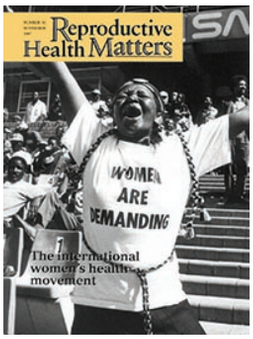

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Beyond The Yellow Wallpaper

Ann Oakley

This paper, first presented at a conference in 1983, challenges the myth that health is a medical product and that the inequalities between men and women are easily removed. It analyses the differences between health, health care and medical care in the context of 'women and health', and of women as providers as well as users of these. Using the lessons of a short story by Charlotte Perkins Gilman called 'The Yellow Wallpaper', the paper identifies and discusses the three most important unsolved problems of women and health as: production, reproduction and the medicalisation of the psychological costs of women's situation in the form of mental illness. Next, it calls for recognition of health as a social product and for women to tell the truth about our own experiences, because these determine women's health. Lastly, the paper shows how women's health-giving role in reproduction and in ensuring family welfare holds the causes of women's ill-health within it, and calls for a world in which women who ask for change are taken seriously.

THE very idea of a conference on 'Women and Health' challenges two central myths of the industrialized world in the twentieth century. The first of these two myths is the one that says health is a medical product, that a state of health in individuals and societies is brought about principally through the efforts of members of the medical profession: illness is prevented or cured and death avoided through the beneficence of medical science. The second myth is that inequalities between men and women are surface blemishes only, and may be removed merely by cosmetic attention to the superstructure of social relations: all we need is a few good laws and minor social changes and women will be able to look men in the eyes as equals.

These myths are powerful organizing ideas in what is commonly, if misleadingly, referred to as 'the developed world'. The enormously important rôle in our cultural thinking and social policy of the myths challenged by the phrase 'women and health' makes this conference even more important. It is a radical departure for two national and international organizations concerned with health issues first of all to pay serious attention to women's role in health care; second, to confront directly the social, economic and political context of health – and, third, to do both at the same time.

In order to set the scene for this discussion, it is perhaps useful to run through some of the main issues to be tackled under the heading 'Women and Health'. From a global perspective, what burning questions need to be asked and answered about women as users and providers of health care? Next, what are the implications for women of the differences between these two conceptualizations: health as a medical product and health as a social product? Finally, I will look at the implications for health-care systems of the differences between the two conceptualizations of women: the 'equal rights' view of women on the one hand, and on the other the rather more disturbing notion of women's oppression.

Women and health: the main questions

Before producing a shopping list of burning questions, we need to make a basic distinction among three terms: health, health care and medical care. The last is the easiest to define: medical care is that provided by a medical professional, with the aim of treating or preventing illness. Health care need not be provided by a medical professional, but can be an activity of non-medical, non-professional groups and even of individuals themselves. Health, as by far the most complex of the three terms, need not have anything to do either with health care or with medical care, and here I am, of course, referring to that substantial body of evidence demonstrating that changes in broad indicators of the health of communities are rarely

brought about by changes in the provision of medical care. Although this type of evidence is limited by the indicators of health chosen (since the most oft-used indicator of health is death – which is more than strange, when you think about it), it does point in the direction of a certain definition of health which is relevant for us at this conference. The definition is that health requires, or is impossible without, a moral basis of good social relations.

The reason why we need a conference on women and health is because women are the major social providers of health and health care, and they are also the principal users of health and medical care services. In these two ways, the truth of the matter negates the dominant cultural message. The dominant cultural message is that doctors, not women, ensure health and that men, not women, are biologically the more vulnerable sex, with a mortality and physical morbidity record exceeding that of women from the cradle to the grave.[1] There is therefore something acutely paradoxical about women's relationship to health and health care which needs to be unravelled.

Women as providers of health, health care and medical care

As providers of health and health care, women are important through their role in the division of labour. In their domestic lives, they provide health care by attending to the physical needs of those with whom they live. They obtain food, provide and dispose of the remains of meals, clean the home, buy or make and wash and repair clothing, and take personal care of those who are too young or too old, or too sick or too busy to take care of their own physical needs. These activities are known as housework, a somewhat peculiar term, since most of the work done has nothing to do with houses, but a great deal to do with maintaining the health and vitality of individuals. Incidentally, or perhaps not so incidentally, it is a matter of great importance to policy-makers as to how this health-promoting work of women is described. Mostly it is described in terms of an ideology which attributes to women a feminine altruism that many would prefer to have recognized as unpaid labour.

