

**The Barnard Summit: Women and Health  
Panel One: Women's Health: A Current Assessment  
Barnard College, New York, NY  
Saturday, April 5, 2003**

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**JUDITH SHAPIRO:** To begin with, Barnard is celebrating the tenth anniversary of our innovative Well Woman Health Awareness Program, a signature program devoted to critical issues surrounding women's health. Many of our alumni peer educators in the Well Woman program have joined us today. Let me ask them to stand. Thank you. Looking ahead, on April 23<sup>rd</sup>, Glamour Magazine and Well Woman will sponsor a body celebration event promoting healthy eating and a sane, balanced look at how women view their own bodies. One of the speakers will be Betsy Lerner, author of "Food and Loathing," two words I myself have never been able to use in the same sentence. Other participants will include television actress Michaela Michalek and Cindi Leive, Glamour's Editor in Chief, and one of today's panelists. Before we continue, I'd like to thank our summit sponsors. First our corporate and foundation sponsors. Merck: Judy Luent (misspelled?), a member of our summit advisory board, deserves special thanks, and I'd like to acknowledge Leslie Hardy, Director of Corporate Communications at Merck, who is in our audience. Let me also thank Pfizer. Let's thank Merck first, very good. Let me also thank Pfizer, with our gratitude to Karen Catin (misspelled?), another member of our advisory board. And finally, the Bill and Melinda Gates Foundation, which has provided support for today's third panel, on global issues. Many thanks to our alumnus and panelist, Helen Gayle. I also want to thank our media sponsors, The New

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York Times, Glamour Magazine, and New York's public radio station WNYC, which gave away free tickets to two fortunate listeners. I should also note that Connecticut Public Television is taping the summit and plans to create a special program on women's health, to be distributed to public television stations nationwide next fall. The summit will also be available as a streaming video on the Kaiser Foundation health site on the web, and I would encourage you to visit our summit website in the coming weeks to view an interactive video report. In addition, I'd like to thank all members of the summit advisory board, whose names are in your program. Three Barnard alumni on the board are here with us today: Alexis Gelber, Nieca Goldberg, and Beth Seidenberg. I also want to acknowledge their presence and thank them very much for their fine work. And also, I would like to make special mention of our colleague, Alan Rosenfield, Dean of Columbia University's Mailman School of Public Health, for the fine ongoing work that he has been doing and his school. We are brought together today for the summit by our shared concern for women's health. At the same time, we recognize that we are convening at a time when our thoughts are very much focused on the war in Iraq, something that may affect many of us, not only as citizens but also more personally. In my case, I have a sister currently serving with an army medical reserve unit in Kuwait. It is important to note the role of women in military conflict, both

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as combatants and more often as civilian casualties. Most often, women and children become refugees in war time. The United Nations counts 10 million girls and women among refugees worldwide, whose lives and health are exposed to a variety of heightened risks. So let us keep those women in our minds as we proceed today, and let us also remember that even as events surrounding the war saturate our thoughts and feelings, there is other vital work that remains to be done in our country and in the world. Today's summit on women's health deals with an important part of that work. I think we would all agree that women's health care has improved dramatically in recent decades, due to medical advances in general, and also to a growing recognition that, to quote the title of a recent book by Dr. Nieca Goldberg, "Women Are Not Small Men," certainly not when it comes to health and illness. Men and women must both be part of a society's responsibility to serve its citizens in sickness and in health, to put it in terms of the traditional marriage vow. While we have seen great success in extending women's life expectancy, there remains seemingly intractable problems about access to health care here and around the globe. I would note the following. It is estimated that of the 515,000 women who die every year during pregnancy or childbirth, 99% of these deaths occur in the developing world. While Americans spend nearly 35 billion annually on weight loss products and programs, nearly half of all women of reproductive

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age in regions of Africa and South Asia continue to be undernourished. In countries like Japan, Australia, and Sweden, life expectancy for women is 83 years of age. For women in sub-Saharan Africa, it is 45 years of age. Diseases like HIV and AIDS have devastating impact and outcomes for women and their families all over the world. Today, 50% of those newly infected with HIV worldwide are women. AIDS has created more than 13 million orphans in Africa. Since 1950, lung cancer mortality rates for US women have increased an estimated 600%. At the same time, there are positive trends that need to be emphasized. Women are taking an increasingly active role as health care providers and decision makers. Nearly half of all medical school graduates in the US are women. And nearly two-thirds of women in the US are solely responsible for health care decisions within their families. So as you can tell, the topics are many and far reaching, and the ramifications loom large. In the course of the day, we will be fortunate upon the considerable expertise, intelligence, and commitment of our panelists, as we map the terrain and see where we go from here. Our first panel will analyze and assess current trends in women's health. The second panel, moderated by Lynn Sherr of ABC News, will address how women are fairing in our nation's medical research and health care systems. The third and concluding session, moderated by Soledad O'Brien of NBC News, will bring an

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international perspective to bear on women's health, especially in the developing world. So, let us begin.

[ VIDEO CLIP ]

**JUDITH SHAPIRO:** Well, let me introduce our panel and begin our conversation. On my far right, Joan Jacobs Brumberg, Professor of History, Human Development and Women's Studies at Cornell University, and the author of "Fasting Girls," a history of anorexia nervosa. Next to her, on her left, Faye Wattleton, President of the Center for the Advancement of Women. On my immediate right, Gina Kolata, Science and Medicine reporter for The New York Times, and author of the new book, "Ultimate Fitness: The Quest for Truth Exercise and Health." To my immediate left, Dr. Christina Beato, Principal Deputy Assistant Secretary for Health to the Secretary of Health and Human Services, Tommy Thompson. To her left, Dr. Marianne Legato, Professor of Clinical Medicine at Columbia University, author of "Eve's Rib," and founder of the Partnership for Gender-Specific Medicine. Dr. Legato has the additional distinction of being both a Barnard mother and a Barnard daughter. To her left, Cindi Leive, Editor in Chief of Glamour Magazine, and to her left, Dr. Judith Reichman, Obstetrician and Gynecologist, medical contributor for the Today Show, author, and Barnard alumnus. So perhaps I will open our conversation by turning to Dr. Legato, and asking her to say just a few things about the major changes she has seen

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in how we are addressing women's health, the major changes over the past decade or two.

**DR. MARIANNE LEGATO:** The major change in women's health has been our attention to women, which was fueled by a movement from the lay public itself. Women began, after World War II, to mount an ever more successful campaign for attention to their unique health needs. As a result, the Public Health Service, as it was then called, in 1985, issued, after a three-year survey of the landscape of what we were doing in medicine, opined that we knew next to nothing about women aside from what we called the bikini view, breast and reproductive health. The Congress, the National Institutes of Health, the FCA, and the whole academic medical establishment responded by insisting, along with women themselves, that we study women directly and no more assume that what we knew about men could be extrapolated without modification to women. The results has been a very exciting revolution, and as I've often said to my colleague, Dr. Vivian Pinn, who has been very important in focusing and moving this movement to study and learn more about women forward, the time has really come that women are making men an offer they can't refuse. The study of women and the comparisons of what we know about the differences between men and women is actually forcing us to form exciting new questions we would never otherwise have asked. Men are fond of saying, what more do women want? They already live six years longer

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than we do. My answer and the answer of all women should be, if we understood why, in spite of the disadvantages under which we labor, in terms of the allocation of resources and the roles we're asked to play, why we do survive for those six years, we might be able to extend that knowledge to you, so that you could be around to keep us company.

