

**The Barnard Summit: Women and Health  
Panel Two: Women and Healthcare: A Critical Analysis  
Barnard College, New York, NY  
Saturday, April 5, 2003**

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[ Applause]

**JUDITH SHAPIRO:** Well, first of all let me again thank my fellow panelists from panel one. It was really wonderful to work with them and they did a marvelous job. [Applause] Now Panel two is on Women and Healthcare, a Critical Analysis. It will be moderated by ABCNews Correspondent, Lynn Sherr. Since 1986 she has been doing major investigative reporting on 20/20 often focused on issues of great importance to women.

[ Applause]

[ Video]

**LYNN SHERR:** That's some of it. We're going to talk about a lot more of it right now. My name is Lynn Sherr. I'm the moderator for this panel. And just before I introduce all of my co-panelists here I must tell you the story, my favorite story, which I think pertains to this issue very well. The story about the man who was in the hospital and the doctor said to him, "Sir, I've got bad news and good news. The bad news is you need a new brain. The good news is I have a few available." [Laughter] And the patient said, "My goodness, I need a new brain?" He said, "Yeah, but it's okay", the doctor said, "It's really fine". And so the patient said, "Well, tell me what you've got." And he said, "Well, I've got two brains. One is a male brain and that will cost you twenty thousand dollars. And I've also got a female brain and that will cost you ten thousand dollars." And the patient said, "But why is the female

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brain so much cheaper?" And the doctor said, "Well, that's easy. It's been used." [Laughter] [Applause] Nothing personal, gentlemen. So with that in mind I now introduce you to the other great brains, male and female who will be discussing this issue of women's health and what's available out there for all of us. To my far right, Elizabeth Wurtzel, author of the best-selling novel, *Prozac Nation: Young and Depressed in America*, soon to be a major motion picture. Dr. Vivian Pinn, Director of the Office of Research on Women's Health at the National Institutes of Health. Dr. Isaac Schiff, Professor of Gynecology at Harvard Medical School and the Director of the Vincent Obstetrics and Gynecology Service at Massachusetts General Hospital. Dr. Susan Wood, Director of the Office of Women's Health at the Food and Drug Administration. Byllye Avery, Founder of the National Black Women's Health Project in the Avery Institute for Social Change. Ellen More, Founder, excuse me, Professor of History and Medical and Humanities at the Institute for Medical Humanities, University of Texas Medical Branch, and Judy Norsigian, Executive Director and Co-Founder of the Boston Women's Health Collective and Co-Author of *Our Bodies, Our Selves*. Bless you. [Applause] So let me, let me get us started. Our issue is the same issue as everybody else is dealing with which is women's healthcare. And we are going to be very specifically talking about what's available, what's not available, how is it changed, and what do we still have to do.

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Let me start with a question, I don't know who's going to take it but I'll ask it pointblank. Is there right now in this country a disparity between the healthcare given to men and the healthcare given to women? Vivian.

**DR. VIVIAN PINN:** I'd respond to that by saying that there, there is to some degree a disparity because we need more information about issues that are important to women's health. We need to make sure that physicians, nurses, pharmacists, and dentists, those who are providing healthcare to women have the knowledge, the kind of information Dr. Legato referred to, sex and gender information about how women should be treated differently or treated the same and we need to make sure that information is used so that women as well as men and other members of their family are getting state of the art care. I would like to come back later and talk more about, about the generation of that knowledge, the importance of research to contributing to that knowledge, which is what we see as providing the foundation for better care for women. But I know for example that Judy and Byllye Avery are hot on the issue of access to healthcare and insurance issues and those kind of issues so I'm going to give that as my introduction to this topic and I will defer to those two.

**LYNN SHERR:** Before we get into specific issues of social disparities and all that is there anybody else who wants to speak to the question. Well, Judy why don't you try? I mean

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you did so much. Your organization did so much to open it up.  
It's the year 2003. Our Bodies, Our Selves first came out in  
1970.

**JUDY NORSIGIAN:** And we're about to start on the eighth  
edition which will be out in 2005.

**LYNN SHERR:** Okay, short answer, is there a disparity,  
is there discrimination against women in healthcare right now?

