

COMMENT

Logical Contradictions in Feminist Health Care: A Rejoinder to Peggy Foster

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Peggy Foster's article (1989) aims to look at the principles and practice of the feminist health care model, within which the doctor/patient relationship is radically redesigned. Her article is a timely, welcome and excellent exposé of the problems women have with health care. She presents an enlightening account of current attempts to introduce health care delivery based on feminist principles, outlining future possible strategies and pointing out the problems that might arise.

However, the term 'feminist' or 'feminist principles' is one that is sometimes very loosely used. Of course feminism is not something that can be pinned down and defined very easily, if at all; but in order to outline strategies or policies based on feminist or any other principles, any suggestions for practical policy should be consistent with the theoretical base from which the problems have been identified. Contradictions and discrepancies arise when the strategies that are suggested involve a change in existing political and social institutions, whereas the causes of the problems have been identified as emerging from deeper structural levels.

Peggy Foster acknowledges that 'different groups of feminists hold alternative views of the basic causes of women's negative health care experiences' and thus have different solutions to the problems (p.340). She claims that radical feminists say modern medicine is inherently patriarchal and *see* attempts to improve the doctor/patient relationship as misguided and pointless. She plans to discuss health care from a 'reformist/liberal and socialist' perspective, claiming that these feminists 'tend not to blame male doctors for all women's negative health care experiences' (p.340–1).

However, there seems to be a slippage between the problems Peggy

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Foster identifies and the solutions, or possible strategies, she outlines. The four-pronged critique of current health care delivery can be traced to the more radical feminist theories of women's oppression, yet Peggy Foster approaches the solutions to these problems within a liberal framework. The strategies she outlines may well be necessary pragmatic measures in the immediate future but it is important that the task of outlining practical changes should not be confused with the task of explaining the existence of those problems.

To highlight the contradictions of Foster's statement of the problems and her outline of solutions, I intend to do the following:

1. Outline the tenets of three of the basic strands of feminist theory—liberal, radical and socialist, spending most time on liberal and radical theories as I take them (for the purposes of this article) to represent the tension in Peggy Foster's argument.
2. Examine Peggy Foster's outline of the feminist critique of the present health care system in the light of these different perspectives.
3. Make a comparison with the policy and practice of a specific area of women's health care: prenatal screening and diagnosis.
4. Conclude by outlining the limitations of the more liberal feminist approach but with a view to positive action and thought rather than negative fatalism, highlighting the contradictions and divisions within current feminist analysis.

LIBERAL FEMINISM

Liberal feminism emerged alongside liberal political and democratic theory. The latter's claim for freedom and the pursuance of individual rights has constantly been accompanied by the expression of dismay that those liberal ideals seemed only to apply to men and not to women. Liberal feminism has taken on board the principles of liberalism claiming that women have an equal potential for reason and thus have an equal right to be protected and enfranchised by the law in the same way that men are.

The liberal feminist perspective places the roots of women's oppression, or more properly women's inequality, in the subordination and denial of women's rights. In the twentieth century, liberal feminist theory and practice has concentrated on:

1. The negative effects of gender role stereotyping, particularly but not exclusively on women.
2. Unequal opportunities.
3. The merits of positive discrimination and/or the attempts to achieve a 'critical mass' of women in areas previously dominated by men, for

example, science professions, higher management levels and the Houses of Parliament.

Liberal feminist theory emanates from existing political theory. Liberal feminist practice works within the existing political system with, for example, lobbying for legislative reform for equal rights and the creation of pressure groups to promote women's interests and their fuller integration into public life (such as the EOC and the 300 Group). The causes of women's inequality are assumed to be founded on irrationality and ignorance, thus the application of reason and knowledge together with legislation to outlaw discrimination, along with positive moves to enhance women's life chances, will eventually eradicate such injustices.

RADICAL FEMINISM

Radical feminism is a relatively new phenomenon emerging alongside the 'leftist' movements of the 1960s. It presented a radical new theory (or more accurately *theories*) of women's oppression with correspondingly radical practical strategies to combat that oppression. From a radical feminist perspective there is a common and universal oppression of women. Obviously, women of different races, classes and colours will have enormously different experiences of life, but for radical feminism, the systematic existence of patriarchy is fundamental. There are many definitions of patriarchy; I will cite one of them:

... a familial-social, ideological, political system in which men—by force, direct pressure or through ritual, tradition, law and language, customs, etiquette, education and the division of labour—determine what part women shall or shall not play and in which the female is everywhere subsumed under the male (Adrienne Rich, quoted in Diana Coole, 1988, p.261).

There are three striking differences in the premisses of liberal feminism and radical feminism.