**JUDITH SHAPIRO:** Let's move from that into points that were alluded to in the video, namely the difference between our perception of major women's health and the real picture, going beyond this bikini view, not that those are not important issues. But perhaps Cindi Leive, who has occasion to hear from many women in many walks of life, in light of her work, what are some of the differences you've been seeing between perceptions of women's health issues and the things we're learning from the medical profession.

**CINDI LEIVE:** Well, I would echo what somebody, I believe, said on the video, which is that, to steal your term, Dr. Legato, women are increasingly concerned, not necessarily taking actions out there—increasingly concerned about bikini cancers. When we polled, for instance, 450 young women, women under 45, about what they thought they were most likely to die of, what were their greatest risks of death coming from, they said, first of all, breast cancer, and secondly, reproductive cancers. Now, it's certainly not a bad thing, in any way, shape, or form to be aware of those risks. But the reality is,

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for a reader of Glamour Magazine, a woman under 45, she is most likely to die either by, number one, automobile accident, or number two, heart disease. Those are two factors that really were not, when we polled readers, on their radar at all. Now, it's another question as to whether young women are actually taking action even on those cancers that they are concerned, and I'm not convinced that they are. But they are worried about them in a way that I think, in some sense, is actually keeping them from focusing in a more productive way on the health risks that they are likely to face at their age.

**JUDITH SHAPIRO:** Well, since you raised the issue of taking action and how women can have an impact on their health in a major way, let's talk a little bit about what kinds of changes there may have been in our lifestyles that are problematic, or not even changes, but things that—or persistent (unintelligible). Maybe Dr. Reichman would like to say just a word or two about that.

**DR. JUDITH REICHMAN:** I think one of the reasons that women are more concerned about reproductive cancers, as you call them, is cervical cancer. One of the reasons that younger women are concerned about reproductive cancers is we've been telling them about the huge increase in risk of human papilloma virus, which is sexually transmitted, and the correlation between human papilloma virus and cervical cancer. And somehow cervical cancer was something that wasn't really talked about

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because we've had the advent of the Pap smear for over 50 years now, and it has decreased the mortality from cervical cancer by 70 or 80 percent. So we all sort of took it for granted. When it turned out that we figured out why we need Pap smears and why we're getting cervical cancer, and that's from this virus, that there are between 30 and 50 strains of virus, depending who you talk to, in the genital areas, and we now feel that 70 percent of sexually active young adults have at least one of these viruses. So there is a tremendous epidemic going on, and when I counsel my patients, I say, well, you know, if you sleep with someone, you're sleeping with that person that they slept with, that they slept with, that they slept with, that they slept with, and it becomes logarithmic and very scary and condoms don't necessarily protect you a hundred percent. And these are the viruses that are causing cervical cancer. Cervical cancer is now considered a sexually transmitted disease. And hence, there's a scare because we are seeing more pickup of the HPVs and something called ascis (misspelled?), and then everyone's becoming hysterical. Oh my God, does that mean I need major procedures. And men come out--life is confusing, medicine is confusing, and when happens is you get a study, and that study is given out in the media, and you think this is the latest study, and it's just a piece in a huge patchwork of studies, and it may be important or it may not. But we now tell women, okay, get your Pap smear routinely. We

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finally educated them to go once a year. Well, guess what we've told them now? We've told them that you don't need a Pap smear or three years after you're sexually active, and after the age of 30 unless you are high risk and you smoke or you've had abnormal Pap smears or you're on steroids, and then you can just get it every two to three years. So there's a lot of confusion at there. But women know HPV. They know sexually transmitted diseases. They know Pap smears. And this is a concern, and it's sort of sexy concern.

**JUDITH SHAPIRO:** I think, though, (unintelligible) because we're going to go back to the issue of how people can become confused by the information that's out there on medical matters. But I know Joan Brumberg, who is an historian, may possibly want to say something on the issue of sexually transmitted diseases that have to do with changes in sexual behavior over time.

**JOAN JACOBS BRUMBERG:** Well, you know, my perception, from an historian, is that we're dealing with some extraordinary life course changes for girls. In 1900, the typical adolescent girls menstruated at 15 or 16, and then married when she was a blushing virgin at 21 or 22. Today, our girls have their first periods earlier, their sexual debut earlier. All of this has enormous consequences for some of the problems that you all are dealing with. You know, our girls, we know now from recent studies that, while the age of first

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intercourse seems to be holding at about 15 or 16, there's some shocking information really about middle school girls and oral sex. I mean, that's a new kind of problem, caused both by a lack of education about the consequences of oral sex—they seem to think in some ways that it's okay, but we also know that it's coercive and involuntary in most cases. So, I guess, from an historian's perspective, it seems to me that you all, the clinicians, are dealing with a situation that I'll call a post-virginal age, since the hymen and virginity are no longer that important, and we are in a new world for younger girls who are sexually active, and we don't really have a new code of sexual ethics for them, which is something that, I think, is beyond the scope of this panel. I think the life course change is very interesting—earlier sexuality, and then a number of things like eating disorders continuing into later in the life course as well.

**JUDITH SHAPIRO:** Well, let's move on to the issue, then, of other lifestyle matters. Eating disorder. While you're speaking to us about sexually transmitted diseases, you might also say a word about that, since that's something that you have been a particular expert on.

**JOAN JACOBS BRUMBERG:** Right. Well, I mean, anorexia nervosa was named and identified in the 1870s, so we can't—you know, a lot of people are shocked that it existed before Twiggy. What we're dealing with now is not really an epidemic.

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Am I correct, those of you who are doctors? It doesn't meet that formal criterion, but at the same time we have this strange kind of morbid obesity in kids, and then we have eating disorders that seem to holding their own in terms of numbers. And I'm not an expert on eating disorders. I only write about them historically, I don't treat people. But I think the really interesting thing is the extension to a new age group—women in their '40s and '50s. Again, I think it points to the relevance of cultural context to disease.

**JUDITH SHAPIRO:** I don't know whether any of our other panelists want to comment on this particular health issue.

**FEMALE VOICE:** I would just like to ask you if you believe that it's a significant problem in boys as well as in girls.

**JOAN JACOBS BRUMBERG:** Well, again, I'm not a clinician, but what I read in the literature is that it's a growing problem in boys as compared to girls. And my explanation again--because I'm not a doctor, I'm a cultural historian--would be that it has to do with the fact that we live in a culture where almost all of us want to believe that our bodies are perfectable. And medicine has offered us some extraordinarily wonderful new advances, but that also means that we can sculpt and replace parts and have plastic surgery. And I think boys are now, because of popular culture, just--perhaps not at risk in the same ways as girls, but they are at

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**FEMALE VOICE:** I think one of the great benefits of the gender-specific medicine is that we take our fascination with some diseases that we thought were exclusive to women and are now seeing that, in fact, we don't have an exclusive hold on those things, and that males are affected as well, so it works both ways.

**JUDITH SHAPIRO:** Well, there's a case that many women, mostly young women, but not exclusively young women, seem to have a greater fear of being fat than being dead. And insofar as smoking, which is related to many things, is also related to the desire to control weight, we might want to say something about that, and perhaps Faye Wattleton would like to speak about that issue.

