At a more constitutional level there was considerable agreement that in a democracy neither the Supreme Court judges nor the federal government should decide, but that the issue has been appropriately sent back to the states, where it belongs. Along these lines one of the Supreme Court judges said that he hoped that the cartloads of mail would now be redirected to the elected representatives of the people. Others likewise thought that it was good for democracy to have the issues fought out at state level, though some feared that the ensuing civil strife could be harmful.

Few voices so far have spoken in favour of compromise. But the *Wall Street Journal* reminded its readers that more than 90% of abortions take place in the first 12 weeks; and since God has not revealed all of His mysteries and science has not been too helpful either the poor humans must often make these decisions. It went on to point out that under common law abortions done before quickening were not considered murder; that society in general seems to agree with this view; and that some compromise may well have to emerge from the legislatures —leaving women to decide on early pregnancies but reaffirming the state's right to protect at some point the life of the unborn. In possibly the same spirit Chicago's new mayor also refused to intervene, though personally opposed to abortion, saying that this was a private matter between the patient and her doctor. Others noted that a total ban on abortion would be achieved only at tremendous cost, were certain it would lead many desperate women to tragedy and death, and hoped that reason and tolerance would prevail.

PERSONAL VIEW

With women in mind

Milica Brozović

It gradually dawned on me that the medical profession was guilty of a special kind of discrimination against women patients. I first became aware of it as a young and very foreign research assistant in a famous London hospital some months after arriving in London. I developed abdominal and back pain, tolerated it for a few days, and then consulted a senior colleague, an eminent gastroenterologist. He was kind, examined me, and talked to me for nearly half an hour. He said that I had the irritable bowel syndrome. He also told me all about the stresses that young married women in medicine had to contend with in order to reconcile their career and their marriage. The next morning I had high fever, brisk haematuria, and pyelonephritis.

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My unease about the diagnostic acumen of my colleagues in my own case was reinforced a few years later. I woke one morning after a difficult night on call with a tight chest and very short of breath. I crawled to casualty. They suspected overbreathing, and I was handed a paper bag to breathe into. It did not help. Some days later it became clear that I had glandular fever and pneumonia.

But it was not just me; many women have similar experiences. A friend of mine in her late 40s became depressed, fearful, and anxious. She lost weight and complained of palpitations. She had always been healthy and had not attended her general practitioner for many years. He was understanding and talked to her at length. She discussed the problems of bringing up teenage children and the increasing workload associated with her job. He examined her and told her that he thought all her symptoms were caused by stress and fatigue made worse by her "special" age. Such symptoms were common in women of her age and not really sinister. She came to visit me some weeks later. I was shocked at her appearance: she was thin and sweaty, with bulging eyes and a rapid, irregular pulse. I took her to the casualty department at my own hospital there and then. Her hyperthyroidism was immediately treated.

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Another friend changed jobs. The new job proved to be rather difficult, and she became anxious and tired. Three months into her new job she developed intermittent crampy abdominal pain. Her general practitioner diagnosed irritable bowel precipitated by the stress of her new job and suggested a short period of sick leave to allow her time to adjust. The pain did not subside, and she consulted him on several occasions. Some three months later she noticed that the pain was associated with spasms visible through the abdominal wall. Very frightened, she called at the local casualty department. She was examined, the diagnosis of irritable bowel confirmed, and an appointment for the gastroenterology clinic made for three weeks hence. Within two days she was very ill, and in desperation her husband asked me for help. She looked drawn, was dehydrated, in severe pain, with visible peristalsis and an easily palpable mass in the left iliac fossa. She started vomiting the same night and was admitted as an emergency. On operation cancer of the sigmoid colon was found.

By then I was convinced that these and many similar episodes were a manifestation of discrimination against women patients by male doctors. I realised that I was wrong when I found out that I was no better than my male colleagues. For many years I had followed up a patient with stable benign paraproteinaemia. She was voluble, polysymptomatic, and rather overwhelming. In the summer before her last visit her elderly father had died and she was left entirely on her own. When she saw me in the clinic she complained of nausea, thirst, dry mouth, aches and pains, insomnia, and tremor. I was very patient; but I spoke about the known effects of bereavement, the need to find outside interests, and hinted (I hope gently) that she was wasting my time. I gave her an appointment in a year's time and heaved a sigh of relief. The laboratory telephoned three hours later to tell me that she was grossly hypercalcaemic with a total protein of over 100 g/l. Her benign paraprotinaemia had become a very malignant multiple myeloma.

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What is it that makes responsible, caring, and competent doctors overlook organic disease in women and consider all symptoms and signs to be due to stress, or "time of life," or psychosexual problems, or simply "the supratentorial element"? My original theory implicated medical education. It is traditionally dominated by men who are consciously or subconsciously propagating the view that women are weak and emotionally unstable. It cannot, however, be the whole explanation. For many years an increased number of excellent women medical teachers have participated in the education of young doctors, yet this attitude to women patients affects young as well as old doctors. Admittedly, the attitude is more blatant in some older doctors, but many younger ones, while very sympathetic, are in practice no better than their seniors.

Perhaps the doctor of either sex in his or her paternalistic role needs to assert that the woman patient conforms with the categorisation of weak, vulnerable, and emotional. Or is the opposite true? The doctor may need reassurance that the woman patient is in fact strong and indestructible. If the mother or the daughter or the wife were to pull herself together she would be all right and could assume her role as the carer, the handmaiden, and the support crew. There must also be something in the patient herself that triggers the response in the average doctor. Whatever the cause, this attitude to women is or may be damaging. It may cause delayed diagnosis, less than optimal treatment, and poor follow up, especially if the woman is shy or is culturally or socially disadvantaged.

By just recognising it in ourselves we may be able to offer better care to many women.

Milica Brozović is a consultant haematologist from London