**JUDY NORSIGIAN:** I think you have to phrase the  
question differently because I think discrimination is a tricky  
term. We have a huge problem in the amount of information  
that's out there and access to good information. And I think  
there are disparities in individual's ability to reach that  
information which is most [unintelligible], most well balanced.  
Not everyone reads the New York Times and other good  
publications that do in fact do a fair job of that. And then  
there's the whole question of access to services. And I think  
these are two very important and distinct matters. You get good  
information if you are not discriminated against in terms of  
how easy it is for you to access that information. That's a  
start. But then say you know what it is you need. If you can't  
get access to the services that are truly going to help you, if  
you're one of those forty plus million Americans who have  
really inadequate access to medical care, then we have a  
problem. I would also say that women are discriminated against  
in terms of a focus on prevention as well. And we can look at

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some specific examples. We are not as much focused on a needs based and public health based approach as we are on sometimes a profit motive approach to solving our health and medical problems. I think of Dr. Uve Reinhart [misspelled?], a well-known health care economist who said, "You know it used to be that necessity was the mother of invention. And now invention is the mother of necessity." And that we have to really step back and say what are our needs as women and are the research dollars going primarily to those places? What about the environment? What about environmental impact on human health, including women's health? Are we spending the dollars there in terms of resources and making our environment healthier for everyone, even low-income communities where we see enormous disparities there and women who are trying to raise families have more problems with asthma because of the environment. I could go on. The list is long. But I think we. It's a different kind of question and I would say it's less in the area in the research now than in other areas.

**LYNN SHERR:** Let me take it right to you; access to public, to health information.

**BYLLYE AVERY:** Okay, if we look at the whole, not just look at the entire population of women brought together but look at women ethnic groups then you will find that there's great discrimination and the types of services people, we live in a country that is still, sad to say, still real full of

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racism, sexism, classism, homophobia, whether it's aware, unaware, whatever. It influences the way people are treated. The information they are given. And the example that I like to use; this is a simple one - someone says, give me an example of racism and [unintelligible]. So I said let me give you an example of racism in dentistry. I, simply I was very religious about taking my kids to the dentist, just very good about it. I stopped off at the BK Lounge to buy a hamburger to get them. I sit down on it and this pain shot up into my head. And so I went on, I said, "Well, I'm going to the dentist to pick up the kids. I'll ask the dentist." So I went in and I told the dentist that I was having problems. And he immediately said, "I need to extract your tooth". And so what did I know. I let him take the tooth out. Later on that afternoon I'm talking to some of my colleagues, I was working at the University of Florida. We were all teaching on a unit for faculty experts on psychotic children. So, you know, that's an educational space where I can afford to pay a root canal. She said, "Why didn't you have a root canal?" "What is a root canal?" He never told me. He made a decision even though I had my kids there for care. He made a decision that I was not, for me, right, that I would get it. Now that was racism as far as I'm concerned and it also can be classism, and it also could have been sexism.

**LYNN SHERR:** Women, women have particular needs though in terms of healthcare. You've used a phrase and I wonder if

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you could elaborate it, elaborate on it that I love which is you don't like being called a single parent.

**BYLLYE AVERY:** There is no such thing. If you have a child and you're rearing it alone you are a double parent. [Laughter] It does not make sense. [Applause]. What is that about? You know, you don't have [unintelligible]. You, you are a mother and a father and you make decisions and you do the best you can and it is, it is a very unique problem for women. And people have great sympathy for men who are doing this alone but they have total distain for women who are doing it. [Applause].

**LYNN SHERR:** Dr. Schiff, talk to us about one of the great egregious moments of disparity or at least in terms of the research in healthcare for women.

