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MEDICINE AS PATRIARCHAL RELIGION

ABSTRACT. This article demonstrates, by use of specific theological paradigms, how medicine functions as religion. In doing so, medicine promotes anti-feminist beliefs, symbols, social memories, and churchly structures. The essay then examines the enhancement of women's health from a feminist philosophical perspective. It argues against fetishizing in health promotion to the extent that everything comes to be regarded as therapeutic. Medicine has advanced the ideology that life itself is a disease to be cured or, at best, prevented. Alternative ethics of health promotion could revise this tendency of regular medicine to appropriate all of life into the medical domain, advocating that all sorts of simple daily activities are profoundly therapeutic in some way. Rather, health must be viewed as the constant attempt to re-create a female environment that is Self-defined on the boundary of an environment that is man-made.

INTRODUCTION

Throughout history, both the art and function of medicine have been closely allied with the idea of the sacred and with religious practice and practitioners. Because medicine has articulated an empirical character and has undergone a process of outward secularization does not mean that it has ceased to operate on cultic, ritual, ecclesial, and theological levels. Ivan Illich has spoken most pointedly and most eloquently to the ritual nature of medicine. The purpose of this essay is to expand the notion of medicine as ritual to that of medicine as religion and demonstrate specifically how medicine as religion has promoted a certain set of beliefs, symbols, social memories, and an ecclesial structure of containment — a patriarchal church — that is centered on male myths, ministers, and ministrations.

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I will further maintain, in this essay, that the most negative political role of the medical system has been to expand its practice and theory on the bodies and minds of women. Women visit doctors almost twice as often as men for most types of medical care. Women shepherd children (and often husbands and other family members) to the doctor. More women than men are institutionalized for medical care in hospitals, as well as in psychiatric care units. Over 70% of the population in mental institutions is female, which also means that more women are drugged and in all forms of therapy. Over 70% of those undergoing electro-shock therapy are women, and more than 70% of those persons whose behavior is modified and controlled by therapy are women. Statistics on those who have undergone lobotomies or psychosurgery also give evidence of this trend.¹

Critical measuring of the medical care system is not new. For the most part, however, these critiques have focused on the politics of health care and its socio-economic implications. With each reproach that is given, a characteristically therapeutic answer is usually proposed to deal with the particular "illness" of the system. John Mc Knight has outlined six remedies which have been enlisted in the service of confronting such censure and of reforming the system: equal access to medical care; improving the quality of health care; meeting costs through various health plans; involving "health consumers"; increasing professional and public concern over ethical issues posed by high technology medicine; and emphasis upon preventive health care (McKnight, 1975).

Implicit in each of these answers are the assumptions that medical care is good for one's health and that when all people have this care available to them the state of the nation's health will improve. More important for the purposes of this essay, however, is that none of these reform remedies contends with *medicine as religion*, i.e., with the ability of medicine to grip people at ultimate levels of power and worth.² Examining medicine as religion also means that we must confront the "absurdity of shared beliefs" about just what medicine can and cannot do.

In doing this, the essay seeks to analyze the state of medicine from a different critical perspective in order to recognize a deeper level of control that medicine has exercised over women's lives in particular. In viewing medicine as religion, I go beyond religion's traditional identification with God, gods, or religious organizations. Medicine is religious in the sense that it raises questions of "ultimate concern" and meaning for women's lives, i.e., questions of bodily and spiritual

integrity. In the most basic etymological sense of *religion* as derived from its Latin root *religāre*, one meaning of which is *to tie* or *to link*, medicine makes claims to bring together fragmented female being. Whether the problem be gynecological, dietary, or even one of appearance calling for the wonders of plastic surgery, more women have come to depend upon medical science and technology to transcend themselves. Medicine has consistently made attempts to "improve" the biological female, offering her a new lease on life through such techniques as prophylactic hysterectomies, reconstructive breast surgery, and "love surgery".³ The technological fix has become the transcendental fix. What medicine ultimately offers is transcendence by technology. And it is women, for the most part, who seek such transcendence.

Specific theological paradigms are important for analyzing how medicine functions as patriarchal religion. I use the term *paradigm* in Thomas Kuhn's sense of a tradition conveyed through historical exemplars (Kuhn, 1970). In turn, this allows that tradition and its assumptions to be explored systematically. It should be noted, however, that traditions, and I include medicine here, are not necessarily self-conscious about certain of their paradigms and the language in which their methods, practices, and commitments are framed and replicate other traditions. Furthermore, these theological paradigms are meant to tease the reader's mind into recognizing that medicine functions as religion. Therefore, each of these paradigms is not fully expanded, as they would be in a more comprehensive treatment of this subject. Finally, it is not necessarily *wrong* that medicine functions on a religious level. What is wrong is that it claims *not* to do so, i.e., it purports to offer *scientific* truth and practice. It is the adequacy of medicine's scientific claim that I question in this essay. I do so by disclosing how scientific medicine actually functions as religion.