To call women's household health work by the name of 'housework' is to ignore an extremely important aspect of the domestic division of labour, and that is women's role as the chief managers of personal relations both inside and outside the family. Emotional support promotes health: there is good evidence that a person's social relationships or lack of them are crucial influences on physical and mental functioning. As family welfare workers – as mothers, mothers-in-law, wives, housewives, sisters and daughters, and often neighbours as well – women take care of personal relations.

The impact of industrial economic development, although commonly seen in terms of the work-home division, also had this other effect: that personal relationships were equated with 'the family', and women were seen as responsible for them. 'The family' – increasingly the nuclear family of parents and children, with its incorporated division of labour – became the paradigm for all female-male relationships, for the division of all labour. Thus, also, before the modern industrial era, the domestic health care provided by women extended beyond the home and out into the community. Women were recognized as the main potential healers for the bulk of the population; hence such terms as 'wise woman' and 'old wives' tale'; and hence the traditional role of midwives purveying a set of skills derived not from formal training but from personal practical experience. With the rise of professionalized medicine, many of women's traditional healing activities acquired a new definition as dangerous to health, if not actually illegal. This did not necessarily put an end to them, since, fortunately, women have almost always been strong enough to put up some resistance to the imposition of the state's power. It is because the subculture of women's healing and midwifery was never entirely eliminated by the combined misogyny of state and medical profession that, in a research project which we are doing in WHO, we are finding the existence of 'alternative services' for maternal and child health in most countries – a coming-out-into-the-open of an old tradition spurred on by the unresolvable dilemmas for women of the health-is-a-medical-product idea.[2]

Even within official health-care systems, women remain extremely important as providers of care. To take Britain as an example, some three-quarters of workers in the National Health Service are women. However, only about 20 per

cent of British doctors are women: there is a division of labour by gender in professionalized health care, just as there is in every other sphere of social life. As doctors, as midwives and as nurses, women health-care providers in Britain and most other so-called developed countries are concentrated in the lower-status grades of health services. For example, while only some 11 per cent of British hospital nurses are male, a disproportionate 23 per cent of senior posts within the hospital nursing service are held by men.[3] When we look at the division by gender of specialities within medicine, we not surprisingly learn that women specialize in areas to do with children, mental illness, microbiology (perhaps a form of housework carried into the hospital setting?) and putting people to sleep, otherwise known as anaesthetics.[4] This pattern is not a reflection simply of choice, for research into medical careers has revealed much more dissatisfaction with existing career opportunities among female than among male doctors.[5] Individual women may struggle against the prescribed pattern, but a collective effort is needed to alter it.

There are many important questions here about the future role of women as health-care and medical-care providers. The two which I would like to single out as the most deserving of our attention are, first, the family health and welfare work of women; and second, female midwifery – women's work as managers of normal childbearing. Both family welfare and midwifery work are areas in which the rights of women are especially threatened today. In the family welfare domain, they are threatened because in most ways and in most countries the necessity to the economy and prevailing moral order of women's so-called labour of love has never been eroded by a recognition of their rights as individuals. With regard to the management of childbearing, and although most of the world's babies are still delivered by midwives, recent technological growth in obstetrics has eroded the independence of the midwife's role, and indeed promises to extinguish it altogether in the future. For women as a class, this, I believe, is more than a marginal retrogressive development, since, if allowed to proceed unimpeded, it will engulf motherhood in a masculine medical structure whose ideologies will, on the whole, project a different definition of health from that held by mothers themselves.

Women as users of health and medical care

'The Yellow Wallpaper': fact as fiction

Before moving on to some of the important questions to be addressed in women's use of health services, I want to go back in time to a story written nearly 100 years ago by the American feminist Charlotte Perkins Gilman. The story is called 'The Yellow Wallpaper',[6] and it illustrates the historical and cross-cultural continuity marking the unsolved problems of women and health. It also highlights three of the most central of these – those relating to production, reproduction and the medicalization, in the form of mental illness, of the psychological costs of women's situation.

'The Yellow Wallpaper' describes three months in the life of a New England woman diagnosed by her husband, a physician, as suffering from nervous depression following the birth of her first child. The physician rents a house for the summer and confines his wife to bed in a large room on the top floor, a room with yellow wallpaper. He prescribes total rest for her, and expressly forbids her to do any work in the form of writing, her chosen occupation. The story describes the progression of the invalid's feelings locked up in that room; it is an account at the same time (and depending on how you look at it) of an escape into madness and a discovery of sanity. The woman becomes increasingly obsessed with the yellow wallpaper since, deprived of companionship, exercise and any intellectual stimulation, she has nothing else to do but look at the walls. Finally, she becomes convinced that there is a woman in there behind the yellow wallpaper waiting to get out, a woman who creeps around the house and garden only by moonlight when no one will see her. So, on their last day in the house, in an act of frenzy, she strips all the paper off the walls in order to let this other woman out, in order to free her once and for all from her prison. Her husband comes home, discovers what she has done, and faints with shock – a most undoctorly reaction – and thus apparently ends the story.

