

**IN THEIR OWN WORDS:  
WOMEN'S SUBJECTIVE EXPERIENCE OF MEDICAL/HEALTH CARE INJURIES.  
THE CASE OF OBSTETRICS AND GYNAECOLOGY.**

**By**

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**B.A., Simon Fraser University, 1993**

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THE REQUIREMENTS FOR THE DEGREE OF  
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## ABSTRACT

During the 1970s, and again in the 1980s, the United States experienced increases in levels of litigation, insurance premiums and awards for damages. These led to the perception of a "crisis" in medical malpractice. As a result of this perception, measures were taken to curtail the problems attributed to this "crisis". Although the Canadian rate of malpractice litigation has not reached the proportion of that experienced in the United States, within the last decade, the number of claims for medical malpractice has increased resulting in the general perception that Canada has or is also experiencing a crisis. To prevent the exportation of the United States crisis into Canada, the Deputy Ministers of Health commissioned the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care [the Prichard Review].

The Prichard Review found that the majority of people who are injured do not file claims and of those who do, only a small number receive compensation. It concluded that there is the potential for an increase in the number of suits filed, and therefore the possibility of a "crisis". The report indicates that all medical specialities are concerned and affected by medical legal liability, but obstetrics and gynaecology are especially concerned. As many obstetrician-gynaecologists leave the practice, or refuse to take "high risk" patients, and as fewer medical students opt for this speciality, the provision of reproductive care to Canadian women is in jeopardy.

Medical negligence has received considerable attention within legal, medical and academic circles, but very little is based on empirical studies. Moreover, these studies tend to focus on the financial and legal aspects of the problem. Despite the vast body of literature and the alleged concern for the uncompensated patient, women's experiences of medical malpractice have not been empirically investigated. Women's inaudible voice and invisibility within this body of literature is indicative of practices within society at large wherein women are relegated to the margins and sometimes to obscurity. This thesis, with its emphasis on the "standpoint" of women who have suffered obstetrical or gynaecological medical/health care injury, addresses in part, this gap in the literature. Women who have suffered adverse effects during the receipt of obstetrical/gynaecological care provide the case study for this thesis. I use Feminist Standpoint Epistemology as a conceptual framework to "think" women's exclusion.

## DEDICATION

To the memory of my mother, D.J. and to all women who refuse to be silenced, especially those who shared their experiences with me.

## ACKNOWLEDGEMENTS

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The Evidence Act. R.S.B.C. 1979, c. 116

Family Compensation Act. R.S.B.C. 1979, c. 120

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Negligence Act. R.S.B.C. 1979, c. 298

## Chapter 1: Introduction and Review of Literature

### 1.1 *The Medical Malpractice Crisis: A Background*

The last few decades have seen increases in the frequency and severity of malpractice claims in Canada, the United States and some Commonwealth countries. These increases generated a preoccupation with malpractice which in turn produced a vast amount of literature. The word "crisis" appears in the literature with some frequency. Stakeholders such as doctors and insurance carriers, assert that this "crisis" is caused by an "excessive number of suits, brought by disgruntled patients urged on by ambulance chasing lawyers, who sue whenever medical care fails to deliver a perfect cure" (Danzon 1985, 4). Patients have always been susceptible to injury in their contact with physicians. Since doctors have constantly been liable for medical negligence this leads us to wonder why this issue is now attracting such media and academic attention. Is this "crisis" a perception or is it real? What is the nature of this "crisis" and who are the real victims? Specifically, why are obstetricians concerned about medical malpractice and insurance costs?

Canadians often view developments in the United States as leading indicators of future developments in Canada (Deweese et al. 1990, 2.3). During the 1970s and again in the 1980s the United States experienced increases in the frequency and severity of malpractice claims and in the number of claims per occupied bed (ibid.). Insurance companies responded to these changes by increasing malpractice insurance premiums. However, the rise was not in proportion to the increase in severity and frequency of malpractice claims. Instead, between 1974 and 1975, insurance companies sought premium increases between 200 and 500 percent (Danzon 1985, Robinson 1986, Wadlington 1991). Danzon (1985) notes that these increases had a significant impact on medical doctors as they experienced a fear that

malpractice insurance coverage would become unavailable because of insurance companies withdrawing from the market. The increases in insurance premiums and companies' withdrawal from the market forced health practitioners to either form their own companies or practice without coverage (ibid.). Dewees et al. assert that based on the United States changes, it was reasonable for Canadian doctors to believe that there would be similar occurrences in Canada (1990, 2.3).

### **1.1.2 The Canadian Crisis**

About a decade ago there was a perception within the health sector that Canada was becoming as litigious about medical malpractice as the United States. There was also a belief that litigation was leaving doctors to face huge court costs (Financial Post May 18/20 1996, p. 12). Doctors concern about malpractice and malpractice insurance is still present within the medical profession as these newspaper headlines make clear: *Malpractice malady: Soaring malpractice insurance costs are driving obstetricians from their field and other specialists may be close behind* (Financial Post 90 (20) May 18/20, 1996, 12); *Baby doctors quitting in droves because of insurance costs, Says Ontario Medical Association* (Canadian Press Newswire May 17, 1996); *Premiums could drum obstetricians out of business* (Canadian Press Newswire, December 26, 1995); *Obstetric crisis: fewer MDs birth babies and the trend gets worse* (Medical Post v. 28 (18) May 5, 1992, p.1, 21).

The Canadian rate of malpractice litigation is significantly less today than that of the United States (Danzon 1990, Dewees, Trebilcock and Coyte 1991).<sup>1</sup> The ratio of claims per physician in the United States is more than eight times that in Canada (Dewees, Trebilcock and Coyte 1991, 218 footnote 2). Nonetheless Canada also experienced increases in the

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<sup>1</sup>See Tables 1, 2, 3 and 4 at pages 219, 220, 221 and 222 in Dewees, Trebilcock and Coyte, 1991. See also Danzon 1990 for a comparison of trends in the United States, Canada, the United Kingdom and Australia.

frequency and severity of malpractice claims. For example Dewees, Trebilcock and Coyte note that between 1971 and 1990, the number of claims paid per 100 physicians grew at an average compound annual growth rate of 4.9 percent representing a 150 percent increase in the paid claim frequency rate over this period. However, average compound annual growth rate in claims filed per 100 physicians in Canada was 6.1 percent, implying that the claims frequency trebled over this period (ibid.). However, a slight increase in the base number became statistically significant because Canada experienced very low claim rates in the past.

Doctors in general are concerned about malpractice litigation and insurance costs. However, obstetrician-gynaecologists, especially those in Ontario, are particularly concerned because they face higher insurance costs. For the past decade, Provincial Ministers of Health have helped to subsidise physicians' malpractice insurance premiums as a way of minimising insurance costs for doctors. Subsidies maintain physicians' premiums at the 1986 levels. Early in 1996, the Ontario government discontinued its practice of subsidising physicians' premiums. In response, many obstetricians threatened to leave the speciality. These practitioners complained that medical malpractice insurance was too expensive for them to practice without the subsidies (Financial Post Daily, June 19, 1996 p. 51). Ontario's Health Minister, Jim Wilson recently restored the subsidy after provincial health ministers endorsed a proposal for an independent audit of the CMPA to be chaired by Justice Charles Dubin (CMAJ August 1, 1996).

The current perception of a crisis in medical malpractice in Canada is not new. The perception that Canada was experiencing, or would soon experience a crisis in medical malpractice was the focus of a national review. It has been nine years since the review was commissioned and six years since its report issued. Nonetheless, newspaper headlines such as the ones cited above are quite pervasive today. Hence, there is a need to question the initial

purpose of the review, why was it commissioned and what were its mandate, findings and recommendations.

## 1.2 *The Prichard Review*

A fear that Canada would experience a crisis in proportion to the United States propelled the health sector to advocate legislative changes. The Canadian health care community, insurance companies and some members of the judiciary urged that tort reform be implemented. In 1987, The Conference of Deputy Ministers of Health, responded by commissioning the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care [The Prichard Review]. The Prichard Review was commissioned with a mandate to "obtain an empirically based understanding of the recent growth in civil litigation *against health care providers* and the effects of this litigation on the quality, cost and availability of health care in Canada" (Prichard 1990, 1-2). The Prichard Review assessed several aspects of liability and compensation in health care in Canada. The terms of reference were:

1. To examine and report on the issues relating to liability and compensation matters associated with health care delivery provided by professionals, institutions, voluntary organisations and the Canadian Blood Supply system.
2. To advise on possible legal reforms designed to ameliorate the cost of liability claims on the Canadian public health care system.
3. To advise on the possibility of alternative mechanisms to litigation for persons who have become disabled following injury occurring during the provision of health care (Prichard 1990, 35).

The seven principal findings of the Review are:

1. There has been a significant escalation in the liability of health care providers in Canada over the past 15 years. This increase in Canadian medical malpractice litigation has been more severe than the increases during the same period against other professionals. Orthopaedic surgeons, anaesthetists, obstetricians



and gynaecologists have experienced the highest frequency of claims and family practitioners the lowest.

2. This growth in litigation has occurred despite the absence of any important changes in the relevant law governing liability. [...] While there has been some expansion in the doctrine of informed consent, it has not contributed significantly to the growth in claims paid by doctors.<sup>2</sup>
3. Accompanying the growth in medical malpractice claims has been an even more rapid increase in insurance costs for doctors and health care institutions. *This increase has been real, significant and disturbing for physicians.*<sup>3</sup> [...] As a result of these increases and rapid increases for hospitals, we are now spending in excess of 200 million annually on liability insurance for physicians and health care institutions.
4. Medical malpractice litigation is very expensive [...] When account is taken of all the legal fees, the costs of the court system, and the time and energy of everyone concerned with the litigation, in excess of 50 percent of all money spent on malpractice goes to the expenses of litigation and not to the injured patient for purposes of compensation.
5. Medical malpractice litigation is having an impact on the quality of medical and hospital services provided in Canada. [...Nonetheless] the quality of health care provided by our physicians and health care institutions is higher than it would be in the absence of the threat of litigation. [Consequently] the benefits of the threat of litigation outweigh its ill effects.
6. Despite the growth in litigation, only a modest percentage of persons suffering health care injuries receive compensation [...] The percentage receiving compensation is certainly less than 10 percent of potential viable claims.
7. Despite the growth in litigation, [...] there is enormous opportunity for further growth in the next decade or two in the absence of a change in policies in this area. (Prichard 1990, 3-5).

Not only are some specialists susceptible to high risk of litigation but The Prichard Review also found geographical differentiations in the level of suits filed. British Columbia

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<sup>2</sup>See also Gerald Robertson, "Informed Consent Ten Years Later: The Impact of Reibl v. Hughes. Canadian Bar Review Vol 70:3 September 1991; 425-445. Robertson analysed 117 cases since Reibl, and concluded that the decision has had very little impact on the frequency and severity of malpractice claims.

<sup>3</sup> Emphasis mine.

and Ontario were found to experience the highest claims costs. (Prichard 1990, 3). A Working Group on Obstetrics and Gynaecology conducted a survey as part of the Prichard Review to assess specialist susceptibility to high risk of litigation. The group concluded that the fear of medical-legal liability was having a serious impact on the practice of obstetrics and gynaecology. Consequently, there is a shortfall of practising obstetrician-gynaecologists (Hannah et al. 1990). Some of the findings as reported by Hannah et al. (1990, 88-90) are that:

1. 36% of respondents indicated that they have stopped or reduced their practice of obstetrics in the past 5 years. [...T]his is occurring among a significant portion of the physician population after relatively short periods of time in obstetric practice and, as expected, while still relatively young.

The three most important reasons for this cessation or reduction in practice cited [...] are a desire for lifestyle change, growth in other practice areas and a *concern regarding liability*.<sup>4</sup> [...] The highest percentages of these [practitioners leaving the practice] are in the group practising over 20 years, the most experienced clinicians will be in this group and this practice change represents an important loss of obstetric skills.

2. There has been a very substantial increase in the past 5 years in the number of diagnostic tests used in the antenatal management of obstetric patients, and litigation concerns figure prominently as a reason for this increased use. This represents an enormous cost to the health care system in this country, particularly when the evidence for the value of these tests in improving the quality of care has not been convincingly demonstrated.
3. In the labour and delivery management of low risk patients, there has been a dramatic increase in use of electronic foetal monitoring and caesarean section for suspected foetal distress[...] *A very significant number [ ...] indicated [...] a preoccupation with potential litigation*<sup>5</sup> (Hannah et al. 1990, 89).

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<sup>4</sup>Emphasis mine

<sup>5</sup> Emphasis mine.

The Prichard Review concluded that Canada did not have a medical malpractice "crisis". However, given the seriousness of the situation and the significant cost imposed on a large number of injured but uncompensated people, if left unattended a crisis will in fact develop (Prichard 1990, 5). The Review made seventy-nine specific recommendations. The three principal recommendations are that medical malpractice litigation should be retained for negligently caused injuries. Second, that the responsibility of hospitals and other health care institutions be increased with regard to quality of health care. Finally, that a compensation system be designed for those suffering medical injuries that would not replace tort law, but would provide an available and accessible alternative and ensure that a far greater proportion of those suffering injury would receive some compensation (Prichard 1990, 5-7).

The Review recommended that Canada implement tort reform policies in order to pro-actively address malpractice litigation concerns and thereby reduce the possibility of a medical malpractice "crisis". The Review rejected alternate dispute resolution mechanisms. Instead, it strongly recommended that Canada, as a matter of priority adopt a "no-fault compensation scheme for persons suffering avoidable health care injuries" (Prichard 1990, 28). It advised that avoidable injuries should be defined with regard to whether "with the benefit of hindsight, the injury could have been avoided by an alternative diagnostic or therapeutic procedure or by performing the procedure differently" (Prichard 1990, 28). The Review further recommended that Canada review the reforms implemented in other countries<sup>6</sup>. These recommendations were predicated on the notion that tort reform will

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<sup>6</sup> Legislative responses to medical negligence litigation include imposing ceilings or "caps" on damages, modifying the collateral source rule to prevent multiple recoveries for the same injury, mandating or promoting periodic or structured damage awards, shortening the statute of limitation, codifying the doctrine of informed consent and introducing pretrial screening or review procedures. Rules were also directed at the initiation of claims, regulation of lawyers' contingent fees, elimination of *ad damnum clause* ('to the damage' -- that part of a declaration or writ, which sets forth the amount claimed), reform of the locality rule and the doctrine of *res ipsa loquitur* (the thing speaks for itself) (Danzon 1985, Robinson 1986, 21, Wadlington 1991, 201, Dewees, Trebilcock and Coyte 1991).

increase patients' access to the compensation system and simultaneously curtail the escalation of a Canadian crisis.

The mandate of the Prichard Review was broad enough to encompass a variety of issues. However, like most of the literature, it was conducted from the perspective of the institutions and health care providers rather than that of the consumers. The focus was primarily on doctors, consequently, it did not address the effects of injury or the impact of medical negligence litigation on patients. Instead, it was aimed at achieving policy changes at the governmental level. Furthermore, a perusal of the literature on medical negligence creates the impression that patients are filing meritless claims and as a result the medical profession is under a constant barrage of litigation. Upon closer inspection, it becomes evident that few who are injured file a claim, and of those who file claims, only a small number receive compensation. Nonetheless, the general perception of a "crisis" in medical malpractice exists.

### **1.3 *The Problem***

There is a large body of literature on medical negligence, but the focus of these studies has been on parties other than those who have suffered physical injuries. Very few of these studies are empirically based (Zuckerman, Koler and Bovbjerg 1986, Metzloff 1988) and with few exceptions,<sup>7</sup> they tend to focus on the financial and legal aspects of medical malpractice (Institute of Medicine 1989, 1). More specifically, these studies stress the rising costs of insurance, the size of awards, and the effects of medical malpractice on doctors (ibid.). Furthermore, most prior research on medical disputes have analysed cases that proceeded through the court system (May and Stengel 1990, 105). However, claims result not so much

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<sup>7</sup> See Coventry et al (1993) The Australian Health/Medical Care Injury Case Study Project undertaken by the National Centre for Socio-Legal Studies, La Trobe University.

from the actual injury, but from factors such as legal rules, social norms, and economic resources (Danzon 1990), "social-emotional" factors (Kellett 1987), and socio-legal factors (Press 1984). These factors have an impact on patients' decisions to pursue a claim. Moreover, most people who suffer injury or harm as a result of negligence do not pursue litigation (Prichard 1990, Brennan et al. 1991, Leape et al. 1991, Elgie, Caulfield, and Christie 1993).

A number of factors may explain, in part, the low rate of claims for medical negligence injuries. Felstiner, Abel and Sarat (1980-81) explain that the emergence and transformation of disputes require that the patient first recognise an adverse effect, blame someone and subsequently make a claim. This is not an easy process as "much medical negligence occurs in hospitals, most of which is covered up or buried along with the patient, or otherwise hidden" (Mandel 1992, 16). Piccirillo (1989) suggests that in medical malpractice cases it is often a hospital employee who advises the family to consult an attorney. Furthermore, the physician-patient relationship discourages the initiation of disputes, as the relationship is usually based on the intimate and trustworthy bond between the patient and the doctor (May and Stengel, 1990, 110). Although the number of claims filed in Canada for medical malpractice has increased within the last decade, an analysis of these claims indicates that only a small number reach the trial stage.<sup>8</sup> It follows then that the cases that reach the trial stage may not be typical of malpractice cases (Metzloff, 1988, Danzon 1986). Therefore studies that focus on claims may grossly underestimate the incidence or nature of injuries.

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<sup>8</sup>See discussion of Florida Birth Related Injury Study by Sloan and Hsieh 1995. Also, *Crossing the Boundaries* (1992, 65) notes that of 208 calls to a toll free line set up by the College of Physicians and Surgeons, only 23 callers actually reported the incident to the College. Of the remaining 185, 43% said they did not report because they thought nothing would be done about it; 36% did not report because they thought they would not be believed; and 14% said they did not know about the college's complaint process. Respondents who completed Agency Questionnaires cited unfamiliarity with the College process 45% (26); fear of the physicians 43% (25); fear of the college process 37% (22); and cynicism 35% (20).

### 1.3.1 Patients' Experience

Despite an extensive body of literature on medical negligence and studies of the effects of litigation on doctors, *"the point of view and the subjective experience of persons who have suffered medical misadventure are often referred to but have not hitherto, been the subject of systematic empirical investigation"*<sup>9</sup> (McMahon et al. 1994, 215 citing Press 1984). Moreover, the rise in public perception of the "malpractice crisis" was viewed from the physicians' perspective and measured in relation to the financial expenditure; "the needs of patients and consumers never entered the debate" (Law 1986, 305). As a result of patients' exclusion, very little empirical information exists concerning patients' experiences. Even less is known about the effects on patients of changes such as defensive medicine and tort reform.

It has been acknowledged that "no effort to explore patients' view of the access issue with respect to malpractice appears to exist" (Zuckerman et al. 1986, 110). While existing analyses have been critiqued on the basis that they are not based on primary data about a set of injured patients, the response has been that "primary data of this type are not available and given the low probability of an injury occurring, this data *may be too costly ever to collect*<sup>10</sup> (Zuckerman et al. 1986, 96). As a consequence, studies have focused on more aggregated units of analysis such as claims per 100 insured doctors (ibid. 96). Patients' experiences are not usually solicited. This thesis with its emphasis on the "standpoint" of women who have suffered obstetrical-gynaecological medical/health care injury, is an attempt to elicit women's experience and thereby address, in part, this gap in the literature on medical malpractice.

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<sup>9</sup> Emphasis in original

<sup>10</sup>Emphasis mine.

#### **1.4 Literature Review**

In this review of the medical, legal and academic literature on medical negligence, I focus on the notion of a "crisis" and the way in which the literature constructs "victims" of medical malpractice. The crisis in medical malpractice is explained in terms of the increase in litigation. Explanations for this increase remain illusive. While there are many hypotheses, no consensus has been reached. Danzon (1990, 50) cites the unobservability of many of the key variables and the complexity of the underlying causal relationship between the legal system and the medical system as two fundamental reasons why empirical evidence remains limited and inconclusive. She explains that the frequency of negligent injuries is generally not measured systematically. Instead, current information on iatrogenic, and specifically, negligently caused iatrogenic injury is derived from "infrequent and geographically limited special surveys of hospital records"(ibid.). As such, what is observed is the frequency of claims and average amount per paid claim instead of patients' experience of injury (ibid.). Nonetheless, between 1986 and 1991, the journal Law and Contemporary Problems devoted three special editions to the topic of medical malpractice. These editions were justified on the basis that "malpractice concerns remain timely, and new information merits the continued discussion" (Bovbjerg and Metzloff 1991, 1). Dissatisfaction with the legal system's ability to establish appropriate levels of compensation and deterrence was also cited (ibid.).

##### **1.4.1 Definition of the Crisis**

Why was the Prichard Review addressed within the framework of a "crisis"? Although it was not specifically stated, the Prichard Review was commissioned to prevent the exportation from the United States of what was perceived to be a crisis in medical malpractice. "Crisis", a term often used in contemporary political lexicon, "is applied to denote a situation where corrective action is long overdue and dire circumstances exist"

(Rochefort and Cobb 1993, 66). The notion of a crisis in Canada is best understood within the context of the legislative and political climate of the 1980s and 1990s; a climate of fiscal restraint. To assess why the issue was defined as a crisis I draw on the notion of problem definition as articulated within policy studies literature. Problem definition as defined by Hogwood and Gunn (1984, 109) encompasses

the process by which an issue (problem, opportunity, or trend), having been recognised as such is placed on the policy agenda, is perceived by various interested parties; further explored, articulated, and possibly quantified; and in some but not all cases, given an authoritative or at least provisionally acceptable definition in terms of its likely causes, components and consequences" (cited in Rochefort and Cobb 1993, 57).

Rochefort and Cobb (1993, 56) note that controversy often surrounds how particular issues are understood; that is, what is taken to be a serious problem is arbitrary. Discrepancy often exists between the seriousness of a problem and the level of attention devoted to it because "factors such as the intensity of advocacy, leaders' openness to the issue and the salience of competing problems, in addition to 'objective conditions' could be responsible for an issue's standing" (ibid.). Citing Dery 1984, p. xi, they further state that "problems do not exist 'out there'; they are not objective entities in their own right" (ibid.). Since use of language is critical in determining which aspect of a problem will be examined, rhetoric can help create and solidify a particular understanding of a problem in the minds of protagonists and the public (ibid.). Consequently, one of the key mechanism for gaining advantage in a social conflict is the definition of an issue to best exploit the advocate's interest. Problem definition, then, is a way of organising information and assigning meaning to it.

The way a problem is defined includes some statement about its origin (Rochefort and Cobb 1993, 61). The medical malpractice "crisis" is perceived to be caused by an increase in the frequency and severity of malpractice liability claims. Although the literature continually



labels the problem a crisis in medical malpractice, closer inspection reveals that insurance companies are the ones who initially reacted by increasing insurance coverage thereby creating a fear in practitioners that there was a problem (Danzon 1985, Wadlington 1991, Robinson 1986). Insurance costs have increased at a much higher rate than the litigation activity itself (Danzon 1985, Robinson 1986, Prichard 1990). However, instead of proposing reforms aimed at the insurance industry, reforms were aimed at restricting the growth of litigation rates.

The Prichard Review reports that if reform is not implemented a crisis will in fact develop. The review notes however that only 1 in 10 people who are injured receive compensation. It is interesting, and contradictory that reform is predicated on the notion that more injured patients will receive compensation. If reforms are proposed as solutions to curtail the crisis while simultaneously seen as a way of increasing the number of people receiving compensation, one wonders whether there will be more money available to compensate for this increase or whether the same amount will be used to compensate more people. At present, patients who receive compensation, are in general undercompensated. The Review, like the rest of the medical malpractice literature does not problematize the number of uncompensated patients. Instead, it suggests that injured patients exercising their right to seek compensation are creating a malpractice crisis; a crisis which is proving debilitating for doctors and lessening the profit for insurance companies. Thus, we need to question whether there is a crisis in medical malpractice. And if so, what is the exact nature of the crisis and who are the victims?

#### **1.4.2 Perception or a Crisis?**

Deweese et al. note that the perception of a medical malpractice liability crisis in Canada has a substantial basis in reality because Canada experienced “dramatic increases in

liability insurance fees, the number of malpractice claims initiated, and the magnitude of settlements or awards paid to *alleged*<sup>11</sup> malpractice victims" (1990, 2.1).

The Canadian Medical Protective Association (CMPA) insures approximately 90 percent of all Canadian doctors (Dewees, Trebilcock and Coyte 1991, 218).<sup>12</sup> The CMPA, like its United States counterparts, responded to changes in the frequency and severity of malpractice claims by increasing malpractice insurance. Until 1983 all physicians paid the same liability insurance fee, approximately \$430. However, in 1984, the CMPA urged members to accept differential fees for physicians in different specialities (Dewees 1990, 2.2). For example, in 1987, obstetricians-gynaecologists paid \$8250 for their insurance premiums. The following year this increased to \$9800. In the same year, general practitioners, who have been designated low risks paid \$800 and \$950 respectively (Dickens 1991, 221, Prichard 1990). In 1995, obstetricians paid \$18,396 for insurance, this increased to \$23,340 in 1996.<sup>13</sup> Prichard (1990, 3) notes that membership fees are misleading because they increased at a much higher rate than litigation activity itself. The insurance premiums also increased faster than the actual trend in settlements would necessitate.

The Association changed the method of allocating costs for future claims by increasing their reserves for claims. In 1984, the association moved from setting fees to recover losses paid in current years to set the fees to anticipate liability that would arise from incidents in current years. This change was predicated on the "long tail" principle of malpractice claims.

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<sup>11</sup> Emphasis mine.

<sup>12</sup> I made enquiries through the College of Physicians and Surgeons whether the other 10 percent were covered by private insurance. They advised that they did not carry that information. In fact, they do not specifically ask doctors if they have insurance coverage. However, a May 1996 *Financial Post* article made mention of a small group of doctors in Winnipeg who have purchased a form of group policy from Lloyds of London.

<sup>13</sup> Telephone consultation with the British Columbia Medical Association and The College of Physicians and Surgeons reveal that it is not mandatory for doctors to carry medical insurance. However, the College of Physicians and Surgeons as well as the provincial medical associations, *encourage* doctors to have liability insurance and most Canadian hospitals require that doctors have liability coverage as a prerequisite for practising or obtaining admitting privileges.

“Long tail” refers to the fact that claims relating to injuries do not always manifest themselves early and often do not mature for as much as a decade. Hence a practitioner can be liable for an injury long after it actually occurred (Goldman 1988, 266). For example, obstetricians can be held liable until the infant reaches the age of majority (Limitation Act).

Despite an increase in the Association’s reserves for claims from \$88 million in 1986 to over \$1 billion in 1996, the Association continues to increase insurance premiums for physicians. Premiums are still increasing but settlements paid are minimal. For example, in 1986, settlements were less than \$18 million. This rose 33 percent and was just above \$24 million in 1987. The settlements rose to \$47 million in 1990. An analysis of disbursements for the same period indicates that the difference between legal costs and awards was not very significant. In 1993, the CMPA spent \$36.3 million dollars for doctors’ legal cost and \$42.5 million in awards and settlement. In 1992, \$33.2 million was spent on legal cost compared with \$41.2 million in awards and settlements (CMPA Annual Report, 1994, 29).

Table 1  
CMPA Table Of Revenues, Expenses And Reserve For Claims  
1989- 1993

	<u>1993</u>	<u>1992</u>	<u>1991</u>	<u>1990</u>	<u>1989</u>
	(thousands of dollars)				
<b>REVENUES</b>					
Membership Fees	170,409	154,047	140,700	131,232	121,460
<b>EXPENSES</b>					
Awards and settlements	42,688	41,204	45,613	47,112	37,661
Legal Costs in support of members	36,342	33,272	26,719	25,508	18,657
Expert consultation cost in support of members	3,141	3,105	2,663	2,324	1,965
<b>RESERVE FOR CLAIMS</b>	<b>892,000</b>	<b>663,000</b>	<b>552,500</b>	<b>418,500</b>	<b>364,000</b>

Source: Compiled from CMPA Financial Statements

A large part of awards and settlement actually goes to plaintiffs' lawyers<sup>14</sup>. While the Prichard Review acknowledges that approximately 50 percent of all money spent goes to the expense of litigation, it does not acknowledge that the CMPA is more willing to pay lawyers to defend doctors than they are to compensate injured patients. As such, where money is spent may be taken as an indication of who is deemed to be in need of protection. It is evident then that instead of patients being viewed as worthy of compensation, doctors are viewed as more deserving of a defence.

Prior to 1980, successful claims across Canada did not exceed 100 in a year (Prichard 1990, 2). Prichard notes that,

by late 1987 [...] the number of law suits against doctors had increased rapidly; doctors' costs for liability protection had increased dramatically; newspaper headlines regularly reported large personal injury judgements; and many representatives of doctors voiced their anxiety and concerns. (Prichard 1990, 2).