**DR. ISAAC SCHIFF:** Well, if one's going to discuss disparities in research, the obvious one is estrogens and heart disease. And let me develop a story for you by historical standards. If we go back about forty years in time there was a book published out of New York called Feminine Forever. This is a book that could never be published in Boston. [Laughter]. So the book Feminine Forever made the observation that women rarely get a heart attack until they reach age fifty. And after age fifty they start to get a lot of heart disease as we heard from the panel before. This fell on receptive ears going back forty years where almost all the physicians were male. So they

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read the book, they heard the lectures, and they assumed that women are getting many more heart attacks after age fifty because they're losing the estrogens from their ovaries, therefore estrogens protect against heart disease. And who were the first people these cardiologists studied? Not women, men. And in fact the first excellent study of estrogens and heart disease was done in men and published in 1963 called the Coronary Drug Project, a superbly designed study that actually showed that if you give estrogens to men who already have heart disease that it will give a further increase in the risk for heart disease. In that same decade estrogens were given to men with prostate cancer and it was learned in very well designed studies that to give estrogens to men with prostate cancer you do not prolong their life. They just die of heart attacks. They don't die of prostate cancer. So it might be a better way to go to die of a heart attack. You go to sleep one night and don't wake up the next morning instead of a miserable death with prostate cancer. And in the seventies we learned that estrogens in the pill led to an increased risk for heart disease. Of course, now in retrospect we know it was all dose related. Then in 1980 a whole lot of observational studies, not randomized trials, not scientifically designed, suggested that estrogens prevent heart disease. But the study to actually prove it was not done yet. Then in the early nineties one of the companies that makes estrogen thought that they would like to get

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approval from the FDA to market estrogens as a preventive for heart disease. Never really proven, all by observational studies and the FDA in its wisdom said no at that time. So two things happened. The company itself designed a study to prove that estrogens prevent heart disease and the NIH through the Women's Health Initiative gave the funds to start the study. What was fascinating to me was that at the end of the drug company's study, at the end of five years, instead of proving that estrogens prevent heart disease, they actually showed that estrogens increased the risk for heart disease just like was shown thirty five years earlier in men. So women had to wait thirty five years for the same study that was done in men. But I want to take it to one more level. That people were so convinced that estrogens prevent heart disease, these investigators, there's a lot of emotion in this field and a lot of bias with a lot of different agendas. At the end of the first year of this five year trial there was actually an increased risk of heart disease in the women who got estrogens. In the second year a slight increase, in the third year it was the same, and by the fourth and fifth year the women who got placebo actually began to have more heart attacks than the women who got estrogens. So if you picture in year one and year two more disease in the estrogen users, year four and five, more disease in the placebo users. By this time, at the end of five years, the investigators said, "If we could only do the

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study another two or three years we'd be able to show many more heart attacks in the placebo group and we would prove to you that estrogens prevent heart disease". Now supposing they carried out the study for another three years, which they did and let's say that the estrogen group actually at the end of eight years had fewer heart attacks. What would I as a physician tell my patient? I'm going to give a medication that when you take it for eight years it's going to prevent heart disease. There is one little problem though. In the first year it actually increases your risk but I guess if you make it past the first year you're golden. [Laughter]. So you can see that there is so much emotion in this field and women had to wait for the drug that they take the most of, if you improve the birth control pill which has estrogen, the most commonly prescribed pill for women, estrogens, women had to wait forty years to learn what was taught to men forty years ago.

**LYNN SHERR:** It's quite a sell. Judy, did you want to jump in? You were shaking your head at one point about the NIH funding.

**JUDY NORSIGIAN:** [off mic] Women's Health Initiative with this story because I think we need to clarify that the results that we have related to women who were taking combination estrogen and progesterone, not estrogen alone. And the study looking at estrogen alone is still proceeding. But I agree with everything else he said but I had to speak up

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because I'm one of those who helped design that study and I'm Co-Director of that study. I don't know whether that's good to say or not good to say. We get hits and we get accolades for it. But we've been very much immersed in that and I wanted to ask one other thing that ties in with some of the discussion we heard earlier. It was when NIH had a woman as its first and in fact so far its only woman director who also was a cardiologist, or is a cardiologist who thought it was time that NIH put an abundant amount of money into learning about some of the issues that we take for granted and that's how the study came about.

**LYNN SHERR:** Yeah, go ahead Ellen.

**ELLEN MORE:** I just wanted to add one other point in terms of how when the Women's Health Initiative got started there was actually a deep concern that it's kind of hard but it was so known by the clinical community that this was good for you and as a long term preventive, not as a treatment for you menopausal symptoms, but for a long term prevention and for heart disease, for bone, for everything that it was actually discussed and there were those who felt very strongly that it was unethical to put women on a placebo. It was unethical to start a trial that would put some women on estrogen and deny it to the other half of the study group. And in fact without this study though we would not have the data now and the data had to be stopped because it was deemed unethical to continue the

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study because of putting women at risk for long term use when, when it was unnecessary. So it is interesting that how over time we really have to go back to asking what's the scientific question and what really is important for the health and safety for women when we're looking at these products that women are taking a lot off.