To begin I shall examine some general Christian paradigms, several of which are drawn from the Roman Catholic tradition, and then proceed to the Roman Catholic sacramental system. In selecting these particular paradigms and this religious tradition, the reader should not assume that they are all-inclusive, or that other religious traditions, as well as other paradigms within other Christian traditions, would not be useful in this analysis. But the Roman Catholic sacramental system is particularly instructive because medieval Catholicism in the West allied the male healer with the male sacred practitioner more consciously and visibly than in any other historical period.⁴

In Christian theology, *eschatology* has come to mean the doctrine of what is to be expected, that which would fulfill the future, that which is hoped for, or the goal of history. More specifically, images of the Kingdom of God, eternal life, and the Parousia are all associated with eschatological thinking. One way of examining the belief system that medicine has generated is to note that medical pronouncements often function as eschatological statements. For example, patriarchal medicine's eschatological vision includes, among its many assurances, that if more and more women get prenatal care sooner, our high infant mortality and maternal morbidity rate will decrease. In this way, doctors have focused attention away from iatrogenic or doctor-induced disease that effectively issues in poor obstetrical care — e.g., unnecessary Caesareans, fetal monitoring, induced labor, and debilitating drugs. Another example of the same eschatological thought is the medical claim that estrogen replacement therapy (ERT) will supposedly relieve menopausal women of everything from hot flashes to wrinkly skin. Even the recent evidence showing the link between estrogens and cancer has not done much to change over-prescribing of ERT. More generally, medical eschatology has promised that more and more money for medical research and technology will enable doctors to conquer the monster of cancer and maybe even death itself.

Another eschatological symbol in Christian theology is the *Kingdom of God*. In the New Testament, the basic function of this symbol was to affirm the belief that God reigns everywhere, in all aspects of personal and social life. If we view regular patriarchal medicine as the rule of the god Medicine, we note that gradually medicine has taken over more and more areas of living. Medicine tells us what to eat, what to feel, how to have sex and when to have it, to name but a few of its forays into previously non-medical areas of life. It has gradually become a catholic church, exercising a universal dominion over life. Like certain periods in Roman Catholic history, medicine has been sophisticated enough to assimilate disparate and even anti-medical movements under its wing. For example, it has co-opted some women's self-help techniques developed in feminist health clinics, such as menstrual extraction (originally and still used in women's health circles to control the flow and length of the menses), and now highlights the technique as an early abortion procedure.

Another powerful way in which both religion and medicine control existence is by their frequent use of *apocalyptic* images and

and warnings. In both Christian and Hebrew biblical literature, there is a certain amount of writing, later called apocalyptic, that describes an imminent personal and/or cosmic cataclysm. Apocalyptic visions usually accompany the failure of God's people to heed God's commands. They prophesy a ruinous end for people guilty of flagrant injustices. Many of the so-called prophetic books in the Hebrew Bible are filled with these apocalyptic symbols and visions of what would happen to a stubborn people whose wickedness was rampant. The people in turn were exhorted to recognize their folly, return to the path of righteousness, and regain favor with their God.

There is a steady stream of apocalypticism in much medical literature and in simple one-to-one doctor-patient contact. Many physicians have warned women of the *threat* of uterine cancer if they do not have hysterectomies. In more recent medical literature, this has become known as the "prophylactic hysterectomy." Imagine a prophylactic prostatectomy or penectomy! More generally, doctors warn of dire consequences if many types of surgery are not performed, if a prescription is not taken regularly, if patients do not follow orders, and do not have the right attitude toward their illness. Moreover, patriarchal medicine has generated the ethic that all sickness is potentially deadly. The slightest of ailments, indeed even the absence of illness as defined by medical conceptions of prevention, require a visit to the doctor. Where the need for constant check-ups is asserted, people become imbued with an almost moral duty to watch for any symptoms that might require clinical defense. Furthermore, untimely and premature death is pointed to as an example that someone did not call for medical assistance soon enough, and that the same might happen to any stubborn individual who does not tread the path of clinical righteousness.

Apocalyptic medicine transforms the concept of *sin* into *sickness*. Sin, in the Christian tradition, of course, is moral disequilibrium; — the state of being in an estranged condition from one's self, others, and God. There have been various types and degrees of sin in the Roman Catholic tradition, although the present and active theology connected with sin has changed in recent years. Original sin is a state into which everyone is born. It is the price one pays for entering the human community. Although original sin is removed by Baptism, its effects linger on in so-called propensities to evil (concupiscence). Therefore, the main struggle in life is represented as the struggle to overcome one's natural inclinations. In past years, there was also a

theology of mortal and venial sins, mortal sins being the most serious and venial sins being of a lesser order.