The CMPA changed the fee structure in 1984 but the peak in litigation did not occur in Canada until after 1987. Medical Protective Association (CMPA) statistics reveal that in 1992, Canada experienced a rise in the number of legal actions commenced compared with earlier years (93rd Annual Report, p.10). In 1992, 1097 actions were commenced from 5752 patient enquiries. From the actions proceeding to trial in that year, 25 saw judgement for the plaintiff while 48 resulted in judgement for the defendant. 306 actions were settled and 496 were dismissed or discontinued. However, between 1966 and 1970 the average number of monetary settlements against physicians averaged only 18 per year (Dickens 1993). The following table presents a breakdown of the association's work for the period 1987 - 1993

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<sup>14</sup> For example in British Columbia the maximum remuneration a lawyer can charge a client in a personal injury action is outlined in Rule 1055(b) of the Law Society Rules which states "Subject to the court's approval of higher remuneration under section (78(3.3) of the Act, the maximum remuneration to which a member is entitled under a contingent fee agreement when acting for a plaintiff in any other claim [other than motor vehicle accidents] for personal injury or wrongful death, is 40% of the amount recovered." (Law Society Rules, Part 11, page 82). Given the time and cost associated with medical malpractice cases, these cases are more likely to be assessed at the maximum fees.

Table 2  
 STATISTICAL REVIEW OF CMPA WORK  
 1987 - 1993

	<u>1993</u>	<u>1992</u>	<u>1991</u>	<u>1990</u>	<u>1989</u>	<u>1988</u>	<u>1987</u>
Misc. Enq.	2705	1585	2166	1892	1502	1446	1217
Patient Enq.	5625	5752	4355	3639	3305	2983	2522
Threats	521	797	794	675	684	560	554
Actions Commenced	1220	1097	984	908	878	873	915
Actions proceeding to trial							
- Judgement for plaintiff	28	25	14	26	26	10	17
- Judgement for defendant	53	48	47	51	32	26	35
Actions settled	258	306	236	251	224	191	189
Dismissals	615	496	493	499	554	504	455
Membership	56236	55189	54469	53817	52418	51316	50621

Source: CMPA Annual Report 1994, p.15

The CMPA statistics indicate that less than twenty percent of filed writs proceed to trial. Most are either settled or discontinued. The association's minutes states that the incidence of litigation is very low in comparison to the association's large membership. Hence, it is encouraging that it wins between 70 and 80 percent of all actions commenced against members (CMPA Annual Report 1991, 34). These percentages are consistent with United States statistics. The United States Bureau of Justice Statistics: Special Report on Civil

Justice Survey of State Courts, 1992, indicates that plaintiffs were less likely to win medical malpractice cases (30 percent) compared to other categories of tort cases (toxic substances 74 percent; auto cases 60 percent, and product liability 41 percent). Legal counsel of the firm that represents the CMPA, in Vancouver, is quoted as saying that

One of the reasons medical malpractice cases rarely succeed is that the Canadian Medical Protective Association co-ordinates its legal work. [...] We are well funded and well organised and we share information nationally with the other firms that do this kind of work. [...] What is unique about medical cases is that you are dealing with well-educated professional people and they are organised nationally in Canada under one umbrella for defence (in Daisley 1995).

It is interesting to note that despite this high rate of success, the CMPA bemoans the doctrine of Informed Consent. Legal Counsel for the association stated in the 1981 Annual Report that " [n]o legal event in the last fifty years has so disturbed the practice of medicine as did the decision of the Supreme Court of Canada in *Reibl v. Hughes*".<sup>15</sup> The doctrine of informed consent acknowledges patients' right to determine what happens to their bodies. Despite the low success rate of plaintiffs' claims, there is a general perception among medical professionals that there is a malpractice crisis and that the increase in liability suits is due, among other things, to an excessive claimant mentality of patients (Danzon 1985). However, Dewees et al. point out that increases in medical activity and the opportunity for injuries, inflation rates and variability in the number of claims made and in the amount awarded from

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<sup>15</sup> *Reibl v. Hughes*, [1980] 2 S.C.R. 880. A 44 year old male underwent surgery. During or immediately following the surgery the plaintiff suffered a massive stroke which left him paralyzed on the right side of his body and also impotent. The plaintiff had formally consented to the operation. He alleged that this was not an "informed consent". That is, he would not have consented to the surgery had he known that stroke was a risk of the surgery. As a result of this case, surgeons are required to make disclosure of "material risks" to patients. This decision impacted several areas of law. There was a diminution of professional autonomy because the Supreme Court of Canada rejected the standard of disclosure of the reasonable physician and replaced it with what a reasonable patient would want to know. The case therefore creates a duty for doctors to disclose risks. The court also decided that informed consent went to the issue of negligence rather than battery. The doctrine of informed consent holds that if a physician fails to inform a patient of material risks associated with proposed treatment, this gives rise to a cause of action. This standard of disclosure is measured by what the reasonable patient in the person's position would want to know, and not what the physician decides to disclose. However, it has to be demonstrated that the information would have had an effect on the patient's decision to undergo the treatment.

one year to the next are three reasons for Canadian doctors' exaggerated perception (1990, 2.3).

### 1.4.3 Antagonists or Victims?

The language of the Prichard Review, like the rest of the medical malpractice literature, makes it evident that doctors and insurance companies are constructed as the victims. The following quotation is an example.

Becoming a defendant in a malpractice claim can be a devastating experience for a physician because his professional competence is called into question, and because he may be subjected to humiliating experiences in the courtroom, whether or not the claim is ultimately resolved in his favour (Deweese et al. 1990, 2.2).

The fifth finding of the Prichard Review addressed the impact of litigation on the quality of medical and hospital services provided rather than on the services received. What are these services and to whom are they provided? What are the impact on those who receive or do not receive these services? When describing what could be an impact on patients, the information is couched in neutralising language and is evidenced by the discussion of impacts of litigation "which are not in the best interest of the patients". "Alleged" malpractice victims, or health care consumers are deemed to be the antagonists for filing cases without merit and lawyers are blamed for increasingly naming physicians as defendants "in order to obtain discovery". By framing the injury as an allegation, the notion of injury to patients is challenged. Thus, the "crisis" is constructed as very severe and could have grave consequences for the health care system because doctors, primarily those specialists alleged to be at high risk, are leaving the practice.

Surveys conducted as part of the Prichard Review soliciting responses from doctors on their current practices have concluded that changes have occurred in the scope and pattern of

practice (Sellers 1990, 44-46). The Prichard Review reported that obstetrician-gynaecologists have responded to the threat of legal liability by refusing to take "high-risk" patients. When a physician refuses to undertake a procedure or activity because of a fear of legal liability, this is known as "negative defensive medicine" (Dickens 1991, 174). Obstetrician-gynaecologists' refusal to take women labelled high-risk could create problems because midwives are prohibited from taking, and are not trained to take these cases.<sup>16</sup>

The use of the term "high-risk" is very capricious. It ranges from a person who has been labelled aggressive and likely to file an action if things do not turn out in her favour to an individual whose prognosis is not good. Factors such as the distance from medical facilities and services may be used to designate a woman as high-risk. Hannah et al. (1990) state that rural women in Canada do not receive as much prenatal care as urban women. However, case studies have indicated that women in general, and immigrant or visibly ethnic women even more so, receive differential care from practitioners (Scully 1980, Ehrenreich and English, 1978).

The extent to which defensive medicine is practised is inconclusive. Sellers (1990) conducted a study comparing the impact of medical/legal liability on patterns of practice for family practice, anaesthesia and obstetrics and gynaecology in Canada. He notes that there is some uncertainty about the extent to which defensive medicine is practised because "the same practice or procedure which one physician claims he employs solely for medico-legal reasons may be employed by a substantial number of other physicians because they believe it to be the appropriate treatment in the given circumstance" (Sellers 1990, 44-46). Although there is

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<sup>16</sup>See section on Midwifery and the Law in Brian Burtch (1994) *Trials of Labour. The Re-emergence of Midwifery*. McGill-Queens University Press. Montreal.



widespread willingness to admit that significant defensive medicine exists, there is little agreement about its extent or even its definition (Wadlington 1991, Glassman et al. 1996).

There is partial confirmation that malpractice concerns influence speciality choice, most notable to enter or leave obstetrics (Wadlington 1991, Hannah et al 1990, Sellers 1990), but it is unclear what effect defensive medicine has on services (Glassman, et. al. 1996, Wadlington 1991). Nonetheless, there is consensus in the academic, legal and medical literature on the need for further information and analysis. Wadlington (1991) cites three reasons for continued studies on issues of medical negligence. First, given the increased knowledge about the unexpectedly high frequency of negligently caused injury, one need is for greater understanding about the causes of malpractice. Second, medical injury from negligence vastly exceeds claims for liability compensation. As little is known concerning the reasons motivating people to bring claims, there is the need to know more about the claiming behaviour of patients. Finally, there is also a special need to clarify the extent of "defensive medicine" and *its impact on health care*<sup>17</sup>. These three justifications do not challenge the conceptual framework of the research on medical negligence. The focus remains on cost and provider, rather than on the injury and the patient.

Lewis (1986, 4) notes that obstetrical care is "the most fertile ground for growth in litigation in all of medicine, owing largely to the difficulty in treating a patient in utero and a mother frequently at high risk". Obstetrical-gynaecological cases are categorised as the most significant malpractice claims because this speciality experiences the highest frequency of claims in Canada (Prichard 1990, 3, Ennis and Vincent 1994, 97). This is also true for Australia (McMahon 1994, 217), and the United States (Metzloff 1988, 235, Bovbjerg 1986, Institute of Medicine, 1989, Chamberlain, Orr and Sharp, 1985). Not only are obstetrician-gynaecologists

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<sup>17</sup> Emphasis mine.

at higher risk for litigation, this speciality also attracts the largest awards and settlements especially when the injury is to a child (Sloan and Van Wert 1991, 1, Metzloff, 1988, 235, Fineberg et al. 1984, 7).<sup>18</sup>

Lewis-Idema (1989) reviewed 39 United States obstetrical care studies (30 states, 9 national). She reports that these "highlight the impact of professional liability concerns on physicians' decisions to provide obstetrical care; [but] only a few studies examine access to care directly" (ibid. 79). Her findings indicate that "professional liability concerns among physicians are generating access problems" (ibid. 87). She notes that because obstetrician-gynaecologists are leaving the practice, attrition could create a vicious cycle wherein the remaining practitioners experience pressure on their time. This pressure may lead them to restrict their practice in ways so that patients perceived as less financially, socially or medically desirable may be affected the most (ibid.). Lewis (1986, ix) summarises these effects. He states, "some of the best trained, most experienced and highly skilled obstetricians have stopped delivering babies. Others literally will not touch any high risk mothers". However, no effort seems to be made to empirically assess the effects of such changes on patients. In fact, there is often no acknowledgement that an injury has actually occurred.

Hence, the perception of a "crisis" has generated a cyclical effect. In this case, the categorisation of patients seeking compensation for injuries was defined as a crisis in medical malpractice. I have pointed out that what was termed a "crisis" is simply a reduction of profit for insurance companies, an increase in insurance premium for doctors – and a corresponding reduction in their income. However, this perception of a crisis has the potential of creating its own crisis; a crisis of women being injured and or refused treatment.

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<sup>18</sup>See for example *Cherry (Guardian) v. Borsman* (1991) 75 D.L.R. (4th) B.C.S.C. in which the Actuarial report is reproduced. This shows the calculation for equipment and daily living for a child taking life expectancy into account.

#### 1.4.4 Studies of Medical Negligence

Not all injuries that occur during the course of medical care result from negligence. Nonetheless, it is no secret that medical injuries are often serious, almost always unexpected and frequently leave the patient suffering disfigurement, disability, paralysis or death (Prichard 1990, 6). While there are numerous studies of malpractice claims, few significant studies of negligent injuries exist. A study commissioned by the California Medical Association and the California Hospital Association, looking at medical injuries resulting from health care management (iatrogenic injuries) in hospitals for 1974, estimated that about one in twenty hospital inpatients suffered injury and one in 125 has a legal claim of malpractice (cited by Zuckerman et al. 1986, 94).<sup>19</sup> Danzon also analysed closed claims data for California hospitals for 1974. She compared the number of actual claims to the estimated number of injuries. Danzon concluded that on average only one malpractice claim was filed for every ten potentially valid claims and that only four paid claims resulted from every 100 injuries (1985, 20-25). Her conclusions are consistent with the finding of the Prichard Review which stated that only one in ten patients with potential claims receive compensation. A more recent study of iatrogenic injuries is the Harvard Medical Practice Study (HMPS) (1991) which reported on the incidence of adverse events and negligence in hospitalised patients in New York. The HMPS found that 3.7 percent of hospital admissions resulted in iatrogenic injury, with a quarter of those admissions (1 percent) resulting from negligence. The majority of injuries (70.5 percent) resulted in disability of less than 6 months, however approximately 2.6 percent resulted in permanent disabling injuries and 13.6 percent led to death. Negligence

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<sup>19</sup> Zuckerman et al, 1986 suggest the following sources for further information. The California Medical Association and California Hospital Association Medical Insurance Feasibility Study. (D. Mills (ed) 1977; also Mills, Medical Insurance Feasibility Study: A Technical Summary, 128. W.J. of Med. 360 (1978).

was more likely to be associated with age and with more severe injuries. The study concluded that many injuries resulted from substandard care (Brennan et al. 1991, 370).

Drug complication, wound infection, technical complication and complication during surgery were also identified as events associated with iatrogenic injury. Forty Eight (48) percent of the injuries were associated with an operation. Negligence, however, was more likely to arise from non-surgical (37 percent) rather than surgical procedures. The highest proportions of injury due to negligence reported were diagnostic mishaps (75 percent), non-invasive therapeutic mishaps (77 percent), and events occurring in the emergency room (70 percent) (Leape et al. 1991,377). The HMPS reported that in New York, only one in fifteen negligent injuries resulted in compensation (Brennan T.A. et al. 1991, Leape, L.L. et al. 1991, Elgie, Caulfield and Christie 1993, 99).

There are no data on iatrogenic injuries equivalent to the HMPS, CMA/CHA or Danzon's studies<sup>20</sup> for Canada. However, Sloan and Hsieh found that injury victims with other sources of funds were less likely to sue their physicians and the uninsured were more likely to sue (1995, 430). It is uncertain whether the need for money to pay medical bills was a factor. If such is the case, it could be inferred that because Canada has universal health care, injured patients in Canada may be less likely to file claims. Hence, the rate of injuries cannot be assessed from suits filed. Moreover, most people who sustain injuries do not file claims (Prichard 1990, Leape et al. 1991, Coventry et al. 1993, Brennan et al. 1991, Sloan and Hsieh 1995, Sloan and Van Wert 1991).

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<sup>20</sup>It is estimated that approximately two percent of all deliveries result in complications. Also given the high rate of hysterectomies and caesareans, the incidence of adverse effects may be higher for obstetrical and gynaecological medical care than other specialties.

To assess the likelihood of an injured person filing a claim, Sloan and Hsieh (1995) combined two surveys, the first comprised of 127 families in Florida who had filed medical malpractice claims and whose claims closed between 1985 and 1990, and the 220 cases described below. Sloan and Hsieh (1995) interviewed 963 women who gave birth in Florida during 1987. Of the 963 births, 67 involved stillbirths, 128 infant deaths and 25 permanent injuries of surviving children evident by age 5. Of these 220 cases of adverse birth outcomes, no claims were filed and only 23 reported discussing the possibility of filing with a lawyer (Sloan and Hsieh 1995, 418). The files were assessed by two practising obstetricians who conducted independent evaluations of each hospital chart. The physicians assessed whether the care rendered was substandard and if so, whether the care caused the injury. Serious injuries were more likely to result in medical malpractice claims (Sloan and Hsieh 1995, 427). They reported that a change of physician during pregnancy, cost of filing a claim, religion and racial background impacted decisions to file. Education, was not a factor (Sloan and Hsieh 1995, 428). However, when doctors discussed the injuries with patients, there was less likelihood of a suit being filed.

Sloan and Van Wert (1991) in a study of birth related injuries surveyed 187 families in Florida with closed medical malpractice claims. Their study found that while birth-related injuries tend to involve substantial losses and compensation, approximately 30 percent of the claimants did not receive any compensation from their claims. This percentage was somewhat higher for families whose child had died (Sloan and Van Wert 1991, 155). Among families who had received compensation, there was a discrepancy between compensation and cost. Families whose child had died were at a disadvantage. These families on average recovered approximately 24 percent of their cost as compared with 71 percent of cost for families with surviving children (Ibid.). There were three major findings in this study. First,

on average compensation is inadequate and generally falls short of the cost of injuries and substantially so for some groups. This was further complicated by the cap on damages for total loss or non-economic loss.<sup>21</sup> Though approximately 1/5 of the claimants were paid more than economic loss, punitive damage was not explicitly made. Thus overcompensation is the exception rather than the rule (ibid. 157). Second, the cost of injury is systematically related to the severity of impairment. Third, undercompensation is more apparent for certain groups than for others (Sloan and Van Wert 1991, 158). The researchers note that undercompensation may, in part, be explained by several practices. These include the practice of discounting for comparative negligence and/or questionable liability; tort based compensation is not taxable; legal rules; claimants may decide to settle for less than the potential award at verdict because of risk aversion and/or substantial costs and delay incurred in bringing a case to trial. However, they also contend that often plaintiffs are not well represented by their attorneys, and finally that personal characteristics, for example, being viewed as less deserving of full compensation, may be applied to the detriment of the plaintiff (Sloan and Van Wert 1991). The study found too that cases which were resolved prior to trial recovered approximately three fifths of their economic loss, while cases which were resolved by trial settlement or verdict awards received slightly higher than their economic loss (Sloan and Van Wert 1991, 160).

The Australian Health/Medical Care Injury Case Study Project was undertaken to assess the experience and perception of people who had suffered a health/medical care injury and had sought compensation for that injury (Coventry et al. 1993, 9). Seventeen females and seven males ranging in age from pre-birth to forty-nine participated in the study. Twenty-two

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<sup>21</sup> Economic loss includes medical expenses, loss of past income, loss of future wages or any other expenses capable of precise calculation. That is, loss that the patient actually incurs. Non-economic loss are expenses, such as loss of amenities and pain and suffering, which are incapable of precise calculation.

of the participants suffered physical injuries. Among those participants with a physical injury, 17 had permanent impairment. In half those cases the disability was greater than 50 percent.

Of the twenty-four participants, 11 received compensation, 1 failed to obtain compensation, 8 had on going claims, 2 were contemplating seeking compensation while 2 had decided not to seek compensation (ibid. 21). Obstetrician-gynaecologists accounted for the majority of practitioners cited. Again, participants with severe injuries were more likely to seek compensation than those who had experienced less severe injuries (ibid. 22). Coventry et al. note that some of the participants did not realise that they had suffered a health/medical care injury until some time after the event (ibid..21). They reported that participants were likely to file claims within 6 months of that realisation. Participants also experienced difficulty identifying and substantiating the occurrence of an injury. Some of them felt worse off financially as a result of the injury. Although the most devastating effect of their injury was financial, participants did not perceive money as adequate to compensate. Instead they were generally dissatisfied with the system of obtaining compensation. They felt that the system was inadequate in addressing the major reason for complaint, that is, the fact that practitioners often came through the process unscathed.

To summarise, an increase in the number of injured patients exercising their rights to seek compensation was defined by many, primarily insurers and doctors, as a medical malpractice crisis. There is very little acknowledgement by malpractice advocates that only a small portion of all injured patients seek compensation and that of this group, an even smaller number reach trial. The rate of success in medical malpractice suits that reach trial is estimated at 30 percent. Nonetheless, the literature defines the crisis with respect to an increase in the number of patients seeking compensation.

Despite volumes of literature world-wide and the creation of a commission of inquiry in Canada the patients' experiences of malpractice are not documented. Given that obstetrics-gynaecology has been designated high risk and could have tremendous effects on women's receipt of reproductive health care and since women are the sole recipients of obstetrical-gynaecological care, it is important to document their experiences. In order that suggested reforms ameliorate rather than worsen the conditions of women, it is urgent that women's experiences be included in this body of literature.

It is important to focus on the exclusion of women's experience of obstetrical/gynaecological medical/health care injury in the definition of the medical malpractice "crisis", because the "crisis" has been identified as the catalyst for most changes which have occurred in the health care and insurance sectors. Despite the fact that insurance costs rather than claims have been identified as the major factor inducing physicians' fear of malpractice and their perceptions of liability to suits, patients are still being blamed. Furthermore, the literature does not acknowledge injuries suffered by patients. Instead, doctors are constructed as the victims and patients are for the most part excluded.

The absence from the literature of patients' perspective of medical/health care injury is reflective of wider societal practices in which several dichotomies (knowledge/experience, professional/layfolk, objectivity/subjectivity, rational/emotional) operate and where those ascribed to oppressed groups are denigrated while those associated with the oppressors are venerated. The absence of women's voice from contemporary scholarship on medical malpractice, is exemplified by Freud's patient Dora. Like her contemporaries, Dora's complaints were dismissed as hysteria<sup>22</sup>. The contemporary examples to be explored in this

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<sup>22</sup>See Freud, S. (1905) "Fragment of an Analysis of a Case of Hysteria", in The Standard Edition of the Complete Psychological works of Sigmund Freud, ed. and trans. J. Strachey, Vol. VII, London: Hogarth, 1953



thesis are no different. Very little is known of women's experience of medical injuries because the literature on medical negligence, or physician's legal liability as it is euphemistically called, is constructed from the perspective of the providers rather than the consumers. What is most bothersome about this absence is that when individual patients speak out, their experiences are treated as anecdotal. These experiences are not validated and patients are often told that without empirical studies their experiences (anecdotes) are inconsequential<sup>23</sup>. Hence the need for this thesis.

This thesis presents women describing in their own words, their experience of medical/health care injury. I used medical/health care injury rather than negligence because iatrogenic injury is not confined to, but includes injuries arising from, negligent acts or omissions. An iatrogenic injury is defined as "any adverse condition in a patient occurring as a result of treatment by a physician or surgeon" (Elgie, Caulfield and Christie 1993, footnote 11). Negligence, however, is a legal construct that refers to "a failure to exercise that degree of care which a reasonable person would exercise under similar circumstances" (Borten and Friedman 1989, 346). Medical negligence is practice which falls below the standard of care established within the medical profession. Only a court can find that a practitioner was negligent. Although malpractice may be distinguished from negligence, law, medicine, professional and popular usage regarding liability generally centres on negligence. In fact, malpractice has not been comprehensively defined or distinguished from negligence (Dickens 1991, 169). Thus because of the interchangeability of the terms, I felt that medical/health care injury would be a better descriptor of women's injuries.

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<sup>23</sup>This was the sentiment expressed by representatives of Dow Corning to approximately 35 women who attended an information session on breast implant held at the Hyatt Regency, Vancouver, B.C. on November 11, 1995. Almost all the women in attendance experienced debilitating effects of silicone gel implants. However, when they attempted to speak, they were told that their stories are anecdotal.

## *1.5 Organisation of the Thesis*

In this chapter, I reviewed the legal, medical and academic literature on medical malpractice in order to raise questions about whether, and to what extent, a crisis exists. I problematized the perception of a crisis and the construction of victims and antagonists of malpractice. I also reviewed the solutions proposed to eliminate or curtail the crisis. First I discussed the Prichard Review to situate the medical malpractice "crisis" within the Canadian context. This information was then used to introduce the object of study -- women's experience of medical health care injuries.

Chapter 2 provides a conceptual framework for understanding women's exclusion from and their marginalization within the literature discussing medical negligence. I draw on feminist standpoint epistemology and methodology as articulated by Dorothy Smith. Smith critiques conventional methodology for its androcentric biases. This methodology therefore allows me to uncover and explicate women's experiences of medical health injury in a way which would not be possible using positivist methodologies.

Chapter 3 reviews information describing the effects of legal liability on medical practitioners. This is then juxtaposed with women describing their experience of medical/health care injuries. I describe women's contact with medical doctors, discuss injuries arising from such contact, doctors' responses to women's injuries, and women's experience with the law when they attempt to seek redress.

Chapter 4 discusses the impact of the injuries on women and their families. Herein women speak of the financial, emotional and psychological effects of injuries, ranging from depression, broken relationships and reduced income. They also describe feelings of alienation, isolation and the lack of people with whom to share their experiences. I describe some of the factors which were found to contribute to women's silencing and address

whether, and to what extent, women resist this silencing. I conclude that speaking is a form of resistance.

I conclude in Chapter 5 by summarising the information presented. I note that the literature defines and discusses the crisis from the perspective of the providers; the impact on women was not addressed. In fact, had the Prichard Review been done from the perspective of uncompensated patients, it would have problematized the construction or the perception of a "crisis" in medical malpractice.

## **Chapter 2: Conceptual Framework and Methodology**

It is up to anyone who listens to a woman's tale to hear the implicit message, interpret the powerful rage, and watch for ways in which the narrative form gives "a weighted quality to incident" extending the meaning of an incident beyond itself. (Emily Martin 1992, 201).

Despite the notion that contemporary society has become more tolerant of, and benevolent towards women, this has not been borne out in assessment of women's position in society. Within society, women as a group still occupy subordinate positions in relation to men as a group. The result of which is that women are still rendered inaudible and invisible. This subordinate position leads to, among other things, silencing. Silencing happens in many ways and can be discerned in discourses such as law, medicine, and science. The absence of the patient's voice on issues of medical negligence, and more so, women's voices on issues of obstetrics and gynaecology, is indicative of practices within society at large wherein women are relegated to the margins and sometimes to obscurity. In this chapter, I provide a conceptual framework - standpoint feminism - to think the marginalization of women. I also discuss the historical process that excluded women from the medical profession and the consequences of professionalization of health care on women.

Women have little control over their health care and even less choice regarding obstetrical-gynaecological health care issues. Lack of control is manifested in areas such as the quasi-legal requirements for pre-natal health care, a restriction regarding use of alternate health care providers (a restriction facilitated through the state's practice of who will be remunerated through the Medical Services Plan) and the criminalization of women for their attempts to control their body. Women also do not have the freedom to chose their health care services and practitioners. These restrictions are generally based on the societal concern

for what is good for women and are exemplified in campaigns such as those which target women who drink or smoke during pregnancy. Another example is the coalescing of medicine and law on issues of women's health to create pathologies such as Foetal Alcohol Syndrome. These examples help to demonstrate how women's everyday lives are affected by institutions which are not readily apparent.

## 2.1 *Researching Women*

Attention needs to be paid to women's life stories if we are to research women's realities and interrogate the constitution of gender. For example,

Life stories of women have all the [...] advantages for the subjects and for social theory, as well as technical advantages in relation to areas of life which would otherwise be unresearchable. In the context of criminology, they also reveal connections and disconnections, at the level of beliefs and ideologies, between these agencies and ordinary people [...] In these ways they make it possible to theorise the articulations between individual lives, institutions and the forms they take, and ideologies and structures of larger or societal scope, and to theorise these articulations in dynamic, processual ways (Cain 1990b, 4).

Not only do life stories facilitate research into areas otherwise unresearchable, they also point out ways in which women participate in their own subordination. Thus, women's struggle against hegemony also necessitates that women and women's experiences be studied.

Cain explains that,

Hegemony is the reason why women have insisted on "women only" spaces [for] only in such spaces could a new language to capture their own incapable-of-being-thought-about experiences be brought to consciousness in a supportive process of giving these experiences voice and (re)cognition. (1990b, 9).

Cain asserts that it is often necessary to silence men's voices in order for "a quite different female discourse, which is not the flip side of a male one to emerge and or to be heard" (Cain 1990b, 9). She suggests that studies of women should focus on who women are and how they become who they are. A focus on women's experiences, then, brings feminists

closer to achieving a transgressive social science which allows women to be conceptualised as women rather than in opposition to men (Cain 1990b). By so doing we can realise an understanding of the process by which ideas are achieved and shared, and the process whereby women become participants in the practices which are often used against them.

Cain critiques traditional approaches of feminist criminology for their focus on women's unequal treatment, the nature of women's crimes and women as victims. She notes that feminists have the potential to continue the androcentric research in which women are usually the objects. Cain suggests an alternative approach which synthesises the three conventional approaches. This she calls Transgressive Criminology. A transgressive alternative, posits Cain, is needed because too often feminist researchers become participants in male hegemonic practices and the pre-occupation on subjects' sexuality rather than on "their industry, their spirituality, or the good time they have together" (ibid. 7). Hence a criminology which focuses on women as victims, using masculinist accounts, denies women any special claim to speak on these matters. Masculinist accounts are further used to marginalize feminist discourse as extremist (ibid., 6).

Criminology is transgressed when feminists step outside of the criminological discourse; that is, when feminists focus on issues other than offences and prevention. Criminology is transgressed when questions are raised about the constitution of gender and the ideological nature of people (Cain 1990b, 6). Feminists have been forced to transgress criminology because "what happens to girls and women in courts and prisons connects to what happens in the playground, in the family and at work"(ibid., 6).