**LYNN SHERR:** Susan, talk a little bit about the insurance issue. How are women served or not served by what's going on in insurance right now.

**DR. SUSAN WOOD:** Well, I'm not an insurance expert but I would know that women are more dependent upon either their spouse' insurance or on the public sector insurances with Medicare and Medicaid. And so there is a large group of women like a large group of men who have no insurance whatsoever but those who are insured are more dependent upon either the public health programs or upon the, their spouse' insurance and therefore if they lose their spouse or lose their eligibility for insurance or if the insurance isn't adequate enough to cover their needs, they're more vulnerable to the changes in insurance.

**LYNN SHERR:** Elizabeth, I don't know if you want to talk about insurance, but I want you to talk a little bit about the commercialization, about the drugs, about the pills out there for women.

**ELIZABETH WURTZEL:** Hi. I do want to start by saying

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it's such an honor to be on such an incredibly [unintelligible] panel and I feel really a little bit flawed by this so forgive me if I'm not quite as articulate as everybody else but I do have to say it was, I was so blind about invention is the mother of necessity. The paradigm I always use, and forgive me, this is really watered Marx is that historical determinism, if they invent the pill, the disease will follow. And as it happens I was, when I tell university students now that when I was depressed, I'm thirty five, I graduated from college in 1989 and I would wander and I actually went to Harvard and had access to every kind of branch of not only the Student Health Services but I would go roaming through the Medical School saying, "Please help me, give me drugs. I've got things going in my head that are not going to be helped by therapy." And they would just be like, "Well, if you try to kill yourself and end up in a hospital then we will give you drugs. But until then, you know, you just have to be, you will be in therapy." They, variously I heard for the next fifteen years. Other times it would be the next twenty years. But it never made me feel very good about life. And it was an incredible, you know, it was salvation for me when Prozac came along because, I mean, finally there was a medication that they felt comfortable prescribing to people outside of a hospital setting. Although by then I had been in hospital. But I caught on and started trying to, you know, tell myself in various ways that I would

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get the care I needed. But that was, I mean not to make light of these things but actually it is good to make light of these things in some parts. But I was going to say, obviously since then I, I just was looking this up in a Rand Corporation from 1993 found that on average doctors spent exactly three minutes talking to patients before they prescribed a psychopharmacological drug to them. And it's very interesting because it's gone from my inability to get medication to students saying, "I go into the health services and they hand out pills. They don't, they don't even talk to me." And I mean all they wanted to do was talk to me. I mean and you know it was in some ways they trivialized my problems by not medicating them. Now they are trivializing them by medicating them. But the one good thing is that, well, or the bad thing the rate of depression has gone way up. I mean you'd think that with this medication it would have gone down but the fact is that [unintelligible] diagnosis is easier to give because you have, it's easier to say to somebody you have depression as your problem because you can now say and I have this cure. But in, in my time of watching it I've even seen stranger things happens which is that as they discovered that certain medications that were anti-seizure medications are very good for, for mood disorders suddenly I've met more and more people who are bipolar. Now bipolar illness, I mean manic depression, that is a really rare and strange disease. Like people, manic

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depression is an extreme thing. It's not up and down moods all day long. I mean so they've invented I think bipolar two is what it's called which means mood swings. Because now they have a really good pill to give people who have mood swings. So it's, it's you know become that way. You know, so suddenly you just meet people and I've got to say to them, "There's no way you're bipolar. I mean that's, you, you'd think they were, you think, the joke is that if you're manic depressive you think you're Jesus. If you're schizophrenic you think you're hearing Jesus. I mean I, it's, you know there are variables on this but I mean some of the good news is that it's made people more aware and more able to deal with depression and the gap between women's rate of depression, which I think at one time was two to one with men, is now I think it's down to like sixty forty.