**FAYE WATTLETON:** Well, I'm certainly not an expert about smoking and women, but I think that it is very interesting that we are starting to look at women's health in a broader context than just simply our reproductive health, which has been mode of the traditional focus. Another (unintelligible) surprise that Glamour Magazine found is that women were much more concerned about dying of sexually related diseases than they were of the real reasons, because they think that women's health has been highly politicized, and smoking is one area that we can (unintelligible) as now women being the focus of many of the campaigns of the tobacco industry, that

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young girls at an early age, are becoming addicted to nicotine before they're male counterparts. So I think that it really is in a larger political context that women's health must be viewed in terms of national policy, but also just simply in the activism of the women, that we have a focus on our reproductive organs that include the breast, to the exclusion of the issues that really do determine the health status and the quality of life of women's health.

**JUDITH SHAPIRO:** Dr. Beato, how do you see issues of where policy decisions need to be made or how policy should be focused going forward in a way that will make the most major difference for women's health?

**DR. CHRISTINA BEATO:** I think the panel has brought up a variety of issues, and I sort of want to go through a global perspective to more of the policy issue that we're doing. Indeed, there has been an incredible change, not just in the political society from the 1900s, but change also on issues of public health, with the clean water system, eradication of infectious diseases—all these things is what allowed our country to have women live just not in the '40s and '50s but as we had clean water systems going into our children and our homes, as we had antibiotics emerge, you know, we were able to control a lot of the infections that were killing us. In the '60s and '70s, we saw an incredible rate of increase in research, focused on cardiovascular issues, focused on

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(unintelligible). We then started taking body systems and focusing on it, mostly with a male perspective, to the exclusion that women were considered truly little men. When we were in medical school, the typical model is a 70-kilogram male. We based everything on the 70-kilogram male. And it's like the rest of us were sort of in the background somewhere. We've made incredible strides, and I think the key is women in medicine, women in health, women in research, women in policy. When we talk about smoking, most of kids that pick up smoking have parents that smoked at home. We set up role models for our children. Indeed, advertisement is geared towards the sliding image. However, in our country, over 60 percent of our adults are overweight. Over 30 percent of them are obese. Children today, 13 percent are considered obese.

(unintelligible) type 2 diabetes in children, which, when I was practicing as recently as five years ago, we used to call it adult onset diabetes. Now we can't use that anymore, because we have it in children, since we have the results of what's happening to our weight. Now why is that? Is it because for some reason, all of a sudden, genes popped up and said we're going to be fat? No. Simply because we're eating incredible amounts of food. They're easy, they're prepared. Super size comes cheap. Super size everything. What's happening to our children and our adults exercising? We're lucky we have people walk 20 or 30 minutes a day. Everything's automated,

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everything's electrical. Some schools at all don't have PE. Kids—what's attracting them? Computers. Play Stations, Game Boys. There's no tennis, there's no bike riding. Exercise, for all purposes, in children has diminished. So what we're looking at is behavior changes in policy. You're going to hear Secretary Tommy Thompson. Diabetes is the (unintelligible) we're using. Cardiovascular disease, we just did. The heart truth campaign was national. (unintelligible) Institute of the (unintelligible) event. Heart disease kills—heart disease and stroke—over half a million women in this country. And most people still think that breast cancer is the number one killer of women. It isn't, it's heart disease for all women. We're living longer. We're picking up on all the bad habits of the smoking, not exercising, overeating. And when you look at public policy, you always hear demographics. We're also, because we're living longer—our medicine's better than it ever has been. The (unintelligible) are better than they've ever been. Our demographics is increasing. More women are becoming older. They're presenting different challenges, Because obesity just doesn't affect heart and kidneys and eyes, it also affects joints. It also affects all kinds of different issues. And something that I haven't heard mentioned at all is the mental health component. Our brains equally are wired different than men. So as we focus on gender research, you can't focus on research unless you ask the right questions.

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And just like hormones affect breasts and estrogen affects reproductive issues, it also affects the brain. So we need to work women in a ballistic fashion, not just these components, and that's what we're doing. At a policy level, it's addressing the issue of prevention. Our society has been very much acute care and treatment. We're wonderful on treatment. We're lousy on prevention. So bringing in issues of public health, community medicine, and focusing on prevention is simple to (unintelligible). If you walk four to five times a week, 20 to 30 minutes a day, and you lose 10 to 15 pounds, your chances of getting diabetes are reduced by 60 percent.

**JUDITH SHAPIRO:** I think it is very important to note how difficult it is for us to really prioritize in the area of health and medicine, because we like to say you can't put a price on human life. And we will all follow a story of Siamese twins being separated at great expense. And massive resources do go into this kind of heroic medicine, when, if you really thought about it, a similar amount going into preventive medicine would certainly have an affect on health of all people, and most notably women and men. But part of that will also depend upon how the general public understands health issues, and that gets us into issues of communication and how the medical establishment communicates its results, but also how the media cover health issues. And I'd like to ask Gina Kolata to say a few things about that from her experience.

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**GINA KOLATA:** I wanted to talk about—I wanted to mention a couple of things. One of them is the perception of risk. I read an article. I can't remember the data, so I have to read the numbers to you. There are some people at Dartmouth who said people have this (unintelligible) perception of what women think they're going to die of breast cancer, they think they're going to die of cervical cancer. So they actually tried to put risks in terms of individual men and women. And they said--and this is kind of shocking because you probably never hear it presented this way—a 60-year-old woman who smokes has a 4.5 percent chance of dying of a heart attack in the next decade, a 6.5 percent chance of dying of lung cancer, and a 7/10 of 1 percent of dying of breast cancer. It's the kind of perspective that you almost don't hear. And then another way of looking at it is, for every 1,000 50-year-old women who are smokers, 45 will die of heart attacks, 65 of lung cancer, and 7 of breast cancer in the next 10 years. So I think that one of the things that I try to do, and I think some of my colleagues do too, we try your best to try to put these risks into perspective, but sometimes it seems like no matter—there are so many ways of describing them, that it's very hard to know what to make of it all. And one of the problems that we sometimes have is we're told, well, okay, here's what the studies show. Now make up your own mind. You decide what you want to do. This came up this year with mammography. There's a big debate

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in the medical community, which is continuing, over how much, if any, benefit you get in having regular mammograms. And I remember I spoke to a wonderful guy, Baron Merner at Columbia, who's an internist and an historian of medicine, and he said, I listen to one side, and I nod my head yes, and I listen to the other side, and I nod my head yes. And I don't know what the answer is. Well, then when you say to women, talk to your doctor and make up your own mind, I think that's kind of a very difficult message. And yet, I also think that it's not fair to people to say, let's just give them this simple answer, just go do it, and don't worry your little head about what the data say, because that's true of getting back into the old patronizing mode. So for us in the media, I think what I try to do is try to lay out the arguments and say anybody who reads these articles maybe can make up their own mind based on their own values. And then there's one last thing I wanted to mention about making up your own mind based on your own values, and that is what kind of a reaction will you get in your own—how will you feel if you think you made the wrong choice? And I'll give you an example once again from the Women's Health Initiative on Hormone Therapy. I was speaking to a gynecologist a couple of weeks ago about hormone therapy for menopause, and she said that she had a woman come in, and she was in her 50s, and she was taking hormone therapy. And this gynecologist said, Well, you know you ought to really try to