Cain explains that there are three strategies and five requirements of a transgressive feminist criminology. The three strategies are reflexivity, de-construction and re-construction. Reflexivity is "recognising discourse as being 'only' a discourse, or simply one

aspect of reality" (Cain 1990b, 6). Deconstruction points out how discourses can be used "to authorise and justify painful even penal practices" and examines the internal (il)logic and the ways and sites in which a discourse is employed (ibid.). Cain further notes that women frequently become aware of discrepancies between discourses and themselves during deconstruction. Often, there is no conventional language in which to express these discrepancies, hence re-construction helps women to get beyond hegemonic discourses and to get beyond it with impunity (ibid.).

The first requirement of a transgressive approach is that feminists undertake *women only* studies in *women only* spaces. Second, these studies must start from outside the criminological discourse. Third, men must also be studied because gender is a relational concept. Fourth is the requirement for reflexivity and self-help. Finally, feminist criminologists must "make an active effort to learn from women who have engaged in political struggle [because ... ] women's political inventions are polycentric, diverse, original and apt" (Cain 1990b, 14). Not only should effort be made to learn from women, but a record should be kept of what is done, and why such works were analysed in a particular setting as opposed to another. There is also a need to explore and record the extent of censure and policing, as well as the effectiveness of forms of resistance employed.

Cain cautions that if transgressive criminology is always serious, it will miss the point of women's struggles. Transgressive criminology facilitates the process whereby "women's unspeakable 'experiences' can be captured, experienced, named and tamed within 'women only' spaces. Transgressive criminology, then, will "enable women and girls to transgress the binding web of co-man sense" (Cain 1990b, 8). Such an undertaking can help feminists transgress conventional social science and illuminate ways in which relations of rulings including "legal apparatus [such as] law, courts, and prisons, embody and express a taken for

granted ideology of family life in a form which profoundly limits women's opportunities" (ibid. 6). Cain (1990a) argues for a particular approach to standpoint epistemologies which will have utility for criminology. This approach calls for a historicity of knowledge. By this Cain means that "knowledge is historically specific rather than timelessly true" (1990a, 129). Cain suggests that standpoint epistemology is useful to transgress criminology because it starts from women's perspectives to tell women's stories.

## 2.2 *Standpoint Epistemology:*

Epistemology is about discerning the nature and conditions of knowledge, and about justifying knowledge claims and refuting scepticism. Empiricism, standpoint, and postmodernism are the three theories of knowledge most often engaged by feminists (Hawkesworth 1989, Bartlett 1990, Smart 1990, Cain 1990a). While empiricists rely on scientific and philosophical enquiry and place strong reliance on systematic observation to establish truth, postmodernists reject the very possibility of a truth about reality (Hawkesworth 1989, 536). Standpoint feminists, however, see experience as the epistemological basis of knowledge (Smart 1990, 80, Cain 1990a, Hartsock 1983, Hudson 1990, Smith 1987). Standpoint theory does not simply problematize truth, instead, it rejects the notion of "unmediated truth". Drawing on historical materialism, Dorothy Smith (1987) posits that the "local and particular worlds in which people are concretely located", that is, their material position, help to determine their consciousness. Standpoint feminist, Hartsock (1983a, 242) asserts that

[...]if material life structures consciousness, women's relationally defined existence, bodily experience of boundary challenges, and activity of transforming both physical objects and human beings must be expected to result in a world view to which dichotomies are foreign.



For Hartsock, women's lives make available a particular and privileged vantage point on male supremacy (Hartsock 1983a, 231). Hartsock's analysis of standpoint is valuable but it has been critiqued for its essentialist notion of biological male and female and its implication that if women no longer occupied a subordinate position, their perspective would be lost (Cain 1990a). Standpoint has also been critiqued for ignoring masculinity as a focus of investigation (Smart 1990, 80). Martin (1992) also cautions against an essentialist notion of woman but notes that despite women's differences, the benefits of "a collective process of political and scientific struggle are undeniable, [... specifically because] everyday life is also a struggle and therefore can and does contain a critical standpoint, at least for some" (Martin, 1992, 200).

Making an argument for standpoint, Martin states

We must not make the mistake of hearing the particularistic, concrete stories of these and other women and assume that they are less likely than more universalistic, abstract discourse to contain an analysis of society. It is up to anyone who listens to a woman's tale to hear the implicit message, interpret the powerful rage, and watch for ways in which the narrative form gives "a weighted quality to incident" extending the meaning of an incident beyond itself (Martin 1992, 201).

Cain notes that the main criticisms of standpoint can be reduced to essentialism, diversity of women, and problem of linking knowledge to presently existing theoretical sites. But as she conceptualises it, standpoint is constituted by "politics, theory, theoretical reflexivity and choice (of site) not biology" (1990a, 134). The value of standpoint, notes Cain, is that it "questions the argument that the social identity of the observer is irrelevant to the results, the belief that bias can be eliminated by ritualistic application of technique, and the idea that political commitment reduces objectivity" (Cain 1990a, 127 citing Harding 1986, 162). A standpoint, as defined by Cain, refers to "a site which its creator and occupier has agreed to occupy in order to produce a special kind of knowledge and practice and of which he or she is aware in a special, theoretical way" (1990a, 132). It is also personally and theoretically

reflexive. Personal reflexivity refers to the acknowledgement of site specific knowledge while theoretical reflexivity means "thinking about oneself in terms of a theory and understanding theoretically the site one finds oneself in" (1990a, 133).

Standpoint, as defined by Cain (1990a) is useful to challenge dominant knowledge, to share the knowledge produced with others in the standpoint and others who share the site. It is also useful to generate new knowledge from repressed common senses. Standpoint can make shareable decisions about how to treat those investigated, can generate change and most importantly, can make alliances and facilitate accountability. As a mechanism for alliance, standpoint facilitates reflection "upon a uniquely fractured site, reclaim it as a standpoint for knowledge production and political work and use this theoretical reflection to understand the relationships with other sites and standpoints" (Cain 1990a, 135). By understanding the dynamic and relational, as well as theoretically reflexive aspects of standpoint, alliances can be forged. However, since the possibility of co-optation exists, Cain argues for an appropriately chosen alliance wherein the researcher becomes accountable to those for whom the knowledge produced is intended.

The basic tenet of Cain's approach is that anyone producing knowledge occupies a relational and historical site in the social world which is likely to shape and set limits to the knowledge formulations produced. According to Cain (1993) sites may be chosen politically and to some extent be changed. But in order to produce knowledge for a group of people it is necessary to share their site, that is, to convert one's own site into a chosen standpoint for the production of knowledge. If this is not done, then the researcher may end up as an out-of-touch "do-gooder", who may indeed do more harm than good. Cain explains that while there are some similarities, sharing a standpoint is not quite the same as being an 'organic

intellectual' in Gramsci's sense, instead, standpoint requires the researcher to grasp and situate herself in the subject's position (Cain 1993, 88).

Cain notes that "changing knowledge of relationships is always produced by someone with a particular set of capacities and these historical and variable capacities shape and constrain the knowledge produced" (Cain 1993,90). There is therefore a need to recognise the existence of the unformulated experience among subjugated peoples. Cain explains that "this does not simply mean that already formed discourses are politically repressed, but due to the play of relations of domination and subjugation, some experiences do not yet have a voice" (Cain 1993, 90).

### **2.2.1 The Subordination of Women's Knowledge**

That some forms of knowledge are privileged and others subjugated is no secret. Subjugated knowledge, as described by Foucault (1980, 81), refers to "the historical contents that have been buried and disguised in a functionalist coherence or formal systemisation." Subjugated knowledge then are "those blocks of historical knowledge which were present but disguised within the body of functionalist and systematising theory and which criticism [...] has been able to reverse" (ibid.). Subjugated knowledge also refers to a

whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledge, located low down on the hierarchy, beneath the required level of cognition or scientificity. (Foucault 1980, 82).

The distinction between, and the ranking of, systematic professional knowledge and experience result in the subjugation of voices which engage in the narrative form. As a result, expert knowledge is given primacy over the knowledge and experiences of lay people. When individuals, and especially women, speak of their experiences, this is generally regarded by

malestream society as anecdotal. As such women's experiences have been, for the most part, excluded from history.

Feminists locate women's exclusion in a white, male, capitalist, patriarchal society. Women's subordination is manifested in several ways, however, the most detrimental has been the silencing of women and the subsequent exclusion of women from participation in the public sphere. Historically, gender role stereotypes have been used to silence women. These practices range from direct to more indirect means of control. Dobash, Dobash and Gutteridge (1986: 19-20 ) describe the "brank" (or scold's bridle) as "a metal apparatus which fit over the head and into the mouth, with sharp points that cut into the woman's tongue if she attempted to speak [...] the purpose of each of these punishment ritual was to silence dissident women". Contemporary forms of silencing are more subtle and include women being dismissed or ignored when they tell doctors what they are experiencing. For example, one of the women interviewed, April Brown,<sup>24</sup> explains,

For a year and a half, they kept saying that there was nothing wrong with me, I was imagining it. He would kind of shush me out of his office as fast as he could. He and my general practitioner [...]

Women's subordination is based on constructed dichotomies which postulate specific methodologies for arriving at knowledge. As a result, experiential knowledge is denigrated for being subjective within the knowledge/experience dichotomy. Objectivity is construed as a defining feature of knowledge and pure objectivity becomes masculinized and excessively venerated while women's knowledge is declared to be naturally subjective and for that reason denigrated and disqualified (Code 1991, 27).<sup>25</sup> While physical characteristics, most notably the sex of the knower, should not be epistemologically important, malestream philosophy

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<sup>24</sup>Pseudonym

<sup>25</sup>This is not to imply essentialist notions of distinctively female ways of knowing or an essentialist notion of woman. This suggests instead, that women's experiences are different from men's and this leads them to know the world differently. Different consciousness therefore generates different theories of knowledge.

constructs dichotomies in which the second of the pair is ascribed to women and denigrated (Code 1991). The resulting effect is that subjectivity becomes viewed as being of no epistemic value. Day to day reality is not entirely objective or subjective but contains elements of both, and so these dichotomies should not be constructed as polar, exclusionary or opposites, but as relational and reciprocal (Code 1991, 29).

Objectivity requires the knower to be detached from the subjects studied. However, the impact of such a practice could be problematic for the social sciences. A methodology which necessitates detachment could, and usually does, ignore the consciousness or the meanings and interpretations of the subjects (Code 1991, 34, Cain 1990, Smith 1987). Since social context is important to understand the experiences and behaviour of subjects, it follows that social science should utilise a methodology that acknowledges the inquirer's position (Smith 1987, Cain 1990, Code 1991). An acknowledgement of the social context and meaning does not deny that there are different descriptions of social realities and in no way suggests that there must be some objective truth about women's circumstances, neither does it suggest that the same truth holds for all women. It simply acknowledges that there is a reciprocal relationship between the researcher and the subject; that is, both affect and are affected by the other. Another reason why social science should utilise a methodology that acknowledges the inquirer's position is that within society there are intricate structures of power which are at work to legitimate knowledge and the institutional practices knowledge informs (Smith 1987). Nonetheless, an analysis of women's exploitation cannot always be worked out by the explication of everyday experiences alone because institutions which are extremely remote from everyday experiences also have a profound effect on women's lives (Code 1991, 45, Smith 1987). These institutions help to generate stereotypes of women. Women's knowledge and experiences are then denigrated.

Feminists are cognisant of the problems involved in documenting women's knowledge. As such, extensive efforts are made to recover women's lost voices. Using experiential knowledge as a starting point, feminists demonstrate that experience is not just anecdotal, but a starting point for scholarly analysis and critique (Smart 1987, Code 1991, Cain 1990). Therefore, "feminists have brought experience back into social science methodology through their emphasis on both its value and legitimacy" (Hudson 1990, 120).

Feminists have with good cause become increasingly hostile to theory (Cain 1990a, 130-1). However, total rejection could be just as problematic as total acceptance. Hence Cain argues for the utilisation of the Gramscian notion of theory as a specially self-consciously formulated knowledge. The Gramscian notion of theory facilitates an acknowledgement that "feminist thought [...] is sufficiently sophisticated to contain both objectivized knowledge and knowledge scepticism and so, for the time being, to attain the best of both worlds" (Cain 1990a, 131). There is then, a reciprocal relationship between politics and theory and the generation of standpoint-specific knowledge (ibid. 132).

Foucault's conception of the power/knowledge connections opens a line of inquiry to take account of the power mechanisms that are used to venerate or denigrate forms of knowledge (Code 1991, 201). It is also helpful for understanding why some forms of knowledge are subjugated and produce certain kinds of subjectivity. Smith however, notes that established sociology/criminology has objectified a consciousness of society that "knows" from the standpoint of its relations of rulings and from the standpoint of men who do that ruling (1987, 2). For Smith, traditional discourse of power is deficient. She suggests, instead, "relations of ruling" which encompasses more than traditional concepts of power. Relations of rulings also include organisation, direction and regulation. "Rulings" also "identify a complex of organised practices, including government, law, business and financial

management, professional organisations and educational institutions as well as the discourses in text that interpenetrate the multiple sites of power" (Smith 1987, 3). Smith notes that since disciplines are determined by their discourse, and since women are excluded from positions of influence within the disciplines, women are not participants in the concepts, methods, relevances, and topics of such disciplines (Smith 1987, 61). Further, exclusion from the creation of the discourse is problematic because "the discourse is maintained by practices that determine who can participate in it as fully competent members" (Smith 1987, 61). Therefore, Smith critiques conventional methodology and suggests that a more appropriate method of developing a sociology/criminology from the standpoint of women is institutional ethnography. Institutional ethnography is a method of inquiry that makes the everyday world its problematic (Smith 1987, 152). This method starts from where women are as subjects. Women's situation and experience are the basis for social inquiry specifically because "the explication of institutional relations brings to light not only common basis of experience but also basis of experience that are not in common but are grounded in the same set of relations" (Smith 1987, 153).

A methodology which encourages inquiry into women's experiences is important because everyday actions are affected by social relations which are not evident, but which nonetheless enter in and organise women's everyday action without all individuals being present or cognisant of one another (Smith 1987, 153). For example, the incorporation of everyday life into the legal sphere is facilitated by medical intervention. This results from the primacy given to scientific professional knowledge and the relegation of experiential knowledge as anecdotal. This reliance on scientific knowledge is then used to subjugate women's experience of their own reality. Investigation based on sensory experience is commonly advanced as the most reliable source of knowledge. For example, except for expert

evidence, testimony given in court must be based on experience. It is odd, therefore, that experiential knowledge is not recognised as accredited knowledge (Code 1991, 245). While discussions of medicine and law claim to have a basis in empirical observation and though epistemologists claim a basis in experience, such discourses systematically discredit women's first person narratives (Code 1991, 214).

Consequently, the distinction between knowledge and experience manifests a gender-linked double standard wherein women's experience is discounted as merely subjective, "but men's experience carries a tacit assumption that it is not just experience, it is *objective* experience, informed by theory" (Code 1991, 245). The implications of such systematic denigration of women's experience is that credibility is intricately associated with status which then determines the recognition of contribution. But women's capacities to contribute knowledgeably remain invisible when their achievements are structurally blocked from acknowledgement (ibid. 250).

As such, women need to re-evaluate their position within and in relation to the hegemonic forms which operate to shape knowledge in society. Code suggests that the solution is not simply to celebrate "women's ways of knowing", but to acknowledge that women, as gendered and political beings, can transform the "epistemological project" (ibid. 262). This project is not to simply replace traditional epistemology with a new form of homogeneity, nor simply to be concerned with the difference between men and women, but to construct emancipatory theories of *difference* which also articulate the diversity among women (Code 1991, 263). Code suggests that feminists also need to develop politically informed studies than can distinguish between what scientific (and other) knowledge enables people to understand and what it enables "man" to do. It is not enough then for women to simply enter masculine preserves (Code 1991, 263), women need to engage in critiques of



malestream epistemology and remap the epistemic terrain (Code 1991, 266). Feminists need to understand 'the epistemological project' in order to decenter it, but the extent to which a feminist epistemology is necessary or desirable is problematic (Code 1991, 314). Indeed, a feminist epistemology that assumes an essence to women and women's knowledge could replicate the exclusionary hegemonic structures of masculinist epistemology (Code 1991, 315). By invoking the mask of neutrality, malestream epistemology conceals the connection between social distribution of power and privilege and the conferral of knowledge status. Feminist analysis, however, reveals that knowledge claims advanced by people in position of power are more likely to be presumed valid than knowledge claims advanced by occupants of 'underclass' positions (Code 1991, 249).

Hence, women need to reclaim their knowledge, but since knowledge is based on acknowledgement, and the capacity to gain acknowledgement is gender related, Code suggests that women need to be cognisant of the ways in which they participate in the hegemonic practices of society. As such, each woman needs to

free herself from stereotyped conceptions of her "underclass" epistemic status, her cognitive incapacity and her ever threatening irrationality. She has to achieve this freedom both in the eyes of other people, who too often deny her capacity by refusing to listen or give credence, and from her own standpoint, shaped as it also is by stereotype-informed assumptions that neither her experiences nor her deliberative capacities are trustworthy sources of knowledge. Politically, spaces have to be created where a woman's knowledge can be judged sufficiently authoritative to deserve acknowledgement, and the spaces have to be constructed variously, to respond to differences between and among women (Code 1991, 215).

Women need to create the spaces in which their knowledge can be recovered because the hegemonic nature of malestream ideology can denigrate women and our everyday practices to metaphorically and literally drive us crazy (Code 1991). This happens because the inability

to gain acknowledgement for our knowledge often leads us to embrace the expert's knowledge which has been used to denigrate us.

### 2.3 *Women and Medical Experts*

Stereotypes and ideologies are embedded in the theories, practices and attitudes of the authorities and experts who have influence over women's lives (Code 1991, 203, Smith 1987).

Moreover, there seems to be a correlation between increased interventions and the end of a practical and social authority which women had over their lives (Code 1991, 207). Code states quite poignantly that

susceptible to the rhetoric of a new scientific era that promised so much, and rendered increasingly passive by the growing mystification of expertise, women were induced to acquiescence in an ideology that reaffirmed their incapacity to think for themselves by signing over responsibility for their well being to the experts (Code 1991, 207).

Medicine has been able to establish itself as an authority over women's lives. Doctors' authority and prestige became mystified on the basis of "esoteric scientific knowledge". Since women for the most part were excluded from access to medicine, this knowledge became a commodity of privilege. This mystification and veneration of "esoteric scientific knowledge" resulted in a situation in which women's reliance on their own experience, intuition and skills was conceived by malestream society as a rejection of scientific expertise and as such a violation of a fundamental epistemic imperative (Code 1991, 207).

Feminist analyses note that technological advancements have enabled medicine to reach further and further into the human body thereby allowing medicine to regulate much of what was previously seen as natural occurrences (Rich 1978, Arms 1975, Corea 1977, Smart 1989, Cain 1986). Despite the fact that most women's health issues, such as pregnancy, menopause and menstruation, are neither illness, sickness nor disease, they have been pathologized and incorporated into the sphere of medicine. This pathologization has led to

procedures, such as hysterectomy and the use of caesarean sections, which have detrimental effects on women. Women responding to a province wide survey of women's health care concerns conducted by BC Women's Hospital reported that their health care concerns and their everyday lives are inseparable. Participants also expressed frustration that everyday normal occurrences such as pregnancy have been pathologized and have become subject to the medical gaze (BC Women's Community Consultation Report 1995, 11). The medicalization of much of daily life has therefore established [physicians'] "unquestioned status as experts and has resulted in their almost unprecedented power over [women's] lives" (Scully 1980, 20).

Historically, women as healers attended to other women's health care issues, particularly during childbirth. However, with the advent of western medicine much everyday occurrences were redefined. Women's health care issues were then incorporated into the realm of the "professional man". Scully (1980, 28) notes that "medicine waged a bitter battle against the popular 'granny' midwife, and in the process imposed new, medically oriented customs on childbirth."<sup>26</sup> But in order for doctors to solidify their position and to establish their claims and eliminate midwives, childbirth, and other women's health care issues were pathologized. The development and use of "aids" or "instruments" were further used to rationalise the exclusion of women as healers and midwives from attending to women in childbirth. Obstetrician-gynaecologists are a special case in that they have designated themselves

the official and legitimate experts on the female reproductive tract, they have also been successful in broadening their sphere of influence to include the female sex role, psychology, and sexuality, despite the fact that these are areas in which they have no

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<sup>26</sup>A significant number of the women who were targetted as witches were midwives and healers. See the film The Burning Times and other books on the Witchhunts such as, Ehrenreich, Barbara and Deirdre English (1973) Witches, Midwives and Nurses: A History of Women healers. Old Westbury [N.Y.] Feminist Press; Willis, Deborah 1995 Malevolent Nurture: Witch-hunting and Maternal Power in early modern England. Ithaca, N.Y.: Cornell University Press, 1995.

particular expertise and which they tend to interpret from a decidedly male point of view (Scully 1980, 20).

Physician monopoly over medical knowledge helped to mystify the public about health and create the belief that medicine is too complicated for the average person to understand. This claim to specialised knowledge helped to establish the medical profession's autonomy and freedom from outside regulation. Hence, childbirth as exclusively physician dominated is a recent phenomenon and is reflective of the power of medicine to medicalize everyday experiences (Scully 1980, 25, Corea 1977 , Martin 1992, Rich 1978). Obstetrician-gynaecologists have been designated the official and legitimate experts on women because of their special training. Women's health care and especially birth has been brought within the domain of these new experts who not only perceive the process as problem rather than natural but who are also surgeons trained to intervene (Scully 1980, 34). The surgical or interventionist mentality has been inculcated in "men who control women's health" and forms an integral part of the socialisation process in medical school, experiences, and training (Scully 1980, 102).

Medicine in general, and obstetrics in particular, pursue an interventionist model (Brackbill, Rice and Young 1984, Scully 1980, Corea 1977, Martin 1982, Rich 1978). Hospitalisation and interventionist practices have their attending risks. Procedures now taken for granted -- obstetrical medication, elective induction of labour, routine foetal heart monitoring, chemical stimulation of labour, routine use of forceps -- distort the childbirth experience and can be damaging to the new-born (Scully 1980, 35). Obstetrical-gynaecological "instruments" brought added danger to mother and child and increased the possibility of physical damage, infection in damaged tissue, haemorrhage, and a crushed foetal head (Scully

1980, 29). Risks include, but are not limited to, infection following caesarean, and psychological and physical risks of hospital deliveries.

While interventions may be necessary in complicated labour and deliveries, there has been a dramatic increase in procedures such as caesarean sections (Scully, 1980, 38). There is also a proclivity among gynaecologists for removing women's reproductive organs. Consequently, prophylactic hysterectomy and other gynaecological procedures are routinely performed on women for "their own good" or because those organs are "no longer useful." This attitude is based on doctors' perception of the uterus as an expendable organ, useless for purposes other than childbearing (Scully 1980, 17, Hieberg 1994, Goodwin 1994). Thus, obstetrical-gynaecological interventions also increase risk of complication. These interventions are raising issues of legal liability. However, the issue which has had the most profound legal impact on medical practice is that of informed consent (Robertson 1991, 424).<sup>27</sup>

Women consume a large portion of medical services and are more frequently in touch with the health care system. However, the health care sector reveals significant occupational segregation. Although more women are employed in the health care field, they occupy lower-paid, less prestigious positions. Women accounted for 42.6 percent of Canadian Medical School graduates in 1993, (CMAJ, 1993, 149(11) 1692) but represent only 13<sup>28</sup> percent of obstetrician-gynaecologists. Women are underrepresented in all the surgical specialities but the percentage of women in obstetrics and gynaecology is even less than in medicine in general (Scully 1980, 14 Larned, 1978). Female medical students generally choose family practice more often than speciality practice (Sanmaretin and Snidal 1993, 984). When they specialise they often specialise in other areas of medicine such as paediatrics and psychiatry.

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<sup>27</sup> See *Reibl v. Hughes* [1980] 2. S.C.R. 880. See also note 20

<sup>28</sup> In 1992, less than 14 percent of British obstetrics-gynaecology consultants were women; their numbers had increased by fewer than four annually in the previous 5 years. (Richmond, 1993, 1149.)

Therefore most medical specialities, and obstetrics and gynaecology in particular, are dominated by white, upper-middle-class, males.

There is a debate as to whether female obstetrician-gynaecologists would make a difference to women's health care. Scully suggests that among doctors, class loyalty is stronger than sex loyalty (1980, 93). As well, power and control appeared to be important to the obstetrician-gynaecologist within the doctor-patient relationship (ibid. 91). Given the combination of class, sex and the authority invested in doctors, female practitioners may not be as strong an ally as most women would expect.

Within a malestream society, femininity became pathologized. This can best be described as a "constant thread running through expert endeavours to control women and channel their sexuality to conform with male expectations and heterosexual norms" (Code 1991, 208). Obstetrics and gynaecology stand as an exemplar of the way in which femininity has been pathologized. Their perception of women is reflected in an 1860 address by Seymour Hadden to the British Obstetrical Society, in which he said that

as practitioners among women, obstetricians have constituted ourselves [...] the guardians of their honour [...] We are, in fact the stronger and they the weaker. They are not in a position to dispute anything we say to them; and we, therefore, may be said to have them at our mercy (in Code 1991, 209).

Consequently, women's willingness to trust in the authority of scientific expertise makes them vulnerable to the vagaries of the medical profession and the profession's conception of women. Thus, there are intricate connections between ideology and the production of knowledge, the relation of power and knowledge and the construction of expertise and authority. Therefore, "behind the mask of objectivity and value-neutrality that mainstream epistemology presents to the world, are complex structures of vested interest, dominance and

subjugation" (Code 1991, 208) otherwise known as gendered subtext and gendered division of labour (Smith 1987).

The preceding discussion outlines some of the problems women experience and some of the ideologies and practices which predispose women to injuries in their contact with the medical/health care system. It becomes important then that women's experiences and concerns are researched and incorporated into the knowledge that is produced concerning medical negligence. The purpose of this research, then, is to illuminate issues bearing on a relatively neglected group of people whose experiences are undocumented. By so doing, it brings forth women's experiences and knowledge of obstetrical or gynaecological injury.

#### **2.4 *A Feminist Methodology***

Feminist standpoint methodology, particularly as articulated by Dorothy Smith, is concerned primarily with "how to conceptualise or how to constitute the textuality of social phenomena, [...] how to write the social, to make it visible" (1987, 106). Smith explains that what she articulates is "a method which creates the space for an absent subject, and an absent experience that is to be filled with the presence and spoken experience of actual women speaking of and in the actualities of their everyday world" (ibid. 107).

As mentioned previously, studies which focus on claims or surveys of hospital records may grossly underestimate the frequency and severity of injuries primarily because the majority of people who suffer iatrogenic injuries do not file claims. Further, the literature on gender bias within the judicial system indicates that women face barriers accessing the court system. Research generally focuses on the perspective of the providers of health care resulting in women's experiences being excluded from this body of literature. Therefore, a research method that problematizes women's exclusion, as well as the silencing and marginality which

they experience in society in general, and in the literature on medical/health care injuries in particular, is needed. This thesis attempts to address this silence. Its main purpose is to present women describing in their own words their experience of injury and any effect this injury may have had on their lives. Consequently, the method used is an intrinsic part of and cannot be separated from the conceptual framework. There is no distinction between the theory and the methodology, hence the applicability of standpoint feminism.

As noted before, women's experience of medical/health injury is for the most part excluded from academic, medical and legal discussions. Even analysis which purports to advocate the patient's/consumer's perspective operates to further silence women. However, conversations with women or perusal of newspapers and magazines tell a different tale. These sources document tales of women being ignored by doctors, or women dying from routine procedures, such as hysterectomies, or women being subjected to unnecessary procedures. Personal experiences relating to medical care raise a few similar themes. Themes such as the opposition between scientific knowledge and personal experience (experts vs. layfolks knowledge), the silencing of women, or the experience of being a nuisance when women persist in asking for help or information. *Georgina Hunter knew her baby was gravely ill but couldn't convince half a dozen doctors. Now, she is determined to ensure that no other parent faces the same horror.* So reads the headline of an article in Chatelaine (Harris-Adler 1996, p.63) which chronicles a mother's quest to get medical attention for her baby. Despite her efforts, the baby died. She contends that a contributing factor was that *no one really listened to her fears.* Women's stories indicate that they do suffer injuries. Why then are their voices excluded from the literature on medical negligence?

Information derived from personal experience is generally regarded within academic circles as anecdotal, unsubstantiated, unscientific or otherwise incapable of verification. The



categorisation of women's experience as anecdotal or unscientific may, in part, be responsible for the absence of women's voice from the literature of health care injury and more specifically the literature on medical negligence. Feminist researchers have long recognised that women's personal experience provide a starting point for research. Hence, feminists need to talk and listen from women's standpoint if we hope "to write women and their diverse experiences into the disciplines" (Devault 1990, 6). Although academic feminism has brought women's experience into theorising (Devault 1990, 6), social science has traditionally been shaped by the concerns and experiences of men (Smith 1987, 1989). The challenge then, is to have these experiences given credence despite the medium used.