**LYNN SHERR:** Let me ask you, and incidentally you don't have to worry about not being articulate. You're quite wonderful. In all of your experiences how many of the physicians that you consulted were female?

**ELIZABETH WURTZEL:** It, it varied although I would say that the better help I've gotten has been from women doctors often because I have to say the women doctors that I've tended have been somewhere in their fifties and I have to say to have gone to medical school in that time and been a woman what an extraordinary person you'd have had to be. [Laughter]. You know, I didn't go that deep.

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**FEMALE VOICE:** In the late sixties I went to medical school.

**ELIZABETH WURTZEL:** Right. So that it's like the women I've come across are like five thousand times more amazing than the male doctors I've come across. [Laughter] I mean in, in just in, in any field.

**LYNN SHERR:** Let me interrupt you for a second because I want to, I want to move it up to the idea that are things changing and does the advent of more female physicians help that. Vivian, I'll give you a chance in a minute. Let me go to Ellen who's [off mic].

**DR. VIVIAN PINN:** She's an expert on that issue but I want to point out about women's mental health. Women's mental health is becoming or is being recognized as a very important issue not only in the United States but around the world. In fact, there are many in the mental health community that have referred to it as an epidemic. And I think it's interesting that it's being picked up not only in the United States, but elsewhere. We really have a dilemma because women for years have said. "Don't take all of my complaints and assume they're in my head and that they're mental." And at the same time when there is true mental illness or conditions that need to be considered women want to have those dealt with and recognized as being true health issues that need to be dealt with. So I think we're making progress. I think, you know, perhaps the

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contribution and Ellen will probably speak to that about women and health professionals in this whole arena will be important but I think it's important to emphasize that focusing on mental health issues for women is a current priority, not only for research but also in terms of education of healthcare professionals.

**LYNN SHERR:** Good news, good news for all of us.

**ELIZABETH WURTZEL:** I just would like to say that that's the thing I'm glad about is that as these medications have brought this to the fore but the results have been, I mean I think they've also enabled HMO's and things like that to not provide, you know, proper, you know, therapy care which, I mean they just hand people pills.

**LYNN SHERR:** And things get classified as mental health once they're referred to others.

**ELIZABETH WURTZEL:** Yeah I mean, and I think it's mostly, it's more women, I think men are much happier to be given pills and not talked to. Whereas women I think are more likely to want to have someone to talk to and unless you're rich it's, I mean this is something that insurance, if you have, if you're lucky enough to even have health insurance, you might be able to get incredible healthcare with everything else. The chances that your insurance covers mental health is so cruel.

**FEMALE VOICE:** Increasingly smaller and smaller.

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**ELIZABETH WURTZEL:** It's so unlikely.

**LYNN SHERR:** Let's turn to the issue of how if at all things have changed because of women becoming physicians.

**ELLEN MORE:** Well, I will say first that when I began to study the history of women in American medicine I was expecting to find that as women became increasingly professionalized in medicine that they were going to drop their traditional interest in the health of women, that they were going to become socialized into the culture of medicine and they were going to become more shapely and attractive male physicians essentially. I don't think that that happened. That's the good news. The bad news is that it's a hard struggle to keep that from happening but I think that the good news is that the interest of women from time immemorial in health, in a, what I have conceptualized as balance, both in understanding their patients' needs and in reconciling their professional needs and their personal needs and their debt to the community, I think women physicians do a very good job on the whole of carrying that tradition along into the present day circumstances of medicine. Now having said that, I will also say that indeed it's not easy to do. It's not easy; first of all, to get back to what was being said earlier, because the state of our, our policy, our public state is making it very hard for physicians, excuse me, to practice medicine, as they would like to, whether they're men or women. The, the

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stereotype you've heard about of the eight minute visit or the twelve minute visit, the figure of these three minutes prior to giving out a primary, initial dose of a psycho pharmaceutical drug is really true. There is very little time to practice good medicine. On the other hand, studies seem to indicate that in the case of a woman patient and women are the majority of patient visits in the United States, where a woman physician is treating a woman patient the length of time devoted to communication, to speaking to that patient and to, I would say, being able to, generalizing hideously, I would never generalize this way in print but I do think it is probably true, engaging in an impassive interaction with that patient, I think women have been shown to do that somewhat better than men. But again, as I say, what the study seemed to show is that that holds up on the patience of the woman as well as the physicians would be.

