be heard

in the political arena. We must be supportive as she attempts to balance the multineeds of her family. Perhaps our country's greatest wealth is her women, and these women want and deserve to be heard. They are our patients.

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Intravenous versus intraperitoneal administration of dextran in the rabbit: Effects on fibrinolysis

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Adhesions are the leading cause of small bowel obstruction and a frequent cause of failure of infertility operations. Fibrinolysis is involved in the formation and resolution of adhesions. Although intravenous dextran (Macrodex) is known to augment intravascular fibrinolysis, the effects of intraperitoneal dextran (Hyskon) on fibrinolysis have not been extensively studied. A fibrin plate assay system was used to assess plasminogen activator activity of rabbit peritoneum and plasma after treatment with intraperitoneal or intravenous dextran 70. Hyskon significantly reduced the ability of severe trauma to depress plasminogen activator activity of visceral peritoneum and was capable of direct plasminogen activation. Untraumatized or minimally traumatized peritoneum was not affected, nor was plasminogen activator activity of plasma. Pulmonary effusions and perioperative deaths were significantly associated with the use of Hyskon. (Am J Obstet Gynecol 1986;155:464-70.)

Key words: Dextran 70, plasminogen activator activity, fibrinolysis, pulmonary effusion

Postoperative intraperitoneal adhesions are the leading cause of small bowel obstruction as well as the most frequent cause of failure of infertility operations. The cause and prevention of adhesions is the subject of several recent comprehensive reviews.[1-3] The prevention of this potentially life-threatening complication is still incompletely understood. Recently, however, it has been shown in humans that the use of intraperitoneal 32% (w/v) 70,000 molecular weight dextran in 10% dextrose (Hyskon, Pharmacia) is an effective adjunct for the prevention of postsurgical adhesions.[4]

Why dextran is effective is not clear. Permanent adhesions persist when the early fibrinous adhesions that universally form between injured and adjacent tissues are not lysed, as a result of failure to activate tissue plasminogen activator.[5-7] Hyskon is a very viscous, hypertonic solution that coats tissues and by its "siliconizing" effect may prevent adherence of injured surfaces. In addition, it produces a temporary ascites,

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