Smith (1987) points out that conventional methodology is problematic. Since conventional ways of knowing have been constructed in a manner which systematically excludes and distorts women's experiences, new methods are needed which will facilitate inclusion of excluded perspectives (Smith 1987, Stanley and Wise 1983). The feminist challenge therefore is how to make these disciplines more inclusive of "outsiders". This is especially necessary because "conventional research methods systematically downgrade the importance of the personal and of experience" (Stanley and Wise 1983, 151). Stanley and Wise suggest therefore that

A feminist social science should begin with the recognition that 'the personal', direct experience, underlies all behaviours and actions. We need to find out what it is that we know and what it is that we experience. We need to reclaim, name and rename our experiences and knowledge of the social world we live in and daily construct [...] we need to reject this imposed language and to construct our own social science or a social science which starts from women's experience of women's reality (1983, 165).

Personal experience is both a phenomenon and a method in that it refers to the structured quality of experiences to be studied and it also names the patterns of inquiry for study (Clandinin and Connelly 1994, 416). Smith (1987) suggests a useful methodology for

researching the "everyday world as problematic", an approach that contextualizes the standpoint of actual women. She explains that the "everyday world as problematic" simply means that social relations external to women affect and help to organise their everyday experiences. For Smith, the matrix of women's experiences within the everyday world can be explored through the relations organising these experiences. Her methodology is a type of textual analysis that reveals how women's experiences of the world are inscribed in relations of ruling. "Relations of ruling" refer to the struggle between women's local or individual experiences and the extra-local discourses of professional expertise (Biesenthal 1993, 58). These relations of ruling reinforce a vision of society which denies women's local experiences and provide a universalised view of life which does not invite input from the standpoint of women.

Thus, what may in some circles be discounted as anecdotal is here categorised as women's personal experiences, specifically because standpoint feminism takes as its point of departure women's relations to the ruling apparatus. Smith's methodology engages women in interview and encourages them to speak of their experience in their own words. She explains that a wealth of descriptive (qualitative) information is gained by asking women to talk about their experience. These accounts can then be examined for the ways in which they are articulated, especially because these specific accounts of particular experiences provide the exploratory framework for analysing the general knowledge produced about women (Smith 1987). This method facilitates an understanding of women's activities and makes obvious that a more extensive complex of relations than those actually investigated are embedded in women's experiences (Smith 1987, 155).

For Smith (1987) one cannot know the specific character of the problematic of the everyday until the everyday is explored. Smith suggests that once the standpoint is

established the researcher can move from women's account of her everyday experience to explore the generalising and generalised relations in which her account is subsequently embedded and eventually transformed. By so doing, we can reveal the institutional practices which penetrate and organise the experiences of women.

Smith's methodology uses an open-ended method of interviewing. She notes that this freedom is important because how informants tell their story is essential to the analysis that defines the problematic. For this reason, Smith points out that her method is also committed to ensuring that the women interviewed speak again in the researcher's text without re-interpretation of what they had to say. No coding is used and there is no attempt to seek common themes. Although recurrent themes are identified, there is no interest in collecting these and talking about the distribution in the sample because "women are not sample but those who provided experience" (Smith 1987, 190). Smith acknowledges however that unless feminist researchers can go beyond what respondents themselves have to say, these experiences will remain descriptive. She claims that as "important as it has been and is to hear the authentic speaking of women, it is not sufficient to ground and guide a sociological inquiry" (Smith, 1987, 111). Smith states that it is necessary for feminist researchers to work from the standpoint of women to create a method of thinking and writing women as subjects into the texts which are created. The aim of Smith's methodology then "is to explicate rather than explain the actual social processes and practices organising people's everyday experiences from a standpoint in the everyday world" (ibid. 151). Consequently the situated nature of the researcher should form the very basis of social science work.

This thesis uses Dorothy Smith's methodology to examine the relationship between women's experience of medical/health care injury and the transformation of these experiences by institutional relations of rulings (medicine and law) which operate to silence women

thereby excluding them from the body of literature discussing these issues. For this thesis I engaged women in "tea talk"<sup>29</sup> where they described in their own words, injuries they sustained when they received obstetrical or gynaecological care. These "tea talks" were not channelled in a particular direction. Instead, an open-ended method was used. However, following Smith (1987) and Stanley and Wise (1983), I attach theoretical terms to these experiences and reformulated them to explicate in a more abstract manner what the women actually said. The resulting conceptual framework challenges the inadequate representation of women's experiences in the social sciences in general, and in the literature on medical negligence or medical/health care injury in particular.

#### **2.4.1 Sample Definition**

Based on the notion that obstetricians and gynaecologists are experiencing the most serious impact of medical liability, I decided that rather than assessing medical care in general, I would focus specifically on obstetrical-gynaecological care. I reviewed the B.C. Civil Decisions to determine what issues were brought to court. Because there were so many variations in the injuries, I decided that the criteria for participation was whether a woman had sustained injury either to herself or her child while receiving gynaecological-obstetrical health/medical care. I had a preconceived notion that obstetrical-gynaecological injuries would all result from childbirth experiences. However, I soon realised that the injuries often cannot be demarcated in such manner. Some of the injuries did not occur during childbirth. However, others were directly or indirectly related to childbirth experiences. An example is injury resulting from gynaecological surgery to tighten vaginal muscles after childbirth or a tubal ligation which was done after a very traumatic caesarean section. I initially planned to

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<sup>29</sup>This refers to the fact that all the interviewees offered me tea. These can therefore be regarded more as tea talks rather than interviews. Quite often women commenced to give me information prior to the formal start of the conversations. I realized this and after the first two interviews I tried to get the Informed Consent and other information out of the way as soon as possible and prior to tea.

access files from the B.C. Reported Decisions - Civil, extract the relevant information and send questionnaires to the identified parties. However, because the cases that reach the court may not have been representative, I decided to do newspaper advertising instead. This, I hoped, would reach a wider cross-section of respondents.

#### 2.4.2 Definition of injury

The advertisements soliciting participants read: "if you or your child suffered obstetrical or gynaecological medical/health care injury and you want to share your experiences as part of a research study, please call". During the initial phone call, the women described their experience(s) to me and asked whether it/they fit within the mandate of the study. Some of the callers simply called to enquire whether I had heard from other women with specific injuries and/or the prevalence of specific injuries. I deliberately did not define injury. Thus, it is women's definition of injury rather than the researcher's that took precedence. However, in all cases, there was a physical injury. Some of the injuries developed from medical procedure which the medical community advocates as necessary to prevent injury to the woman. One such example is episiotomy. Others, such as infant injuries resulting from foetal oxygen deprivation, arose directly from the birth experience.

No province in Canada (and few states of the United States)<sup>30</sup> has formal requirements for filing information on malpractice claims. Consequently, I pursued several avenues for identifying respondents. In Canada, approximately 90 percent of all doctors are covered by the Canadian Medical Protective Association. The Association is represented by a legal firm in each province, except for Ontario where more than one legal firm is retained. The association [CMPA] was approached for access to either aggregate data or information

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<sup>30</sup> Florida law requires that closed medical malpractice claim forms be filed with the state and made available on a public use basis (Sloan & Hsieh 1995, p.417).

on claimants for claims arising from obstetrical/gynaecological medical/health care in British Columbia. They refused access claiming that because the CMPA is a national organisation, it does not keep information on a regional basis.

I also contacted legal firms known to have particular experience with malpractice litigation. The firm most willing to help did not do obstetrical or gynaecological cases. However, I was introduced to a partner with a firm that specialises in such claims. No respondent was obtained through this avenue.<sup>31</sup> Advertisements were also placed in newspapers<sup>32</sup> and a one page information sheet was posted at legal services, the Vancouver Women's Health Collective, the University of British Columbia and the Vancouver Community College. Faxes were also sent out to self-help group, women's resource centres, community centres, and informal networks such as friends and family. The research project was also listed on the School of Criminology web page under Research Projects. Participants were also encouraged to pass the information on to other people known to have had similar experiences. In addition, the project was included in an editorial in the Vancouver Sun Newspaper. A telephone number was listed for interested parties to contact.<sup>33</sup> Despite the variety of avenues pursued, and the offer of anonymity and confidentiality, the sample does not represent women in all their diversity.

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<sup>31</sup> Because of ethical concerns, I provided the legal firm with an information package which contained a letter of introduction, background information on the project, informed consent form, a questionnaire and a self addressed envelope. The questionnaire was developed so that women who were willing to participate but who were otherwise prohibited from discussing their cases may have the option of providing information anonymously.

<sup>32</sup> Classified advertisements were placed in The Vancouver Sun and The Georgia Straight. The project was also discussed in an Editorial done by the Vancouver Sun Writer, Archibald Rollo.

<sup>33</sup> I added a second telephone number to my home telephone and I changed the message to say if the call was about the health injury research project, the caller could leave a name and number and I will return the call. Only three people left their numbers for me to return their call. All the other respondents reached me on their initial call. However, during the period of data collection, each day there were several calls where the caller did not leave a message. This may indicate a reluctance for people to leave their name on an answering machine without knowing who will actually retrieve it. It is interesting to note also that a few of the women expressed some reservation about placing the initial call. It is possible then that many people were dissuaded by the answering machine.

### 2.4.3 The Participants

Table 3

Source of Participants

Source	Response	Participated	Total
Newspaper	11	7	7
Community organisations advertising	0	0	0
Snowball sampling	4	2	2
Through legal firms	0	0	0
Internet	3(1) <sup>34</sup>	2(1)	2(1)
Total	19	11(10)	11(10)

The women were between the ages of 32 and 50. All but two were EuroCanadian. The other two were of Asian descent. Four of the ten women were born in Canada. Four of the remaining six have been in Canada for more than ten years and the other two were Americans.

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<sup>34</sup>This eleventh respondent was sent the interview schedule as a guideline to assist her in preparing written responses. After several correspondences, she stated that she had waited 8 years for her case to reach court. The case was about to go to trial and she expressed some concern about writing about her experience prior to the completion of the case. However, when cases are decided in favour of the plaintiff, the defence still has the option of appealing. Hence this case could very well stretch on another two years or more before there is a final resolution/disposition.

Table 4  
Respondents' Profile

	Name <sup>35</sup>	Approx. Age	Education	Marital Status	Primary Injury	Severity/type of Injury	Claim
1	Violet Kerr	30s	College	Unmarried	Self	Permanent Minor: Damage to organs	Statute Barred
2	Rose Hall	30s	College	Unmarried	Self/ worries about latent injury to child	Temporary major: Recovery delayed. Damage to organs	Police WAVAW College Hospital Family Doctor Plans to file legal suit
3	June Gentle	40s	College	Divorced	Self	Permanent Minor: Damage to organs	Did not claim
4	Blossom Grey	40s	College	Married	Child	Permanent major: Brain damage	Initiated complaint
5	Crystal Walters	40s	High School	Unmarried	Self	Temporary major:  Post-op complications	Did not claim
6	Primrose White	40s	High school	Married	Self	Permanent significant: Damage to organs	Statute Barred
7	April Brown	50s	University	Divorced	Self	Permanent Significant: Damage to organs	Abandoned Claim
8	Cherry Barrett	30s	University	Married	Self/ worries about latent injuries to child	Temporary major: Recc very delayed. Additional surgery required	Did not claim
9	Pauline Jones	30s	College	Married	Child	Permanent major: Brain damage	Claim ongoing
10	May Anderson	40s	University	Married	Child	Permanent major: Brain damage	Claim ongoing

I originally hoped that interviewees would include cases from across all spectrum of the claim process rather than just those who had litigated. Although most of the participants

<sup>35</sup> Respondents were assigned pseudonyms.



had considered litigation, none had as of yet completed litigation. The Statute of Limitation had run out for two respondents; two respondents had filed or were in the process of legal consultation; and three had proceeded through to the deposition. This sample, therefore, contains respondents who have pursued, as well as those who have not pursued litigation, or filed a formal complaint but none who actually completed the litigation process.

Table 5  
Claim Status

Claim Status	Participants
Did not file claim	3
Initial complaint process	2
Claim ongoing	2(1)
Statute of Limitation expired	2
Gave up after legal consultation	1
Total	10 (11)

At the time of the interview one women had made a formal complaint to the College of Physicians and Surgeons. One expressed the desire to do so as soon as her injury is corrected. However, she expressed a reluctance to discuss this with her family doctor for fear that it might impact on her future health care. One woman filed complaints with several organisations, with the police, the hospital, her family practitioner and a woman's organisation. She also made contact with legal counsel but had not yet filed a formal suit. Three of the women had not considered any form of complaint.

Table 6  
Avenues for Filing Complaint

College of Physicians and Surgeons	1
Police	1
Women's Organisation	1
Legal Suits	7
Hospital	1
Family doctor	1

Five of the eleven participants either completed or have some college education. Of the three with university degrees, two have professional designation, the other has a Bachelors degree. The other two women completed high school.

Table 7  
Highest Educational Qualification

Educational Qualification	Participants
University Degree	3
Some College	5
High School	2

#### 2.4.4 The Instruments

The sources of information are the semi-structured interviews which I conducted, the results of the practitioner questionnaires located at the Vancouver Women's Health Collective, and judicial decisions identified from *B.C. Decisions - Civil Cases*.

##### 2.4.4.1 Semi-Structured Interviews

I conducted ten interviews between October 1995 and February 1996. The information gathering was facilitated through semi-structured interviews in which women spoke of their injuries (Appendix 1 - Interview Schedule). The interview elicited information with respect to

the injury suffered and whether or not litigation was pursued or claim filed. I initially intended to canvass women's satisfaction/dissatisfaction with the outcome of litigation/claim, their perception of, or effect of litigation on the ability to receive health care and the effect their injury has had on other aspects of family life and current standard of living. However, none of the respondents had successfully litigated, therefore the conversations garnered information about the injury, the nature of the injury, the effect of the injury on their and their family's lives, whether or not complaint was filed and with whom, and the experiences they have had with the complaint organisations and or practitioner. I also asked women about their perspective on tort reform issues.

Interviewees were drawn primarily from British Columbia. However, one respondent was from out of province. With this one exception, which was conducted by telephone, all interviews were held in the participants' homes. The interviews were tape-recorded (with prior permission from participants). The length of the interviews ranged from 45 minutes to 2 1/2 hours and yielded transcripts ranging from 9 to 33 pages single spaced. There was a deliberate attempt to avoid a question and answer format. The interview schedule was simply used as a guideline to ensure that all the needed information was covered. Respondents were not streamlined into answering questions in a particular order, instead, they were encouraged to give an account of their experience in their own words. As such, I facilitated the data gathering process, rather than interviewed the respondents. The interview guideline was also prepared as a questionnaire to be administered to respondents who were willing to share information but who were restricted by factors such as confidentiality clauses. No such respondents were found.

#### ***2.4.4.2 Women's Health Collective Medical Practitioners' Questionnaires***

During the course of research I came across questionnaires administered by the Vancouver Women's Health Collective which solicited women's feedback about their contact with medical practitioners. The questionnaires were administered by the Collective as a way for women to share information about their experiences with health care practitioners in and around Vancouver. However, one of the questionnaires solicited information specifically about women's experience with obstetricians, gynaecologists or general practitioners who deliver babies. This information was incorporated into the thesis because some of the experiences described in the questionnaires were similar to those described by the women with whom I spoke. Further, the Collective can be viewed as a mechanism for filing an informal complaint. (Appendix 3 - Sample Health Collective Questionnaire).

#### ***2.4.4.3 Reported Cases***

Reported cases of obstetrical injuries identified from the *B.C. Decisions - Civil Cases* were also reviewed. These were analysed in terms of the kinds of issues which were important in judicial decision making.

### **2.4.5 Ethical Issues**

#### ***2.4.5.1 Informed Consent***

This research focuses on the experiences of women who have suffered iatrogenic injuries during the receipt of obstetrical or gynaecological medical care. Some have suffered severe physical or psychological damage. During the initial telephone contact, respondents were informed of the reason for the study and the general issues to be covered. Prior to the commencement of the interview, participants were required to read the background

information on the study, they were then given an Informed Consent Form to read and sign (Appendix 2 - Informed Consent). The Consent Form states that participation is voluntary and can be withdrawn at any time. None of the participants were members of captive population, nonetheless, confidentiality and anonymity were provided.

#### ***2.4.5.2 Confidentiality***

Participants were informed that the information provided would be kept confidential and that it was collected for the purpose of completing a Masters thesis. The Informed Consent forms were assigned a number, and only this number appears on the audio cassettes. During transcription these numbers were randomly assigned pseudonyms. These pseudonyms appear in the transcript and the thesis.

#### ***2.4.5.3 Anonymity***

Anonymity was provided because several women expressed fear that a complaint would elicit reprisal by medical practitioner. That is, they were afraid that this would impede their chances of getting medical care. Also, one respondent had filed criminal charges, made a complaint to the hospital, the College of Physicians and Surgeons, and was still contemplating the possibility of civil action. It was important therefore that all effort be made not to impede her chances in court.

#### ***2.4.5.4 The Issue of Bias***

The women represented in this thesis are self-selected rather than randomly sampled. That is, women who do not have access to the newspapers, and who do not use women's resources centre nor have access to the Internet have been excluded. A few women also wanted to make sure that the study was legitimate before they participated. This might indicate the reluctance of women to speak and/or fear of reprisal. Moreover, there are women who are still very uncomfortable talking about their experiences. Thus, the extent to

which the information contained herein is representative of women who have been injured cannot be ascertained. Consequently, there is no attempt to generalise. In fact, this thesis is exploratory and specific rather than general.

#### ***2.4.5.5 Problems of Methodology***

Problems associated with the interview method, specifically reactive bias are acknowledged<sup>36</sup>. Further, the questionnaires administered by the Women's Health Collective were not designed specifically to collect data for this thesis. As a result it excludes information such as demographic data. Problems associated with using secondary sources are therefore acknowledged.

Being consistent with the requirement of reflexivity which is integral to my methodology, I should acknowledge that I feel constrained by not being able to present the full text of what women have told me. I would have preferred to simply transcribe each woman's story and present it as is. Thus, I too have become part of the silencing mechanism.

In this section, I argued that the professionalization of women's everyday experiences has operated to exclude and or marginalize women's experiences. I presented a framework for understanding women's marginalization within the literature on medical health care injury. I will now present women describing in their own words, their experiences of injury.

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<sup>36</sup>See Palys, Ted Research Decisions: Quantitative and Qualitative Perspectives. Harcourt Brace Javonovich Canada Inc. 1992 (Pages 160 - 166)

### **Chapter 3: Women's Experience of Medical Health Injury**

The literature on medical malpractice, or physicians' legal liability as it is euphemistically called, constructs doctors as victims. Little, if any, consideration is given to patients. They are silenced or rendered inaudible by medical, legal and academic discourses, and are, for the most part, excluded from discussions of medical malpractice. As a result of this silencing, little is known of patients' experience of medical/health care injuries.

This chapter reviews the literature describing the effects of legal liability on medical practitioners. This is then juxtaposed with the experience of patients [women] who have sustained medical\health care injuries. First, I discuss women's contact with medical doctors then address the injuries arising from such contacts and doctors' responses to these injuries. I also talk about women's experiences with lawyers and their attempt to seek redress for their injuries. These cases demonstrate that not only are women injured physically as well as mentally, but they are also injured by the treatment they receive in response to their complaints, particularly by their inability to access justice. Although much is known about doctor's experiences with medical negligence, women's experiences are rendered inaudible, invisible and non-existent in literature.

#### ***3.1 The Effects of Legal Liability on Medical Practitioners***

Discussions of medical negligence report that the "crisis" produced very demoralising effects on medical professionals (Wadlington 1991, Dickens 1991) resulting in increased costly "defensive" medical practices, decreased willingness to perform needed but "high risk" procedures (sometimes termed "negative" defensive medicine), increased incidence of "going bare" (practising medicine without liability insurance) and "dropping out" of medical practice partially or entirely. Academic literature, as well as texts that doctors write on their own experiences, categorise the consequences of legal liability on medical practitioners in terms of

personal, emotional and financial effects. Ennis and Vincent, in a review of the literature, indicate that doctors report feelings of anger and betrayal, feelings of being utterly alone and isolated from colleagues and patients (1994, 103). They experience deep and visceral emotions, insomnia, appetite changes, irritability, headaches and a host of other symptoms characteristic of stress-induced illness. They also note that few who had been sued talked to anyone about the experience. In general, practitioners reported feelings of shame and isolation.

Many took it as a personal attack, feeling that their personal integrity was under assault. They lost confidence in their ability and lost the feelings of pleasure they previously had in the practice of medicine (ibid.).

Dickens (1991) suggests that liability to law suits strips physicians of the personal satisfaction gained from their work and causes them to pursue alternative careers that do not involve interactions with patients or others likely to sue. In other words, the threat of law suits creates a fear of litigation which then operates to undermine the physicians' self confidence. This emotional injury leads to what has been identified in the literature as *litigation trauma and compensation neurosis*<sup>37</sup> (Dickens 1991, 179). Expanding on the notion of emotional anger, Dickens notes that

the allegation of emotional injury transcends the natural disappointment, frustration or anger, and feeling of betrayal that may be felt when a patient who was considered a friend, and to have been competently and conscientiously treated, *behaves unreasonably about some actual or perceived failure of slight*<sup>38</sup> (Dickens 1991, 180).

The literature constructs an image of doctors who are emotionally scarred and who are disadvantaged by their incomprehension of the judicial system. For example, Dickens notes that being served with a writ, having to endure the pre-trial process and having to appear in

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<sup>37</sup>Emphasis mine.

<sup>38</sup>Emphasis mine.



court to be publicly examined, cross-examined, and second-guessed causes the physician great emotional trauma because "the physician, normally masterful and self confident in the setting of medicine, becomes infantilized in the setting of adversarial litigation and liable to feel powerless at the disposal of others" (Dickens 1991, 180). It is suggested that these feelings are especially exacerbated because physicians are not afforded the same level of control to instruct their counsel since the defence lawyer generally represents the insurance company.

Emotional trauma is also alleged to arise from physicians' feelings of incomprehension, alienation, outrage at the opponent's distortions and fear about an arbitrary and unjust outcome. Dickens described these feelings as being analogous to existential death. That is, the physician experiences a range of emotions similar to grief reaction following bereavement such that "being sued may be like suffering a death in the family, the more stressful because the death may be sensed to be the defendant's self image" (Dickens 1991, 181). Although doctors are not personally liable for damages awarded, they report financial losses arising from lost billing for the time spent in court or from the loss of clients as a result of newspaper reports about the allegation of a suit.

Although doctors are generally of the same social class as judicial officers, doctors describe feeling very powerless. What is also interesting to note is that patients who have suffered injury and were able to gain access to the court or file a complaint or suit are seen as victimisers who have subjected physicians to an emotionally draining experience by exposing them to an environment in which they are powerless. Nowhere is it acknowledged that patients experience injury or that although practitioners may have done their best, injury and/or death still occurs. It should be pointed out that women who shared their experiences described similar feelings as those identified by the doctors. While it is not the intent to

construct a hierarchy of whose feelings are more legitimate, it is important that we recognise where power lies and who are powerless in these social encounters.

### *3.2 Women's Experience of Injury: The Role of Physicians*

I will now present women describing in their own words, their experiences of injuries. There are three reasons for doing so. First, women need to reclaim their experiences. Second, there is a paucity of information from the patient's [woman's] perspective. Finally, there is a need to reconstruct women as victims of malpractice.

As noted before, the ten women interviewed experienced obstetrical or gynaecological injury either to themselves or to their child. They all describe being affected physically, financially, psychologically and physiologically by their health care injury. The injuries described vary from brain damage to genital mutilation. For some, the injuries are long term. For others, the actual injury has healed, but the financial, emotional and psychological effects remain. When women complain of their injuries they are dismissed by the practitioner(s) directly involved and when they attempt to get accurate assessment of their injuries for legal purposes they are further injured by medical practitioners' reluctance to provide "expert witness evidence".

Doctors in general, and obstetrics-gynaecology specialist in particular, pursue an interventionist model. In fact, obstetricians-gynaecologists are surgeons trained to intervene. Critiques of this interventionist model indicate that interventions commonly lead to further interventions. This has been confirmed by the ten women interviewed for this thesis, almost all of whom reported chain reactions of intervention. These include, but are not limited to, allergic reaction to prescribed drugs, infection, extended hospital stay, and surgery to correct problems from prior procedures. Other effects include new problems which can be attributed to the initial procedure. For example, if a woman is given an episiotomy she needs stitching.

In three instances the stitches were improperly done. Twice the sutures opened prematurely and once the patient was completely sutured up resulting in surgery to correct the problem.

Rose Hall explains

He made a large cut but then he did not put enough stitches in, so it split open on day four [...] Well, I phoned his answering service and his partner was on, [name] and he was very cold to me. He just basically said to me that "you'd better be fastidious with your hygiene, because basically you don't want to get an infection." Because my only choice was to deal with it and try not to get an infection or come in and have it re-cut and re-sutured.

Cherry Barrett describing her experience states,

she [the resident] stitched me up all the way you know. Like I was completely stitched. And it was terrible, I could not even, you know, when I, like I, after 6 week check-up, my doctor said who did this? [...] she said she could hardly put one finger in to check my uterus, it was all stitched up. I could not even squat like, it would hurt because I was all stitched up.

Caesarean sections have all the attendant risks of surgery and also prolong the woman's stay in the hospital. Two women attribute their injury to their caesarean section. Violet has been diagnosed with endometriosis which has been linked to the tubal ligation she had some 15 years earlier. However, the tubal was precipitated by the initial caesarean. Injury arising from the initial intervention has also been found to lead to subsequent health care problems.

One respondent states,

So it's not just the pain or the depression. I've been on Demerol for a year, I'm allergic to codeine, I'm allergic to morphine, so it is just a vicious circle, *and it all stems back to the injury in 1990*. I'm having a dilation done next Monday, because medication does not seem to work, and it is a direct result of the bladder rupturing. (Primrose White)

Six respondents developed psychological injuries, three children have been diagnosed as neurologically impaired and five participants sustained long term disability. One mother was administered oxytocin during her delivery. Although her injury did not arise from the administration of labour inducing drugs, she now worries whether her child will suffer

neurological impairment because the oxytocin was delivered in concentrate causing rapid contractions. As a result, the Foetal Heart Rate (FHR) decelerated very fast. A low FHR is generally an indication of foetal distress and may indicate that the foetus was oxygen deprived for a short period. Since neurological impairment is closely related to oxygen deprivation, she wonders if the baby sustained damages which are not yet evident. The following is her description of the incident:

You know when I said the heart beat really dropped, well, they ripped that piece of sheet off the monitor. I don't know whether they put it in my file or they threw it away [...] Yeah, they ripped it off. [...] They continued to monitor, you know after that, but they tore off that piece that the heart beat went down. The resident took it away. So I don't know whether they put it in my file or what. Actually when he came, when he came rushing in he said oh, he said, oh, "I think we're going to have to have caesarean" because they thought I was not reacting to the oxytocin well. Then they realised that it was all concentrate that she gave me. Yeah, they tore it, and my husband said "didn't you see it, he ripped it off and he took it away". I said no. But he saw it, and my father was in the room too, and he saw it. Yes, I don't know what he was going to do, maybe he was trying to hide it, or he put it in my file, but you see, we never get to see our files, right? (Cherry Barrett)

The severity of injury scale table is very helpful to understand how injuries are generally categorised.

Table 8

## Severity Of Injury Scale

Severity of Injury	Example
1. Emotional only	Fright, no physical damage
2. Temporal insignificant	Lacerations, contusions, minor scars, rash. No delay in recovery.
3. Temporal minor	Infections, missed fracture, fall in hospital.
4. Temporary major	Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
5. Permanent minor	Loss of fingers, loss or damage to organs. Include non-disabling injuries.
6. Permanent significant	Major loss.
7. Permanent major	Paraplegia, blindness, loss of limbs, brain damage.
8. Permanent grave	Quadriplegia, severe brain damage, lifelong care or fatal prognosis.
9. Death.	

Source: Sloan and Van Wert (1991, 143)

It is evident by looking at the severity of injury scale that some of the injuries are classified as insignificant. However, what may be viewed as insignificant, can in general prove to be very detrimental for women. As in some cases, the injuries arise from procedures which are foisted upon women for their own good. Thus the proclivity to intervene is itself creating and contributing to women's injuries. Most notable however is that the general reluctance to "hear" women often leads to injuries.

The following table is a classification of the injuries sustained by the ten women and their children. Seven of the women sustained injury to themselves, and of the seven, two still wonder if their child may also have suffered injuries which have not yet manifested. In the

other three cases the child suffered the primary injury, however these mothers are also affected psychologically as a result of their children's injuries.

Table 9  
Type of Injuries

TYPE OF INJURY	PARTICIPANTS
Infection	2
Surgical Failure	4
Hysterectomy	1
Neurological damage	3
Drug Related injury	1
Psychological <sup>39</sup>	6
Post-op complication	8
Long term disability	5
Total	29 <sup>40</sup>

### 3.2.1 Description of injuries

April Brown sustained two different injuries. During the procedure to correct the first injury, she suffered a second permanent injury. She states

[About 15 years ago] I went into [hospital] and had this procedure done. And immediately after the surgery, I noticed that there was a kind of, probably at that time, almost like a pimple on the outside of my vagina and so I asked him about it, the doctor, and he said "Oh, it's nothing, it's a stitch abscess and it will go away, it will drain spontaneously and go away." And so naturally I assumed he knew what he was talking about. And, it did not go away, and so for another two, maybe year and a half, yeah, year and a half I would go to my family doctor and go back to this gynaecologist and say, I have a smelly discharge, I have a lot of pain in my perennial area, especially by 5:00 in the afternoon. It's very painful and both of them just kind of dismiss me. And then one day the pain was incredibly bad, and I went to the washroom and the smell was really awful, so I took a mirror and looked, and I could see that my skin was punctured in that spot. There was a little hole, not bigger than a pin head, what is the dimension, I am not good with dimension, but say the size the two pens, ball-point pen tips together, round, and there was this putrid

<sup>39</sup>Conditions for which anti-depressant is prescribed.