In the same way that sin is moral disequilibrium, sickness is physical disequilibrium, the state of being in an estranged condition from one's self and others. Within the history of medicine, sickness has been perceived as a result of moral turpitude. Still births, leprosy, as well as many types of physical blemishes were indicative of this correlation. Sinners, in early Christian times, were exhorted to repent of their sins in temporary isolation from the community. Likewise, those who are seriously ill, or who have contagious diseases, are often quarantined.

The medical parallel extends to the various types and degrees of sickness. Each of us begins life with original sickness in the sense that we are all born into a germ-laden world. It is the price we pay for being physically fallible beings in a world that is polluted. Instead of having natural propensities to evil, we contain within us thousands of microbes which, although harmless most of the time, may be potentially sickening or lethal, if activated in various ways. As Barbara Ehrenreich and Deirdre English have pointed out, women have been seen historically as the carriers of sin and the seducers of men. In the same way that the symbol of Eve represented the entrance of sin into the world, the symbol of Typhoid Mary represented the entrance of sickness into Victorian America (Ehrenreich and English, 1978, pp. 127-135). Furthermore, like sin, sickness also varies in kind and degree. Some germs, viruses, and bacteria are mortal, lethal, or death-inducing. Others are venial or amenable to treatment.

SACRAMENTAL MEDICINE

In the Roman Catholic tradition, there are seven *sacraments*. Since Vatican II, there has been a revision of the theology and ritual pertaining to several of these sacraments, most notably baptism, penance, and extreme unction. Reflective of a change in theology and ritual has been a change in the nomenclature of penance and extreme unction to the sacrament of reconciliation and the anointing of the sick. It is my contention, however, that even though the sacramental theology and ritual may have been revised in the last twenty years, the traditional sacramental paradigms that I use are still applicable to the way medicine functions in the lives of many women who use the medical system. Indeed I would maintain that

revisions in the theology and ritual of the sacramental system have had a negligible effect on the way the sacraments are perceived in the lives of most Roman Catholics.

Baptism, the first of the sacraments, has been classically defined as spiritual rebirth. As symbolized by the pouring of or immersing in water, baptism is the sacrament of purification and sanctification. It cleanses the newborn from original sin. One can view baptism in quite a different light, however, depending upon one's perspective; that is, as the process which the religious fathers used to take over the power of birthing. In baptism, however, men surpass mere natural childbirth since they see themselves as conferring spiritual life and raising the newborn to a higher level of existence. Physical birth, that done by women, becomes secondary.

There are many baptismal counterparts in modern obstetrics, gynecology, and genetic technology. The obstetrician is said to "deliver" the child, not the mother. He indeed slaps the child into existence, thus inducing it to breathe. The specializations of gynecology and obstetrics have consolidated male mothering by not only taking over the birthing process from biological mothers but from those women, in every culture and in every period, who have attended women in birth — the midwives. The outlawing of the American midwife at the turn of this century is an instructive lesson in the politics of male medical maneuvers and manipulation, and an eye-opener for those who continue to believe that the good doctors took over from the dirty midwives because of the progressive march of modern science and medicine (see Kobrin, 1966; Barker-Benfield, 1976; and Rich, 1976).

Confirmation is the sacrament which initiates the adolescent into Christian adulthood and maturity. The young person is confirmed in the church, renews the baptismal promises made for her at birth by godparents, and is reminded of her Christian responsibility and mission. The young adult, as she is viewed, is told that something different has now happened to her, and that she is a changed person. This transformation is symbolized by a blow on the cheek which the bishop gives her during the ceremony itself.

Confirmation has a specific medical counterpart for the adolescent girl. With the onset of menarche, usually at puberty, she is impressed with her advent into sexual and reproductive maturity. In some traditions, girls are slapped, either on the face or the buttocks, by their mothers. More important, the adolescent girl becomes a potential medical consumer because of her maturing female body. She will

visit the doctor more often than her male counterparts, due to her so-called reproductive organs and processes, and he will perhaps remind her, in a moralistic manner, of her sexual and reproductive responsibilities. Patriarchal medicine will reinforce the cultural socialization that a woman's biology is her destiny. Furthermore, gynecology as it is practiced, is medical care for heterosexual women. The traditional male gynecologist will stand (or sit) dumbfounded before a female client who tells him that she is a lesbian.