**LYNN SHERR:** Ellen, is what you're saying that when there's a female patient and a female physician that the communication is better and therefore the treatment will be better?

**ELLEN MORE:** I think that that is the case within the constraints of an under funded healthcare system where nevertheless women are the majority of poor patients, poor patients with children who are not getting care and who are getting excluded from the mental health care, for example, that

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you were talking about just a minute ago.

**LYNN SHERR:** Byllye, you want to talk.

**BYLLYE AVERY:** Yes, I want to make two points. First of all it is getting better because we as women started ourselves. The whole women's movement started off with PR groups, consciousness raising groups, groups of women came together, talked about their lives, talked about their health, that gave rise to the perspective that allows us to sit here today and talk about women's health. That's the first thing. When I started the National Black Women's Health Project in 1981 I was really concerned because in 79 they did the Inhane [misspelled?] study, the National Health And Nutritional Study and in it I found one line that had been printed in a book and put on the shelf and no one paid attention to it. It said that over, that over half of the African-American women they interviewed ages eighteen to thirty five rated themselves as living in psychological distress. And they rated that distress greater than white women of the same ages who were diagnosed mental patients. So our whole quest for the first ten, fifteen years of the organization was what was this distress and what we found out that women were dealing with being victims of sexual abuse, and that this sexual was rampant across income levels. And we also know it's across all races, it's there and [unintelligible] Oprah was doing himself up on the television in the afternoon. [Laughter] The violence, how to rate the

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violence and, and a lot of us were participating in what we called a conspiracy of silence. That is we didn't talk about [unintelligible]. That was our family's business and we kept that hidden. So just by us not being psychologists, not being psychiatrists, and realize we're talking about psychological distress in which people are doing every single thing they do every day. They take care of kids, they go to work, they go to church, they do everything but living with this distress. It's through those kinds of groups of people coming together and supporting each other, then you begin to understand who needs a little more help. You get to look at what's going on with you, do the analysis of it, and chart your course.

**LYNN SHERR:** Yeah, Judy I want to, I do want to return to you. Might I just say on a personal note and I'm sure there are others who will agree with me in the room that when Our Bodies, Our Selves first came out this idea of learning about yourself and all of that, the tiny little concept, the little idea that a speculum didn't have to be freezing cold [laughter] was indeed a revelation. [Applause] What other changes are you seeing?

**JUDY NORSIGIAN:** Well, I wanted to get back to the subject of women physicians just for a moment. I think in many respects we are all the product of our training and some of the men and women in medicine that we've worked with over the years who are very concerned about the ways in which physicians are

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trained really need to be listened to. Those in many cases are men who take an outcome-based approach. Who are feminists in many ways? Who think that we've done a lot of disservice, we've overmedicalized an asset for being a woman, everything from menopause to childbearing to our sexuality and they're with us in asking those questions. But for many women they're simply uncomfortable dealing with a male physician and for a woman who's simply uncomfortable I can guarantee probably she's going to be better off finding a woman physician. There are other women who are perfectly comfortable. My physician is a man. I'm perfectly comfortable with him. I think he's terrific and we have very good communication. It depends on who you are. It also is important not to accept that just because a woman is a physician she's going to give better care. You've got to be informed yourself.

**LYNN SHERR:** This is a heretical statement.

**JUDY NORSIGIAN:** No, it is not heretical. We've had it in *Our Bodies, Our Selves* actually since the beginning. But you know I'm thinking more recently about the, this issue of preserving core values and fine, FX is the title of a petition that the Association of Reproductive Health Professionals has posted at its website. And the beginning of this petition is a quote from Donald Kennedy's recent editorial in *Science* called an Epidemic of Politics. If you haven't read it, go read it. This is the past president of Stanford University, now the

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editor of Science. And in it he, he really speaks to what he sees as a trend away from science based, evidence based decision making in the federal government and he gives a number of examples. And I think it's very important that we ask men and women as physicians and as sometimes our gatekeepers to what we will and we won't find out about, to pay attention to these laws and issues, to pay attention to the influence of the pharmaceutical industry and its practices. We're very active in the coalition that's now looking at direct to consumer advertising of prescription drugs and who are our allies in that? Physicians, men and women who are concerned that people are getting a lot of misleading information from the kind of advertising out there and we don't always balance that with the information that says, you know, these are the risks, these are the benefits and give you the whole picture.