<sup>40</sup>Some respondents had more than one injury.

matter pouring out of it, so I phoned the gynaecologist right away, and I said "are you having an office?" and he said "yes", and I said, "Well I would like to come over I have something to show you". He said "oh no you can't". I said, "well sorry, I'm coming" and so I went. And he was very embarrassed, and he said "oh, you have a fistula". So I said "what is that". He said, "well it is a communication between the vagina and the rectum", because, what had happened that instead of the stitch abscess bursting and pouring outwardly it went inwardly and formed a canal. [...] And so I said "what do you do now" and he said "oh well, it is not a gynaecological problem anymore. Now you have to go to a general surgeon, and what he has to do is, he has to lay open that canal, that tract and scrape out all that debris that has been accumulating there for a year and a half. And clean it all up and stitch it back together". So, I went and, funnily enough the general surgeon's name was [name] the same as the one who did the first procedure and he did that. And unfortunately, when he was doing that, he severed my sphincter muscles, so now I'm incontinent of faeces inflatus which is very embarrassing and very difficult, because it limits what I can do. (April Brown).

Primrose White also sustained two injuries. She explains

And he said it was either a ruptured bladder or a failed kidney and it turned out to be a ruptured bladder. [...] and in 1990 they went to remove the cyst on the right ovary, what was left of the right ovary, and [...] severed the urethra and my right kidney. And this was a second gyn, this was a different gyn.

June Gentle's genital mutilation occurred in the following way

I was hurt, when they used the forceps they had to put in one part and then put in the other part and then connect the two parts together, and that's when they caught some of my genital parts in between, and then, when he pulled and I pushed, it really hurt [and snipped part of the labia].

Most obstetrical or gynaecological injuries are not obvious to the lay person and often take a long time to be discovered. In some instances women are unable to identify the source of their illness. While women often suspect that something has gone awry, this often has to be confirmed by another medical practitioner. For example, in 1981 Violet Kerr experienced what she termed an "extremely traumatic" emergency caesarean delivery. During her follow-up visit her obstetrician informed her that if she decided to have another child it would have to be another caesarean delivery. She explained having had problems with the pill and that she had heard very negative things about intrauterine devices (IUD's) so she consulted a

gynaecologist and had a tubal ligation done in 1982. She did not find out that the gynaecologist had done a ferocious procedure until she saw another doctor years later. In 1991 when she checked with a specialist to see if there was a possibility of having the tubal undone, she was informed that it depended on the method initially used. She states,

[A]nd then I went back to him for the report. He said in his report, which he read to me, he had written it up before I went to see him. He said that was absolutely, he used the word "ferocious tubal I have ever seen". And he said that "the reason I am telling you why I think it is ferocious is because he never gave any reasons why he cut out my tubes on both sides completely". He never gave me a tubal. He cut them right out completely (Violet Kerr).

Cherry Barrett also suspected she was injured. The injury was confirmed by her doctor during a follow-up visit six weeks after giving birth.

Women who completed health practitioners' report at the Vancouver Women's Health Collective described experiences similar to those described by the women who were interviewed. They too report that often the injury is discovered by another health care practitioner. One questionnaire respondent states

He performed the abortion improperly because of rushing. [He] failed to measure me properly during the medical exam prior to the abortion. Afterwards he failed to detect his negligence. Only two weeks after, during my hospitalisation, did I find out I had a perforated uterus.

Inability to identify the source of the illness distinguishes action in negligence for obstetrical-gynaecological injuries from most other personal injuries such as motor vehicle accidents. Participants found out about their injuries in different ways. Violet Kerr and Cherry Barrett found out about their injuries on subsequent medical visits. Rose Hall and June Gentle found out immediately after childbirth. April Brown discovered her injury while doing a self-examination and Primrose White developed medical complications the day following her surgery. She states



When I came out of surgery my husband was there and I was hooked up to so many tubes, I knew something had gone wrong, and he said they cut right into my kidney and they re-implanted it.

Pauline Jones, May Anderson and Blossom Grey suspected injuries soon after their babies were born. The injuries were diagnosed and confirmed by another medical practitioner. Generally neurological injuries sustained by infants during childbirth, if not diagnosed at the time of birth, are often diagnosed by specialists such as paediatricians. However, obstetrical literature indicates that neurological impairment sustained by children at birth often does not manifest early and in some instances is not diagnosed until about age five.

The management of three pregnancies resulted in neurological injuries to the babies. Blossom Grey underwent an emergency caesarean because her doctor ignored her concerns about problems delivering vaginally. As a result of being ignored, her daughter sustained neurological impairment. She was informed by the neurologist that her daughter sustained injuries either during or immediately after birth. Although she suspected there was a problem when her daughter was four months old, it took her three months to convince her general practitioner to give her a referral to a specialist. Her suspicions were confirmed during the consultation with the specialist. She explains

[A]nd he said, "put her down" and he just looked at her, he did not even take three minutes and he said, "we're going to get her right into physiotherapy. She has some serious brain damage. I don't know to what extent at this point we will have to order a cat scan". She was seven months by that time. (Blossom Grey).

Scully (1980) notes that the unpredictability of childbirth is one of the reasons why some practitioners decide against obstetrics and gynaecology. Rindfuss (1977) in a study of post-war fertility trends found that there were substantially fewer births on weekends than would be expected by chance. His research has identified an increasing trend to induce labour for the sake of convenience. "Induced Labour for Daylight Hours" is a term used to

describe the practice of speeding or prolonging labour. Holidays are also classified as an inconvenient time to have a baby.

Pauline Jones and May Anderson's children sustained neurological damage because their timing was deemed inconvenient. Pauline Jones went to a perinatologist on Good Friday, April 13, 1990. She was in the 43rd week of her pregnancy. He advised her to report immediately to her obstetrician-gynaecologist for delivery because there was no amniotic fluid. She called her obstetrician and, without an examination, he told her there was nothing to worry about, that she should come in the following day. As a result of the delay her baby sustained neurological damage. She later found out that at the time she saw the perinatologist he diagnosed the baby as having a 1 in 100 chance of dying overnight, and a 1 in 10 chance of neurological impairment if the pregnancy was not terminated immediately. However, because it was Easter Weekend, her obstetrician-gynaecologist told her to wait and come in after the holiday.

May Anderson went in to see her doctor for a pre-natal examination. Hers was the last appointment of the day. However, the doctor was preparing to leave for her vacation and had a medical student do the examination without proper supervision. The injury sustained by May's son has been attributed to the student's inexperience. She explains

I had fibroid on my lower left side, and the medical student she pushed really hard with her fingers. It was very unusual because I had never been touched like that before you know. [Doctor] was always gentle, and she always felt for the baby's head in a certain way. So then I was jabbed so hard with these fingers digging into me. I felt a sharp pain and it went right away. It was not like something that lingered on. But I felt it and I said, "Oh, what's that" and she said, oh, she was looking for, she was feeling for the head, and I was just irritable then, and I snapped at her and said "well, that's not how, that's not where you look for the head." And I showed her where. And I said, "that's my fibroid, and the funny thing is when I said that's my fibroid, the student wanted to feel it again, she said, "oh, I've never felt a fibroid before" [...] so she continued to feel it again even though I felt a pain and I stopped her, she felt it again the second time. [...] And I went down to get some blood test done, and I

walked to the street, just in front of the building, and I felt this awkward jabbing in my tummy.

The following day about 9:00 a.m. May started to bleed and by 1:00 p.m. she had a precipitate delivery. In the attempt to manage the delivery, she was administered some drugs, however by then the baby was too far down the birth canal to do a caesarean. She notes

If they had done a caesarean he would not have had any "bleed" because he would not have been bruised. I was not fully dilated and he came shooting through, so he got bruised on his head and his arms. [...] he was born at 27 1/2 weeks [...] he was a precipitate baby, so after two days he started to have haemorrhage. [...] We were told that the toxins built up in his system because he was bruised. He was a precipitate baby and his kidneys were not so developed to get rid of the toxins. So he went into stress.

Pauline, Blossom and May's children can be described as "grey area" children. "Grey area" is used in reference to these children because their neurological injuries cannot be fully described as cerebral palsy. They are not wheelchair bound and for the most part their injuries are not obvious to the average person. The injuries are mostly to the limb, particularly paralysis of the arm which restricts movement. This incapacitation restricts their ability to perform routine activities such as tie a shoe lace, do up a zipper and hold a utensil. Blossom Grey explains that her daughter

[She] cannot draw up her zipper. She just learned to tie her shoes, and she just use one hand and using her teeth. Buttons, small buttons, she can't do that. She can't cut meat, well she can but it is very hard. It's the little things. She can't ride a bike. She can't balance, but she tries hard, she really tries hard.

Although injuries are often discovered by other practitioners, doctors are often reluctant to criticise the work of fellow practitioners. Since only doctors can give evidence as to the standard of care required of a medical practitioner, this reluctance has implications in that it impedes women's chances of successfully bringing a suit for liability. If lawyers are unable to get a medical assessment of an injury, they are less likely to litigate. Primrose White, whose bladder was ruptured during gynaecological surgery could not get the

urologist to confirm that the rupture occurred during the operation. April Brown describes her experience with the doctor with whom she consulted to confirm her diagnosis. She states

And then after the sphincter muscle was severed [...] I went to this really obnoxious specialist, [...] And he basically said, "Well, you know, you can't really re-attach muscles. It's not like a bone where you can reattach it, and get result, it is kind of tough, you have to live with it". And so I said "would you be prepared to be a witness in a court case", and he just turned on me like a viper. And he did this total power trip on me, and said "ah, the burden you have to prove it, you know, it might have been an honest mistake, you have to prove it", and he went on and on about proof and proof and proof and proof and I was just so really upset anyway about the break-up of my marriage, and I was not feeling well mentally and I felt I just can't cope with this, especially if I have to deal with such an obnoxious person and he basically said "You'll never get a doctor to give evidence against another doctor, because it just doesn't happen. It is a closed shop and we look after each other".

All ten women shared the opinion that doctors "close ranks" against outsiders. That doctors look after each other's interest is no secret. Not only do they have legal authority over medical procedures, but also, because they are self regulated, medical procedures are monitored only by the practitioners themselves. This can be problematic for women who sustain injuries since they have to rely on the same body of practitioners against whom they have a complaint.

### **3.2.2 Contact with the Doctor after the injury**

What is interesting to note is that when asked specifically whether any effort was made to contact the specific doctors involved in their injury the responses were overwhelmingly in the negative.

No. Never. I did not want to contact him. I was so angry. It never occurred to me to go near him, just because my response would be to avoid them. Oh, absolutely. Absolutely, because I knew what he was like. (Violet Kerr)

No, I did not. I did not know really know what kind of doctor or what was the name of the doctor. I never even thought that there was anything I could do, that I had any right to question what went wrong. (June Gentle).

Three respondents reported contacting the doctor after the injury. In those cases, the doctor refused to speak with them.

No I did not confront him [the practitioner responsible for the first of her two injuries] and I did not see him as a patient after the hysterectomy. The second gyn refused to see me and refused to see my husband, he refused our calls. So, with him I did not see him again and any of our friends or any of our girlfriends or anybody who I knew was having any gynaecological problem I made sure they avoided them like the plague. (Primrose White).

Pauline was one of the women who actually contacted the doctor, his response was that all mothers blame the doctor when something goes wrong.

It became obvious that women's reluctance to contact the practitioner was based, in part, on the perception that a complaint could have negative impact on their future health care. The perception of a backlash was also expressed by respondents who completed agency questionnaires as part of the enquiry into physician's sexual misconduct. 43% of those respondents cited fear of the physician as a reason for not filing complaint (Crossing the Boundary, p. 65). Commenting on their reluctance to complain, two participants state

I think I would be looked at differently. Yes. I think they would. I wonder, if they would wonder, if I would sue them. Maybe in one case it would be good because they would pay more attention, and that is a good thing but then we might have doctors who might not even want to see us. (Blossom Grey).

My husband and I, we thought I should get my problems corrected before I did anything, because, we, I'm at the mercy of these doctors, right? So at least my OB, I know, she, I think she's very, very well known to the residents. They all work at the same hospital. So before I pursued anything like that, I wanted my problem corrected. [...] Because if I complain, she might, like my OB might not, does not help me, or you know, do something wrong. Not do something wrong but she might not take any notice until it will stretch or something like that, you know. [...] Well, I am not saying that she would feel threatened, but it's just a fear in case she does, because she is in close contact with these residents. I just felt she might. And I have a general feeling that doctors are always for doctors right, they will never, you know, they'll never even admit to wrong doing. (Cherry Barrett).

This notion of a backlash, whether based on perception or experience can be attributed in part to the power doctors are assumed to hold over patients. Thus, even if the backlash is based on a perception, it is still having an effect on women. Feminist literature on women's health care

notes that medical practitioners perceive as threatening women who appear knowledgeable . Furthermore, the construction of "high risk" patients is predicated on the likelihood of bringing a suit. As one woman puts it, "when you ask doctors for guarantees their defences go up and they see "litigation bells". Therefore individuals who present themselves as knowledgeable may be less likely to be accepted as patients.

Participants noted that they were frequently treated as hysterical and that too often their concerns were dismissed. For this reason it appears that women kept silent for fear of being labelled hysterical and/or criticised for overreacting. The following excerpts articulate this concern.

[B]ecause you could not see this [the injury] from the outside, they [the doctors] would say, "Oh, no, there's nothing wrong with you". I'm being invalidated. I'm being told, you are imagining it, you are crazy, you're mentally ill, you don't see things straight, there's nothing wrong with you, it's not happening, and that's that. (April Brown).

I feel like the doctors can just make you feel, make you look like a crazy female. Like, you know, why would you do that, and it is dangerous, and we have to do it, and we have the control, and the power and you don't know how to deal with it on your own. It is dangerous and all this crap. And so, anyway, also with respect to his care, he made you feel like you were this crazy pregnant woman on hormones. (Rose Hall).

She never took my concerns seriously - always doubted my judgement [...] I had a very large lump on one of my breasts we had done a mammogram. I always complained about it, that I thought it was growing. Two years later it is still there and bigger. I finally went in again and decided I was not going to leave until she did something. Either drain it or send me to a specialist. The day I went in, she had a sub. It took me 1/2 hour to convince this woman that she had to do something. So she had not even seen my lump yet she finally says "okay I'll drain some and send it to a lab". Well when she felt it, she almost died. She said "oh my God, I didn't know it was so big, Oh my God, no wonder you were worried". Six needles later, she still couldn't drain it. (Health Collective Questionnaire).

Women's susceptibility to being treated as hysterical is heightened because obstetrical and gynaecological injuries are primarily internal, and are often not readily obvious. For that

reason, women are more vulnerable to being dismissed as hysterical. For example, April Brown was dismissed by her doctors for almost two years despite the fact that she had evidence of injuries. Primrose White was told by her doctor that her pain was being aggravated by her depression. She notes,

Some of the physicians are saying, "you are feeling more pain because you are depressed" and I have said to them, hold on a minute there, I have been in severe pain since 1990 and I was not depressed before the pain, so it is not the depression that is resulting in the pain, it is the pain that is resulting in the depression. (Primrose White).

Feminist literature indicates that complaints and disorders take on a gendered dimension (Ehrenreich and English 1978, Weiss 1978) which may be explained by the (mis)education of doctors. Doctors' education reflect a gendered dimension that is for and by men. Analysis of textbooks used in medical education reveal that most of them focus more on how neurotic women might be, rather than on the aetiology and treatment of disease (Scully and Bart (1977) in Weiss, 1978, 213). Koutroulis, (1990) did a partial replication of Scully and Bart's 1977 study in an effort to assess whether institutionalised changes and the women's health movement had had an effect in changing the sexist ideology dominant within these texts. She reports that while sexist notions recur to a lesser extent, these ideologies are still prevalent. She found that obstetrical and gynaecological texts still contained outdated and erroneous views about women's sexuality and women are still portrayed in stereotypical roles. Hagell (1990) also reviewed nursing education to assess the extent to which they have incorporated women's health into their curricula. Although nursing is female dominated, it was found that nursing education also present women's health issues in a traditional, medically-defined manner. Findlay (1993a) notes that Canadian medical schools are no different. Thus medical schools are, in part, responsible for inculcating

or (mis)educating medical practitioners about women's health. This miseducation results in the gendered nature of illness diagnosis.

Weiss (1978, 212), commenting on the gendered nature of illness, notes that there are gendered differences in doctors' diagnosis of disease. Women's diseases are more likely to be undiagnosed. Women are also more likely to be referred to a psychiatrist. She notes, for example, that the adult female population was more often given tranquillisers for the same diseases for which men were given medicine. Weiss also notes that medicine regards female disorders as being inherent in women's "defectiveness". Historically, medical perception of female nature was explained as being embodied in the "psychology of the ovary" (Ehrenreich and English 1978). Women were believed to be completely governed by their ovaries and uteruses. This was used as the basis for creating a new disease of hysteria or "disease of the uterus." However, hysteria as a disease has no discernible organic basis and is totally resistant to medical treatment. Thus women, in general, become vulnerable to vagaries of the medical professions, but

[t]he field of gynaecological surgery provided the most brutal direct medical treatment of female "personality disorders". And the surgical approach to female psychological problems had what was considered a solid theoretical basis in that theory of "psychology of the ovary." After all, if a woman's entire personality was dominated by her reproductive organs, then gynaecological surgery was the most logical approach to any female psychological problems. (Ehrenreich and English 1978, 50).

Women are more likely to be diagnosed with nervous disorders, thus hysteria had a lasting significance, since "it ushered in a totally new 'scientific' approach to the medical management of women" (Ehrenreich and English 1978, 56). Within contemporary medicine, hysteria is more closely associated with "mental disorder." The transference of hysteria as a disease from the arena of gynaecology is credited to the work of Freud who "in one stroke solved the problem of hysteria and marked out a new medical speciality" (Ehrenreich and



English 1978, 50). Hysteria became labelled as a mental disorder which fell within the ambit of the "psych" profession. This shift became possible because

Freudian theory of female nature was in direct contrast with the gynaecological view which it replaced. It held that female personality was inherently defective, this time due to the absence of a penis, rather than to the presence of the domineering uterus. Women were still "sick," and their sickness was still totally predestined by their anatomy (Ehrenreich and English 1978, 56).

Women are more likely than men to be diagnosed as mentally ill. Smart (1977, 152) reported that her study found more women than men in in-patient psychiatric units. Thus, the use of hysteria to explain female related phenomena has implications for other aspects of women's lives. For example, Smart (1977) noted that women who offend were more often labelled mentally ill or sick in a psychological sense. It is interesting to note that hysteria is used to explain not only women's illnesses, but also women's deviance.

There is, then, a long established tradition to explain women's pathology in psychological terms. Women are told they are imagining their symptoms; their sickness is in their head. Hysteria's current label is depression and women's complaint of injury are now being explained as part of their depression. There is therefore the need to question whether or not depression is a catch all phrase<sup>41</sup>.

### 3.3 *Women's Discomfort In Talking*

The patient's knowledge is experiential, general and unsystematic in comparison with that of highly trained professionals (Stacey 1994, 129). It is evident then that women are silenced by doctors ignoring their concerns and by the diagnosis or potential diagnosis of their complaints as hysteria. Another factor which operates to silence women is embedded in the

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<sup>41</sup>See discussion below on depression as an effect of women's injuries.

notion of private parts. Women are often reluctant or discouraged from speaking about their "private parts" because of the taboos and secrecy within which these parts are shrouded.

Anthropological and feminist literature reveal a long tradition of woman's bodies being regarded as polluting both within religious and medical contexts (Douglas 1966, Martin 1992). Mary Douglas in her review of anthropological literature on pollution and taboo notes that most practices have their foundation in religion, but became solidified within Judeo-Christian tradition. She suggests that in order to understand bodily pollution "we should try to argue back from the known dangers of society to the known solutions of bodily themes and try to recognise what appositeness is there" (Douglas 1966, 123). Douglas cites the dietary rules from the Book of Leviticus to argue that "defilement is never an isolated event which cannot occur except in view of a systematic ordering of ideas" (1966 44). The notion of uncleanness or pollution, notes Douglas, does not have clear-cut distinctions regarding the sacred and the profane, instead, "uncleanness" or dirt is that which must not be included if a pattern is to be maintained (ibid. 41). Within contemporary society, notions of pollution are applied to disjointed, separate areas of existence, but affect women most.

Douglas (1966, 3) notes that pollution ideas operate at two levels, one instrumental the other expressive. For her, the instrumental level is more obvious and can be used to describe how people try to influence each other's behaviour. The expressive role refers to what she describes as an "ideal order of society [which] is guarded by dangers which threaten transgressors" (ibid.) She further explains that the law of nature is used to sanction these moral codes in that "certain moral values are upheld and certain social rules defined by beliefs in dangerous contagion" (Douglas 1966, 3). According to Douglas, most cultures exhibit concerns about bodily emissions. However, these notions seem to be indiscriminately applied

to women creating "ritual behaviour concerning menstruation, childbirth and death" (ibid. 35).

Western society also exudes notions of blood, childbirth and menstruation as polluting agents. Martin (1992) notes that western medicine constructs as pathological bodily functions such as menstruation. As such, medicine also plays a part in the notion of women's bodies as polluting. Historically menstruation has been seen as a foul and unclean process shrouded in secrecy (1992, 31), a process which results in cultural conceptions relegating menstruation to the private realm of the home and family (ibid. 47). This notion of privacy led to the conceptualisation of women's bodily functions as a "hassle" which means that "no one must see you dealing with the mechanics of keeping up with the disgusting mess" (ibid.). This notion of shame surrounding women's bodily functions created a cloud of secrecy; not only were these functions to be dealt with in privacy, they were also not to be spoken of. Thus women were effectively prohibited from speaking about their "private parts" and "private functions". These notions further perpetuated the silencing of women and are still felt within the areas of obstetrics and gynaecology. We see then why women's obstetrical or gynaecological injuries are usually not spoken about.

Participants report feeling some level of discomfort in discussing their injury. This was attributed primarily to the intimate nature of the injury and the general discomfort exhibited by others. According to Rose Hall

Now I feel kind of isolated because it's not a lot of people that I can talk to about what I am doing with respect to fighting back that would really understand. The people just don't really want to hear about stuff like that and want you to get on with your life kind of thing. And it's such an intimate thing too you know. It is hard to just talk about it with just anyone. Actually I can talk about it better with a stranger better than I can talk about it with relatives and friends.

It is very difficult to cope with because, I, you don't want to talk to anybody about it. In fact, I could not talk to anyone about it for a long time. So I think

this is a big break-through for me that I would talk to you. For many years, I never talked about it until I realised that as long as we all stay silent, and don't say hey, mistakes are made, people will still be hurt. (April Brown).

When obstetrical and gynaecological injuries are placed within the context of pollution, taboo and secrecy, one sees how women become vulnerable to the vagaries of the medical profession. Women who are injured or otherwise abused within medical context often remain silent because they are not encouraged to speak about them openly. Women's injuries are often constructed as intimate or they are led to believe that their experience is normal. The following excerpt from a study of women's first sexual experience (Bouris 1994, 92) articulates how women's silence around "private issues" made them susceptible to inappropriate behaviour within obstetrical and gynaecological medical encounters.

My family doctor, a trusted family friend and elder in our Presbyterian church, gave me a 'premarital exam' without a nurse present. During the exam he pulled out a vibrator (I'd never seen one), he told me he needed to see if my responses were 'normal' and then proceeded to stimulate my clitoris with the vibrator, bending over me, breathing heavily. I suppressed this memory for a long time. Now I feel very angry. My family and my religion drilled into me not to question authority.<sup>42</sup>

Concepts of pollution and taboo, and the general treatment of "female troubles" as private, contribute to women's vulnerability to being abused, dismissed or denied treatment. Another factor which contributes to women's vulnerability is the refusal to question authority.

### **3.3.1 Social Status of Doctors**

Physicians enjoy very high prestige relative to other occupations in general and other skilled professions in particular (Coburn 1993, Freidson 1986, 1986, 1970, Rossoff and Leone 1991, 321). As a result, patients in general, and women in particular often rely on doctors'

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<sup>42</sup>This excerpt was taken from *The First Time* (Berkeley, California: Conari Press, 1993). This section of the book "First Rites" is based on interview with 150 women who were asked to describe the time they lost their virginity.

judgements and often do not question their authority. This reliance, however, has had detrimental effects. Primrose White states this quite poignantly

It was just a case of I'm the doctor, you're the patient, do as I say. And not being well versed in medical [knowledge], you know, you're very intimidated as a woman. You seem to put, I did anyway, put these physicians on a pedestal [because] they've got all these years of studying, they know what's right and what's wrong, and you're just a layperson, you don't know what you're talking about, and I have run into this problem with basically every gyn. (Primrose White).

This is not to suggest that women are accepting this treatment without resistance. As indicated in the preceding excerpts, women have recognised their vulnerability and are cognisant that there is a need to speak out against practices which are to their detriment. Women are also responding to what they consider gendered practices and are changing their medical practitioners.

There has been, and continues to be, the perception that when practitioners share the characteristics of the population they serve, treatment will be better. However, Scully (1980) suggests that among medical practitioners class loyalty appears stronger than sex loyalty. Waitzken (1989, 227) notes that the vast majority of doctors have come from upper-middle-class families. While only 12 percent of North American medical students came from working class families in 1920, the numbers are almost exactly the same at the present time. Despite changes to recruitment by race and gender, the percent recruited from working-class families has persisted despite recent increases in the proportion of women and racial minorities entering the profession (ibid.). However, there is the perception among the women interviewed that female doctors will make a difference in the kind of care they receive. Among the women who were interviewed, all except one had changed to or made an attempt to be seen by a female obstetrician-gynaecologist. Even women who were not seeing a female

practitioner, when asked if they think that female obstetrician-gynaecologist would make a lot of difference, answered yes. According to April Brown

Yes I do, because I go to one now. I think so, because they know what it's like. They have the same anatomy. So, somehow I think they are a bit more sensitive. I think the medical profession will be a lot better when we have a balance of male and female practitioners because, you probably know that for years all the research had been done by men who had no clue, and so it just was not accurate. A lot of what they were saying, even in my life time, it has changed dramatically from what we were taught and told. It is different because people know that that's not right. But they, at the time, they thought they were right. Oh yeah, they know all about our bodies and how to control them. Oh yeah, female practitioners would make a big difference.

While women seems to be favouring female practitioners, they have reported mixed reactions from such contact. For example, June Gentle was very disappointed with the treatment she received from the female doctor who attended her during her delivery. According to June, "she should have been easier to understand what I am going through, because she is a woman".

One female health practitioner file at the Health Collective had 11<sup>43</sup> questionnaires covering the period 1983 to 1995. All these questionnaires were negative and described her as condescending, rushed, and authoritarian. One questionnaire respondent described her as relaxed, gentle and did not rush but said she would not recommend her because "she is always on the defensive if any problem develops which might reflect on her treatment and this attitude took precedence to her more than the medical problems." Even a more positive questionnaire respondent described this female doctor's attitude as "a bit supercilious and scornful of my ideas." The complainant wrote

[she] was completely unwilling to consider possible side effects to hormone therapy which she insisted was the only reasonable treatment short of a hysterectomy. She was not fat phobic although she referred to my fat once. She made no effort to see me before the D and C although I had only talked to

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<sup>43</sup>This may seem insignificant given the time frame but given that not very many people know of the existence of the files and that files tended to have an average of 4 forms, this may in fact be significant .

her on the phone about having it so it had been weeks since my original exam.  
(Questionnaire)

Although women in general believed that a female practitioner may make a difference, given the class composition of medical practitioners, female doctors may be more aligned with their male counterparts than they are with their female patients. The same may be true of practitioners from racial sub-groups. It appears however that women expected female practitioners to be different from their male counterparts and practice in female friendly ways.

### 3.3.2 Different Expectation Of Female Practitioner

Traditional medicine is generally conceptualised as male dominated, and conforming to a "male model of practice". However, women doctors are expected to practice in a different, more female friendly, way. During data collection it became evident that women had different expectations of female practitioners than they do of males. When questioned specifically about these different expectations one woman notes

Oh yes, I would feel that a woman would be more sensitive and more caring than a man or at least being a woman knowing what it all is about. Maybe she did not have any children of her own, but still she is a woman and she's to be easier to identify my point of view of what the patient will be going through. (June Gentle).