Firstly, liberal feminism accepts the liberal theoretical belief in *one* human nature and one human culture, whereas radical feminism asserts that there are two distinct human cultures. One is the male culture, traditionally defined, perceived and internalised as the standard or norm. The other is female and more closely associated with nature rather than culture and thus is seen as secondary and inferior to male culture.

Secondly, radical feminist theory postulates that women are ascribed a specific role and status in society which has been defined by men and exists to serve the interests of men to the detriment of women. From the liberal feminist perspective, human individuals are of the same ultimate worth and potentiality and no specific roles are ascribed; they may be chosen but they are not ascribed.

Thirdly, whereas liberal feminism assumes that the basic unit of society, as identified by traditional liberalism—the individual—includes women as well as men, radical feminism claims that this basic individual is male and does not, and in the main is not intended to, include women.

Radical feminist theory claims that the oppression of women is rooted in male control of women's fertility and sexuality (Jaggar, 1983). Women are defined in terms of their reproductive and sexual capacities, which serve the interests of men. Women are seen primarily within the confines of their roles as mothers and wives. It is argued that the tenets of liberalism do not apply to women in the same way that they apply to men. For example, radical feminist critiques of traditional democratic theory point out how traditional theorists such as Rousseau, Locke and even J.S. Mill (and many more), define women's 'natural' role in terms of their duty to men and children (Coole, 1988; Zalewski, 1990).

Radical feminism criticises the dominance of modernist thought which encourages a tradition of binary divisions with their attendant ascribed statuses (culture/nature, reason/emotion, aggressiveness/passivity). The claim is that such divisions, as they are applied to women and men, serve to create a hierarchy—with women at the bottom. Women, therefore, are not only defined in terms of their use to men, but also in terms of their inferior abilities.

In order to combat women's oppression, radical feminists want to promote a womanculture which celebrates the traditional qualities of women—nurturing and caring—and, in varying degrees, advocates a political practice of separatism in terms of creating women-centred and women-only institutions.

SOCIALIST FEMINISM

Contemporary socialist feminist theory combines the insights of radical feminism with a marxist appreciation of the dynamics of historical materialism and economic exploitation. From this perspective, there is no belief in a universal mode of domination, but an understanding that there are many forms of domination, exploitation and oppression (class, race and gender, for example) and all need to be eradicated.

The realities of patriarchy and capitalism mesh together to create a society in which men as well as women suffer oppression, but women suffer the double oppression of both patriarchy *and* capitalism. Socialist feminism moves on from a more traditional marxist analysis of women's oppression to include sexual and procreative activity. Women and men will only be free when they have control over the means of production. But the liberation of women entails the regaining of control over sexual and procreative activities.

Socialist feminist practice is multifaceted, incorporating, for example, separatism, community childcare and a boycott of luxury goods and of goods made by exploited third world women (Ramazanoglu, 1989, p.175).

IMPROVING THE DOCTOR/PATIENT RELATIONSHIP: A FEMINIST PERSPECTIVE?

Peggy Foster identifies four main strands to the feminist critique of health care, focusing particularly on the nature of the doctor/patient relationship.

1. Doctors' diagnoses of women's problems are based more on subjective assertions about women's natural drives and roles than on scientific facts about their physiology (p.338).
2. Doctors' perceptions of women's role in society—as primarily centering on home and family—hugely influences their advice to women patients. Women who have paid jobs and complain of tiredness, exhaustion, stress and depression, are often advised to give up their paid work rather than get extra help in the home (p.339). (I can confirm that this exact situation happened recently to a friend of mine—and the doctor was female!)
3. The advice or medical treatment sometimes suggested by doctors is often perceived as being for the good of society as a whole—such as the sterilisation of 'stupid' or 'feckless' women (p.339).
4. Doctors tend to push patients into very passive roles, not often appreciating patients, particularly women who appear to be 'know it alls' (p.340).

Where do these critiques fit in the light of the feminist perspectives I have outlined? Taking the first two together, there is much evidence, both from systematic social research and anecdotal sources, that women's primary role is still seen as mother and carer for her family. Women are still constantly expected to sacrifice their health, time and independence in order to serve their families. This is seen in an extreme form on those rare and tragic occasions, when women, pregnant and suffering from serious or terminal illnesses, refuse treatment because of the effect on the fetus. This sacrifice is regarded as the pinnacle of altruistic motherhood.

But within which of the theoretical categories I have outlined can such an observation be placed? The ascription of a specific role for women can be squarely located within radical feminist analysis. Beliefs about women's natural drives and/or passivity can be placed similarly. However, an equally important point is that such perceptions of women are not confined to doctors or the medical profession generally, but are

views commonly held and entrenched in society as a whole. These views are reflected and reinforced by social and legal conventions such as the laws on abortion, rape and welfare benefits (see Zalewski, 1990).