**LYNN SHERR:** It comes back to a little bit of common sense. Go ahead, Susan.

**SUSAN MORE:** I just want to talk also about the role of women, not just as physicians, but as scientists and as policymakers and as Members of Congress and as members of the media. And I think as, although the women's health movement in recent years builds upon the consumer movement and patients empowering themselves, while the eighties and nineties we were moving to a chance where you could have women on the inside as well as on the outside as policymakers and as physicians and as

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scientists who, who did take those questions to heart and then to change the policies and the research agenda and the clinical knowledge so that when women came in as informed patients they would be able, they would have a sympathetic ear. I mean there's the line if you fund what you fear. And when the people in charge were all males, or mostly males what we heard about was men and heart disease, you know the, the big era when the concern about heart disease, about men in their forties and women all rallied to make sure their husbands got good diets and exercise because that was the real concern. Ulcers in men in their you know forties and fifties. These have changed. The focuses have changed over the years because we have women in places who are making some of the funding decisions and who are making, and are raising the issues of the concerns we've been talking about today.

**LYNN SHERR:** So it's a kind of a trickle up theory as well as a trickle down?

**SUSAN MORE:** Yeah, the kind of thing would be that we all need to meet in the middle.

**LYNN SHERR:** Right, Ellen.

**ELLEN MORE:** I will, first of all, give an example of how input from women in general has filtered up and that is that of course physicians became very concerned about their declining popularity with their patients, which certainly was evident in the 1970's and 1980's. One of the things that has

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happened is that medical schools are now consciously trying to educate medical students to do a better job of interviewing their patients, of talking to their patients. And so it is now a requirement starting this coming year that every graduating medical student will be examined formally on their ability to do a decent history. It's surprising that that wasn't the case before. Think about it but at least we're beginning to make inroads. Now this is...

**LYNN SHERR:** And after, and after that they will be judged on their handwriting. [Laughter]

**ELLEN MORE:** Yes, that's a, now you're being utopian. [Laughter]

**LYNN SHERR:** But medical errors those prescriptions [cross talk]

**ELLEN MORE:** But the, the format for doing that using standardized patients was indeed initially developed by a male physician but it was then adapted for these purposes by female physicians and it is, I think indeed, the influence of women becoming more integrated at least numerically into all of the healthcare professions and this also applies to nursing, for example, being taken seriously by the policymakers so that the nursing perspective is taken seriously by physicians which, you know, the earth will shake as I say that. These are important developments that are the result both of the political movement and the general movement and moving with that and women staying

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true to their roots and hoping and helping to make it work from [ off mic] .

**LYNN SHERR:** Let me just turn to our, our token male on the panel. Isaac is this, is it insulting to you as a male physician to hear the criticism of male physicians? Is it, was it, I'm not going to put you on the spot and say how did you feel about having other women, women become doctors because I'm sure you thought it was a wonderful idea but [ laughter] how do you respond to this?

**DR. ISAAC SCHIFF:** Well, I don't feel defensive at all about it having, being in charge of a department where I hired a number of obstetrician-gynecologists over the last twenty years or so. The part that I get concerned of is when a woman, when people say, "Well, women gynecologists are better than male gynecologists" without giving enough credit to the fact that the women gynecologists work just as hard or harder in some cases to get to where they are. So I think to just say it's gender related. A woman's a better doctor takes away all that hard work, all that smarts, all that effort that she has put in. And that always makes me a little concerned. On the other hand, you can have female physicians who are insensitive. You could have male physicians who are insensitive. A lot of that is age related and the decade in which the individual has been trained. So I really, when someone says that female physicians are better I think it takes away from them and it's