[S]he did not treat me as if I had any amount of knowledge about my own health. [She] was very much into the "Male Medical Model". [She] made me wait 1/2 hour too. [I] would not recommend her because her attitude is demeaning. She has the ability to upset/disrupt your whole person. I was upset all day long. (Health Collective Questionnaire)

Women perceived doctors [both males and females] to be more understanding when they had children of their own. This was very much evident in the collective questionnaires.

Sample responses are

understanding, modern attitude, has 3 children of own. (Questionnaire)

Has had 5 children - extremely well informed, supportive, enthusiastic and very matter fact, pregnancy is not a sickness. (Questionnaire)

It may be that women have higher expectations of female practitioners. Female practitioners are held to higher standards, and, as a result, there is a greater likelihood that they may fall short of female patients' expectations. It is interesting therefore that female practitioners were less likely to be sued than were male (Langwell and Werner (1980) cited by Zuckerman et al. 1986, 96). Nonetheless, these descriptions illustrate some of the issues which are important to women. They also illustrate that female practitioners are expected to be "Mary Seacoles" or "Florence Nightingales" and practice in ways which more generally reflect concepts of women's role.

Not only is the medical profession dominated by practitioners from upper-middle class families, it is also dominated by males. Thus women are under-represented in the medical profession in general but more so in the field of obstetrics and gynaecology. According to Scully (1980, 15) the percentage of women in obstetrics and gynaecology is even less than in medicine in general, and is indicative of the occupational segregation in health care. Women are under-represented in all the surgical specialities, not just obstetrics and gynaecology. Female medical students generally choose to specialise in other areas of medicine and the evidence seems to indicate a general attraction to family practice, paediatrics and psychiatry "where their particular humanistic qualities are welcomed" (Scully 1980, 16).

The small number of females practising obstetrics and gynaecology may become overworked. Overworked female practitioners may result in women receiving worse treatment from a female doctor than they would receive from a male doctor. For example, one questionnaire respondent categorised her female doctor as follows:

I found her understanding at first. Perhaps she's become more busy now and has less time for one-on-one. (Health Collective Questionnaire).



Furthermore, medical school socialisation is the same for male and female practitioners. Therefore females may enter the profession with good intentions, but in order to fulfil the requirements of the job, may eventually succumb to the norms as practised within the profession. Feminist literature, specifically literature about legal practice, notes the contradictions which feminist practitioners face in representing their clients and upholding their feminist ideals. So too, female doctors and practitioners from racial subgroups may face contradictions fulfilling their work requirements and representing the interest of the group of which they are members. This is not to suggest that women cannot change the way a profession operates, however, their representation within those specialities would need to be altered dramatically before changes are felt.

Scully (1980) found that power and control seemed to be important in doctor-patient relationship. Respondents also perceived doctors as wielding a lot of power. April Brown was quite articulate in this regard.

I think it's very much an issue of control, I think it's very unfortunate, and this is just my own personal belief, right, but Western medicine to me is absolutely a power structure, and the patient, up until relatively recently has almost not been consulted.

So basically what happened, he came in, and he said, stood between my legs, and in a very much power position over me, I was lying flat on my back with an oxygen mask on my face and an IV in my arms and he stood there menacingly. (Rose Hall).

One indication of the power of medical practitioners over patients is reflected in the practice of having medical students observe. Women find it bothersome that their permission is not being solicited before students are invited to observe and/or practice on them. June Gentle explains

I remember that I did not like it very much, because [...] I just tried to tune them out. I just closed my eyes. I guess, in a way, I just wanted to have more privacy, so I know I just kind of tuned out.

She further explains that her permission should have been asked

I feel that I should have been asked if it was O.K. to have some student nurses or whatever there. That's the way that I feel. So I know that they need to get some training and learning about all these things. If not asked, at least to be informed ahead of time. You're going to be having some student nurses here, they will be attending, so you're going to be prepared and can make some adjustments.

May Anderson does not mind students watching, but she was quite emphatic about not having them practice on her. Rose Hall, however, finds it problematic that strangers are allowed to share your most intimate moments without your approval. She states

I talked to friends who birthed at the different hospitals in the city and they had some really gross things happen to them, like just the loss of control and not a lot of choice and not treated with respect and dignity that I think a woman should be treated with and also I was not happy about the fact that you did not really have much of a choice with respect to any stranger putting their hand inside your vagina. Like with a lot of the hospitals are teaching hospitals, like B.C. Women's and St. Paul's and so students can come in and perform a vaginal exam and I just think that's really offensive and I mean that I think that doctors need to learn but I just have a problem with that.

Interviewees and questionnaire respondents also find it problematic that medical practitioners are often reluctant to share medical information with them. They report that often they have to drag the information out. Blossom describes her experience trying to find out the exact diagnosis of her daughter's injury.

[W]hat was funny, was getting the doctor to say it. I went to the doctor [...] she said that your daughter has right-sided hemiparesis, and she's got hemiplegia. O.K. I'd never heard this. I went to the library, I could not even spell it. I went to the VNC as usual with the doctor and the therapist. And I said, could you please explain to me what hemiplegia is, cause I'd never heard of that. So they say to me, don't you know what hemiplegia is? It is cerebral palsy. It's a form of cerebral palsy. Oh, didn't the doctor tell you that? No, she said she had right-sided, she is hemiplegic. She's got cerebral palsy. So I went back to the doctor and I asked her why didn't you tell me she has cerebral palsy. And she did not answer. But she got hemiparesis. So I said O.K. then so she does not have cerebral palsy. [...] It is just paralysis on the right side. So I got fed up and I went back to the other doctor [and said] "here's her case load, tell me what is going on", he [said] yes [she's got] cerebral palsy. (Blossom Grey).

In addition to doctors being guarded with information, they are also reluctant to include women as decision makers. Rose explains

[T]hey did not tell me the state of the baby or we are doing this to save the baby, your baby could die or your baby could be brain damaged. Nothing, they just did all this stuff to me and did not bring me into the decision making process.

Consequently, participants want medical professionals to listen and to acknowledge that women are the expert on their bodies. Primrose White, describing a conversation with her doctor, reiterates this quite poignantly.

Two days before the surgery, I really felt that the cyst had ruptured. I know my body very well and I had reached a point when I could tell when I had a cyst and when it was ruptured. I said to the gyn, "I think the cyst has ruptured" [...]. and he came in the night before the surgery and after doing a pelvic exam he said "I can't feel the cyst" [...] And I said to him, maybe next time you might listen to what I have to say, I know my body. I know my body better than you, better than my husband, better than my mother, better than anyone, I know my body. And I said, I am a woman that carried twins to full terms, asking two or three times, are you sure I'm not having twins, because I know my body and I said, I was laughed at.

Participants also express displeasure at the rushed nature of medical visits and the childbirth process. Rose Hall notes

Like I could only ask a few questions. The appointments were like 5 minutes. I'd wait like 30 minutes to an hour for an appointment with him and then he'd spend 5 minutes with me checking everything that my midwife would check but with my midwife, I had the same care, but my midwife, I'd wait about 5 minutes for an appointment with her and then I'd have about an hour to two hours with her and we'd talk about everything and we'd talk about my birth plans. The doctor had not even brought up my birth plans with me so, I was not even sure what hospital I was going to because I was not sure I had been accepted at B.C. Women's. He delivers at B.C. Women's and St. Paul's. So I was really choked about that because I only had about a month left of my pregnancy and we had not even talked about the birth and you know I just spend these 5 minutes appointments with him in and out.

Complaint about the rushed nature of medical visits was also the strongest sentiment expressed by women who completed the health practitioners questionnaire. More than ninety percent of the questionnaire respondents expressed displeasure at the rushed nature of their

medical visits. A sample response from a health practitioner file containing 15 obstetrician/gynaecologist questionnaires articulates some of the concerns

[I] saw her 10 - 15 times over 4 years. [She has a] wait period 15 - 45 minutes [but] spends 5 - 10 minutes. She rushes too much she should install a revolving door in her office. She does it [the examination] so fast sometimes she only looks in one ear and one eye. She is gentle but quick and fairly open but only when assertive. In spite of her quick style she does present herself as quite warm and concerned and not paternalistic. I don't feel I could recommend her, but I do keep going back to her while looking for an alternative GP She's certainly not the worst GP I have seen. (Questionnaire).

Rushed (but positive attitude) [...] seemed to want to get to the point quickly and was not interested in accompanying problems. [not enough time spent] [...] very rushed - huge patient load. Seemed threatened by informed patients. (Questionnaire)

[She's] not as thorough as I'd like. Gentle but sometimes rushed. Fairly warm and friendly, very up and cheery. She's sometimes rushed and seems a little threatened by alternative approach and has not discussed preventative care. She's open to suggestion about health care only if they're fairly traditional. (Questionnaire)

[She's] pleasant enough but rushed, somewhat condescending, quite vague and brief. She was seeing one patient every 15 minutes, she talked to you then while you undressed, she talked to next patient, while she undressed examined you, then examined next patient a little assembly line. Leaves you feeling as if she is not really attuned to your concerns at all doesn't really listen. (Questionnaire)

### 3.3.3 Complaint to Other Regulatory Bodies

As noted previously, most consumers do not file complaints. Complaints may be filed with the College of Physicians and Surgeons, the hospital, the police and with women's advocacy organisations such as WAVAW (Women Against Violence Against women)<sup>44</sup>, and the Women's Health Collective. However, only one respondent filed a complaint with the hospital, with WAVAW and the police<sup>45</sup>. The College of Physicians and Surgeons was not perceived as being very helpful. Instead women believed that the College represents

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<sup>44</sup>Depending on the injury, used primarily for sexual assault.

<sup>45</sup>Allegation of sexual assault.

doctors' rather than patients' interest. Women also felt that the college was condescending and dismissive of their concern. As April Brown notes, the college is there to protect the doctors not the patients. For example, the College made the following reply to an allegation of sexual assault.

If I may make a suggestion, it might be wise for a sensitive and nervous patient such as you appear to be, to take a trusted friend or relative to act as chaperon when you attend a doctor's office. (Letter from College contained in Health Collective File).

Hence, organisations and mechanisms which are supposed to provide relief can further victimise women when they file a complaint. Rose Hall complained to the hospital about her injury and the subsequent treatment that she received from the obstetrician. She describes the hospital's response as insulting. She states

I basically felt like one of the statements that they made in their letter to me was insulting to me. I was not satisfied with the investigation. I feel like there was a conflict of interest because they had the head of obstetrics and gynaecology at [name of hospital], the perpetrator of this crime, or assault, he is his partner. So I feel like he could not be, he would be biased, because it affects his livelihood if something happens to this doctor [...] so I don't think he'd be the best person to be involved in an investigation, so I was not satisfied with the hospital's response.

At the time these interviews were conducted, the length of time since the injury ranged from 5 months to 20 years. Two of the three neurologically impaired children were approximately 10 years old. Two babies were still under 2 years old. One mother was still concerned about neurological impairments. The other was concerned about manifestation of birth trauma. It is obvious that even after several years, women are still angry about the way they were treated. April Brown's initial injury occurred nearly 14 years ago. She states

Well, I remembered how much pain it caused me physically, mentally and emotionally, over all these years. And I thought maybe she can come up with a way to make other women feel safe about, or have finding somewhere else to go where they do not have to go through that pain, because the stress and the pain that I went through, that's 14 years now and that's a long, long time and my life is not being enriched by it at all, it's being diminished by it. I would

really hate that to happen to another woman because it is hard, it is very difficult, you know, to stand out, especially when you are not feeling well physically, you just want to get out there and go and lie down, that's what happens.

Women are being silenced by medical practice. Hospitals and the College of Physicians and Surgeons also participate in women's silencing and therefore contribute to women's injuries.

Participants expressed dissatisfaction with the current model of medical care.

Commenting on the kind of system they would like to see, two respondents note

I don't know how to work it, but there should almost be like a Woman's committee set up by women, because we are the one's being injured, for gyn to refer to, because I don't think they look sometimes beyond their nose [...]. (Primrose White).

April Brown thinks that more community-based systems should be implemented. When asked specifically how she would like to see the system operate, she notes

Again, it is a big question, because [...] I don't think the system is working right for anybody at the moment, except the doctors, and even some of them are really disgruntled. I think we have to radically restructure the system so that it's a partnership as I was speaking about before. Once it becomes a partnership, people would be more reluctant, I think to abuse the services, because they'd know it takes time and if they abuse the system the doctor would not have enough time for other patients. So maybe more community based. I go to Reach Clinic now, it is community based, and so I think having more of those community based where patients are welcomed and encouraged to say what is wrong with them [...] I think the women are all, they have a ceiling on their practice, I think that happens a lot of time, but most women I know, I know our age, we want to go to a woman doctor. So yes, that is a different system, you know, what Reach is. I mean you can go everyday, you can go once a year, all the doctors are salaried so that is the incentive. I mean it is disgusting to hear doctors talking about, brag about who could do a total hip replacement in the shortest possible time, and still get paid \$480 for it or whatever, or I can do it in 17 minutes. Now it would make me sick when I would sit around and listen to them say things like that because then, where is the concern for this poor patient who is having her whole hip yanked out and a new one put in. They're not, you never hear about the patient. You just hear about the amount of procedures they can do in order to generate X amount of dollars. And then, all the ones I knew with my husband, they all knew exactly how many patients they needed to see per day to generate a certain level of income, and for the surgeon it was how many patients, how many procedures, [...] and I think it would be better for doctors too, but doctors, I don't think they're able to see it now. Because it is very stressful to churn out 40 patients

per day. It is incredibly stressful, I'm sure it would be far more enjoyable and you get far more out of your practice if you were limited to say 20. And so I think it would be a better system and it would be cheaper too. I'm not saying that doctors go into practice to make money, I think some do, but the majority of people go into medicine because they genuinely want to help, but once they're in there, and I know that's certainly true for the one I was married to, it is like a game, you know, who can drive the biggest car into the parking lot in the hospital, who has the biggest home. All these things take money, and who has the highest income, because you know, they have published the Blue Book every year and it shows how much each makes and to them, whoever makes the most money is the best doctor, and I don't agree with that. Yeah, so I definitely think that another structure would be better on everybody.

It is interesting to note that the women interviewed were all interested in knowing whether other women had reported similar experiences and the prevalence of their specific injuries. While no two women who participated had the same injury, the feelings and impact of the injuries reported by the women were quite similar. The injuries affected their income, health, relationship with their family and their overall sense of well being. Despite the notion that lawyers are encouraging claims without merit, this is not the opinion of women who were injured. Although their injuries were serious, some women expressed concern that their pursuit of litigation would have an effect on doctors. For example, Blossom Grey's daughter has long term injuries requiring special care and additional expenses for medication but she was still concerned about the effect on her doctor of any action she might take. She states

[H]ere I would be probably taking this very nice man who has apparently 5 children, and lives in West Vancouver and has a wonderful life and I'm going to say, you made a mistake, and you did this to her. [...] But it could, if it got into the papers it could really ruin his reputation I suppose. And I don't want to do that to anybody. (Blossom Grey).

She, however, was cognisant of the fact that the litigation probab<sup>l</sup> would not have much effect on the doctor.

[L]ike I really think it is going to make a difference to him, like he probably has insurance. That's the other half of my head going, it's not going to make any difference to him, the insurance will pay it any way if I win. (Blossom Grey).

These accounts demonstrate that women suffer debilitating injuries. However, obstetrical-gynaecological concerns are generally shrouded in secrecy. These concerns are confined to the private spheres and, as a result, there is a general intolerance for discussion of private issues in the public realm. As well, notions of shame, pollution and taboo operate to silence women. Consequently, women report very little support and few people with whom they can speak about their injuries.

By juxtaposing the experiences of women with the literature on medical malpractice, it becomes evident that the literature constructs doctors as victims. In the process, women's experiences are not acknowledged. Yet women do experience injury but, because of the way in which the crisis is defined, patients are seen as victimisers rather than victims. Thus women's experiences are excluded from discussions within this body of literature. The construction of the literature, therefore, becomes part of the marginalization of women's experiences and can itself be seen as an injury.

By employing feminist standpoint epistemology and engaging women in dialogue, women are able to give voice to their experiences. In this way their injuries are uncovered. This methodology is also important because a preconceived notion of injury would have constrained women and thus eliminated most of the experiences which they described, especially if such injuries were constructed to conform with the severity of injury scale. It is through methodologies which allow for the construction of women as subjects and experts of their own realities that women's experiences are given credence and enters into the discourse to challenge the construction of malestream ideologies. It is evident then, that letting women explicate their experiences challenges the dominant construction of doctors as victims. Women's articulations make clear that they suffer debilitating injuries. These, however, are relegated to the margins or to obscurity.



I outlined the medical injuries women sustain in their relationship with doctors. I also highlighted the mechanisms which operated to silence and prevent them from discussing their injuries. I will now discuss women's encounter with the legal profession in their attempt to seek redress.

#### **3.4 *Women's Experience of Injury: The Role of Lawyers***

There is a vast difference between a medical injury and a legal injury, consequently, not all debilitating injuries sustained by a patient can be litigated. It is not enough therefore, for a person (woman) to sustain injuries, it has to be proven that the injury was negligently caused in order to be eligible for compensation under the tort system. However, lawyers are advised to watch out for cases in which the plaintiff is complaining of poor results rather than actual negligence (Daisley 1995, 3 quoting plaintiffs' counsel Maris McMillan at a Continuing Legal Education Seminar). Thus women's experience of injuries and the legal criteria for defining injuries are generally incongruent. Despite the fact that the injured person faces life long disability or experienced the loss of a loved one, when legal advice is sought, she is told that she might have a case, but it would be hard to prove. Another response is that there was no negligence, or there is negligence but all efforts to find an expert to assess and give evidence have proved futile. The result is that very few people are able to use the law as a means of redress for personal injuries arising from medical/health care encounters.

##### **3.4.1 Medical Negligence**

A civil suit rather than criminal charges is generally filed when legal action is pursued for an injury sustained during the receipt of health care. In the case of death, the personal representatives of the deceased may bring civil action under the Family Compensation Act<sup>46</sup>

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<sup>46</sup> The Family Compensation Act is a statutory instrument which provides remedy. Previously, if the injury resulted in death, no action could be brought. However, actions brought under this Act can only recover cost.

(R.S.B.C. 1979 c. 120) or the Estate Administration Act. (R.S.B.C. 1979 c.114 as am. by S.B.C. 1980, c.1 s.7). Contract, fiduciary duty, and tort are the three basis of civil actions under which a doctor can be liable to a patient in damages. Breach of contract<sup>47</sup> is hardly ever used and breach of fiduciary duty<sup>48</sup> has been confined to issues of disclosure of information. The majority of civil cases for negligence are therefore brought in tort.

Linden (1993, 1) defines tort as "a civil wrong, other than a breach of contract, which the law will redress by an award of damages". A tort is also distinct from criminal law.<sup>49</sup> The main purposes of tort actions are compensation and deterrence. However, educational, psychological and market deterrence functions may also be realised. The willingness of the courts to award punitive and aggravated damages also serve as a mechanism for punishment (Linden 1993).<sup>50</sup> Tort actions available against medical doctors are assault and battery, false imprisonment, negligence, and defamation (Picard 1978, Linden 1993). Although the same behaviour may give rise to several causes of action, the majority of medical malpractice

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<sup>47</sup> Breach of contract is more likely to be an issue when a product has been implanted. See for example, *Hollis v. Dow Corning*, ([1995] 4 S.C.R. 634) which involved breast implant and *ter Neuzen v. Korn* ([1995] 3. S.C.R. 674) pertaining to artificial insemination. See also Atiyah, P.S. (1986) Medical Malpractice and the Contract Tort Boundary in Law And Contemporary Problems, Vol 49 [2] Spring 1986 pp.287-304.

<sup>48</sup> Fiduciary duty as a basis of liability in medical context was considered by the Supreme Court of Canada in *McInerney v. MacDonald*, [1992] 2 S.C.R. 138 and *Norberg v. Wynrib*, (1992), 68 B.C.L.R. (2d) 29. As explained by LaForest J. in *McInerney V. McDonald* at p. 149, fiduciary duty is the same position of trust as that which "exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent and a guardian and his ward. However, the fiduciary relationship should not be thought of as a fixed set of rules and principles which apply in all circumstances or to all obligations arising out of a doctor patient relationship. This means that the doctor has a duty to act with utmost good faith: he must never allow his professional duty to conflict with his personal interests; he must not mislead his patients" (Picard 1984, 3). A doctor's fiduciary function is to protect the contents of medical records from other aspects of the doctor-patient relationship and may be more pertinent to cases involving sexual assault or medical experimentation (McMillian 1995, 4). See also Madam Justice McLaughlin's dissenting opinion in *Norberg v. Wynrib*, (1992), 68 B.C.L.R. (2d) 29.

<sup>49</sup>Criminal law involves the state and the offender. Also criminal sanctions are concerned with punishment and seek to rehabilitate the offender.

<sup>50</sup> See *Hill v. Church of Scientology* [1995] 2 S.C.R. 1130 in which the Supreme Court clarified the purpose of aggravated and punitive damages.

actions<sup>51</sup> brought against physicians have been based on claims for negligence (Evans 1991;16 Picard 1984, 49, Robertson 1991,427, Brackbill, Rice and Young, 1984).

The basic elements of negligence are duty of care, standard of care, injury and causation. Negligence occurs when harm or injury results from a breach of a duty of care that the doctor owes to the patient. Further, the resulting harm or injury must be directly related or linked to the breach. Negligence attributes blame on the basis of the defendant's conduct and is premised on the notion of "reasonableness". Liability for negligence is assessed based on an imaginary objective construct of the reasonable and prudent person, and whether his/her conduct would be the same as the defendant's under similar or same circumstances. In the case of doctors, the imaginary construct is that of a reasonably prudent doctor. In theory then, the malpractice tort system has two main goals, to compensate the victim of negligent behaviour and to deter medical practitioners from substandard medical practice (Picard 1984, Linden 1993). For a tort action to succeed, a person who has suffered an injury must prove on the balance of probabilities that his/her injuries result from the omission or commission of an act by the other party. Thus, those who are unable to prove a direct link between their injury and the fault or negligence of another will be unsuccessful. If any of these requirements are not met, then the action will be dismissed.

Examples of negligent conduct include, the failure to properly review a patient's medical history of the nature of his complaint, failure to properly diagnose, failure to refer a patient to a specialist or another physician, failure to treat, negligence in administering anaesthetic, the negligent use of needles, negligent treatment during an operation, negligence in post-operative care, negligence in the administration of prescription drugs, failure to

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<sup>51</sup>It is important that one distinguishes between professional malpractice and medical malpractice. The first refers to actions which call into question the conduct of a professional in his area of expertise. Professional malpractice actions are not necessarily medical malpractice. Medical malpractice, however, exists where an act or omission by a physician requires exercise of expert medical judgement.

properly follow up with a patient and unorthodox practice (Picard 1984). Three general features of all medical cases relate to whether the actual treatment constitutes a battery<sup>52</sup>, whether the treatment is negligence by performance, that is, did the practitioner's treatment fall below the standard of care expected of a reasonable practitioner and/or, whether there is negligence on the part of the medical practitioner with regards to informing the patients of the risks involved in the treatment -- informed consent (Professor Burns, Tort 207 Lecture).

"Conventional wisdom" within the medical malpractice literature is that lawyers encourage patients to file non-meritorious claims and are in part responsible for the increases in malpractice litigation. Although suits may be filed before an adequate investigation has been concluded, several factors encourage this. These include the rule of "discovery" requiring that suit be filed before defendants can be forced to give statements about what happened and the limitation period within which a suit must be filed.

Having briefly described the legal background, I will now present the voices of women describing their efforts to seek redress.

### 3.5 *Pursuit of Litigation*

Felstiner, Abel and Sarat (1980-81) note that patients have to first perceive an experience as injurious before a complaint is filed. Mandel (1992) explains though, that often when injury occurs, it is a hospital employee who advises patients to contact a lawyer. One participant, Blossom Grey, confirms this assertion. She explains

I had a wonderful woman when we were at the [name of Institution] who, bless her heart, said that everything should be open records or common knowledge, she photocopied the entire file for me and said, "I'm not supposed to do this but I think you should have this", and I was stupid, I did not use it.

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<sup>52</sup>This turns on the doctrine of informed consent. See *Riebl v. Hughes*.(1980) 114 D.L.R. (3d) 1 (S.C.C.).

Pauline Jones was in a somewhat better position than most other women. She worked as a medical transcriber in the same facility where her injury occurred and was able to photocopy her own file. As a result, she has both the hand-written and the typed notes from her medical file. The women interviewed all expressed the perception that taking on the medical system is an onerous task. They generally felt that doctors cover for each other and that holding them accountable is almost always impossible. Nonetheless, seven of the ten participants sought legal advice.

### 3.5.1 Women's Perceptions of Lawyers

The medical negligence literature blames lawyers for encouraging cases without merits. However, women were not of the view that lawyers are there to serve plaintiffs' interest. Instead lawyers were perceived to be aligned with doctors based on social class standing. Violet Kerr describes her perceptions of lawyers. She states

I know that it is really tough for somebody to sue a doctor. I thought that just because they [lawyers and doctors] are buddies on the golf course, that they're in the same income type of bracket, and that they share some common interests, and they were friends.

May Anderson had this to say about lawyers

I think he could not be bothered with the case anymore, he just wanted to please the doctor because you know, if the lawyers for the doctor, which is the big firm, [law firm] if he scratches their back now, then they will go easy on him in another case. It is all a trade off, and he was willing to trade off my case and I wasn't about to give up.

Blossom Grey had the impression her lawyer was more concerned with the financial gains she would derive from litigating the claim, rather than a concern for her welfare. She notes "all we are is a pay check and to me this whole issue runs a whole lot deeper". Rose Hall describes one of the two lawyers she was referred to as supportive. She, however, felt that the nature of the court system restricts what the lawyer can do. She explains

[I spoke with two lawyers] one said I did not have a case and this other lawyer I talked to, did give me, she's about \$200 an hour, free legal advice. She supported me in phoning her anytime I needed to talk about it or get advice. So she was really great but she just said, she just kind of tried to dissuade me from taking civil action. She said she could take the case on, but that, she did not say I would win, she just said that she was worried about me going through all that and then she did not think that the financial rewards would be that great, but she was concerned. She did say what happened to me was wrong and she did say she was concerned about the size of the episiotomy and the fact that I was not given a choice in that and that I did not sign a consent or anything.(Rose Hall).

Therefore, it is evident that lawyers are perceived as being closely aligned with medical practitioners and or colluding with the medical practitioners against the patients. Even when lawyers are sympathetic, as in the case of Rose Hall, whose lawyer expressed sympathy for the treatment she received and the injury she suffered, the constraint of the system leads to practices which operate to keep women from pursuing some recourse at law. In Rose's case, although the lawyer was sympathetic, she had to advise the client that because of the amount recoverable, it would not be prudent to pursue the case.

### **3.5.2 Reason for Contacting a Lawyer**

Kellett (1987) suggests that an apology would go a long way in preventing the pursuit of most litigation. Sloan and Hsieh (1995) also suggest that patients often complain or sue when they are given inadequate information. Participants have indicated that their main reason for contacting a lawyer results from the anger and frustration they feel when doctors give inadequate answers and/or treat them as if they are stupid. Commenting on her reason for contacting a lawyer, Violet Kerr notes

At first when I walked out of the doctor's office that day I was in tears. You know, I was really hurt and then after that hurt went away, I got angry.

According to Rose Hall,

If there is some kind of acknowledgement before hand then maybe you might not even pursue litigation. [...] Yes, if the hospital had acknowledged me instead of blowing me completely off [...] so especially if the college took it

seriously and did do something like take his license away, well, I would not even care about that I could not sue him, I would not care about suing him for civil damages. [...] So definitely, if I was acknowledged in some way, I would not really pursue it, unless I was still really mad and just felt like it.

The participants cited anger as the major factor in their decision to contact a lawyer.

However, they also felt that doctors needed to be held accountable for these adverse consequences. April Brown explains her reason for contacting a lawyer thus:

I'm not a greedy person, I'm not saying I want to go and get millions of dollars, but I think that if someone makes a mistake, they should acknowledge it and not make you feel worse about bringing it to their attention. And, just the whole way I was treated, was always, "oh, she's depressed, she's neurotic, she's married to this guy. Doctor's wives are always trouble, if you can, don't have one for a patient. Because if anything goes wrong, it is usually with them and they make a lot of trouble". (April Brown).

She further states

Well the other thing, as I think I mentioned before, is for my own satisfaction because they refused to acknowledge that they had done something wrong. I feel like once you are heard you can put the issue to rest, so as long as you are not heard, even if they would not say "yeah we've messed up" the judge or the jury would say they messed up, so it is the equivalent to bringing closure to it.

[...] Because this way, there is never any closure. It is a condition that is permanent. So that's kind of something I've learned to live with, but it's not easy. [...] I don't necessarily need to hear the word I'm sorry, but just to acknowledge that it is unfortunate that this happened, I wish we could have avoided it. However, you know, I think the worst thing is just feeling that these people think you are, you don't know what you are saying, and you're just a nuisance and let you come away feeling, so that you as a person feel really very horrible.