So, in 'The Yellow Wallpaper' we have the following moral lessons: don't put women with postnatal depression into solitary confinement; and avoid yellow wallpaper if possible. Actually, I think that the real moral is the one summed up in

that dictum of the American writer Tillie Olsen: 'Every woman who writes is a survivor',[7] which translated into everyday language, means that what is good for women's health is involvement in productive activity, involvement in, not withdrawal from, society. There is also a message in 'The Yellow Wallpaper' about reproduction. This is a complex message which runs as follows: childbearing, women's special biological and social contribution, may be either a source of weakness or a source of strength. Which it is depends less on the woman herself than on the social and medical context in which pregnancy, childbirth and childrearing take place. But I suppose the most profound message in 'The Yellow Wallpaper' (remember it was written nearly 100 years ago) is the one about how women's problems are constantly individualized: it is the individual woman who has the problem, and, even if many individual women have the same problem, the explanation of a defective psychology rather than that of a defective social structure is usually preferred. Here we are up against not only individualization but also medicalization. The medicalization of unhappiness as depression is one of the great disasters of the twentieth century, and it is a disaster that has had, and still has, a very big impact on women.

Some twenty or so years after 'The Yellow Wallpaper' came out, Gilman published a note about it in which she admitted that the story came directly from her own experience.[8] She observed that at the age of 27, married and the mother of a two-year old, and having felt unhappy for some time, she had visited in 1887 a noted specialist in nervous diseases who put her to bed and prescribed a fate much like that of the woman in the story. The eminent man told her never to touch pen, brush or pencil again as long as she lived. She followed his advice for three months and then, on the verge of what she felt to be total insanity, and with the help of a woman friend, she left her husband, moved to California and established a writing career for herself. She sent a copy of 'The Yellow Wallpaper' to the specialist in question, and, although he did not acknowledge receipt of it at the time, she learnt many years later that he had publicly said that not only had he read the story, but he had also altered his treatment of nervous depression in women after reading it. I think we may be justified in concluding that there is something intrinsically valid about personal experience and that, in coming clean about their own perspectives on health and illness, women may actually bring about the beginning of a change in those who hold powerful alternative views.

Women and production

The first of the three burning issues which I mentioned under the heading of women and health services is women's economic role, their participation in production.

Whenever we discuss women's employment, we have the sense of being caught up in a circular, historical, but also timeless, debate: is women's employment a good thing or a bad thing; should women/wives/mothers work, or not? What is the effect of employment on health, both physical and mental; or, indeed, what is the effect of women's health and illness on employment? These questions cannot be given general answers. But we can easily note some important features about the employment of women. According to that oft-quoted United Nations Report, women perform two-thirds of the world's work hours, receive one-tenth of the world's income and own less than one-hundredth of the world's property. Thus, whatever else work may be, it is a dead end in the business sense for women – a bad deal. In undeveloped countries, the reality behind the myth of the male hunter-provider has always been the woman hunter-gatherer supporting her family through her own autonomous agricultural work. Once the process of urban industrial development sets in, what seems to happen is that women remain locked in the subsistence economy, while men become involved in the cash economy of the cities, and from then on the road is downwards, according to the rule that women's labour earns them less.[9] In industrialized countries today, women earn some 30 to 40 per cent less than men, and it matters not a great deal from this point of view whether the country is capitalist or socialist in character – the same kind of earning gap exists.[10] This is because most political structures ignore the politics of gender, or tend to pay lip-service to the idea of gender equality by passing a few weak laws referring to the illegality of certain forms of sex discrimination, or exhort women already overburdened with domestic work to enter the paid labour force for their own good,

when they are not really talking about women's own good at all.