Foster's third critique suggests that doctors often prescribe with the good of society as a whole in mind, for example, making judgements about the suitability of some women to give birth. Liberal ideology, both traditional and feminist, begins from the premise that the individual must be the best and final judge of their own best interests (given the prerequisite of adequate information) and that it is the individual's worth which is paramount. To make a judgement about an individual, in terms of either their use to society or their suitability in one way or another, moves well away from such liberal ideals. It is, however, compatible with socialist and radical feminist analyses which identify women as being defined and perceived in terms of their use to men and society in general.

The fourth critique has more ambivalent roots. Those in the higher echelons of the medical profession generally perceive themselves (and are perceived) as having expert knowledge and tend not to encourage 'equal' participation in decision-making by patients. However, the evidence as cited by Foster (p.340) indicates that women are expected to take a more passive role than men—which again is rooted in a more fundamental perception of what it is to be a woman.

In sum, the problems with women's health care as outlined by Peggy Foster are fundamentally structural and no amount of tinkering with various aspects of the health service can hope to change this underlying fault. The inherent contradictions of applying liberal solutions to structural problems are highlighted by Peggy Foster, for example, with her comments that a capitalist/patriarchal state is unlikely to create welfare services which are solely designed to meet the needs of the least powerful groups in society (p.355).

A COMPARISON WITH PRENATAL SCREENING AND DIAGNOSIS

Turning briefly to my own area of research, prenatal screening and diagnosis, I want to look at this area in the light of Peggy Foster's critique of women's health care and the feminist perspectives I have outlined.

A recent *Report on Prenatal Diagnosis and Genetic Screening* (Royal College of Physicians, September 1989) describes the objective of prenatal diagnosis as 'to provide reassurance when the fetus is unaffected, and information, prognosis and choice, when a severe abnormality is present' (p.51).

Two years ago, the King's Fund Forum, which had convened to discuss prenatal screening and diagnosis, issued a statement which described

prenatal screening as 'a means of acquiring information that increases the scope for choice by participants ... a goal of our society is to promote the autonomy of our citizens' (p.2).

It is clear that prenatal screening is presented within a classical liberal framework, identified as providing more information and thereby facilitating greater choice. However, this description of prenatal screening and diagnosis presupposes that the choices pregnant women make are free choices, free of ideological baggage and accompanied by viable alternative choices. However, the emergence of prenatal screening and diagnosis as a service has taken place in a society where there is already a strongly entrenched belief that one of the primary roles of women is to bear not just babies but certain types of babies—those which are 'normal'. In a society where it is not easy for a woman to get an abortion for reasons of her own, it is relatively difficult for women to turn down the offer of a termination when her fetus has been diagnosed as abnormal, despite the fact that it is impossible to predict prenatally the severity of the abnormality, as is the case, for example, with Down's Syndrome.

However, it is also abundantly clear that many women are thankful for the possibility of terminating an abnormal fetus. The difficulties of raising a child with an abnormality can be enormous. But is not this choice to abort defined more by the structure and ethos of our society, in which a mother of a Down's Syndrome baby is faced with the knowledge of having a child that has been labelled as abnormal and in which the main responsibility for childrearing falls on the mother? From a socialist feminist perspective childcare would be a much more shared enterprise, not just within families but at a community level. If the structure of society was changed in this way, together with a move away from dividing people into those worthy of life and those not, women might feel they had more choice, as there would be a real viable alternative to termination. It must always be remembered that abortions are not something women like, or do not mind having. Abortions are traumatic experiences, particularly later on in a pregnancy when most terminations for abnormality are carried out. There is some evidence to show that women suffer much more psychologically after 'genetic' terminations than after abortions for 'social' reasons, the former being initially wanted fetuses unlike the latter (Donnai et al., 1981).

Prenatal screening and diagnosis has expanded enormously since the 1960s, with increasingly sophisticated techniques for examining the 'pregnant uterus' (a term used in Kohorn et al., 1968). The best ultrasound equipment can now detect minute structural abnormalities

and can even measure blood flow and it is likely that the earlier method (between 8 and 11 weeks' gestation) of invasive screening, chorionic villus sampling (as opposed to the more established amniocentesis) will enter into widespread use. There is no doubt that some women have benefited from the service but there is evidence to show that the increasing use of such screening tests is having a detrimental effect on the vast majority of women who are carrying normal fetuses (Dr. Martin Richards, head of Cambridge University's Child Care and Development group, quoted in *The Guardian*, 14 September, 1989). Although at an individual level some women do benefit and many doctors are indeed caring and compassionate about their patients, it should be pointed out that the growth of prenatal screening and diagnosis began with a concern that Britain's perinatal mortality figures compared unfavourably with comparable countries (*British Medical Journal*, 1961). At about the same time (early 1960s), concern was also being expressed about the likelihood of a population explosion, prompting suggestions that a reform in the abortion law was needed (*British Medical Journal*, 1965). I mention these facts because it seems that the emergence of services such as prenatal screening and diagnosis, plus the eventual reform of the Abortion Act, had much more to do with the good of society as a whole, rather than with the needs and desires of individual women.