Holy Orders is the sacrament of ordination to the male priesthood. In other religious traditions, women have been admitted only recently and in suitable proportions. This sacrament ordains men to perform the sacred activities of the cult. It confers upon them the church's official license and sanction to cure souls and invests them with the authority to forgive sins. Only the bishop can ordain priests and transmit the priestly office to select men — those who have studied and prepared for such a calling.

Medicine has its own sacrament of initiation into its healing priesthood. There are certain educational requirements set up by the A.M.A., the collective bishop of the medical church.⁵ The classical version of the Hippocratic oath is a prime example of the priestly tradition of modern medicine. It represents medicine as a sacred calling and the doctor as the sacred recipient of mysterious, yet empirical, healing power. It contains an invocation to the gods, with the first god addressed being Apollo, the anti-matriarchal god. It contains a promise to transmit the healing art within certain limits, specifically to the sons of other doctors; a refusal to perform or encourage abortions; a promise of chastity which binds the physician to refrain from sexual relations with female or male clients; a vow of priestly confidentiality; and a hope that all men will honor the doctor.

As there is a sacrament for every life passage, there is one for death and dying. For a long time, *extreme unction* was only administered to persons who were in serious danger of dying. Now it is given to persons who are sick, not necessarily dying, and instead it is called the anointing of the sick. Its purpose is to remind the ill person of the church's power over sickness and death. In medieval times, and until fairly recently, the ceremony was attended by the sick person's relatives and friends. In a real sense, the priest acted as the *nuntius mortis*, the announcer of death, and his presence and activity symbolized that the appropriate time of death had come.

Extreme unction has its medical counterpart in the intensive care

unit of a modern hospital. Here the religious ceremonial of death is transformed into the technology of warding off death at all costs. Life-extension apparatus often becomes death-prolonging. The doctor transforms the past ceremonial of death into the last grandstand context of therapeutic pretensions — the one last technological hope of conquering death and of fulfilling medicine's ultimate eschatological vision. The death chamber loses its candles, closed drapes, family and friendship reunions, and above all, its honesty, and becomes a mechanistic, lonely, and antiseptic environment for deception about the imminent. The doctor, as Elisabeth Kübler-Ross has shown, is the first professional yet priestly healer who does not act as the *nuntius mortis* when death is near. More often than not, the doctor fails to tell the patient the truth.

Penance became the sacrament in which the repentant sinner had the guilt of sins committed after baptism blotted out through the absolution of the priest. If sickness is the modern counterpart to sin, the cure of bodies picks up where the cure of souls left off. Penance, now called the sacrament of reconciliation, readmits one back into the community of believers, when serious sin has put an individual in spiritual exile. It is one of the few sacraments that a person can receive more than once, because sin continues to be a reality in the life of even the best person. Therefore, sin continually needs to be forgiven. The sinner is kept returning for more forgiveness in the same way that persons who are sick are kept dependent on medicine for health. Self-help is not enough, in both cases, and the mediation of the priest or healer, the simple words of absolution or of an office visit, function as curative. In fact, the recent medicalized version of preventive medicine, as it has been incorporated into various pre-paid health plans and health maintenance organizations, could make persons patients every day of their lives. Preventive medicine, in this genre, keeps persons coming back for more and more check-ups, laboratory tests, shots, and prophylactic treatments precisely because it is based on the ethic that individuals are not able to recognize their own sicknesses. Such prevention calls for multitesting that encourages more persons to use the system more frequently. Yet, as recent medical articles have indicated, there is no demonstrable difference in health and/or longevity between those who have regular physicals, and take regular medicalized preventive measures, and those who don't.⁶ Moreover, the Yale University Health Plan advises its members to think seriously before having an annual physical check-up because of many physician-induced illnesses, such

as unnecessary and dangerous medications and operations, that have followed in the wake of the discovery of, for example, large tonsils, heart murmurs, slight elevation of blood pressure, etc.

Why, then, do patients return for annual preventive poking and probing? I think the medical counterpart to the sacrament of penance is most obvious in answering this question. As sinners become cleansed of their sin, patients receive the security of "a clean bill of health." Medical absolution thus becomes a spiritual and physical assurance of "a sound mind and a sound body." And further, patients believe in the ethic of medical prevention – i.e., that they need the medical system because they *do not* and *cannot* perceive their own needs.

An important factor in the traditional notion of penance was the contrite attitude of the sinner. There were two types of contrition, perfect and imperfect. Contrition signified the proper moral and religious attitude of persons toward their own sins and sin in general. It involved having the courage to fear God and face the truth about one's own fallible existence; the serious and active will to amend one's life (*metanoia* or conversion); the willingness to endure humbly the consequences of sin that remain even after sin has been forgiven; and the turning away from one's past by accepting the unshakeable validity of the divine deed in one's self.