The paradox of working more and earning less than men derives from the double meaning of work for women: working inside the home for love and outside it for money; maintaining the health of families through housework and by earning a wage. In Britain and other industrialized nations, it now requires two incomes to maintain a family at the same standard of living provided by one income 20 years ago,[11] and many employed women are the sole breadwinners for their children or elderly parents. The notion that most of women's employment is accounted for by married women working for pin money or purely to escape the worst excesses of captivity in the home never had any real basis. It was a self-perpetuating myth rooted in the postwar sexism of social science, whose investigators found what the dominant mood of the culture told them to find, namely an apparently harmonious acceptance of the inequality model of family life. The idea of the family wage earned by a male breadwinner, with women's income as a luxury extra, is still the basis of many countries' tax, national insurance and social security systems – even though it has always been based on a fictionalized and therefore unreal middle-class view of the world. Further, the family wage presupposes an equal division of income inside the family. But the reality is income rarely divided so that women get their due share: women (and children) may well be in poverty when men are not.[12]

The relationship between the division of labour inside the family and division of labour outside it has provided much fuel for theoretical debate. Which is the cause of which, and is it women's role in production within a capitalist economy that condemns them to relative disadvantage, or is it their role in reproduction within a patriarchal family that explains this continuing discrimination? We see everywhere the interconnections between the two divisions of labour, and nowhere better than in the statistics of part-time employment, which the American sociologist Alice Rossi described many years ago as this century's panacea for the problems of women's disadvantaged social position. A part-time job individualized the problem by seeming to index a state of personal liberation while actually very often representing further exploitation. In Britain, some 40 per cent of employed women work in part-time employment, an increase of 28 per cent since 1956. Part-time employment is a large factor in the low status and low pay of women's work. Women are concentrated not only in a small number of occupations but also in those in which both male and female workers tend to be poorly paid and poorly unionized. There is also homeworking, working for pay at home, a 'solution' 'chosen' by increasing numbers of women and frequently carried out under appallingly unhealthy conditions.

A paid job may not signal liberation, but in the modern world it is an important basis for self-identity and self-esteem. The money which it brings in is important, and so is the kind of involvement in social relationships provided by it. That is the plus side, and supporting data come from various groups of studies on factors correlated with work satisfaction, on social factors in depression, and stress and employment. On the negative side, there is the interesting, but as yet unproven, suggestion that if women adopt male employment patterns they will lose the edge that they have over men in life expectancy and in cancer and heart-disease mortality – a kind of moral penalty for liberation, a reworking of the old Victorian idea that God will punish any woman who unsexes herself by doing anything except sitting or lying still with a blank mind and even blanker smile on her face.

We do not, of course, have any idea what would happen to men if they assumed women's typical double burden of unpaid domestic and poorly-paid non-domestic work. Perhaps they would die less often, or perhaps their health would suffer through their not having been socialized to the role. Since domestic accidents are a leading cause of death among young and middle-aged adults, if men tried their hands at women's juggling act there would certainly be some shift in causes of death. It is an interesting reflection of the cultural trivialization of housework that, when we think of fatal accidents, we think classically of the dramatic motorway collision, whereas the kitchen, seemingly a most innocuous place, is the place that ought to come to mind, the place that we all must try to avoid if we do not wish to die in an accident.

Of the less fatal and more chronically painful effects of housework we know very little for a

similar reason – that the overlap of housework and family life has underestimated the power of what happens in the home to shape life and death and public events. It is simply not the case that only the really momentous historical events and processes take place in the public arena; this alternative truth being, of course, implicitly, if dishonestly, recognized by patriarchy in the enormous preoccupation that has grown up over the last 100 years with the impact of mothers on children's health. Mothers have been held responsible for everything bad and everything good about children, a conflating of female power that, significantly, men have hardly created a protest about. As mothers create children's personalities, so they also create adult personalities in such a manner that all conformity to, and deviance from, social norms has been laid at women's door, from homosexuality to schizophrenia, from the stuff of which the Yorkshire Ripper or American Presidents are made, to His Holiness the Pope – yes, even the Pope had a mother. This cultural fixation on mothers' ability to mould children's health and character has not been matched by any corresponding degree of concern with the impact of children on women's health. Indeed, the three questions of whether housework is good for women's health, whether motherhood is good for women's health and whether marriage is good for women's health are three very basic questions to which we can only give partial answers because the assumption that domesticity promotes health in women has been an obstacle to serious research for a long time.

Women and reproduction

The place of childbearing in women's lives, like the competing claims of patriarchy and capitalism as controlling structures, has been a theme of debate for feminists. Whether childbearing is good or bad for women's health of course cannot be answered without paying attention to the exact historical context in which it occurs; it is one thing to talk about maternity in Europe or North America 50 years ago or the Third World today, where maternal deaths due to childbearing were/are one or more for every 250 babies born, and another to discuss it in a context where death is rare – so rare, fortunately, that epidemiologists have been heard to mutter under their breath that they will have to find some other way than counting deaths to measure health. However, to speak of the risks to physical health and survival of pregnancy and childbirth, one must remember the contribution of induced abortion, contraception and sterilization. These aspects of women's health care (or lack of it) have tended to make childbearing itself safer, but carry their own risks of death which need to be computed in order to obtain a complete picture of the impact of reproduction on the health of women.[13]