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get off of this because you shouldn't be taking this indefinitely. And the woman said, I'm sorry, I can't live without it. I just can't live without it. And so this gynecologist said, according to the Women's Health Initiative's most recent study, which caused a lot of uproar, a woman who takes these hormones for five years will have a 1 in 100, (unintelligible) chance of having breast cancer, a heart attack or a stroke, and usually not a deadly stroke but the kind of stroke that puts you in a wheelchair. So if you come into my office next year, and you couldn't live without these drugs, and you're in a wheelchair because you had a stroke, will you say, that's okay, because I couldn't live without them? So that's a very powerful, emotional argument. And the woman, as you probably would guess, said, Oh, I think I'm going to stop taking them. I mean, most of us would react that way. But you can think of it another way too, and you can think to yourself, am I a person who lives my life through regrets or not? Because you could also say to yourself, if I got a stroke next year, I will never know whether it was because of the hormones I was taking or whether I was due to get it anyway. And if you're the kind of person who says, I will never know that answer, and I will blame the stroke on something I did. Or with mammography, if you say, I'm going to take a chance. I'm not going to have a mammogram. And then if you have breast cancer, will you say, it's my own fault? Or will you say, I

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will never know what would have made a difference. I think it's that kind of a value. Everybody has a different way of approaching these things. Some people live their life through the regret of the path not taken. Other people say, I will never know, so I can't blame myself. And I think if you don't start asking questions like that, then just saying, let women make up their own mind or talk to their doctor is not going to be the answer, because the way this information is presented, like the way this gynecologist presented the data about hormones, has a powerful, emotional impact on the kind of decisions you make.

**JUDITH SHAPIRO:** Well, let's talk more gynecology.

**FEMALE VOICE:** (unintelligible) if you take hormones and you come back in a year, you have a one percent chance of either having a stroke, heart attack, or breast cancer. But what I would say to this patient, first of all, I mean I look at it even from a public health point of view. And in a country where 60 percent of women are overweight, 23 percent of women smoke, 45 percent of women over the age of 50 have abnormal limping, and 70 percent are sedentary, to start giving the panic that was given with the way that the media reported on the WHI study, that if you take estrogen something terrible's going to happen to you, when the absolute risk was less than one-tenth of one percent, I think was unfair to the women in this country, and I think it was presented in a

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totally incorrect manner, and I don't think women got the message. The same thing with mammography. Yes, it is a choice. But it's a choice that has been presented to women by various large agencies that really looked at the data, and again, there was one article that came out claiming, based on a Lancet article that had come out a year before, that not only was getting mammography not going to save your life, but women who got mammographies were more likely of all causes. And then when it was looked at by the various agencies, including those in the United States, it was felt that this was just picking at data, and it was really not a study, it was statisticians trying to report something, and they took away 80 percent of the evidence and said, we don't feel this is appropriate. And again, negative reporting in medicine has a huge impact. And so many of us are trying to get women into some sort of scheduling, some sort of way of taking care of themselves, I think to tell a woman who's horrendously symptomatic, who really doesn't have the quality, who really says to the doctor, I can't live without his estrogen, to tell her you've got to stop because I don't want you coming back and blaming me or blaming the medicine. It's not every woman who can't take estrogen. I think women who are at high risk for heart disease, who have underlying abnormalities, these women should be screened, and they should not be getting the medication. There is no medicine, there is no screening that is universal.

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You have to look at the individual patient and make a decision.

**JUDITH SHAPIRO:** Dr. Beato

**DR. CHRISTINA BEATO:** I think this is an initiative we also have and it's the way it's reported. When we try so hard to have women pay attention to preventive issues, mammogram being one of them. And our department came out very strongly, both the President and the Secretary, on the issue of mammograms, to continue it, for one simple reason. The diagnosis of the actual technique is better than it has ever been, and there have been improvements since those studies referred to in Lancet which were using old technology. Technology 10 years ago is now old technology. We have incredible new technologies, specifically with mammograms, and there are tactic mammograms to be able to see things that we did not see before. There's also been an evolution of the people reading those mammograms. As more experience comes about in reading this, then women are getting two benefits here: the next technology and the new training of the individuals reading it. Many women cannot see microscopic calcification, and that is something that we--I don't care how many breast exams you have. I don't care how faithfully you're doing it. You cannot be catching it early. The reason women are living longer, the reason we're curing some breast cancers really by (unintelligible) survival five years after the diagnosis is because of the wonderful new research going on

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with new drugs that are really helping women live longer and taking care of their cancers. That's what's changed the mortality of this disease. Why? Because there was prevention, catching them early, being able to treat them and giving them hope, a hope for a healthy life. And if we take away one of the great tools that we have for early detection, that's not good, number one, and it's not good to give messages of something that we know has been working in favor women and create doubt around it. It's not fair to the message that we're trying to bring.

**JUDITH SHAPIRO:** I would like to underline one thing that Gina Kolata has said, that I think is very important to keep in mind. Aside from the issue of what particular conclusions we may draw about mammograms or other forms of screening, I heard her to say that there are areas where the results will not be clear. And we all know this as scientists, we don't always have—one group of doctors may feel this, another may feel that. We certainly want to be sure that we're using the best possible methods and focusing on the most recent best possible studies. In those areas where uncertainty persists, first of all, I think we have a problem in that the average person is probably not highly literate in probability theories. So we're not used to thinking of risks in that way, and it would be better if more of us were. And then, if we say to ourselves, as perhaps we're more used to doing with our

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financial planning, how much risk can I tolerate as a person?

It seems to me that a very important point here, and we can go back to the issue of the media and it covers health issues, because I think we have some differences of opinion here which are good, as long as the light to heat ration remains exactly as it should be. But there was a very important made here where each of us does have to think about what kind of a person am I in terms of my feelings about risk. But I think you also get a chance to respond a bit, and then I want to here from Faye Wattleton.

**GINA KOLATA:** Well, of course, people have very strong opinions on these matters. And people that are highly respected and have really looked at the information have very, very different opinions, which is why I mentioned (unintelligible) who said, yes, (unintelligible). He said I think a lot of people feel that way. As a reporter, my role is not to be an advocate. I'm not an advocate. My role is to try to present these different opinions to you in a dispassionate, so you can try maybe to understand where those different people are coming from and why they're saying this. Not why, what they're saying. I don't really care as much why they're saying it, are you a representative of this group or another. The most interesting thing is what is the intellectual argument here? What do the data say? What we tried to do with the mammography was we went on and on and on at the New York Times

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having one person explain—we had the same data, and we had two statisticians look at it. And one of them would say, I look at these data and my bottom line is this; and the other one said, I look at these data and my bottom line is this; and they were completely different. And one of the more interesting things was one guy who said, I look at these data and I cannot convince myself that mammograms are saving lives, and he said, However, I didn't convince my wife, and she gets one every year. The other guy said, I look at these data, and I am absolutely convinced that mammograms are not a magic bullet, they're not what they've been cracked up to be, but they're better than nothing. But my girlfriend refuses to have one. So, you know, it's like they couldn't even convince the women they lived with, but these are arguments I think people should see. And we laid them out in detail because we thought that, for our readers, if you care enough to try to form your own opinion on this, you should see as complete as possible an explanation of why people who really are very well respected dispassionate experts have very different views on these very controversial subjects. So what's why, in my role, I am not advocate. People here are advocates, and that's fine because I like to present the views of advocates too. I mean I think there's something to be said for all of you.