Several of the women stated that they went through a mourning period immediately after their injury. When the injury is to a child, the women were primarily concerned to take care of the injured child. It is only after this mourning period subsides, or after unsatisfactory contact with the physician, that there is any concern given to litigation. Blossom Grey explains what it was like for her after her daughter was diagnosed

I was too busy trying to get -- basically, after [daughter] was diagnosed as having a disability my first husband crawled himself into a bottle. He did not have anything to do with it. So it was just me and [daughter] and my mom

and dad who would help me out a tremendous amount, but it was just me and [daughter] on our own and I was frustrated and I was scared and I did not know where to turn and I tried talking to the physio and they just said, "there's just no way you can prove", you know, I just did not, I didn't stand a chance. [husband] did not want to do it because there was not enough money. He did not want to cause a problem because he did not want people to know and he thought that the doctors would not treat us if they found out we've sued them. (Blossom Grey).

I was kind of grieving for myself at first. I was. At first when I walked out of that doctor's office that day I was in tears, you know. I was really hurt and then, after that hurt went away, I got angry, then I phoned the lawyers. (Violet Kerr).

The Limitation Act (R.S.B.C. 1979,c.236) sets out the time within which a suit can be brought. Pursuant to s.3(1) of the Act, the limitation period for most personal injuries is two years after the date on which the right to do so arose. Two respondents noted during the interview that when they contacted the lawyers they were told that the statute of limitation had already run out.

### 3.5.3 Access to the Courts

In addition to the barriers posed by the Limitation Act and women being discouraged from pursuing litigation, legal and financial constraints hinder women's access to the courts.

Commenting on legal constraints, some women state

I could not afford to sue. I could not afford to hire a lawyer and when we pursued the initial injury with another lawyer, a lawyer that specialises in medical injury, and he said you have 50/50 chance, you can win or you can lose, you got a pretty good chance of winning, but it is going to cost you \$5000 just to go look at this and it is going to cost you about \$20,000 by the time you're finished. And if you loose, you have their cost. We were young. We did not have that kind of money. My family did not have that kind of money. We did not think or we were never presented with the fact that maybe legal Aid could be able to help you out. (Primrose White)

She just said that she thought there is a case there but it would be burden of proof. You'd have to prove that there was neglect and I knew that it would cost me a lot of money to pursue the avenue, I know they do not come cheap. (Blossom Grey).

According to May Anderson



We've just been yanked around by lawyers from one to another. One lawyer, I must have spent around \$7,000, he would compile a whole bunch of stuff and then he looked at the chance of winning and though he did not want to waste his time and risk his time if he had a 50/50 chance of winning. He has to have at least 80% chance of winning to take a case on for no fee. Something like that [...] and he said that he could not do it, because it is expensive [and] the chances are so slim of winning, a 60/40 chance, something like that, but he was going to take it on if it was 80. So after, \$7,000 later, I had nothing.

Rather than degree of injury or harm, the lawyer, as expert, uses economic criteria to assess whether or not to pursue a suit. Thus if the chances of winning are less than eighty (80) percent<sup>53</sup>, there is a reluctance to pursue the issue at law. Therefore, the idea that tort law protects an individual's bodily integrity and that where injury is sustained, a person may apply to the court for redress is not the reality for many women, and particularly the ten women in this study. Although most of the women interviewed for this thesis considered litigation, none were successful in their pursuit. Therefore the issue of formal and substantive equality has been, and continues to be problematic for women. Economic, social, and psychological elements impede women's access to the legal system. Thus, women are differentially affected by the tort system. Women are being silenced by what appears as collaboration or co-optation between the medical and legal system. The hospitals and the College of Physicians and Surgeons are also implicated in that women's complaints are often trivialised or somehow minimised.

To summarise, some factors which operate to silence women include notions of sexuality, the limitation period, women being made to feel inadequate and "crazy"

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<sup>53</sup> Very few people are able to finance the cost of litigation out of pocket. A contingent fee arrangement provides that a plaintiff's obligation to pay an attorney is contingent upon the plaintiff recovering damages for an injury. If the plaintiff is denied compensation, the attorney receives no payment. Hence lawyers often screen out cases that are not likely to have significant recovery. The contingent fee is the principal avenue by which the majority of individuals who are injured are able to access justice. It is often the only practical means by which a plaintiff can economically afford, finance and obtain the services of a competent lawyer. See B.C. Law Society Rules, Part 12, Page 82 – Contract for Remuneration (a) Contingent Fees and Professional Conduct Handbook. Chapter 9. Page 25.

(hysterical), the power dimension of the doctor's social status, and the ranking of knowledge, with experiential knowledge being relegated to the realms of anecdote and dismissed.

Within contemporary society, sexuality is still not openly discussed. Taboos and secrecy surrounding women's bodies often dissuade women from speaking about their health care concerns. These issues are not openly discussed. For example, during the interviews, there was a tendency for women's voice to fall when they were talking about issues which they considered intimate. This was most evident when Cherry Barrett was describing the effect of the injury on her marital relations, she did not actually say what she meant, rather she implied it and then added the clarifier, "You know what I mean?". Because of the notion of private parts, women are reluctant or uncomfortable speaking about their injuries. This operates as a silencing mechanism.

Women were also silenced by a fear of being labelled hysterical. This operates in one of two ways. First, women are labelled hysterical and dismissed when doctors cannot readily identify and diagnose their pathology. The second way is illustrative of Blossom Grey's statement to her general practitioner when she was attempting to get her daughter assessed to confirm her own perceptions of injury. She notes, "maybe I am hysterical, but let the specialist tell me that." This was after several attempts to get a referral from her. This fear of being labelled hysterical often prevent women from challenging doctors. The social status of doctors also operates as a silencing mechanism. Women often are reluctant to challenge doctors, because doctors are viewed as the experts who have all the knowledge. By not challenging doctors, women unwittingly participate in the perpetuation of the mechanisms which are used to silence them.

Lawyers often need an "expert" to validate women's experience of injury. However, they often encounter difficulties locating a doctor willing to give expert evidence. Also,

layfolk's knowledge is seen as subordinate to professional knowledge. These are two ways in which the ranking of scientific professional knowledge over experiential knowledge silences women.

Women's fear that the pursuit of litigation will have a detrimental effect on their health care seems to be the most effective mode of silencing. Women often suffer in silence because they think that doctors will deny them services if they attempt to seek redress for their injuries. This in itself creates injuries especially because women incur additional financial expenses as a result of their injuries. There is also a chain reaction in that anxiety, depression and anger have been described to arise from injuries.

Women are also silenced by the requirements of the legal system. First by the criteria used to assess the cases that are deemed meritorious. Second, by rules of evidence, particularly those which relate to expert evidence. Third, by the cost of accessing the courts. Finally, women are silenced by the coalescing of medical and legal discourses, primarily because in order to gain access to redress at law, medical injuries must be and has to be translatable into legal discourse. The Statute of Limitation also operates as a silencing mechanism. That is, regardless of the merit of the case, if the statute has run out, women are not able to access the courts to seek redress.

## Chapter 4: Women's Voices

Women's injuries affect all aspects of their daily lives. In this chapter women talk about the consequences of their injuries. They describe financial, emotional, and psychological effects ranging from depression, broken relationships, and reduced income. They also report feelings of alienation, isolation and anger and very few people with whom to share their experiences. I discuss some of the factors which were found to contribute to women's silencing. I then address whether, and to what extent, women resist their silencing. I conclude that speaking is a form of resistance.

### 4.1 *Financial Effects*

Loss of income was the most widely reported effect of the injury. Additional costs for medication and other equipment, as well as legal costs, were also cited. Losses were sustained by women as a result of loss of employment. They describe having to take time off work, reduced hours of work, and/or loss of sick or holiday leave. They also lost income because the injury affected the ability to work. Some women had to take more time off work for additional doctor's appointment. Blossom explains

Well, obviously it [my pay] went down because I was only working part-time [2 - 3 day a week].

Both Primrose White and April Brown state

I can't take a job full time working 9 - 5 because I have a lot of allergies and I get diarrhoea sometimes and it goes on for quite a few days, and since, you see when you're incontinent, you have no idea when you need to go to the washroom, it just happens. So I work at home, but I don't get very much work, so my income is very low, really struggling. (April Brown).

I have not been able to work since 1990. One thing I cannot do is work. I cannot work. I cannot take on an additional responsibility outside my home. I am responsible not only for my comfort but for others and [...] physically I can't do it. (Primrose White).

Other expenses which have accrued as a result of the injury include increased child care cost and missed days from work. Cherry Barrett explains

Like I had to ask my mother to come [from outside of Canada] because I had to go in for surgery and stuff like that. And lots of trips to the doctor, that I would not have to otherwise. [...] Three plus one to surgery so that's four and she has asked me to come in again after Christmas. She's in Vancouver, quite far from here. [whenever I go to the doctor] [...] I need someone to look after my children.

Losses sustained include hospital costs, medical fees not covered by insurance, medical tests, medical opinions, continuing medication and other therapies and aids. For example, not all medical expenses are covered by the Medical Services Plan and without extended health or any other plan, these expenses must be borne by the person. Two of the three children who sustained permanent brain damage need hand and leg braces, special shoes and other special supplies. Blossom explains

So medication alone, which is, I mean, I know there are a lot of people who are worse, a lot worse with medication than for us, but medication alone is more than \$100 per month. [...] Well I can see that for instance, leg braces costs \$700 and a wrist brace cost \$300. \$1000 and now she's got curvature of the spine and she's got the epilepsy. [...] I mean, we went to Children's and we were involved in this thing with Medchem, you know, building up the muscles, she was on that program. She got in there, and the lady there told me that she should be having some sort of, even if she had a biofeed back machine it would help, we don't have a \$100 extra to pay for the biofeed back machine.

He needs special foot lifts because one foot is so much shorter, because the left side is growing with so much weight, to the right side. [...] and I have a hand brace for him. It is about \$600 for both of them, there's that, plus there's lots of expenses running him around. You know, hidden expenses. I have to buy special shoes for him. Shoes that are, that have Velcro, I have to look for the good quality Velcro shoes, good support, because his left foot did not have very much support. When he was younger I had to buy him shoes with higher boots to keep his ankles nice and firm, so his shoes and stuff like that is expensive. I have to get special pants for him. I can't, he can't wear regular jeans because he has to pull his pants down with one hand so he cannot button up anything. So there is that and I have to dress him all the time [...] I have to shop specially for clothes that do not have zippers and buttons. (May Anderson).

Expenses are also incurred for educational aids over and above what is normally required.

Blossom explains

So I'm looking at extra money for extra education because she gets very little at school because they [school] can only allocate so much per child, and so she does not get that much. And I'd really like to get her a computer. A decent computer that she can use, that she's going to need anyway. Like right now we don't have the funds, the resources, and she, it would be a lot better for her if she had one. [...] But then you see it all cost more money, and you know nobody is really helping me anyway, now that is the frustrating thing.

#### 4.2 *Psychological Effects*

The American Psychological Association's (APA) bulletin on women and depression identifies reproductive issues such as pregnancy, menstruation, infertility, miscarriages and surgical menopause as risk factors for depression. The bulletin also notes that motherhood, especially the presence of young children, makes a person vulnerable to depression. In addition it reports higher rates of depression among women than among men. The APA estimates that 2 to 25 percent of all women will undergo clinical depression at some time in their lives. Whether this is an accurate reflection of the rate of depression, or a reflection of diagnostic practices, still needs to be assessed. Nonetheless, women who shared their experiences for this thesis identified depression as one of the psychological effects of their injury. Three of the 10 women were themselves on medication [anti-depressant], and incurred additional expenses for their own medication. They also identified feelings of anger, anxiety and being apprehensive of doctors.

I suffer from depression from it [injury], and anger and grief and you know, a lot of emotional harm too. (Rose Hall)

So, just from the point of view of my mental health, it's hard, because I have a lot of anxiety now about going to the hospital. I have a real dread of doctors now. Fortunately, I've found a family doctor now that I get along with, but I hate going, I hate having to deal with the medical community. It's very anxiety provoking. So yeah, I think it does contribute to my [injury], because it affects your self esteem, you know, it is how you view your self, and it is hard to kind

of describe it, it just does, it just makes you feel like, you don't feel comfortable. (April Brown).

Blossom Grey and May Anderson describe the anxiety they experience with their children's injury.

For the first week after we found the epilepsy and 20 minute seizure, I literally was sleeping on the floor [in her bedroom] and [husband] said you can't continue, you can't do that. What happened, I was so worried, I am always so worried that somebody's going to kill her or hurt her, she's going to die or something, so we got the dog, because somebody had said that sometimes dogs can clue in and that they can foresee the seizure. Luckily with her they are minor, but there are 3 or 4 a day and the medication is not working, so they can't stop them from coming. Sometimes if she is just startled, if somebody just startles her, suddenly she gets seizures. (Blossom Grey)

[A]nd he used to have these brady cardia, where he would turn all blue and his heart would go funny and stuff and he would have these brady. And he would sort of be panting for breath. You know turn all weird colour you know. [...] When I brought him home, I was so worried that he would turn blue on me, so I was up all the bloody night. All the bloody night I was up. Half the time, you know.. He was in the cradle next to me, and I would be up like every hour watching if he was breathing. So that was very traumatic for me (May Anderson).

The mothers explain that as a result of the increased time required to take care of the injured child, other members of the family are neglected. Neglect causes problems, especially with spouses. While not directly a cause of, the injury sustained contributed in part to the dissolution of two marriages. Asked about the effects of the injury on her life April Brown replied

I'd say profound. Really profound because I know it really, my husband could not cope with it, and I'm not saying that's the reason he left, because certainly there were other factors, but that's one of them. He did not want to be with somebody who was incapacitated in anyway. He did not want to have to go to a function and in the middle of the function I have to leave and he has to explain why or have an accident and something and people talk, or whatever, so he left.

[my husband] and I went through really bad times and we end up splitting [...] because even though she is not in a wheel chair, there are still issues that he could never, he could never, I would say he was embarrassed that he did not have a normal child and that he never told anybody at work. I kind of blurted

it out by mistake to somebody and up to that point it was a secret, nobody knew that she had leg braces, and wrist braces and hand braces and she had physio once per week (Blossom Grey).

Even when the marriage remains intact, the injury can have a tremendous strain on the relationship.

I can't look past next week. Like even with my kids, or [husband] and they'll say do you want to do this or this next week. And I'll say, I'll see what next week brings. I can't plan anything. [...] I can't even plan next week. You know. [...] As a couple and as a family we are very close knit family, very close family, but it has had its drawbacks. Because I take Demerol I can't drive them here, I can't drive them there. I have not gone skiing with the kids and husband. I'm too uncomfortable and I've also reached the point where I'm afraid to try things. [The injury ...] has had a tremendous effect. It has had a tremendous effect on us as a couple, and has affected our marriage, we struggle. (Primrose White).

The injury also had other effects on relationships.

It is affecting my relations with my husband, I mean, it has been 5 months [since she had sexual relations]. (Cherry Barrett).

Oh, because I was in a relationship with a younger guy, and we decided, he really wanted kids, he was really pushing me about children. [...] And he left me because of that. He left me because I could not have kids. O.K. that was one of the reasons he left me. That was one of the big reasons he left. [...] So it affected my relationship, with men because, sometimes I go out with a lot of younger men and sometimes they want kids, and when they find out I can't have kids, that's the end of that relationship. (Violet Kerr).

#### **4.3 *Effects on Children***

In addition to the financial, physical and psychological effects on women and their marital relationships, the injuries have also affected the children in the family. April Brown explains the effect her injury had on her daughter

I'll give you a recent example, and my daughter is almost 15 now. She spends a lot of time at home with her friends. And we only have one washroom, so I have to go to the washroom pretty much right away. One day she was here, and two of her friends were there in her room, and she was in the bathroom, and I said, can I come in and she said no, I'm still busy or whatever, and I had an accident and [...]. (voice lowers - almost inaudible). My daughter she has two doors to her room, right outside and the girls were watching, and it was



terrible for me and for them, and for her, so I tried to clean everything up. I just got them together, and I explained what was wrong, and they were very kind about it. But it was hard.

Two of the three mothers whose children suffered neurological injuries stated that the additional time required to take care of the injured child affected their relationship with the other children. May Anderson explains

[uninjured child] would sit in his playpen and look and because I had to spend so much time with [injured child] that [uninjured child] probably felt neglected. You see. So he's not resentful, but he become frustrated because he can't really have too much of an intelligent, same level kind of conversation with [name].

Pauline Jones also explains that the older sibling of her injured son is very jealous and anxiety prone because he feels neglected.

One respondent articulates how her injury has affected her ability to form intimate relationships.

I met a very nice man about 6 months ago, and we saw each other for a couple of months, but as the relationship developed I became really apprehensive. Because I did not know, because I guess, it was intimately involved. I did not know how to tell him and then he asked me to go away for a weekend with him, and I said that I could not go, and he said why not, and I said, well because you know, I'm not really feeling that well. I don't want to be some place, you know that I don't know where I am and that. And I just realised from then that I could not really tell him, I could not say. I think he was really hurt or disappointed that we could not go away so I just sort of walked away from that. [...] It was hard because, I really got along with him and he was, he's a good person. And I had to kind of just realise that I just have to be alone for the rest of my life. (April Brown)

Concerns with aesthetics also seemed to be an emotional effect of the injury. June

Gentle remembers

When I started another relationship, I was wondering what they would be thinking because it did not look quite, the one side was not quite looking the same thing as the other side, and I was wondering what they would be thinking.

It is just that scar. On the aesthetic standpoint, it might seem silly and every thing, but it is your vagina and I think if it was a man and it was his genitals I

mean, they'd feel the same way and they would not feel silly about feeling like it was an aesthetic thing you know, but it is kind of gross. (Rose Hall).

A problem affecting women's response to injury has to do with socialisation patterns. For example, women are taught to think of themselves as potential wives and mothers. Thus, when their reproductive capacities are somewhat not in accord with dominant ideology, women are seen as damaged goods and less worthy of being considered feminine. It is interesting to note that the notion of damaged goods is also used as a rationale to subject women to particular gynaecological procedures. For example, the popular euphemism for episiotomy is "husband's stitches." Episiotomy has been advocated to prevent irreparable stretching and a sagging perineum, said to result from the natural expansion of the vaginal opening. One participant was encouraged by her husband to undergo surgery to correct "the stretching and sagging" which resulted from her childbirth experience. This surgery resulted in her injury which in part contributed to the dissolution of her marriage.

The injuries therefore have far reaching implications for other aspects of women's lives. This includes financial, psychological, social and emotional injuries. The injuries also affect women's relationship with spouses and children.

#### **4.4 *Social Support Network***

Not only are women silenced by medical and legal practices, they are also silenced within other relationships, most notably by husbands and female relatives. May and Stengel (1990, 107) note that actors external to the relationship between dissatisfied patients and their doctors play a significant role in patients' decision to pursue litigation.<sup>54</sup> Ladinsky and Susmilch (1983) refer to these actors as "audiences" (in May and Stengel 1990, 108). Women's

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<sup>54</sup> Persons and organizations involved in the disputing process are called brokers because they act as helping "middlemen" in defining and managing problems, grievances, claims and disputes. They may discourage complaints and convince the injured party that he or she does not have a problem or that nothing can be done about it, or may inspire or persuade them to "voice" rather than "exit," (May and Stengel 1990, 108 citing Ladinsky and Susmilch (1983,7).

feelings regarding litigation may, in part, be based on the support they receive from others. Informal input from lawyers, friends, or someone who could help decide what to do and the perception of support from family and friends help to determine whether legal actions will be initiated.

Bearing in mind that women report feelings of isolation and discomfort speaking about their injuries, it is not surprising that most of the women did not report receiving significant encouragement from family members in the decision to pursue litigation or file a formal complaint. Rather, some family members were reported to discourage litigation. The rationale behind these discouragements include the perceptions that there is no possibility of winning or, it would be too expensive to pursue litigation. Blossom Grey recounting a conversation with her mother states

She said, you don't have the money to go through the courts to sue, and even if you did you won't win, because they'll see to it that you don't win so you should keep quiet and be happy with what you have. [..A]nd she said why do you put yourself through this? Why do you do this?

Among the women who shared their experiences for this thesis, fathers were more likely to encourage litigation. Blossom notes,

My father kept saying to me sue the bastard. Those were his exact words to me "sue the bastard." And my father is generally a very quiet man but he was so upset about what had happened to his granddaughter. (Blossom Grey).

My father's favourite expression was if something went wrong, he always used to say, "sue the bastard" and we should have. I did not live by what my father said, and it's been a regret. (Primrose White).

None of the respondents reported being encouraged to pursue litigation by another female family member. Another male person other than a father was mentioned by two of the women. One person was a boss, the other a minister. Primrose and May's husbands were supportive of their wives' pursuit of litigation. In two other cases, husbands advised against

litigation. These, however, seemed to be based on selfish reasons rather than on a concern for the injured party. For example, April's husband was concerned about economic repercussions. She states

I wanted to sue the gynaecologist, but my former husband said that since he was on staff at the same hospital, and they worked in the same area of the city, I couldn't because then the general practitioners would not refer any more patients to him and we'd get poor.[...] My husband was adamant that under no circumstances was I to initiate litigation against any of the three. (April Brown).

Blossom's husband was concerned for his reputation. She notes

He was more concerned with his reputation. Because [if we pursued litigation] then it would come out, my god, I've got a daughter who's got an handicap.

He was also concerned that no one would want to associate with the family but most notably he feared a backlash from medical practitioners, primarily a refusal to treat.

Hence, support or discouragement from "audiences" affect the decision to pursue litigation or file complaint. For example, Engel (1984) found that personal injuries litigation generally produced public criticism. These criticisms were based primarily on the notion of exaggerated harm. Litigants were often seen as over-litigious. As a result, victims who brought suits were perceived as trouble makers. One result of these perceptions was that people who sought compensation were characterised as "very greedy" , "quick to sue", "looking for easy money" or "trying to get something for nothing". These perceptions, notes Engel, "can be explained partly by culturally conditioned ideas of what constitutes an injury and how conflicts over injuries should be handled" (1984, 554). Some of these themes were quite evident in comments made by respondents. Discouragement from "audiences" and a fear of physician's backlash are affecting women's decision to pursue litigation.

Are patients' fear of a backlash realistic or simply based on perception? There are two ways of interpreting this. The perception itself may be based on the power dynamics

embedded within the doctor-patient relationship, or may be based on actual experience.<sup>55</sup> What is problematic however is that a doctor can claim s(he) is not accepting new patients rather than actually admit that a particular patient is considered a risk factor for litigation. Doctors have reported that a fear of litigation is prompting changes in their practice -- defensive medicine. It may be reasonable to assume that they may subscribe to the maxim that "the best way of predicting future behaviour is to look at past behaviour". Therefore patients who have litigated may be viewed as having a predilection for litigation and may be categorised as high risk. If the patient is accepted, positive defensive medicine may be practised. The patient may benefit from the over-zealousness of doctors but even positive defensive medicine has drawbacks, especially if procedures such as x-rays or other diagnostic tests, which further expose a patient to other illnesses, are used.

An assessment of the effects of medical/health care injury on women reveals that women are silenced not only by the relations of rulings, most notably medicine and law, they are also silenced and ignored by family members on whom they rely for social support. Not only are patients required to seek medical and legal assistance because of the injury, but injuries to children often require the use of additional resources such as educational facilities. As documented previously, the receipt of educational resources or other therapeutic services often prove to be difficult and time consuming for most mothers. Thus, Dorothy Smith's statement that institutions and relations which are remote from women's everyday experiences have a profound impact on their lives, often without individuals being present or cognisant of the other participants, seems to hold true in these instances. This assertion makes

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<sup>55</sup>A patient who was involved in a medical malpractice suit mentioned in a personal conversation that when she changed doctors the new doctor recognized her name and was aware of the case (despite the fact that the name was not very unusual and it was almost two years since the case was reported in the newspaper).

available a particular way of understanding the far reaching implications which medical health care injuries have on women's lives.

#### 4.5 *Transformation of Silence*

And where the words of women are crying out to be heard, we must each of us recognise our responsibility to seek those words out, to read them and share them and examine them in their pertinence to our lives. (Audre Lorde, 1984, 43)

Do women resist their silencing? The answer can be found in women's own words. This necessitates listening and hearing what women have said. Women's primary response after their injury was to change to female practitioners. There was also a tendency to reduce reliance on western medical remedies. Thus they also pursued alternatives such as homeopathic and naturopathic medicine. One engaged a midwife to assist in her childbirth. These women have also become or have pledged to become more informed about health care choices. According to Primrose

Because as a woman during the 70s you did not question, I did not anyway, maybe it is just my personality, I did not question at that point, [but now], I read up on everything. Everything that is said to me, I read up. Any medication I am given, first thing I do, I go down to the pharmacist and he gives me the information from the [compendium of pharmaceutical services].

April notes

I'm 50 now. You know, when I grew up, we would not talk about sex or anything like that, that was just some mystery. You found out on your own about how your body worked and all of that. I always felt that was really a shame, so I've always had a very open relationship with both my kids. We can discuss things freely and they can ask whatever questions. [My daughter] is too young so far to go for gyn check-up, but she said, she would prefer to go to a clinic of women where they are sensitive to her emotions as well as to whatever complaints she may have.

April and Primrose have tried to prepare their children to deal with the medical establishment. They acknowledge, however, that women need to take responsibility for

their bodies because if they do not no one else will do it for them. As a result of their experience these women are wary of the hospital experience and some are seeking alternatives. Midwifery has been identified as less invasive and more supportive of childbirth. For example, Rose Hall was expecting another child and was quite emphatic about avoiding the hospital. However, given that her last childbirth experience was interrupted for a transportation to the hospital, she was cognisant of the fact that her plan to have a home birth or alternative birth options could be changed. In addition to being more vigilant about their health care and being less reliant on doctors, two respondents expressed the desire to make their stories public so that other women may become informed.

One participant speaks of fighting back but she notes that there are very few people that she can talk to who understand what she is doing to fight back. She has now become involved in associations such as those which support and encourage vaginal birth after caesarean, [VBAC], she reads extensively on medical issues, particularly alternative, homeopathy cures. She has also contacted a birth trauma specialist and she has read extensively in the area of birth trauma. Hence, women are not totally powerless in these situations.

Where there is power, there is resistance (Foucault 1980:95). Martin (1992) cautions however that one needs to employ an interpretation of resistance which is productive because the dominant notion of resistance uses "unreasonably stringent" criteria which may also include race, gender and class notion that further operate to mask acts of resistance. Martin identifies several forms of consciousness and resistance which may be employed by women. These she labelled acceptance, lament, non-action, sabotage, resistance and rebellion. By employing Martin's notion of resistance, one can acknowledge that women have in their own way resisted their silencing.

Audre Lorde (1984, 42) suggests that breaking the silence can be the most powerful form of resistance, mostly "because the transformation of silence into language and action is an act of self-revelation and that always seems fraught with danger." It is understandable then that women will be afraid, but by "sharing a commitment to language and to the power of language, and to the reclaiming of that language which has been made to work against us" (Lorde 1984, 43) it becomes possible to transform silence into language and action, -- that is, resistance.

By speaking out, women have expressed a desire to change things. They are resisting the mechanisms which have been used to silence them. They resist the practice of silencing and acknowledge that speaking is a form of resistance. It is important to break the silence, states April Brown, "because other women need to know what is happening and to know that their experiences are not unique". A determining factor for speaking out seems to be the realisation that remaining silent is analogous to being complicit with those who seek to silence. Some of the reasons given for speaking out are:

Because I really felt something needs to be said for women like myself who go through these horrendous experiences and not being able to receive any restitution or peace of mind, because of what has happened to us. (Primrose White).

The main reason I guess would be, well, I don't know if this is naive, but would be to see justice served, because I feel so violated. I feel like such a sense, like there's such an injustice done and I feel so helpless about that injustice. So the main reason would be to see justice, but also because I really care about women and also now I really care about babies and I feel like unnecessarily a lot of women and children, babies. innocent babies are coming into the world in a violent way, being assaulted. (Rose Hall)

I think it is really to help other women who are in that position, because I'm perfectly sure that many women, have OB/GYN services that leave them somehow impaired, but because it is such a personal thing, especially you know, you are young, but my age group, we did not talk about things like that, and so, it is to let women know that you have the right to at least say, hey look, you've ruined my life, you know, and you have to be held accountable, because



it is not good enough that they are just able to convince women that they're neurotic or whatever. (April Brown).

I thought maybe I can get some information I don't know about. Maybe this person will be able to tell me something I don't know and this person will validate my feelings and say yes, you should give it a try, don't be scared to try [litigation]. And maybe I might help somebody else. Maybe somebody else could be helped. And that's not a bad reason to want to think that you can help somebody else. That's the way I work. (Blossom Grey).

These doctors treat you as if you have no clue (Cherry Barrett)

It is evident then that women resist. They also want redress, not necessarily financial redress, but acknowledgement that they suffer injuries. Acknowledgement is a form of validation, but within this context it is gender related. However, instead of acknowledgement, apology or redress, women are being silenced. They are rendered inaudible and invisible or, in their own words, "treated as if we have no clue". The lack of acknowledgement of women's injuries creates obstacles to women's receipt of redress. This is evident in women's absence from the literature addressing medical health care injuries. As Lorde quite poignantly states, women "can learn to work and speak when we are afraid in the same way we have learned to work and speak when we are tired" (1984, 44). Hence women need to speak and not hide behind the constructions that have been imposed upon them and which women so often accept as their own.