Having babies and trying not to have babies makes women sicker than men in terms of use of hospital and other medical services. But here the question arises as to whether the management of childbearing itself has fallen under a medical rubric because there is something genuinely sickening about the process of having a baby, or for some other reason. In short, whose idea was it to treat having a baby as an illness, and was it a good idea? Taking the second part of the question first, there is no doubt that the rise of modern obstetric care has been accompanied by a fall in the mortalities of childbearing, but (as is usual with such issues) there is little evidence on which to hang the belief that medical maternity care was what did it. This point was made, some years ago, by a British epidemiologist who observed that, whereas perinatal mortality had declined as the proportion of hospital deliveries had risen, the figures could be alternatively presented to show that childbirth became safer the shorter the length of time mothers stayed in hospital after the birth.[14]

The extent of medical surveillance over pregnancy and birth is virtually 100 per cent in most industrialized countries today – that is, all women attend for prenatal care, and, in addition, the majority give birth in hospital. The extent of medical intervention in childbirth has risen exponentially over the last twenty years. In some European countries, operative deliveries are now in excess of 20 per cent. The evidence as to the benefits of individual obstetric technologies such as ultrasound scanning, other prenatal screening tests, instrumental or Caesarean delivery, induction of labour, etc., is equivocal, and an unexplained factor about obstetric technology policies is the enormous variation that exists between countries, between regions within countries, and even between hospitals and individual practitioners within the same

region. This is a variation far greater than any 'biological' variation between different populations of women having babies.

Most of all, perhaps, we cannot answer from the available data three questions about reproduction and women's health. The first question is: what would have happened to the health of mothers and babies had the obstetric technology explosion not taken place? Might survival and health, for example, have been even better than it presently is? The second question is: what will be the long-term effect on women and children of this level of use of technology in childbearing? Some consequences of a high level of technology are already making themselves felt: for instance, Caesarean section rates rise geometrically as one Caesarean delivery becomes the reason for another in a woman's subsequent pregnancy. The third question, which cannot be answered so easily by an appeal to perinatal epidemiology (even an appeal to an appropriate perinatal epidemiology), is: what does it do to women to have their babies gestated and born so very much within such a closed structure of medical surveillance? It is hard to feel in control of one's body and one's destiny during 16 trips to the hospital antenatal clinic for the ritual laying-on of hands by a succession of different doctors, none of them especially trained in the art of talking to the faces beyond the abdomens, or in the science of knowing about the interaction between mind and body, the connection between peace of mind and a competent cervix, or between emotional confidence and a coordinated uterus.

What we see involved here are issues of control and responsibility that come up again and again in looking at women's health. Who is in control of the process – of having a baby, of being ill, of determining the relative balance between housework and employment work? Who is responsible for the outcome of any choice that is made, and is it really a choice? At the present time, it is not often women who are in control of matters affecting their own health, and this situation arises not only through the overall medicalization of life – a process which, after all, affects men too – but also through the infantilization of women as incapable of taking responsibility for themselves. Pregnant women are especially seen as being incapable of taking responsible decisions on behalf of themselves and their fetuses. What this conference is about is someone's resistance to the patronizing, professionalized health care formula that women cannot take responsibility for their own health and illness. It is, indeed, a paradox that, although women's lives are all about providing health for others, as users of formal health care services, custom decrees that they be no more than patient patients.

Turning to motherhood, we see this paradox written large. Infantilized in pregnancy, and delivered of their babies by others, women as mothers are liable to discover that the devotion of the state to the necessity of reproduction is too often a devotion in name only. Whenever the demand for out-of-home child care among mothers is surveyed, it is found to be many times greater than its supply. Time-budget studies of the division of labour in the home are not convincing on the topic of men's willingness to share child care, and insofar as men seem to be doing more for children than they were, they have chosen the more pleasurable aspects of child care – playing with the baby rather than changing its dirty nappy, or playing with the baby so that mother can get the dinner ready. If more active fathering along these lines is good for health, the question remains as to whose health it is good for.

So, there is a contradiction here at the heart of women's situation: women are both irresponsible and they have too much responsibility. They cannot make decisions and have to make all of them. In the privacy of the home, and as mothers, women are powerful, but in public they are not, for always there is a relationship between power and responsibility. You cannot have power without responsibility, and the taking of responsibility brings power; this is why it is essential for women to resist the arbitration by anyone else on their behalf of their responsibilities in both health and health care.