**JUDITH SHAPIRO:** A brief sociological point. Husbands are not always the first people that their wives listen to, so

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you want to keep that in mind. Faye Wattleton.

**FAYE WATTLETON:** I think that this exchange reflects the caution that we should all apply to trying to use broad demographic data to assess an individual woman's health status. And I also think it's rather interesting that this conversation, as largely focused on women's reproductive organs, that we, as women sitting here, talking to you about women's health, seem not to be able to escape our reproductive organs in the conversation. And I think that we really—that a lot of this has to do with the political context that women's health continues to be mired in, that we focus on our cervix and our breast, and we don't look at those broader issues. And I think that one of the reasons is we really don't have a lot of data on some of these other issues, and women need to raise the bar to say we need to look at women in a much more holistic way. We also look at the question of what access do women have to health care in this country? We're a privileged crowd sitting here today, and we can talk in the intellectual jargon of the demographers and the statisticians, but the reality is that 42 million people in this country this year will not have health care coverage, and the majority of them will be poor women, working women, women trying to make ends meet, and their children. And so it's really a much larger conversation than just our breasts and our reproductive organs. Those have been the political hot buttons, but women need to be very cautious

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about how that limits our view of what women's health is about. Women live longer. We break down more. How often do we hear women raised in the conversation around Social Security? We are the ones who take the medicines. We are the ones who are going to be most directly as individuals affected by these policies. Violence against women is a major public health problem against individual women, not just the demography or the demographics of this. So I hope that even within this conversation that we can think of ourselves beyond our breasts and our reproductive organs. They're very, very important. I've spent my career fighting for them, but there is something very, very broader about women's health that we need to be about than just those reproductive organs.

**JUDITH SHAPIRO:** I would like to note that I think probably, while we certainly, as Faye Wattleton said, do not wish to trash our reproductive organs or the things that afflict them, I think there's a great deal of agreement on the panel that the picture for women's health is wider than that, and I particularly want to turn to Dr. Legato, who has written an entire book on this very subject, and she might want to say a few things about the immunological system, the brain, the skeleton, the heart—not at great length, possibly, but just a few observations.

**DR. MARIANNE LEGATO:** We have only been at the business of really looking at women for about a decade. Women are

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learning that, as a matter of justice, they have to be part of clinical studies because they are going to benefit from them. They have traditionally been relatively more protected than men from the hazards, if you will, of being research subjects. There are immense differences in every system of the body. That's why I wrote "Eve's Rib." Vivian Pinn's entire life, I would dare to say--although I am sure she can speak for herself, and Susan Wood, who is the head of the Office of Women's Health at the FDA, are dedicated to projecting a more realistic view of women as actually having more working parts than just their pelvis and their breasts. Our brains are different. So is our digestive tract. There was a very interesting in the New York Times about passing out chewing gum to people in combat. What the reporter didn't say is that men's salivary flow rates are twice that of women, and maybe women in combat should be even more careful to have special kinds of gum or more of it in combat. That's only one of the myriad of differences we're discovering. And I can assure you that the National Institutes of Health and the FDA have their eyes trained on much more than just the bikini.

**JUDITH SHAPIRO:** (unintelligible) did you want to say something?

**CINDI LEIVE:** Well, I don't want to circle back too much to the reproductive organs, but I think this relates to your point, and one think that we hear from our readers a lot

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is that they are intensively worried about infertility. Now infertility obviously is an issue for a number of women in this country. But I think for my reader, and I think for American women in general, the odds of accidental pregnancy are much larger than the odds against fertility. You're much more likely as a woman in this country to get pregnant when you don't want to be pregnant than to not be able to conceive when you want to. And I think that's another way in which the media's attention to issues that affect a lot of us in the media and also issues that are socially charged and socially facts seen. I think infertility is an interesting issue for everybody to write about because it allows you to write about interesting science technologies, and it also taps into people's concerns about women's changing roles and what the choices of women who find themselves to be infertile in their late 30s or in early 40s have been. I think that's a much sexier issue than accidental pregnancy, which can be very much about economics. It can be very much about basic denial. It's a mystery and not something with an easy an answer as infertility.

**JUDITH SHAPIRO:** Well, I think it would be fair to say that there is certainly at least a relationship of codependency between the general population and how things are reported in the media, because the issue is also what do people most want to read about. It's not as if the media sit around in the back

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room inventing these things. So the question then becomes how can the media fulfill its own responsibilities in a way that is maximally informing and helpful and moves things along in terms of really educating. To what extent, can the media have that kind of function, and how do you try to do it in your work over the years?

**GINA KOLATA:** I really don't think that it's necessarily our role. It's the role of the NIH or of HHS to do this kind of education. I mean, one editor once said to me, about 15 years ago, he said, When people read a story, they should be able to answer two questions. Why am I reading this, and why am I reading this now? So we are driven by news. And if there's news in infertility, then we're going to write about infertility. But (unintelligible) said, people ought to be concerned about this, so therefore I'll write a story. That's not really our mandate. And when she said, why do we write about mammography? Because there was something happening in mammography? Why did we write about hormone therapy? Because the Women's Health Initiative raised some questions about hormone therapy. We write about these things because they're in the news. Why don't we write about violence? Well, we do when there's some—and you can generate news sometimes just by going out and investigating something. We call these enterprise stories. But our role is not to say we think people ought to be educated about this, therefore we will go out and

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educate them. That's really the role for other kinds of organizations.

**FAYE WATTLETON:** Well, I think that there's a difference between a reporter's role and an opinion leader on the opinion page of the paper, which can be enormously powerful. And I think we need to make the distinction here between those two, I think you would agree. And I think that, in that case, there is a role for opinion leaders to set forth a vision that is more than just what's in the news or what people want to read about. As a woman and as an African American woman, if news organizations had not spoken out against the injustice against the women and against African Americans, there might not have been a women's movement and a civil rights movement of the sort that we saw in the '60s and the '70s, so that there is a role for the media to play in raising issues. I think that violence against women has become the number one issue that women are concerned about, right up there with economic security, because the media has, in fact, played an incredibly important role in driving that issue. So I think that you report your views and there are (unintelligible).

**GINA KOLATA:** But there's different venues for the media. But as reporters we don't say, in general, I think people ought to be aware of this (unintelligible) and then write an article. That's something for you to write about.

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**DR. JUDITH REICHMAN:** I think that it's a little bit different between print and between media, for example, when we do the shows on NBC or we do in-depth reporting on television, because there we can create an interest. We have an ability to take a subject and follow it, and it doesn't necessarily have to be a response to the news. I've often thought to myself, well, what allows me to give certain segments to the producers and say let's do this on a show. Usually it has to do with segments that interest them in their own health or their own family, or there is some way that I can get to their sense of guilt and say we really need to discuss this because the American public and women need to know about it. So we've done shows on heart disease, and actually I wore a heart on my sleeve because I thought that that might show the issue. And we've tried to talk about the fact that you're ten times more likely to die of a heart attack. More women die of heart attacks than men. That their chance that they're having appropriate care is probably 50 percent that of men. And we talked about the gender differences and tried to bring it up. So I think we don't have to sell a magazine, we don't have to sell a newspaper, we can be a part of a general news show that gives interest. And I think that you have to talk about the media in its various components, and not all of the media works the same way.

**GINA KOLATA:** We don't write our articles thinking that

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we're selling a newspaper, and the business side is totally separate. We don't know which articles are most read by readers, and that's never entered a (unintelligible) decision to write an article.

**DR. JUDITH REICHMAN:** But it is news derived.

**GINA KOLATA:** Well, it's news derived to a certain extent. We've covered things--I've quoted some articles about risk. That was based on something that was published, but in (unintelligible), it was an issue people should know about. And lots of things are news derived. But some things are sort of like--the Women's Health Initiative, for example, those data were really, really--you couldn't not write that article.

**FEMALE VOICE:** I think maybe it's up to us, who are on the inside of what's new and exciting, to call you up and say, did you know? And you, Dr. Shapiro, who are educating a whole generation of women, that women are 20 to 70 percent more likely to get lung cancer than men, smoke for smoke. I think that's exciting and interesting. There's more going on at the NIH than the Women's Health Initiative, and there's more in the Women's Health Initiative than breasts and pelvises. Joanne Manson (misspelled?) wrote a brilliant study for the first time quantifying what the impact of exercise and other kinds of preventive medicine are going to mean for women. So maybe we do mine wrong silos, if you will.

**GINA KOLATA:** It came out, and it was interesting. I

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wrote about it. It was interesting news. And we're waiting for the Women's Health Initiative on things like osteoporosis. We'd all love to know, does calcium really make a difference? That's going to be an incredible story when it comes out.

**FEMALE VOICE:** By the way, the New York Times does have the very best science and health section of any paper in the United States. Let's get this clear.

**FEMALE VOICE:** I'd like to (unintelligible) to that. We may be giving you a hard time, but it's the best one out there.

**GINA KOLATA:** All I'll say is that we do cover many issues besides breast cancer and hormone therapy. And we are interested. And when Joanne Manson wrote that article, I agree it was fabulous.

**FAYE WATTLETON:** Well, when all else fails, it's easy to turn around and beat up on the media. But I think that it's really important that we take personal responsibility for activism on women's health. It's easy to say the media ought to do it, they ought to be reporting. Why don't I know, blah, blah, blah. But the point is that each of us has a responsibility, and especially each of us of a privileged class, because so many women do not have access. The whole idea of preventive care is completely off the block, let alone thinking about whether calcium matters. But rather, their health care is likely to be given to them in the emergency room

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of their local hospital. And we really simply cannot let those conditions continue to exist in a country that is just wealthy and as advanced as this one.

**FEMALE VOICE:** I totally agree. I totally agree with you.

**FEMALE VOICE:** And this conversation, I think, illustrates that. NIH and my colleague and dear friend Vivian is going to come on the next panel, and she's going to be able to share the (unintelligible) we're doing for the future in women, in terms of knowledge and information and ability for them to come up with treatment. But the right questions are being asked by the right people, and many of them are women actually doing the research and the clinical trials. There's another issue going on here, and that's we are the ones that are able to enjoy and create these things, but the people we serve, the American public, the majority of those women don't really understand risk relationship. Some of them are barely making it to feed their kids. Some of them are barely making it to survive. It's very hard to understand and reach those groups, and we're spending incredible resources, through agencies like the CDC, issues with NIH, Office of Women's Health, to form messages that are culturally appropriate, with the diversity of this country, ethically appropriate, so that we can reach people in their homes in messages they can relate to. It's not just women. There are differences between Mexican-American

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women and African American women. They don't have the same rates of diabetes. They have different culture issues. And I dare to say that with the advent of (unintelligible), a lot of what we're thinking about here is going to take a whole new creation of how we treat patients. But health literacy, I'm not talking about just language translations—but true health literacy is the key to empower women to learn about clinical issues, to take the first steps in prevention, to make it better for themselves and their families. We have 42 million people in this country uninsured, by reports that vary from 38 to 42 million. Many of them are between the ages of 18 and 24. There's already habits being formed of not (unintelligible). Health insurance does not necessarily always mean access. But for some people, it does. And even those that do have access, like many African Americans in our study that we did with IOM of unequal treatment, the same outcomes were not evident for those that had insurance coverage and treatment, because they were perceived, you know, differently or the treatment was differently given to them. That's not acceptable in our nation. And in this Administration, we're very focused on that, and you're going to see that eliminating health disparities is one of the things we're working very hard at. It's not just an issue of gender, it's an issue of our genetic component, who we are, what our culture is, and how we live in our family and our communities. That's where presentation and

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community really come in. 42 million Americans uninsured is not acceptable. Many of those, about 12 million of them, currently get health compulsive at community health centers. They're doing a wonderful job. We need more of them. We have about 3,000 of them across our country right now. We need to have 1200 more. That's one (unintelligible) can fix it. There has to be more in terms of pool risking. There is a whole economic agenda that goes along with this. It's not just health care access. It's health care access, it's prescription. That's why the Medicare transformation is critical as we get older.

**JUDITH SHAPIRO:** And one very brief comment from Joan Brumberg, and then I want to go to questions and answers from the audience.

**JOAN JACOBS BRUMBERG:** Very brief. Again, from an historical perspective, I believe that health literacy are very important. Those are campaigns and words that people use in progressive era, in the early 20<sup>th</sup> century. At that point, progressive women across race and class knew that sex education was part of health literacy--the women and girls. I am personally disturbed by the kind of cutbacks in money in this particular area. I don't think, as an historian, that abstinence is going to work. I think we need to teach kids about birth control. I think we need to look to Western Europe as the model. I was in Holland recently, where girls talk very

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proudly with one another about their boyfriends and the fact that they're doing double Dutch. Okay, they're both using birth control, the boy and the girl. You know, that's the model in the heterosexual couple in Western Europe, okay? I'm not optimistic about what we're doing in this area.

**DR. CHRISTINA BEATO:** Thank you for doing (unintelligible). You know, wherever I go, the same questions, sort of wonder and ask, and first I like to lay out the facts. You know, we don't have misinformation. We have not cut money from what we'll call the regular sex ed. What this President has done has added a new component for abstinence education. The whole program is called ABC, abstinence to be faithful and condoms where appropriate. \$35 million were devoted last year. The money next year—and you can challenge me, and I will bring the charts, and I will be glad to email them to you—because we approved those budgets. It's over 12 million from what it was last year for the regular sex ed class. I don't understand how this information got that way, but I'll be glad to provide the budget numbers for people. There's a lot of misinformation, and I'd really like to sort of lay out the numbers and the facts, because I think they can speak for themselves. I'm a scientist; I like data; I love to share my data.

**JUDITH SHAPIRO:** And we can certainly have some of this information on the website. So now let us go to questions from our audience. Yes. You got there first.

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**FEMALE VOICE:** Hi. My name is Ellen Gene [phonetic]. I'm a well woman at Barnard. I actually would like to hear more from Professor Blumberg about the issue of the media's role in women's body image, and whether that's getting better or worse. And maybe Ms. Leive would be willing to discuss that in relation to Glamour's effort in those respects. Thank you.