The subordination of women's knowledge about their own experiences about their bodies, has an impact on woman's position in society. In order to address this subordination, women need to be heard, they need to be listened to and more specifically, they need to speak in their own voice. Thus, recovering voices is the first step in reclaiming women's knowledge about their reality. By so doing, women can begin to transform disciplines to be more inclusive of humans in all their diversity.

## Chapter 5: Conclusion

What a powerful thing it is when women speak to women (Cain 1990a, 9).

### 5.1 *Discussion and Findings*

As outlined in the introduction, the thesis uses medical/health care injuries as a case study to elicit women's voices. The object of study -- women's experience of obstetrical-gynaecological medical/health care injuries -- is introduced through the medical, legal and academic literature on medical negligence. I raised questions about the recent preoccupation with medical malpractice insurance and the perception of a malpractice "crisis". The Report to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care [The Prichard Review] provides a point of entry into the Canadian context. Emphasis is placed on why the literature, as well as the Prichard Review, categorise the actions of patients exercising their human and legal rights to seek redress for malpractice litigation a "crisis". I draw on the concept of "problem definition" to interrogate the notion of a "crisis". By looking at the "crisis" in terms of its definition, it became evident that the rhetoric employed by stakeholders, such as doctors, and insurance carriers, was instrumental in generating the perception of a crisis. In addition, an interrogation of the definers of "crisis" within this body of literature reveals that women's experiences are not taken into account.

Ten women provided their experiences, giving an insight into an aspect of medical negligence which is under-researched. Their voices point out ways in which women's experiences are deemed irrelevant by both medical and legal practices. Women talking about their medical/health care injuries help to explicate the subordination of women's knowledge about their own experiences and their bodies. These discussions illuminate ways in which

women have been silenced and/or rendered inaudible and invisible. This silencing is evidenced in the practice of doctors and other professionals in their capacity as "experts" speaking for women. The discussions make obvious that medicine and law -- as professional discourses and bodies of rules and practices -- operate to silence women. However, women's exclusion from, and marginalization in discussions of medical negligence, occur primarily because the literature constructs doctors as victims. Such constructions help to relegate women to the margins and footnotes.

Our existing knowledge of medical malpractice has produced a view of doctors as the victim. By interrogating the notion of a "crisis" and the construction of victim, it became evident that the rhetoric of advocates and stakeholders such as doctors, insurance carriers, politicians, and attorneys laid the foundation for the treatment of medical malpractice as crisis. In fact, a reduction in profits for insurance companies as well as an increase in the premium rates for doctors generated the perception of a crisis in malpractice. The Prichard Review stated that Canada has not yet experienced a "crisis" but that given the number of uncompensated people, even a modest increase in the rate of litigation could result in a malpractice crisis. That such a small number of patients who are injured receive compensation is itself a crisis. However neither the Prichard Review nor the literature problematized the number of uncompensated patients. Instead they define the problem in a way that implicates women as victimisers.

The medical malpractice literature constructs a knowledge of malpractice that systematically excludes and distorts women's experiences. It relies on a methodology that venerates objectivity and professional knowledge and downgrades personal experience as subjective. It means therefore that the methodology used to research women's condition is important. This is important because professional discourses such as medicine and law

reinforce a vision of society that denies women's local experiences. These discourses provide a universalised view of life that does not invite input from the standpoint of women. In this thesis I proposed to remedy this situation by utilising a feminist framework -- feminist standpoint epistemology -- that starts from women's standpoint. Feminist standpoint epistemology is specifically about method. It facilitates the inclusion of excluded perspectives and transforms disciplines in ways that are more inclusive of "outsiders". Dorothy Smith notes that standpoint is not a totalizing theory but rather, a method of inquiry that recognises women's personal experience as a starting point for research (1992, 91). This method aims to have women's experiences recovered from the subordinated positions to which they have been relegated. The open-ended method of interviewing which informs this methodology, notes Smith, is important because how informants tell their story is essential to the analysis that defines the problematic. Because medical/health care injury was not predefined, I was able to discover injuries that would not otherwise become evident. I also uncovered experiences that are not deemed to be injury within the medical or legal sense. By so doing, I was able to uncover problematics not readily apparent. Therefore, feminists' standpoint epistemology allowed me to challenge the construction of doctors as victims within the literature on medical negligence.

In order to challenge the construction of doctors as victims of medical malpractice, I juxtaposed their experiences with women's. The ten women who spoke, articulated diverse experiences of physical and psychological injuries arising from their contact with doctors. They described injuries ranging from post-operation complication, neurological damage to babies, adverse reaction to drugs, damaged or mutilated organs, or generally being rendered incapacitated by medical intervention. Women reported financial, psychological, and emotional consequences of their injuries that range from job loss, reduced incomes, anger,

anxiety and depression. Women's injuries sometimes render them unable to work, but more often forced them to reduce their hours of work. Women were more likely to work part-time when the injury was to a child. The inability to work, or reduced income from part-time work has implication for women's ability to afford resources, especially resources necessary to enable the injured child's everyday routine activities.

The women noted that when they suffered injuries, doctors dismissed or discounted their experiences. Furthermore, women's knowledge became categorised as subjective. While women often had evidence of injuries, they were constantly told that they were imagining it, and that it is "all in their heads". For example, April Brown was dismissed by her doctors for nearly two years. When she complained, she was led to believe that she was a "neurotic" and "depressed" person. Moreover, when women attempt to speak, their experiences are further discounted as anecdotes which need to be validated by empirical evidence, that is, by social science researchers, professionals or "experts". Most often women's experiences are pathologized or psychologized and explained as hysteria.

Most women who have been injured have limited access to legal redress. They explain that preliminary charges for initiating a case can cost thousands of dollars. Therefore constraints such as cost, problems finding their way through the legal maze and/or problems accessing lawyers restricts women's access to the courts. Problems accessing lawyers are further impeded by legal screening procedures and problems obtaining an "expert" to confirm the other practitioner's breach of standard of care. Lawyers do not evaluate cases solely on the basis of injuries. Criteria such as the probability of success and the amount of damages recoverable are also assessed. If the amount recoverable is not enough to cover the basic legal cost, the case is often not pursued. However, not all injuries which women suffer can be quantitatively assessed. For example, how does one attach quantitative value to the

loss of a uterus, or injury to a child? While it is possible to calculate the cost expended for care, other aspects are incapable of precise calculation. Medico-legal literature suggests that causation is the "missing link" in proving damages. Damage, however, is the "thorn in women's side". Damages, to an extent, determine whether a case will be litigated. Given that women are primarily concentrated in low paying jobs with low wages and are less likely to recover significant amounts of damage, lawyers are less attracted to their cases. When lucky enough to reach the courts, women are further constrained by rules of evidence. Therefore, not only do women suffer physical, psychological, financial and emotional injuries, but they are further injured by their inability to obtain redress.

The emotional and psychological consequences of injuries on women's lives include depression, anxiety, anger, broken relationships and concerns with aesthetics. The injuries also affect women's relationship with their spouses, children, family and friends. In addition to the effects on existing relationships, women's ability or potential to form new relationships are affected by their injuries. Not only are these consequences of physical injuries, but they are themselves injuries that create their own problems and raise issues that need to be addressed. Nonetheless, the medical and legal literature does not categorise these consequences as injuries. Furthermore, notions of taboo, pollution and secrecy around women's bodies and the designation of women's issues as private create a climate in which women are generally uncomfortable speaking about their experiences.

The greatest impact of women's health care injury arises from women's interaction with their family physician. Women explicating their problems note that their inability to be heard is a major problematic. They find it discouraging that doctors do not acknowledge that they are injured. They are also disheartened that doctors do not listen to what they have to say or acknowledge that they have valuable information. Women also report feelings of

abandonment. That is, when women report an injury the patient-practitioner relationship changes and the practitioner is unwilling to speak with them. The protective association's requirement that physicians do not discuss legal matters with their patient exacerbates women's injuries. Thus women are seeking redress not only to obtain financial compensation, but also to achieve closure. As one woman notes, even if doctors do not acknowledge that they have done something wrong, maybe the court will. Hence, these women want practitioners to take responsibility for their actions. They note that often they simply require an apology or an acknowledgement from doctors that they are injured. However this does not seem to be an option that the medical profession is willing to encourage. That is, within an adversarial system, an apology is interpreted as culpability, and the practitioner is unwilling to expose him or herself to liability in a medical negligence suit.

Another problematic of women's everyday relating to medical/ health care injury is that of the different roles they occupy within different discourses. Within medicine, women are patients. At law they are clients of lawyers, but litigants within the courts. They are consumers of the health care system. Women are also mothers and wives. For those whose children are injured, they are parents in their dealings with the schools. These different roles are further compounded by the fact that a medical injury is not necessarily a legal injury: that is, the medical injury must be translatable into legal discourse. If the injury is not amenable to translation, it cannot be litigated. While discourses are somewhat different they often interrelate and borrow from each other to legitimate their position. For example, medicine often uses legal rhetoric to justify practices such as whether or not to perform abortion. Medicine also uses law to regulate women's bodies. Law uses medicine to define issues such as viability of foetus. Both rely on science. Hence there is a coalescing of all these discourses. They operate to silence women's voices and impose their definitions of events on women's

everyday life. The major problematic for these women, therefore, is how to negotiate these roles and discourses in ways that will transform medical health care injuries into medical negligence claims.

Women's experiences of medical health-care injuries are excluded from the literature on medical negligence. However, a finding of this thesis is that women suffer debilitating injuries that are often not acknowledged by the medical profession. Furthermore, women speaking about their injuries are often dismissed. Their accounts are treated as anecdotal, subjective or discounted as hysteria. As it relates to medical negligence in general, and obstetrical-gynaecological injuries in particular, women's injuries are further compounded by practices wherein doctors and insurance companies are the foci of studies. These studies then blame patients (women) for creating a crisis.

Women's accounts reveal that although the consequences of their injuries are debilitating, they often suffer in silence. Factors contributing to this silence are: the intimate nature of the injuries, a fear of being labelled hysterical, a fear of physicians' backlash and the operation of legal rules. Women's susceptibility to being silenced is heightened in obstetrics-gynaecology which is concerned with "private parts" and where health issues are more likely to be designated intimate. The application of notions of taboo, secrecy and pollution to women's "private parts" results in women being reluctant or uncomfortable speaking about their injuries. These notions also make others within women's social support network uncomfortable hearing about the injuries. As a result of the intimate nature of women's injuries, women become vulnerable to the vagaries of the medical profession.

Women's injuries are further complicated by the fact that obstetrical-gynaecological injuries are not readily obvious. Women therefore become susceptible to being labelled hysterical. However, even when women dismiss the notions of secrecy surrounding their



bodies and overcome the fear of being labelled hysterical, they often keep quiet. Women keep quiet because of a fear that complaint will have a negative effect on them. Women fear that practitioners will refuse to treat them if they complain or litigate.

The preceding factors are compounded by the requirements of the legal system. These include the criteria used by lawyers to assess the merits of an injury, the cost of accessing the court system, and the requirement for expert witness to validate the injury. Legal rules such as rules for discovery and those relating to statute of limitation also compound women's access to legal redress. Hence, the criteria used by lawyers and the application of rules have detrimental effects on injured women.

Hence, the subordination of women's knowledge about their own experiences, and about their bodies specifically, has an impact on women's position in society. This subordination serves to silence women and relegate their concerns to the "private sphere". Nonetheless, women speaking in their own words articulate that they need to be heard, that they need to be listened to and more specifically, that they need to speak in their own voice. Most important, however, is that they want to be acknowledged as the experts on their own bodies.

Martin's (1992) non-restrictive notion of resistance made it possible to acknowledge that speaking is a form of resistance to silencing. Therefore, I was able to uncover and discuss ways in which women have transformed their experiences into acts of resistance: breaking the silence. Thus, women's willingness to speak -- the shattering of silence -- is a form of resistance. Audre Lorde notes that there are so many silences to be broken (1984, 44). Makeda Silvera asserts that in order for the voice of the silenced to ring fully, "they need to be heard over the clamour of [those] who after all, have a vested interest in keeping them mute" (1989, 105). Women have also resisted by changing their practitioners, becoming participants

in the management of their health care, and becoming more informed about their health. Women have also learnt that it is through their interaction with other women and in the sharing of their experiences that they receive validation. Hence, they have acknowledged that validation does not and often will not come from professionals. Women have resisted their silence. They have taken the first step in reclaiming their knowledge about their reality. They are speaking. By speaking women can begin to transform disciplines that have historically excluded them. More specifically, the ten women who have spoken have included their voice in the literature on medical malpractice. They have helped to deconstruct the notion of doctors as "victims" of medical negligence, hence, raising the need to undertake a deconstruction and re-construction of the "crisis in medical malpractice".

In conclusion, women are silenced because their health care issues are constructed as private. Women are silenced by a fear of being labelled hysterical. They are also silenced by a fear of a backlash from medical practitioners. To compound these, women are further silenced by institutions -- such as the courts, hospitals, the College of Physicians and Surgeons -- which are supposed to provide redress. In fact, women do not believe that these institutions operate in their interest. The ten women who spoke articulate in their own ways the need to learn to acknowledge their own experiences. This, they suggest, is needed because too often women look to others for validation. Hence they articulate that women need to speak in their own voice. More important, women need to speak to other women. Women need to speak to other women because of the isolation in which they normally exist and the mechanisms that are usually applied to render them inaudible, invisible and marginalized.

In what way is a discussion of women's experience of obstetrical-gynaecological medical/health care injuries, or the exclusion of women's voice from the literature on medical malpractice transgressive criminology? By pointing out that medicine, law and science are

'only' discourses and that there are other ways of conceptualising women's health care injuries, the requirement of reflexivity is fulfilled. The notion of a crisis in medical malpractice and doctors as victims of this crisis were deconstructed. Women were then reconstructed as victims, who not only suffer injury, but whose injuries are dismissed as hysteria or as being "all in their heads". Addressing Smart's (1990, 80) critique that feminist criminology rarely uses standpoint feminism as a starting point, I used standpoint feminist epistemology and methodology to study women from outside the boundaries of criminological discourses.

The thesis did not specifically study men. However, the majority of medical practitioners are males. In fact, the entire literature and studies of malpractice can be conceptualised as being about men. The transgressive requirement to study males was fulfilled by examining doctors' description of their experiences of medical malpractice. I point to the need for medical practitioners and others to listen to, and include women as part of the decision making process. This is important because women are the experts on their own bodies and realities -- hence fulfilling the requirements for reflexivity and self-help. The Women's Health Care Movement arose as a political movement to challenge the medicalization of women's everyday experiences such as menstruation, pregnancy and childbirth. I incorporated Women's Health Care literature into the thesis as a way to challenge the incorporation of women's everyday into psychology and medicine.

As this thesis points out, women's experiences are not recorded. These experiences do not form part of the existing literature on medical malpractice. This, however, is not an isolated event. Such exclusion is quite pervasive and has historical antecedents. This is one reason why feminists need to transgress criminology. A transgressive approach allows the uncovering of women's experiences. It helps to recover and remove women from the margins, footnotes and other subordinate positions. Transgressing criminology will help to

get women off the preface, out of the footnotes, and will place women and their experiences, in the body of the text.

The underlying premise of this thesis is that individuals, primarily women, are differentially affected within a society that is for and by men. The gender subtext embedded in most social relations, institutions and apparatuses such as the state, courts, educational and health care system, all have an effect on women's everyday life. These effects are not always obvious or already named. Therefore, criminology, as a discipline cannot and should not confine itself to criminal issues because entry into crime has its roots and causes outside the criminal justice system. Transgressive criminology helps to point out that a system that focuses primarily on offences and offenders needs to be restructured to encapsulate other facets of offender's lives. Most importantly, the system needs to identify and know what is happening before it can attempt to ameliorate those conditions. Any other strategy is merely "band-aid" and will only achieve short term or no effect. According to Cain (1990), it is only when we understand how women are treated within institutions such as the courts that we can understand how women are affected within society. Hence, the need for a transgressive feminist criminology.

## **5.2 *Recommendation for Further Research***

This thesis was exploratory and general. It is now important that more extensive efforts be made to discover and uncover the extent of women's medical injuries. It is important to refute and dismiss the notion that doctors are under a constant barrage of litigation. As well, there is a need to know why many persons do not obtain legal representation. This takes on increased importance in light of media reports of a shortage of obstetrician-gynaecologists in Canada in general, but primarily in Ontario. This shortage is attributed to a fear of litigation, that doctors are leaving the practice and that less medical students opt for obstetrics-

gynaecology. The average age of obstetrician-gynaecologists who still practice is 52; an indication that most practising obstetrician-gynaecologists will be retiring soon and without adequate replacement. Hence, it is reasonable to believe that defensive medicine exists

Another reason for further research is that quite often changes are made in one arena without regard for its effects on other aspects of society. The reforms recommended by the Prichard Review suggest that Canada implement a no-fault or some derivative of a no-fault compensation scheme. Research is needed on the effects of "social engineering" in tort. That is, it is important to know what the implications are for the health care system of shifting the cost of compensation for tortuous acts of medical professionals from private insurance to tax payers. Hence research is needed on the interplay between tort policies and health care policies. Such research takes on special importance because the government is in an era of "fiscal restraints" and retrenchment in social programs. The health care sector is also postulating a crisis in health care funding.

The Supreme Court of Canada in *Hill v. Church of Scientology* used the "floodgate policy" to distinguish defamation from other personal injury cases. As a result they were able to circumvent the need to apply the cap on damages. Hence, research is needed on the effect of judicial application of tort reform policies. Specifically, what are the effects of judicial decision-making on women suffering tortuous, medical malpractice, injuries. As well, attention needs to be paid to the potential that defensive medicine has for creating problems for women's health care. Given the shortage of obstetrician-gynaecologists, it is important to assess how this will impact on policies aimed at midwifery. Other issues to be explored are the experiences women have had as a result of being considered "high-risk". It is important to know who are affected most, to whom do women who have been denied services turn, and what are the factors which predisposes a woman to being designated "high-risk".

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## **Appendix 1**

### INTERVIEW GUIDELINE

As outlined in the consent form, I am interested in your injury which resulted from obstetrical/gynaecological care.

First, prior to your injury, were you satisfied with the amount of time your doctor spent with you during medical visits?

Did your doctor inform you of what he/she was doing and why?

Did your doctor involve you as a decision-maker in the diagnosis and treatment?

How would you evaluate your doctor's competence before you realised there was an injury?

How would you evaluate your doctor's competence after you realised there was an injury?

Did the unsatisfactory medical care result in injury for yourself or your child?

Can you tell me about your/your child's injury?

When did you become aware of the injury?

How did you become aware of the injury?

When you became aware of your injury, did you complain directly to your doctor? -

If yes, What happened?

Were you satisfied with the explanation given?

Was the injury obvious to the lay person?

Was the medical issue which led to the injury complex or simple? (i.e. did it involve a complex procedure such as surgery or other more routine procedures?

How many doctors were involved?

Is/are the doctor(s) involved highly qualified and widely respected?

Did you seek advice from family and friends?

Did you decide to seek legal advice or were you advised to seek legal advice?

What was the result of the legal consultation?

Did you pursue litigation?

What was the outcome of your claim?

- a) settled prior to trial
- b) dismissed prior to trial



- c) proceed to trial
  - i) favourable disposition
  - ii) unfavourable disposition
- d) still in progress

Why was your claim settled prior to trial?

How long after your injury was the settlement?

Why was your claim abandoned?

Did you obtain damages?

What form did it take [lump sum or periodic payment]

What were your total legal cost?

Do you still face some of the costs that the compensation was intended to cover? [e.g. medical treatment, loss or reduction of wages]?

Do you still have parts of your compensation left?

Do you still receive compensation payments?

Would you say that your compensation was enough to cover the costs arising from your injury?

What was the major factor in your decision to pursue litigation?

What could have prevented you from pursuing litigation?

Have you ever been involved in litigation before?

Can you describe your experience with the litigation process. (From beginning to final disposition).

Anything you found especially bothersome

Anything you found comforting?

Did your lawyer inform you of what he/she was doing and why?

Did your legal team include you as a "decision-maker" in the legal process.

How would you evaluate your legal representation?

Did you pay the legal cost yourself or did you have a contingency fee agreement?

Do you have knowledge of or exposure to lawyers

Do you have knowledge or exposure to health care providers

What is your current relationship with doctors?

Have you heard about any legislative changes to medical negligence litigation?

What have you heard?

If you had a choice, which of these changes would you support? Why?

Workers Compensation Board and Insurance Corporation of British Columbia were instituted to deal with workers and automobile accidents on a no-fault basis. Would you be in support of a similar way of dealing with medical injuries?

Now, I would like to ask you some general demographic questions?

Did you work outside your home prior to your injury?

What was your occupation

What was your income (before taxes, but after business expenses were deducted) before the injury?

What was your total household income at the time of the injury?

What was your total household income after the injury?

Do you work outside your home now?

What is your occupation?

What is your present income?

What is the highest level of education that you have completed?

What year were you born?

What languages do you speak or understand?

What is your ethnic or racial background?

What was the ethnic or racial background of your doctor?

Are you living in a married or equivalent relationship?

Do you have any other comments to add on to any of my questions? Did I miss anything?

## Appendix 2

SIMON FRASER UNIVERSITY

INTRODUCTION TO THE STUDY  
(Please read before signing the consent form)

### Title of Project:

"In Their Own Words" The Effect of Medical Negligence Litigation on Women Receiving Health Care: The Case of Obstetrics and Gynaecology.

### Description of Project:

Much has been written on medical negligence, however, very little is based on empirical studies. Of the studies conducted, most concentrate on the financial and legal aspects of negligence litigation. The issues addressed generally relate to factors such as the raising cost of liability insurance for doctors, the size of awards and the effects of the medical malpractice litigation on medical practitioners. Consequently, the focus is generally on the practitioners or the insurance companies rather than individuals who have suffered harm. Further, a concern with the rising cost of malpractice litigation led several countries to implement, or are implementing reform. These reforms are justified on the basis that not enough people who are injured receive compensation under the current system. Despite the rationale for these reforms, no effort is made to include the point of view of the injured patient. It is important therefore that patients who have suffered injury get a chance to make their voices heard.

This research is interested in the experiences of women who have suffered injury/harm resulting from obstetrical/gynaecological medical care. The research will solicit information on women's experience with regard to (1) the actual harm experienced, (either to self or to child) (2) experience with the legal system in pursuit of litigation (3) satisfaction/dissatisfaction with the outcome of the litigation (4) the effects of the litigation on ability to receive care at present, (5) the effects the harm has had on other aspects of family life and current standard of living and (6) opinion on the proposed reforms. The research also seeks to find out what are the factors which determine the pursuit of litigation.

Your participation is voluntary and will remain confidential. If you choose to participate, it will involve:

1. filling out a consent form.
2. participating in an interview which solicits particular information about your injury, whether or not you pursued litigation, if so, your experience with the legal system (lawyers and the court system in general) your satisfaction/dissatisfaction with the outcome of the litigation, your opinion on the proposed reform and on the effects of the legal action on your current receipt of medical care.

SIMON FRASER UNIVERSITY

CONSENT BY RESPONDENTS TO PARTICIPATE IN A RESEARCH PROJECT

(Please read the "Introduction to the Study" prior to signing the consent form)

The University and the researcher conducting this project subscribe to the ethical conduct of research and to the protection at all times of the interest, comfort and safety of the respondents. The purpose of this research is to collect information on the experiences of women who have suffered injury/harm resulting from obstetrical/gynaecological care. The thesis will solicit information on women's experience with regard to (1) the actual harm experienced, (either to self or to child) (2) experience with the legal system in the pursuit of litigation, (3) satisfaction/dissatisfaction with the outcome of the litigation (4) the effects of the litigation on their ability to receive care at present, (5) the effects the harm has had on family life and current standard of living and (6) opinion on the proposed reforms. The research also seeks to find out what are the factors which determine the pursuit of litigation. The data collected in this research will form the basis for a Master of Arts Degree in the School of Criminology, Simon Fraser University.

I take part in this study voluntarily and with the understanding that I may withdraw my participation at any time. I hereby agree to participate in this research under the following terms:

- I agree that the researchers may quote me by name when publishing the results of their research or
- I request that the researchers identify me by respondent number only, so as to maintain my anonymity.

Respondent's Name: \_\_\_\_\_ Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_

If you should have any questions or would like the result of the study, the researcher (Marlyn Jones) can be contacted at the School of Criminology, Simon Fraser University, Burnaby, British Columbia, V5A 1S6

Professor Dany Lacombe (the researcher's supervisor) or Professor Neil Boyd, Director of the School of Criminology, Simon Fraser University, may be contacted should you have any questions or concerns beyond those which can be addressed by the researcher.

## **Appendix 3**

Sample Health Collective Questionnaire

## **READ THIS FIRST!**

The Health Practitioner file, located at the Health Collective, is made up of completed copies of the following questionnaire. It is a way for women to share information about their experiences with health care practitioners in and around Vancouver.

We would appreciate your helping us keep the directory up to date by taking time to complete a form for each health practitioner you have seen in the past year. Please complete both sides of the questionnaire.

We cannot use questionnaires that could be considered libelous. In other words, describe what the doctor/therapist did to justify a negative response from you. For example, rather than state "s/he acted like a jerk", describe what s/he did to make you feel that way. We would be happy to explain this further. Please ask someone in our Information Centre.

We value your opinions and your contribution to the directory is greatly appreciated.



**NAME OF HOSPITAL:**

**DATE**

**19**

**DOCTOR'S NAME:**

1. Did you feel in control of decision-making about your labour and during the birth of your baby? Were you consulted and given options as decisions came up?
  
2. Describe any arrangements you made with your doctor beforehand that were changed or made impossible due to hospital policy. Please include: labour and birthing positions, who and how many could attend the birth - were they welcomed?, etc.
  
3. Describe: (a) the admission procedures upon entering the hospital  
  
(b) rooms for labour, giving birth and post partum care
  
4. Did any medical or nursing students attend you and was your permission asked for them to be there? Please describe your experience with them:
  
5. a) Were you administered drugs?                      If yes, did you think they were necessary?  
  
b) Did the hospital staff encourage you or discourage you from using them?
  
6. a) Please circle any obstetrical procedures you underwent during your labour and birth.

x-ray shaving enema internal fetal monitor external fetal monitor repeated dilation checks intravenous for drugs/glucose labour induced by oxytocin rupture of amniotic sac epidural	pain relief drugs during labour nitrous oxide caesarian section episiotomy vacuum extraction forceps umbilical cord cut immediately antibiotic drops in baby's eyes vitamin K shot for baby circumcision other-
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6. b) Did you feel that any of these procedures were unnecessary and if so, which one(s)?
  
7. If your child was born via caesarian section:
  - (a) Was your coach allowed to be with you in the operating room?
  
  - (b) Were you given a choice of anesthetics?
  
  - (c) Were you encouraged to hold the baby after the birth?
  
8. Were you separated from your baby after the birth?  
If so, why and for how long?
  
9. If you chose to breast-feed:
  - (a) Did the hospital staff give informed, practical support?
  
  - (b) Was your baby given glucose water and/or formula in the nursery?  
With your consent?
  
10. Describe provisions and times for visiting hours.
  
11. If you chose to leave the hospital early, did you experience any difficulty doing so?
  
12. Overall was your birth a positive experience in this environment? If not, what could have made your experience more positive?
  
13. Other comments:





Vancouver Women's Health Collective  
219-1675 West 8th Avenue  
Vancouver, BC V6J 1V2

### Health Practitioner Questionnaire

PRACTITIONER'S NAME:	SEX:
ADDRESS:	TELEPHONE:
TYPE: (gp, gynecologist, homeopath, chiropractor, massage therapist, etc.)	
DATE:	19

1. Approximately how many times have you seen this practitioner?
2. Can you explain briefly what you have seen her/him for?
3. Did s/he take a thorough medical history?
4. Did s/he do a thorough medical exam if applicable?
5. If prescribing drugs or x-rays, does s/he explain the effects and dangers involved?
6. Describe briefly how this practitioner has been during an exam consultation or treatment, (gentle, rough, relaxed, rushed, cold, warm, etc.)
7. Was the practitioner open to a thorough discussion of your health problems, answering questions and discussing options for treatments?
8. Did s/he spend an adequate amount of time with you or did you feel rushed?

9. Does s/he stress preventive care such as pap tests, breast self-exam, nutrition, vitamins, exercise, etc.?

10. Does s/he suggest non-drug treatments such as massage, physiotherapy, acupuncture, etc.?

11. Is s/he open to your suggestions about your health care?

12. Please give each description a yes or no response. The practitioner's attitude toward me was:

Understanding

Respectful

Took me seriously

Non-authoritarian

Supportive

Non-judgemental of my lifestyle

13. What did you like about this practitioner?

14. What did you not like about this practitioner?

15. Would you recommend her/him for any particular area of health care?

Please explain:

16. Further comments: