Medicine still needs feminism

Women continue to lack equality of opportunity, writes **Helena Watson**, considering family planning, subfertility, and childbirth

Whenever I hear of the shackles of patriarchy, I implore, "Come and see where I work!" On labour ward a diverse group of mainly women thrive in a high stress environment that requires equal measures of quick thinking, physical stamina, skill, and compassion. Our foremothers would be proud. Over the past century childbirth has become safer and less painful; women are no longer prisoners of their biology thanks to contraceptives, and the stigma of subfertility is being reduced at the frontier of medical science. Couple this with vast improvements in breast cancer care and awareness, and you might think that feminism's work is done in medicine. Indeed, some believe the pendulum has swung too far.

I would argue that in complacency and in gratitude we ignore legions of feminist issues still left to fight.

Firstly, consider the benevolent sexism deeply embedded in the culture of pregnancy: the patronising tendency to shelter women from the truths of childbirth. This attitude results from the gentlemanly tradition of protecting so called vulnerable pregnant women and the well meaning crusade for normalising childbirth. The resulting lack of preparation and awareness that accompanies many women to the labour ward ensures that what may be a common and safe obstetric outcome is forever perceived as traumatic to the woman.

In one qualitative study, mothers, most of whom had attended National Childbirth Trust classes, described guilt and sadness at the chasm between their expectations and the reality of childbirth.[1] Women would be far better placed to make informed decisions about pregnancy and birth if they were familiar with the basics. The popularity of the UK television shows *One Born Every Minute* and *Call the Midwife* shows a public curiosity for the subject, which we should exploit as there may be pitfalls with the media's provision of antenatal education.

Squeamishness about female anatomy leads to superstition. When will we see *Loose Women* discussing menorrhagia, let alone prolapse?

Much debate exists in obstetrics about a woman's right to choose a caesarean section or non-conventional home birth. Although pertinent, this preoccupation with intricacies of maternal choice exemplifies a frustration I have with modern feminism: too much focus on the opportunities afforded to educated middle class women. Today's feminism ought to be standing up for those less privileged who may not yet be benefiting from conventional care.

A recent recommendation for interpretation services was prompted by the high maternal mortality among women who don't speak English.[2] The mortality rate continues to be significantly higher for black women than white women. What can we do to reach these women and make the world more equal for them?

After more than 50 years of the contraceptive pill, the fact that more than half of UK pregnancies are unplanned is staggering. What prevents women controlling their own destiny, and do we do enough as professionals? Caitlin Moran's candid discussion about the taboo of abortion in *How to be a Woman*[3] made me examine my own reticence to discuss reproductive choices in early pregnancy settings. As doctors it is more comfortable to assume that every pregnancy is wanted, unconsciously contributing to the social pressures on women to continue the pregnancy. Perhaps our vocation renders us fantasists about motherhood, loath to disrupt the idyll and confront difficult issues such as postnatal depression, female genital mutilation, and domestic violence.

In subfertility consultations, the common absence of the male partner demonstrates how much stigmatisation and blame remains. Such attitudes are worse in some ethnic groups, where the strain of subfertility may also be worsened by the prevalence of conditions like fibroids, a shortage of oocyte and semen donors,[4] and lower success rates for in vitro fertilisation.[5]

When our wombs are not carrying babies how do we speak of them? Surely the *Sex and the City* generation has unearthed the great mysteries of a woman's "insides." I'm afraid not. We all know women martyring themselves for their wombs—walking around with rock bottom haemoglobin, terrified of flooding, because a hysterectomy is still perceived by many as a mortal wound to their femininity. Squeamishness about female anatomy leads to superstition and hearsay dominating decision making about many gynaecological interventions, from intrauterine devices to hormone replacement therapy. When will we see *Loose Women* discussing menorrhagia, let alone prolapse?

Readers may struggle with the word feminism: it has been tarnished by the caricature of a man hating fundamentalist. It is a word the likes of Sheryl Sandberg[6] and Caitlin Moran are helping us reclaim, by bringing feminism up to date, with humour, honesty, and room for men. It is not about equating men and women, but making opportunities equal. The sort of feminism I believe in also means a more inclusive attitude towards men. I was pleased to discover that King's College Hospital now permits fathers on the postnatal ward 24 hours a day, but most hospitals still turn the fathers out at night, sending the wrong message about fatherhood from the start.

In conclusion, the medical world, with its legions of strong, intelligent, nurturing women and men has a unique platform for promoting sex equality. We have more female leaders than in commercial or political spheres, and have the doctor's privilege of confidence and influence at crucial moments in people's lives. We have come so far, but we should be honest about where sexism remains. Feminism is not a dirty word.

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NO HOLDS BARRED **Margaret McCartney**

Research press releases need better policing

Blaming the media for bad reporting is good sport. It's easy to find headlines in the broadsheets as well as the tabloids breaking health news with overstated research findings. Caveats of scientific conclusions are often abbreviated or absent. Scientific uncertainties can be left diminished or invisible.

The media have been repeatedly blamed for misinformation and health scares, and no wonder: when patients voice or act on misconceptions in the press, trying to redress the balance can eat up scarce clinical time.

I confess a previous secret pleasure in playing the dissing bad headlines game. My own crossness with bad health reporting was the reason I started writing. But the rules were never fair, I now realise.

Doctors and scientists are expected to be trustworthy, and journalists may reasonably assume that press releases present the facts fairly, unambiguously, and without spin. For a few chosen authors, media officers at universities or journals will decide their paper is worthy of a press release. It will be sent out under embargo, before the research is published. The aim is to generate interest in the paper.

The press release encouraged "yoga, meditation and mindfulness" despite the study considering none of these interventions

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A typical press release will contain a summary of the paper, a few statistics aching to be used in a headline, and some quotes from the authors. Some include access to the full paper; but others don't.

The result can be bad reporting. For example, when the press release's first line says, "Eating 7 or more portions of fruit and vegetables a day reduces your risk of death at any point in time by 42%"[1] and that the effect was "staggering," no wonder the press bounced "42%" around, and the BBC used the headline, "Seven-a-day fruit and veg 'saves lives'."[2 3] But this study was capable only of finding association and not causation.[4]

And then there are postulated add ons. For example, in a study that found higher salivary concentrations of one of two possible markers for stress in women trying to conceive, the author in the press release encouraged "yoga, meditation and mindfulness"[5] despite the study considering none of these interventions.[6]

The CONSORT (Consolidated Standards of Reporting Trials) guidelines have been successful in improving the reporting of randomised controlled trials.[7] Yet we know that the public still miss out: half of press releases on randomised controlled trials get spun.[8] We urgently need to ensure the public get better information about medical research. We need guidelines for press releases. Research should be placed in context, caveats made crystal, limitations defined, and the meaning of an association spelled out. And relative risks should be banned forthwith.

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BMJ BLOG OF THE WEEK **Päivi Hietanen and Matthew Richard**

Providing healthcare in a Syrian refugee camp

Assisted by the UN Refugee Agency (UNHCR) and the Jordanian authorities, large families flee their homes in war torn Syria to seek refuge in Jordan. Refugees cross the border in the shadows of night carrying their life possessions in rope bags and cardboard boxes. They are first registered at the Raba Al-Sarhan reception centre where they receive immediate medical screening and vaccinations against polio and measles, along with vitamin A supplements. Patients with more serious medical conditions, often the war-wounded, are referred directly to a hospital in the nearby city of Mafraq. The rest are then transported to their new temporary homes at Zaatari refugee camp.

Zaatari camp opened in July 2012 and has grown exponentially ever since. The camp is now at full capacity and is in the process of moving from an emergency settlement to a well organised tent and caravan city. However only a fifth of the 600 000 Syrian refugees in Jordan are living in the camp, the rest have been absorbed into communities across the country. This is a concern for UNHCR and its partners as it is much harder to provide healthcare assistance to refugees outside the camp.

There are almost a hundred doctors working in clinics across Zaatari. Inside the camp there are five primary healthcare facilities and three hospitals with ambulance services to the nearby hospital in Mafraq for more serious cases. Common medical cases include diabetes, scabies, infections, headlice, skin diseases, and treatment of the war wounded. Many of the refugees suffer from post-traumatic stress disorder related to the fighting witnessed in Syria. This condition is treated to a degree through psychological support at the clinics. Clinics also provide reproductive education, maternal and postnatal care. Disabled people and the elderly have their own specialised care units and facilities. Malnutrition is not a significant issue in the camp, however there is a contingency treatment plan in place for vulnerable children.

Zaatari functions very well, however, there are still many challenges to overcome—for example the use of communal toilet and washing facilities in the camp. Refugees naturally do not want to share these facilities with large groups, especially women and young girls who are at risk from harassment. To avoid the communal facilities refugees have developed their own private latrines adjacent to their tents and caravans. The logistics for camp management to collect wastewater from thousands of private pits is near impossible. This poses a serious health risk with the approach of summer and the potential outbreak of acute diarrhoea and cholera.

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