**JUDITH SHAPIRO:** Okay, Joan Brumberg and then Cindi Leive.

**JOAN JACOBS BRUMBERG:** There's a lengthy answer here available in a book. I mean, you know that I've written a book called, "The Body Project: An Intimate History of American Girls," and it shows how the emphasis on the body has kind of escalated, and the pressure on girls has ratcheted up from the early 20<sup>th</sup> century to the present. I don't want to blame everything on media. You know, if the media alone, for example, caused anorexia nervosa, then I would have--you know, all of us in the audience would have it. There are obviously individual, psychological, biological, familial factors that are important. On the other hand, I think that we've got to think about the media environment right now as a cultural pathway into certain kinds of behaviors. I think there's a lot of evidence that anxiety among women--young women, and also I would add adolescent boys now, about the body, that's kind of ideal, a perfectionism, that you have to have a really slim body. You've got eight and nine-year-old girls apparently

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showing up in pediatricians' offices saying that they want to be on a diet. But we've always got to look at that, you know, in terms of the problem that we also have with morbid obesity. I mean, we're a culture where we're selling so many products, so many images, so much food altogether, that I think it's a very, very hard thing to kind of untangle. But, I think, from an historical perspective, I certainly would say that the hundreds of diaries that I've read, from the 1830s to the present, indicate that girls today live with the kind of—this is not my term, it's Jane Hirschman's (misspelled?), who's a clinician here in New York—bad body fever, not liking their own bodies or a piece of their bodies. You never heard that in the diaries of women in another time period.

**CINDI LEIVE:** One thing that we do at Glamour is set out ground rules. You know, we don't use models who are too skinny. We don't cover fad diets. We don't encourage women to ever go below their healthiest weight. Now, I do that for two reasons. The first is that philosophically I believe that it's right, and I don't want my reader to be caught up in that bad body fever that Professor Brumberg described. But I also do it because I'm running a business, and I believe that that will sell. I believe that women are hungry for images of nonstarved women. I believe that they want to see women looking not like a size negative 2 but like a size 12 or 14, even as (unintelligible). And I say to you, prove me right. I mean,

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when you see a magazine that's doing that, buy the magazine.

If you see an advertisement from a company that is showing you women who are not these little skinny-minis that you see everywhere, buy that product. That really is fundamentally the only way that you're going to see different images.

**FEMALE VOICE:** How do you feel about boycotting magazines that run cigarette ads?

**CINDI LEIVE:** I think women need to take a stand on smoking, and I think that is one very valid way to do it. Many women's magazines do run these ads. I have to say that Glamour has run them on occasion. It's not my decision, and it's not one, as everyone knows in the business structure of my company knows, that I personally support. I think that smoking is another area where women have to be their own activists. When I open up the pages of Newsweek, and I see a picture of Whoopi Goldberg posing with a cigarette in her hand, Connie Nielsen (misspelled?) on the cover of Esquire with a cigarette in her hand, I want to know that women are going to take action on those (unintelligible).

**JUDITH SHAPIRO:** We were talking about how cigarettes seem to be creeping back into Hollywood and into movies, and that's kind of a distressing development. I think another thing to say is that indeed we do live in a kind of society, and this is why it can become so complex, where money is to be made on products by which you can starve yourself and on

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products by which you can make yourself morbidly obese, and it all is sort of grist for the money making mill. It's true, also--there's a balance here. It's true that Marilyn Monroe, I believe was a size 12 in "Some Like It Hot." But we could also say that there's been both good things and bad things since that time, namely maybe too much of an emphasis on, really a ridiculous amount of thinness. But also, some of this body awareness has been to the good, because I think many of us are taking better care of our health--that is, those who are in a socioeconomic position to do so, when it stops short of a narcissistic obsession. Next question.

**FEMALE VOICE:** My name is Lulu. I'm (unintelligible) of All Women this year. My question is basically for the whole panel. You've touched on specific issues regarding women's sexual health, and I was wondering what about women with specific health needs, like lesbian and bisexual women?

**JUDITH SHAPIRO:** Who would most like to--in other words, specific needs for women who are in so-called sexual minority groups or--. Does anyone want to?

**DR. JUDITH REICHMAN:** There's always been a problem for many of these women to get appropriate care. Often they'll go into the doctor's office and won't admit to their sexual preference. Doctors don't ask them. Doctors will start with, well, what birth control are you on, and just assume that everybody is heterosexual. And they've had a lot of stigma in

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many doctors' offices. I think we're getting better. I think doctors are being educated that they have certain health needs, that they have to be addressed, and that they have to feel comfortable in the doctor's office. The other thing that I think is increasing comfort is the fact that we have so many more women's physicians. When I went to medical school, there were two women in my class. Barnard was one of the few schools, that if you were interested in science--and this is 1966, and you were interested in science, and they said, well, here are applications to medical school. I mean, you didn't have a choice. I didn't think I was going to medical school. Barnard put me in medical school, and I'm very grateful. But I think that there has been a change in the way we're approaching women. And I appreciate it very much when a patient comes to me and tells me, and I'll ask her to state whether she's bisexual or homosexual or heterosexual and who her partner is. I have to know because of issues of sexually transmitted diseases. I have to know everything about her really, in order to give her health care. And so, I'm not sure that that would be so much a medical issue as a social medical issue, and one in which a comfort level has to be established with a physician, so that her health concerns can be addressed. The only other time that I find it's very important is in my women couples who want children, and we have to figure out where we're going to get the sperm donors, who's going to be the

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carrier of the pregnancy. But we're dealing with that too, and we're having very successful outcomes.

**JUDITH SHAPIRO:** Next question here.

**FEMALE VOICE:** Leslie Cantor. I'm from Planned Parenthood of New York City. I'm proud to be a 1989 Barnard graduate. I guess I would say—there are so many things to say, but I wanted to talk about the policy point for a moment.

**JUDITH SHAPIRO:** It has to be a question.

**LESLIE CANTOR:** It has to be a question?

**JUDITH SHAPIRO:** Absolutely, please.

**LESLIE CANTOR:** Well, let me do clarification on the abstinence only piece.

**JUDITH SHAPIRO:** It has to be brief.

**LESLIE CANTOR:** Sure. The Administration is very interested in pouring more money into unproven abstinence only until marriage programs. In fact, in the President's budget, he's asked for 33 million more dollars in abstinence only until marriage education. I wanted to clarify whether the increase you're talking about for what you called sort of regular sex education is actually the sort of cost of living adjustment in Title X, which is for family planning services, not for sex education?

**DR. CHRISTINA BEATO:** First of all, I take exception with your comment of not proven. There are studies that are coming out that are showing proof. It is one component—yes,

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they are. The AP had an article in the Washington Post just last week. So they are out. We're using Uganda also as an international model. And like I've been saying, abstinence is only one piece of this whole component. There has never been anything devoted to abstinence for young people. There are programs around the country that are working. We're not saying to the exclusivity of the issues of birth control pills. And, if you look at who are writing Titles—if you're talking Title V (unintelligible), under Title X, which is family planning, there's two very different programs. We're talking about Title V (unintelligible). We're not taking from one to give to the other. There's nothing in the federal government that ever dealt with that before.

**JUDITH SHAPIRO:** Faye Wattleton.

**FAYE WATTLETON:** (unintelligible) say that there's not been anything ever for abstinence. It seems to me that our whole lives we've been taught to be abstinent about sexuality. Our whole tradition—our whole religious tradition is one of such. And the whole business of teaching abstinence has been around ever since the Reagan Administration. And I think studies will show—and who doesn't want—I mean, I have a daughter. I didn't want her to be sexually active until she was 30. She did not oblige me. I sent her to (unintelligible). I tried her. But who wants to encourage their daughters to be sexually active before they can assume

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the responsibility? I think it's really important to put this in the proper social context. And what those studies show is that yes, abstinence as a choice is something that should be discussed, but it's not the only thing. It's not the solution, and it will not be the answer. There has to be a larger answer.