CONCLUSION

The main claim of this rejoinder is that despite the advances and insights made by Peggy Foster in her article there remains a dilemma, one that applies to most feminist attempts to deal with existing political and social infrastructural issues. That dilemma is that the problem can only be understood within a more radical feminist perspective and yet any solutions to the problem have to be within the realm of the practical; and this location of solutions within the practical fits most easily within a liberal feminist framework. Peggy Foster is indeed aware of these problems but one is left nonetheless with the feeling that her own solutions to the problems of women's health care would not meet the objections she so pertinently points out in her four-pronged critique of existing health care provision.

But where does this leave us for policy prescriptions and strategies for change? If an understanding that many of the causes of women's negative health care are grounded in the patriarchal perception of women and their role in society leads us down the path of despair and fatalism, then it is not surprising that Peggy Foster eschews radical feminism as a viable theoretical and practical tool and instead suggests

alliances with other groups and a watering down of demands (p.359). But we must understand that even if improvements in women's health care along liberal feminist lines can be likened to 'plastering over the cracks'—a temporary measure but doing nothing to repair the underlying structural fault—they are indeed very necessary measures. The alternative would be to regress and ignore the positive benefits that liberal feminist solutions can offer. Incremental changes can change some aspects of health care, albeit slowly; but the scope and depth of change is finite when approached within a purely liberal feminist framework.

Radical feminism, in so far as it offers a solution to the problems of women's health care, comes up against two problems:

1. Separatist women's health care, as it has been practised, reaches only a small minority of women and has little impact on mainstream services (as pointed out by Peggy Foster, p.349–50). Moreover, most radical feminists believe that changes within health care are unlikely to make much difference. They feel that separate health care is one major way to help women and is therefore good in itself, but remain convinced that the source of the problem is not to be found in the health care system: it is structural and lies elsewhere.

2. The current move towards a more market responsive NHS may have the effect of curtailing the small amount of money currently used to fund Well Woman Clinics. Added to that danger are the lessons to be learned from the American experience. Worcester and Whatley (1988) describe how the American model of Well Woman Clinics—Women's Health Centers—are being usurped by mainstream medical care. Women have been accurately identified as major consumers of health care and therefore represent a potentially highly profitable category of consumer. Worcester and Whatley claim that women are being enticed into choosing particular health care practices by advertisements such as one which has the caption 'we know how you feel' underneath a picture of two women health care practitioners (1988, p.121). Worcester and Whatley point out that while this is positive in many ways, having women practitioners does not guarantee a particular (feminist) philosophy. The reality is that profit is the main goal of these services and not the delivery of health care to women along feminist lines. The point is that separate health care, under those circumstances, may lead to greater market control over women's health care.

In short, radical feminism is dubious as to the *impact* of separate health care. The fundamental cause of the problem is seen to lie in the wider societal and political arenas. This does not mean that the radical feminist

analysis cannot explain the problem of women's health care, but nor does it mean that this perspective can offer practical solutions *within* the health care system.

However, it seems that we end up at an impasse: radical feminism offers the theory but liberal feminism offers the practical solutions. One way out of this impasse is to recognise what the nub of the problem is—the lack of a more thoroughgoing and comprehensive feminist theory and practice. This should not lead us down the path of setting up different camps of feminism as such divisiveness tends to obscure strategies for liberation rather than make them clearer. As Jaggar points out, the aim is not to expose rival theories as pretenders or to find some ideal theory of feminism, but to contribute to the present range of theories in order to help women further their liberation (1983, p.5).

If two of the goals of feminist analysis are to extend our understanding of gender relations (Flax, 1987) and to alleviate sex specific (particularly women's) oppression, then we must recognise that there are contradictions within feminist theory and practice. They must not be allowed to fragment and divide. But crucially it must be recognised that progress, within feminist theory and practice, will be severely restricted if feminist analysis initially emerging from a more radical perception of women's oppression, which does not have its roots in standard political and social theory, returns to suggest practical policies which are embedded within and limited by the nature of the existing political and social structure.

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