An important part of any medical ritual is the instilling of a proper attitude toward one's health and/or disease. There must be a complete willingness to trust the doctor, to ask few if any questions, to be a good patient, to follow a physician's orders, and to endure the consequences of medical procedures, even when they are ineffective or damaging. In short, there must be no resistance to therapy, else the medical deed cannot take effect. Moreover, the recalcitrance of the patient is often blamed for the failure of the physician and the medicine he employs.

The outward and sacramental sign which made the traditional sacrament of penance valid was the priest's absolution, the words of forgiveness which are pronounced orally. In medical practice it often happens that if the patient comes away empty-handed, with no prescription or other tangible token of possible alleviation from the doctor, the visit seems worthless because there is no outward sign of the medical deed. Drugs are thus medical absolution, and women have been its most frequent recipients, very commonly in the form of tranquilizers. Another version of medical absolution is the verbal therapy a physician gives, especially when he thinks the

illness or claimed disorder to be psychogenic. The medical literature on menstrual cramps, menopause, pregnancy, as well as the drug ads for tranquilizers and other pharmaceuticals, give ample testimony to the medical perception that women's complaints are very often psychological.

Oral therapy leads naturally into a discussion of the sacrament of the *holy eucharist*. The eucharist became the sacrament in which Jesus gave his body and blood, as food and drink, under the appearances of bread and wine. When Jesus announced originally that he would do this, many of his followers turned, away, repulsed at the notion of spiritual cannibalism (John 6: 52-66). Finally, in the sacrament of the eucharist, the high priest, Jesus, also is the victim.

In medicine, it is hardly the high priest, the physician, who becomes the victim. Very often, it is the patient. As Jesus gave his body and blood, voluntarily, to be consumed under the appearances of bread and wine, the patient, "voluntarily," gives her body and blood (literally — no transubstantiation here) to be consumed by the surgeon's scalpel. But the involuntary result is that often medicine cuts out flesh and blood for no healthy reason. In the realms of hysterectomies and breast surgery, *prophylactic* and *reconstructive* have become accepted and sound medical reasons for warranting surgery. Radical mastectomies have been performed, on a grand scale, when less radical or other forms of treatment would achieve the same results. Unnecessary surgery is proliferating, especially in the area of unnecessary hysterectomies. In 1975, and again in 1978, a House of Representatives panel found that if the scalpels of American surgeons remain so active, nearly half the women in this country will have undergone hysterectomies by the time they are seventy. Surgery on women remains a graphic type of medical cannibalism with the woman as victim whose sacrificial status does not entitle her, as it did Jesus, to the role of Christological or Messianic figure.

The last of the seven sacraments is *matrimony*. Here, one man and one woman commit themselves to each other for life, with the blessing of the church to engage in sexual intercourse, for the primary aim of propagating the human race. Thus the erotic element is always allied with the reproductive aspect of marriage in the Roman Catholic tradition, as is shown by the traditional ban on birth control.

Christian matrimony, of course, is strictly heterosexual, and any committed erotic union between members of the same sex is strictly

forbidden. Yet the religious priesthood is a prime example of a male homosexual or homo-relational union. The church sanctions the "marriage" of man to man in spiritual brotherhood under the appearance of celibate brotherhood. The medical fraternity has historically been another example of a male homo-relational union. Looking closer at this latter fraternity, we see that women comprise more than 75% of all hospital workers but have always been on the lowest rungs of the medical hierarchical ladder. As in the religious priesthood of non-Roman Catholic traditions, women have only recently been admitted into some medical schools in suitable proportions.⁷ Those women who progress into practice are found mostly in the so-called feminine specialties of pediatrics and psychiatry. Neurosurgery, the apex of surgical status, remains an almost exclusive male club.

Clearly, what we observe here is no outright promotion of male homosexuality because, as Andrea Dworkin has noted: "Male homosexuality in male-supremacist societies has always been contained and controlled by men as a class, though the strategies of containment have differed, to protect men from rape by other men, to order male sexuality so that it is, with reference to males, predictable and safe" (Dworkin, 1981). While visibly promoting heterosexual ideals and institutionalizing these in family practice, gynecology, obstetrics, and psychiatry, what is really being legitimated is, in the words of Mary Daly, "male power bonding, while the erotic component in male mating [is] concealed and denied." (Daly, 1978)

It was the *church* which instituted the seven sacraments, and thus it is appropriate that I end this paradigmatic excursus by discussing medicine as church, i.e., as a structure of containment for the symbols, rituals, and activities that it generates. The general notion of church in the Roman Catholic tradition is a hierarchical one: Pope, cardinals, bishops, priests, nuns, and the faithful who are ministered unto. Although the word *catholic* means universal, the church has historically seen itself as an exclusive remnant of the "chosen people." The Reformation doctrine of church shifted from this hierarchical and exclusive notion to a conception of the church as the "priesthood of all believers." All were encouraged to participate in the spiritual Protestant community, and the distinctions between the minister and the congregation were, in various traditions, consciously minimized.

The traditional organization of the medical church is based more on the Roman Catholic model. Medicine has a clearly delineated

hierarchy with physicians on top and gradations of other health workers, mostly women, in lower echelons. Until very recently, and still in some circles, medicine excluded many groups from treatment – those who couldn't pay, or those who had little faith in the medical model. Recently, there has been some shifting to the Protestant ideal of the church. Efforts to broaden the medical base have included paraprofessionals, yet always under doctor control, as well as the recent emphasis on medical care as "everyone's right," incarnated in such proposals as National Health Insurance.

One of the theological debates that raged in the history of the Roman Catholic church centered on the doctrine that "outside the church there is no salvation." This saying emphasized the nature of the church as one, holy, true, and visible, outside of which believers maintained that it was difficult to be saved. Various qualifications were made, such as the notions of baptism by blood and baptism by desire, yet the orthodox emphasis still held sway.

Medicine has its own doctrine of "outside the church there is no salvation." Transformed, the medical doctrine might be phrased as outside regular, orthodox, licensed medicine, there is no healing. Historically, unorthodox practitioners such as midwives, chiropractors, and others were branded as quacks and dangerous. Medical schools that trained mostly women and minorities were defined as irregular and closed down in the late 19th and early 20th centuries because the force of the orthodox doctrine was supported by the political and economic clout of the emerging specialties, and by the Flexner Report and its backers. Today, lay midwives, who may have assisted in hundreds of births and apprenticed to other skilled midwives, can be arrested. The women's self-help movement, a nation-wide development in women's health circles, must be constantly wary of accusations of practicing medicine without a license. A woman who applies yogurt to another woman's yeast infection, for example, can be held technically liable for this "offense." Lay midwives have been arrested in Santa Cruz, California, and women's self-help centers have been searched and seized by legal authorities. In both cases, local medical pressure instigated the legal action. In the face of such medical orthodoxy and political and economic pressure, it is remarkable that during the last decade, a nation-wide women's health movement has burgeoned. Much of the health care that is rendered here is testimony to the efficacy of unorthodox healing. Outside the medical church, therefore, there continues to be much healing.

A FEMINIST PERSPECTIVE OF HEALTH

It has been a persistent theme of this essay that medicine may have little to do with health. After making this criticism in various ways, throughout this writing, I want to conclude by discussing a feminist perspective of health. I have been explicit about critiquing medicine as patriarchal religion not because it is wrong that medicine often functions in a religious manner, but because medicine purports not to do so and, further, is based on male supremacist theology, ritual, and practice. It is appropriate, then, that my own vision of women's health finally relies on theological factors.

The World Health Organization, among others, has attempted a comprehensive definition of health. According to the WHO, health is "A state of complete physical and mental and social well-being and not merely the absence of disease or infirmity." This definition, especially the factor of social well-being, needs to be placed in a feminist context to see what promotes women's health.

In any consideration of what enhances health, social and environmental dimensions are important. I am not saying that health has no physical base, but that the physical base is always surrounded by events external to the individual. Thus it is imperative to ask how healthy are the social milieus and environments of most women? How do most women live their lives? Another way of phrasing this question, from a different vantage point, is to what do most women adapt?

René Dubos and others have seen adaptation as a significant indicator of health:

The concept of perfect and positive health is a utopian creation of the mind. It cannot become reality because man will never be so perfectly adapted to his environment that his life will not involve struggles, failures, and sufferings . . . The less pleasant reality is that in an ever-changing world each period and each type of civilization will continue to have its burden of disease created by the unavoidable failure of adaptation to the new environment (Dubos, 1965, p. 346).

Because Dubos is using adaptation in a restricted sense here, he can define health as maximum adaptability to the unavoidable course of disease. Anyone seeking a more expansive definition of health must view adaptation in a wider sense. I would argue that Dubos and other adaptationists, in their restricted use of this concept, overlook in their emphasis on *man* adapting, that *woman* over-adapts.

As failure to adapt is disease-producing and not healthy, so too

is over-adaptation. Woman adapts to a self and a world she never created. Simone de Beauvoir's description of woman as "The Other," existing through man's fabrication of her, is re-phrased by Agnes Varda in her film, 'One Sings, the Other Doesn't' – i.e., women are made, not born. Initially, then, women adapt to femininity or man-made construction of female behavior, roles, and life choices. A host of adaptations follow: channeling energy and creativity to others (mainly men) and away from the self; learning indirect discourse; assuming the body language of an inferior; wearing immobile and constraining clothing, such as shoes and dress, designed to outline the feminine figure and please men; cosmeticizing the face and other parts of the body; assuming the burden and "side effects" of birth control, to name but a few of the numerous ways in which women adapt.

Pat Hynes, a writer and environmental engineer, has pointed out other aspects of female adaptation by comparing conditions of women under patriarchy with those of natural ecosystems under the stress of extreme pollution. She notes that polluted or stressed environments are identified by their low species and occupational diversity.

Now imagine a graph of the number of women in various occupations: large numbers of women are concentrated in few occupations: housewife, secretary, and service professions. In other words, women may be characterized by low occupational diversity (Hynes, 1980).

Hynes cites Howard Odum, a noted ecologist, who states: "When ecological systems must adapt their function and organs to survive in conditions which are physically severe for life . . . energy is required for the process of adaptation and less energy remains to support complex network specializations" (Odum, 1971). Many feminist scholars have reported the stress that women have undergone, and the energy women have exhausted, in merely surviving. The burden of survival, for many women, has not allowed time or creative energy for the pursuit of complex cultural activity. As Virginia Woolf noted, women have not even had "a room of one's own." What is remarkable is that women have created, in all periods and in all cultures, as much as we have, under conditions that undermine our life and health.

Statistics bear out, for example, that:

– Two thirds of the world's illiterates are women (United Nations, 1980a).

– 42% of women heading families in the U.S. have incomes below

the poverty level in the United States (U.S. Department of Labor, Bureau of Labor Statistics, July 1980).

– Women earn 59.4% of what men earn (U.S. Department of Commerce, 1980).

– Women are vastly more underemployed than men. In addition, the effects of “longterm cumulative processes of discrimination” are apparent in the world profile of women. While women represent over 50% of the world adult population and one third of the official labor force, women perform for nearly 2/3 of all working hours and receive only 1/10 of the world income. Women also own less than 1% of world property.

– Every seven minutes, a woman in the United States is raped (U.S. Department of Justice, 1980).

– Every 18 seconds, a woman is battered (Moore, 1979).

Yet there are many women who managed to create and to do great things, in spite of these conditions or other constraints that were put upon their creativity: the Brontës, Zora Neale Hurston, Marie Curie, Helen Keller, and the multitude of unsung women whose ideas and work were “incorporated” into the creations of their husbands, brothers, or male colleagues.

To return to the central point, women have adapted to environments that are unhealthy. It is, of course, nothing new to say that environmental factors are a major health determinant. One must be clear, however, that environment in this essay means much more than ecologists or environmentalists currently define it. Environment is more than clean air, clean water, and the like. It defines the whole personal and social environment in which a woman lives, including clean air, water, proper nutrition, light, and sleep – but, more expansively, it also includes economic independence, ability to make choices, motivation and opportunities to choose, and friendship, among others. In other words, *health is the constant process to recreate a female environment that is Self-defined,⁸ on the boundary of an environment that has been man-made.* The first imperative for female health is mythic, in the sense that women must reverse our patriarchal creation myth and live Self-defined lives. This is not a mere individual act. It is a political reality. And it is a spiritual reality. It is not creation *ex nihilo*. For it happens in the midst of pre-existent man-made chaos when women rediscover an integrity that was ours to begin with, and which centuries of patriarchal force, brutality, and conformity to man-made femininity have eroded (Raymond, 1979).

There is a further sense, however, in which the definition of health listed above is actually the definition of a *good life*. Only secondarily is it a definition of health. The point I wish to make here is crucial.

A persistent message in this article has been the omnipresence of medicalization. By the same token, I have both a philosophical and functional concern about shifting from a medical services approach, which has emphasized the treatment and prevention of disease, to a *health promotion* approach which emphasizes the extra-medical context. Health promotion, instead of leading to the medicalization of life, may encourage the "healthicization" of life. In this view, everything could become health-promoting or therapeutic.

My point is this. Medicine has advanced the ideology that life is a disease that has to be cured or, at best, prevented. Health promotion could revise this, advocating that all sorts of daily activities are therapeutic rather than just simple daily pursuits. Jogging is healthy, but only secondarily. In a primary sense. Jogging is jogging. It is an activity in its own right. Only secondarily does it promote health. Granted, many persons may jog primarily to keep fit, i.e., to stay healthy, but this fact does not change the nature of jogging itself. The point is not trivial nor a mere semantic distinction. It indicates a philosophical and functional concern about the extent to which not only medicine, but health promotion, could encourage therapy as a way of life.

Thus, in offering the expanded definition of health above, I am trying to point out that a good life is conducive to good health, not suggest that all of life and life's activities are therapeutic. Any woman who has learned karate, who has lifted weights, who has gone beyond the diet of expected physical exercise served to women, for example, in the feminine health and figure salons, knows the revelatory power of such activities for both the body and the spirit and the climate they create for *living* differently. When these activities are contained under the headings of health activities, they misname the deeper reality and limit female transcendence. Rather, the definition of a good life and the possibilities of female transcendence contain the definition of a woman's health.

I am concerned with women's health, but I am more concerned that health not become the final statement, the conclusive and comprehensive category for female existence, living in the world, and lively activities. First things first. Health is not the central question. It is *a* question, and an important one, when it is seen

in the context of the total environment of woman-defined living. Nothing less is at stake than a new creation.

NOTES

¹ Statistics on persons in mental health facilities are indexed in the 'Reference Tables on Patients in Mental Health Facilities,' U.S. Department of Health, Education, and Welfare (now the Department of Health and Human Services). These are published yearly and diagnostic classifications are referenced by sex. For psychosurgery statistics, see the *Congressional Record*, February 24, 1972.

² I do not wish to engage in debate about calling medicine a religion. Others might wish to argue that the religious dimensions of medicine, as I have explicated them in this essay, are also the proper domain of psychology or anthropology, as well as other fields. I would not deny this and, further, I am not asserting that religion can be separated from other aspects of living. No definition of religion can state the necessary and sufficient conditions that neatly distinguish it from other areas.

³ "Love surgery" is the creation of Dr. James Burt, an Ohio gynecologist. He has devised, through this procedure, his own version of the female orgasm through vaginal reconstruction surgery, which he also calls "Female Coital Area Reconstruction" or "Surgery of Love." In Burt's schema, the ideal candidate for surgery is a heterosexual woman who climaxes easily when her clitoris is stimulated but who rarely achieves orgasm through penile-vaginal intercourse. Basically his surgery is designed to bring the vaginal area closer to the clitoris by relocating the vagina. The angle of vaginal access having been changed, the penis would supposedly stimulate the clitoris during heterosexual intercourse. For marketing purposes, he has branded his product as the 'Mark II Vagina.' The clitoris and labia minora are pulled completely inside the vagina, and the clitoris has been circumcised or its hood cut back to further increase stimulation by the penis. Burt claims to have performed the operation on 4,000 women over the past twelve years. He has recently opened up a clinic in Ohio which will service many more patients.

⁴ Furthermore, the alliance between medieval Catholicism and medicine and, later, between Reformation Protestantism and medicine, was achieved over the tortured and dead bodies of millions of women. During the Inquisition, the majority of women burned as witches were healers. The inquisitors reserved their greatest wrath for the witch-midwife. As Barbara Ehrenreich and Deirdre English have found, the wise woman, or witch, as the authorities named her, possessed much empirical healing knowledge as well as a whole pharmacopoeia. Moreover, she had years of what would now be referred to as clinical experience. In contrast, the university-trained physician spent his years studying theology and philosophy, with his medical study being limited to the works of Galen. Even before the witch hunts began, the male medical profession made a concerted effort to eliminate the female healer. During the 14th century, especially,

the more literate women healers, who had received some unspecified training in medicine, were being fought against by university-trained physicians. Their crime, as well as that of their more poverty-stricken sisters, was to cure without the blessing of the church and without having studied. The prohibition against female healers can be found in the *Malleus Maleficarum*, literally *The Witch's Hammer*, which was the witch-hunting manual authored by the Dominicans, Sprenger and Kramer, and used by the inquisitors. Ehrenreich and English note:

The witch trials established the male physician on a moral and intellectual plane vastly above the female healer. It placed him on the side of God and Law, . . . while it placed her on the side of darkness, evil, and magic. The witch hunts prefigured — with dramatic intensity — the clash between male doctors and female healers in nineteenth-century America. (See Ehrenreich and English, 1978, especially pp. 29–35.)

⁵ Educational authority is, of course, shared by the American Association of Medical Colleges and specialty boards. However, there is, most often, enormous overlap in the membership of these groups with that of the AMA.

⁶ For a readable summary of medical articles and studies documenting the insignificance of regular physical exams and other medicalized preventive measures, see Richard Spark, M.D., 'The case against regular physicals', *The New York Times Magazine*, July 25, 1976, pp. 10–11; 38–41. Spark is associate clinical professor of Medicine at Harvard Medical School and Beth Israel Hospital in Boston.

⁷ Until recently, the more prestigious medical schools such as Harvard took in even fewer women.

⁸ I use Mary Daly's device of capitalizing *Self* here to distinguish between the man-made feminine self, the 'imposed/internalized false 'self'' of women, and the authentic Self which women are beginning to re-create (Daly, 1981).

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