**DR. CHRISTINA BEATO:** We're not saying only. We're saying ABC, and we're encouraging as part of that abstinence until marriage for young people. The B and the C seems to drop off in the conversation.

**JUDITH SHAPIRO:** I'm going to act as referee because I think we believe that we are here having differing strong views, and my prediction is that five more minutes of talking about this is not going to surmount them, so--. Yes?

**FEMALE VOICE:** My name is Joanne Kaback (misspelled?). I'm a Barnard class of '69 and an independent health writer. And both anecdotally and in my writing, I keep meeting women who suffer from stress related disorders and from illusive disorders like fibromyalgia and chronic fatigue, disorders that barely only got a name maybe a decade ago. And they still report that they go into a doctor's office and are told, go home, take a rest, or whatever. I would to ask the panel to address this question, both whether these are getting adequate levels of research now, these types of disorders, and kind of a guidance to women when you are experiencing these feelings, how

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do you express them and what kind of track to take.

**JUDITH SHAPIRO:** I think Dr. Legato might be a particularly (unintelligible) the subject.

**DR. MARIANNE LEGATO:** There's a great deal of interest in what we used to call the waste basket diagnoses, in which women were brushed aside and told they were neurotic and hysterical because they were "tired all the time. I happen to know personally, because I just made contact with Dr. Steven Katz, at the NIH, about what's available for these kinds of diseases, that there are very important investigators looking at them quite carefully. And those of you who have those illnesses are able actually to be seen by clinicians at the National Institutes of Health who are very interested in the biology, if you will, or the pathophysiology of what these diseases are and what they mean. They seem to predominate in women, but they're not exclusive to women. So there is research going on. It is being taken seriously. And there are people at, just to give you one example, the National Institutes of Health very much interested in these illnesses. The fact that women go into physicians' offices and are disrespected often goes across the board. It's not just for those illnesses. And I think women have to be clear, concise, and appropriately assertive, which, as Dr. Shapiro would say, with the right ratio between heat and light in the physician's office.

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**JUDITH SHAPIRO:** I think Dr. Beato has some specific information.

**DR. CHRISTINA BEATO:** Vivian, as people on this panel—but we first, for the first time this year, formed a chronic fatigue syndrome board to recommend to the Secretary new steps to take. It's based in my office. And we have people from advocates as well as scientists that are actually doing the research, as well as physicians that are treating these patients, to see what are the questions we need to be asking, how can we best meet the needs of these patients? So it's a very good question. Thank you for bringing it up.

**JUDITH SHAPIRO:** Thank you. Yes?

**DR. JUDITH REICHMAN:** The more media talks about our diseases, the autoimmune disease, fibromyalgia, various diseases that occur in women, the more they'll be ready to go into the doctor's office and say, these are my symptoms, this is what this—do not send me home, I want a workup.

**JUDITH SHAPIRO:** Cindi Leive has probably given the kind of—the place in the media she is perhaps is well positioned, more easily positioned to do that sort of story. Although the health section of the New York Times cover that. We just have time for another two or three questions because we're going to strictly maintain a schedule of being 15 minutes late. Yes?

**FEMALE VOICE:** Thank you. I'm Dale Matthew. I'm

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Director of Women's Health for Hadassah. And I just wanted to ask our esteemed representative from the Administration why, if ABC airs again—I'm going back to that issue because I just went on the website, why then has the website removed choices and has focused on abstinence for women?

**DR. CHRISTINA BEATO:** Which website are you referring to? The HHS Department website?

**DALE MATTHEW:** The HHS Department website. The FDA, all the different websites.

**DR. CHRISTINA BEATO:** The thing that we updated was the condoms, CDC website, that's updated and back up after NIH and CDC and FDA got together and did a study in the summer of '01, so they updated the scientific evidence to really focus on things like HPV, which it is now a sexually transmitted disease, cause of cancer disproportionately in African American women in our community. So that's all back up. So I don't understand what the choice component is.

**DALE MATTHEW:** The choices that are not there, other than abstinence.

**DR. CHRISTINA BEATO:** For Title V--

**DALE MATTHEW:** I'm not talking about any Title. I'm talking about the information that women go into the website for.

**DR. CHRISTINA BEATO:** If you would give Josephine the website, I'd like to see it.

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**JUDITH SHAPIRO:** We're ultimately going to look at the website, all of us.

**FEMALE VOICE:** I think that what she's trying to say is that you don't have abstinence, and you're sexually active, what choices are left to you, and those have been eliminated.

**DALE MATTHEW:** Exactly. Thank you.

**FEMALE VOICE:** And I think that's been widely reported.

**DR. CHRISTINA BEATO:** Okay, we didn't have sex ed on our website. We never had sexual education, so I'm a little confused here.

**JUDITH SHAPIRO:** Okay, next question.

**FEMALE VOICE:** Ruth Steinberg, class of '72, Barnard, OB/GYN in New York City. We're still talking about sex. I have a question particularly in the present budget. Where the money is going to come from for the two things I think are most important, nutritional teaching and exercise. Most people say, I don't have time to exercise, but they do have time for radiation therapy if they need it. They also say they don't have time to cook, and they don't know how to cook, but they also don't know about food. We have a country in which people buy pills. Health food stores contain pills. In France, health food stores are called markets. And I think we have to start at a much earlier age inculcating health, capital H, nutrition and exercise as part of life. Where are we going to get the money, and when are we going to start it?

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**JUDITH SHAPIRO:** Is it possible to treat that as a statement contribution and go on to another question?

**DR. CHRISTINA BEATO:** April 14<sup>th</sup> and April 15<sup>th</sup>, Prevention Summit in Baltimore, DC, Secretary Thompson. New grants strictly dealing with what you're discussing will be showcased and put out for (unintelligible).

**JUDITH SHAPIRO:** Thank you, because those are very important points. Yes?

**FEMALE VOICE:** Hi. My name's Nicki Candolor (misspelled?). I'm a Well Woman here at Barnard, class of (unintelligible). And you've been talking about research and health literacy, but I was hoping that we could go back to—we were talking more about stress at the beginning and women's double duty—working women of every race and every class. How does the stress that can cause, can affect both your mental and your physical health? And as researchers and health advocates, I was wondering how we, as the women in this audience, how we can promote these issues and what's being doing about this sort of stuff?

**DR. MARIANNE LEGATO:** Brief answer. Stress is different for men and women. Different things stress men than women. Women are more sensitive to stress from human relationships. For women who have had a heart attack, it's 300 times more likely to have another one as a consequence of marital difficulty. The Framingham study has tracked the

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impact of stress on susceptibility to cardiovascular disease, and there's a big literature on that. And there's another impact of stress, among other things, on the immune system, which is very interesting and well investigated. So we are looking at stress, what stresses you as opposed to the male equivalent, at Columbia, and what to do about it to preserve health.

**JUDITH SHAPIRO:** Now what is stressing me at the moment is that as much as I desire to continue with this wonderful conversation with this excellent panel and the many questions you still have, we absolutely must conclude the session. And so I am going to ask all of you to take 15 exact minutes as a break and a stretching and all of that, and to reconvene.

[ END]