Medicalization of women's distress

The last of the three issues which I extracted from the story of 'The Yellow Wallpaper' was the issue of the medical labelling of women's distress as mental illness.

Although women are physically healthier than men, it appears that they make up for this superiority by a certain mental instability. That is, when one looks at psychiatric admission to hospital and at prescriptions for psychotropic

drugs, women predominate over men. Hidden biases in the data are possible; thus it may be that unhappy or mentally ill men are more likely to be cared for by women at home than vice versa and/or that the more help-seeking behaviour of women as against that of men leads them more readily to take their unhappiness to doctors. However, it does seem that when men and women present essentially the same symptoms to GPs, the women are more likely to receive a psychiatric diagnosis.[15] A clue to this mystery is provided by a study of doctor's attitudes to patients carried out in this country in the 1970s. In this study, doctors were asked to say which types of patients caused them the most and least trouble. The least troublesome type of patient was defined as male, intelligent, employed and middle-class, with specific, easily treatable organic illness. The most troublesome patient was female, not employed, working-class, described vaguely as 'inadequate', and possessing diffuse symptoms of psychiatric illness that were difficult or impossible to diagnose and treat.[16]

What this suggests to me is that a psychiatric or pseudo-psychiatric diagnosis is most likely to be dragged in when men are unable to understand the problems that women have. It is not accidental that the two main biological events placing women beyond men's understanding, namely menstruation and childbirth, have both generated psychiatric diagnoses in the form, respectively, of premenstrual tension and postpartum depression. Since menstruation and childbirth are liable to make women ill, and all women menstruate and over 90 per cent of them give birth, the chances are that quite a lot of us will be out of action at any one time. The attribution to women as a class of mental instability is obviously highly consequential, since it affects one's claim to be a responsible person. Historically speaking, the evolution of these diagnoses of women's distress has gone hand-in-hand with a continuing cultural prejudice against the ability of women to hold responsible public positions.

The Catch 22 here is that, while the concepts of premenstrual tension and postpartum depression may have a particular meaning within medical discourse and in terms of the structures affecting women's health, some women do have problems in the lead-up to menstruation, and some do feel especially distressed after childbirth.[17] How do we recognize the subjective validity of the problem without enclosing it in a terminology that inhibits political insight? How do we name it in such a way that we remain interested not only in what the problem is but also in how it might be caused and in what might be done to prevent it on a social and not purely individual level?

Health as a social product

In an essay on 'Professions for Women', written in 1931,[18] Virginia Woolf described two particular obstacles which she found had to be overcome in learning to be a writer. Although she was talking about writing, I think that what she said is important for all women. Woolf described first of all a phantom with whom she had to battle in her writing. She called the phantom after the heroine of a famous poem, 'The Angel in the House'. The Angel in the House was the ideal woman – intensely sympathetic, immensely charming, very domesticated, completely unselfish: 'if there was chicken she took the leg, if there was a draught she sat in it – in short she was so constituted that she never had a mind or a wish of her own'. This spectre of womanhood plucked the heart out of Woolf's writing, drained it of all strength, prevented her writing what she wanted to write. Many women recognize the same problem in themselves today. It is all too easy to hide behind the defence of femininity and to mask behind a facade of smiling and commendable altruism our own refusal to take ourselves seriously. The second obstacle which Woolf confronted concerned something of even more obvious relevance to this conference, and that is the problem of telling the truth about the experience of one's own body. As a novelist, Woolf felt that she had not beaten this problem, that no woman yet had, that the weight of convention, of male power and masculine history, was against such truth-telling.

Recognizing that health is a social product is a first task confronting women, as is to tell the truth about our own experience. Our own experiences determine our health; they do so whether or not they are experiences which put us directly in contact with professional medical care, and whether or not professional medical care is able to provide any form of treatment which will make us feel better.

Not telling the truth about our experiences is equivalent to lying about them, and the social significance of lying is, as the American writer Adrienne Rich[19] reminds us, that it makes the world appear much simpler and also bleaker than it really is. Lying takes away the possibility of honour between human beings, and the possibility of growth and change. It destroys trust and contorts history.

Another challenge following from an acceptance of health as socially determined is that women take a wider degree of responsibility for their own health and health care decision-making in the future, even if this means in part taking such responsibility away from medical professionals. In a way, this is already happening with the growth of the self-help movement in health care. What comes under the heading of self-help is, however, a mixed bag. Some of it is fairly accepting of the conventional division of labour; for example, branches of the consumer movement in maternity care present themselves in terms of a defence of natural childbirth that sounds awfully like the Angel in the House; they may even worship charismatic male heroes along well-established angelic lines. But, on the other hand, other self-help groups could hardly be a more direct threat to the status quo, for example the early self-help gynaecology groups in the USA which led to women being placed under police surveillance because they had looked up their vaginas, an official response whose bizarre nature is perhaps only fully clear when one considers under what circumstances men might be subject to police surveillance for looking at their penises.[20]

Health care and oppression

Finally, I want to say something about what it means for the health care system to recognize that women are not simply prone to suffer from the last vestiges of an unequal social relationship with men, but in fact constitute an oppressed social group.

Most modern medical care systems, whether financed on a state or private insurance basis, have not succeeded in distributing medical care equitably throughout the population. Class, ethnic and gender oppression are all political facts affecting health and illness and medical care. However, the oppression of women is unique among the three forms of oppression, in that women's function as guardians of the nation's health forms the central core of their oppression. Women's role in reproduction, their role as unpaid family welfare workers, the personal emotional support that they provide for men and children – these activities, which are indistinguishable from the fact of being a woman in our culture, may also be said to encapsulate, to hold within them, the causes of women's ill-health. For example, a high proportion of physical problems in women (including maternity) are due to their habit of having sexual relations with men. I am thinking here not only of rape and marital violence, but also of diseases such as cancer of the cervix, which are apparently associated not only with women's own sexual history, but also with the sexual proclivities of the men with whom they live.[21] But most of all I return once again to the ghost of the Angel in the House. The emotional, political and financial *dependency* of women's family welfare role is perhaps their – our – greatest disablement today. In being carriers of our society's unsolved problems of dependency in human relationships – how to love one another without giving up one's autonomy as an individual – in carrying this cultural dilemma, women are not helped even to articulate, let alone put forward for serious consideration, their own interests.

When I said that health depends upon a moral basis of good social relations, I meant that it is attempting the impossible to pursue health in a society in which one social group is systematically at a disadvantage in relation to another. It is attempting to erect a healthy community on the basis of unhealthy, that is exploitative, human relations. Whether the exploitation is rationalized, maintained and mystified in the name of love – the phantom Angel in the House of Woolf's essay – is, in a sense, neither here nor there. In contemporary industrialized cultures, female babies are not exactly thrown away, as they were in the past, but there is a painful metaphorical throwing-away of women still. While this continues to be condoned, there will be no radical change. And not condoning it means combatting the processes which I have been discussing: the medicalization of women's distress; the individualization of their problems; the infantilization of women. An isolated, unhappy child is not a

political threat to anyone. But the political energy of a socially involved adult prepared to accept conflict and contradiction as a part of life is, on the other hand, enormous.

These issues possibly matter more now than they have ever done. Economic recession combined with the cash and confidence crisis of western medicine make 'women' and 'health' key words. Not all that women have gained in emancipation this century, but a good part of it, is threatened by new talk of bolstering the family, of a need to shore up the haven of community care for those who cannot care for themselves (what is community care but the work of women?) and of a need to take another look at the social costs of liberating women. All the traditional answers are the cheapest ones – of course. It is cheaper to edge women out of the paid labour force and traditional to say that nurturing others comes best to women. But we cannot say that these solutions are what women want, or what is good for the health of women. At the same time as the old answers are heard again, there is a growing and healthy recognition on the part of government of the need to curb the power of professionals to control people's lives. This offers a route even within conservative political dogmas to changing the traditional relationship between women and health care.

None of the tasks ahead of us are easy, and all of them demand confrontation of the conflict endemic in social relations between people and professionals, women and men. In the end, everyone has a stake in moving towards a more humane society where health and illness are not split off from the rest of experience, in which bodies are seen as connected to the environment, and minds and emotions are understood to shape the way in which bodies function; everyone also has a stake in appreciating the limits of science, and in understanding the new technologies of our brave new world. What we want is a brave new world, not a defunct, dispirited and depressing old one. What we want is a world in which women who ask for change are taken seriously.

Note

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References and Notes

1. For a summary of the evidence see Oakley A, 1981. *Subject Women*. Martin Robertson, Oxford, chapter 3.
2. Houd S, Oakley A, 1983. Alternative perinatal services in the European region and North America: a pilot survey. WHO, Copenhagen, unpublished.
3. Macguire J, 1960. Nursing: none is held in higher esteem. *Careers of Professional Women*. Silverstone R, Ward A (eds). Croom Helm, London.
4. Hospital Medical Staff, England and Wales, National Tables, 30 September 1977. Department of Health and Social Security, Statistics and Research Division, February 1978.
5. Elston MA, 1960. Medicine: half our future doctors? *Careers of Professional Women*. Silverstone R, Ward A (eds). Croom Helm, London.
6. Gilman CP, 1902. The Yellow Wallpaper. *The New England Magazine*. Reprinted in *The Charlotte Perkins Gilman Reader: The Yellow Wallpaper and Other Fiction*. Women's Press, London, 1981.
7. Olsen T, 1980. *Silences*. Virago, London.
8. Gilman CP, 1923. Why I wrote 'The Yellow Wallpaper'. *The Forerunner*. October. Reprinted in *The Charlotte Perkins Gilman Reader: The Yellow Wallpaper and Other Fiction*. Women's Press, London, 1981.
9. Boulding E, 1977. *Women in the Twentieth Century World*. Sage Publications, New York.
10. Chiplin B, Sloane PJ, 1982. *Tackling Discrimination at the Workplace*. Cambridge University Press, Cambridge.
11. Hamill L, 1978. *Wives as Sole and Joint Breadwinners*. Government Economic Service Working Papers No. 13. HMSO, London.
12. Land H, 1980. The family wage. *Feminist Review*. 6:55-77.
13. Beral V, 1979. Reproductive mortality. *British Medical Journal*. (15 September):632-34.
14. Cochrane A, 1971. *Effectiveness and Efficiency*. Nuffield Provincial Hospitals Trust, p. 64.
15. Shepherd M, Cooper B, Brown AC et al, 1966. *Psychiatric Illness in General Practice*. Oxford University Press, London.
16. Stimson GV, 1976. GPs, 'trouble' and types of patient. Stacey M, (ed). *The Sociology of the National Health Service*. Sociological Review Monographs 22, University of Keele, Staffordshire.

17. For a discussion of this dilemma in relation to premenstrual tension see Laws S,1983. The sexual politics of premenstrual tension. *Women's Studies International Forum*. 6:19-51.
18. Woolf V, Professions for women. Reprinted in Woolf V, 1979. *Women and Writing*. Women's Press, London.
19. Rich A, Women and honor: some notes on lying. *On Lies, Secrets, Silence*. Virago, London.
20. A point made by J Hirsch and cited in Ruzek SB, 1979. *The Women's Health Movement*. Praeger, New York, p. 58.
21. Robinson J, 1981. Cervical cancer: a feminist critique. *Times Health Supplement*. 5:16.

Résumé

Cet article s'attaque au mythe qui fait de la santé un produit de la médecine, et à celui selon lequel il est facile de supprimer les inégalités entre hommes et femmes. Il analyse la différence entre la santé, les soins de santé et les soins médicaux, en se plaçant dans le contexte "les femmes et la santé" et dans celui des "femmes dispensatrices et bénéficiaires de soins". S'appuyant sur les leçons d'une courte histoire de Charlotte Perkins Gilman, "The Yellow Wallpaper" (La tenture jaune), l'auteur définit et discute les trois grands problèmes non encore résolus concernant les femmes et la santé, à savoir : la production, la reproduction et la médicalisation des coûts psychologiques de la situation des femmes sous la forme de maladie mentale. Elle demande ensuite à ce que la santé soit reconnue comme un produit social, et à ce que les femmes parlent véridiquement de leurs expériences, car cellesci déterminent la santé des femmes. L'article montre enfin comment le rôle de dispensatrices de santé que jouent les femmes dans la reproduction aussi bien qu'en assurant le bien-être de la famille renferme en lui les causes de la mauvaise santé des femmes ; il appelle un monde qui prenne au sérieux les femmes quand elles veulent que les choses changent.

Resumen

Este artículo desafía los mitos que definen a la salud como un producto médico e indican que la desigualdad entre el hombre y la mujer puede ser fácilmente superada. En la monografía se analiza las diferencias en cuanto a salud, atención sanitaria y atención médica en el contexto de "la mujer y la salud", y de la mujer como proveedora y usuaria de esos servicios. Basado en el cuento de Charlotte Perkins Gilman, "The Yellow Wallpaper", el ensayo identifica y discute los tres problemas más importantes (aún sin resolver) vinculados a la mujer y la salud: producción, reproducción y medicalización del costo sicológico producto de la situación de la mujer traducido en enfermedades mentales. Una vez establecido este marco, la autora exhorta al reconocimiento de la salud como un problema social, y a que las mujeres hablemos con honestidad sobre nuestras experiencias, ya que las mismas son determinantes a nivel de nuestra propia salud. Por último, artículo señala que el papel de la mujer como proveedora de salud en el proceso reproductivo y en la protección del bienestar familiar genera, en sí, problemas de salud para la propia mujer. En tal sentido, el artículo exhorta a considerar con seriedad la exigencia de cambio expresada por las mujeres.