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not a compliment necessarily. In terms of the heart disease, if I may go back to that for a moment, we hear a lot because it just keeps on coming up, heart disease in women and yet from a statistical point of view women die more of heart disease than any other cause over the long term but since I take care of patients and I ask them I don't recall the last fifty year old woman who walked into my office saying, "I'm terrified of having a heart attack." Fifty year old women are worried about breast cancer and mammograms, even though the chances of them dying of this is less than of heart disease. But every fifty year old woman has a friend, a relative, a colleague who's developed breast cancer and very few women in their early sixties know of somebody who suddenly died of heart disease. So although we hear of the statistics, it's really a personal approach and the individual patient is concerned about that. I wanted to come back to one other point that was mentioned. And some of this may be related to gender differences. If you go back to the nineties when many of the women gynecologists were younger than of course the average male gynecologist, we found that women gynecologists were much more likely to prescribe hormone replacement therapy than men. And men were much more likely to advise their patients to have surgery or have a tooth removed or have a hysterectomy as opposed to the female physician. There is plenty of gender bias in the type of treatment advocated but there's not only gender bias, there's

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geographic bias. A woman in the south is much more likely to have a hysterectomy than a woman in the northeast. A woman in New England is least likely to have a hysterectomy. A woman in California is much more likely to be given hormones than a woman in New England. So we have geographic disparities, we have gender disparities...

**LYNN SHERR:** Urban, suburban, rural as well. Yeah.

**DR. ISAAC SCHIFF:** And we're trying to learn why that is occurring.

**LYNN SHERR:** Elizabeth, you had a question.

**ELIZABETH WURTZEL:** Yes. I'm just listening to everything everyone has said and I just stop and think about the female versus male thing and I did want to say that younger male physicians are not, that has been my strength, [laughter] but there is, that men who have grown up in the post feminist era are actually, that disparity is less between them and female doctors I've noticed less because I have a male GP who I just love and I, you know I don't, but I will say that in overall, in my experience dealing with psychiatrists and psychopharmacologists men have been, in terms of prescribing drugs, they'll just do anything, they really, female psychiatrists have been so much more careful and so much more concerned that like, is this the right thing. Whereas you know I've more male, mostly psychopharmacologists and I think there are more male psychopharmacologists who have just been like

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"Let's throw it against the wall and see if it sticks". And I mean and I will also say that strangely I mean I was supposed to be on Prozac for six months or something and it's now sixteen years later so something and, still so something has changed in how they understand how these medications work and I would really like to know when they're going to do a long term study about whether I'm going to end up with like inoperable brain cancer or something like that. But the, the question I had, oh by the way, is as somebody who's thirty-five which seems to be always a turning point age whenever they do studies about women. I remember maybe it was a year ago on the front page of The New York Times there was that study on nurses, I think it was at Harvard where they found that something like eight in ten thousand after taking, you know, hormone therapy got breast cancer. And I remember, and so this was suddenly, there was this big debate, should we be on this, shouldn't we. And I remember thinking like it was something like eight in ten thousand, I remember thinking that's what point o eight percent, and for this everyone's going crazy. And I am really curious because every you know one year it's lapels, or [unintelligible] have benefits causes it, I mean it changes all the time and it's very frustrating particularly as a young woman who is trying to, you know, do it's impossible to do the right thing.

**LYNN SHERR:** The question is how do you know what to do

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and Vivian, talk about that and talk about the Women's Health Initiative as well.

**ELIZABETH WURTZEL:** There's such hysteria with whatever report, I mean for the hysteria that followed as I said a point o eight percent rate. Did no one notice how crazy that was?

**DR. VIVIAN PINN:** Let me see if I can respond to this there is, and keep it brief because I could go on for hours in response to many issues you raised. First of all, let me just set the stage and sort of get to this point from what has been said before. We've talked about the effort going up. I want to point out that the whole explosion of research, women's healthcare issues, and attention was started by the grassroots community. Women getting together, being concerned about women and women's health; men and women joining in, a grassroots effort. We know Judy's group's been active for more than thirty years, Byllye's for more than twenty years and many that you belong to there. But just think about the fact that concerns about questions such as that you just raised about women's health, what is research doing, are we getting the answers, started with the grassroots efforts that led to changes in public policy, led to changes in public requirements and has even led to a change in public laws such as many of you may know, others may not that since 1993 we have a law passed by Congress that requires the inclusion of women and minorities in clinical studies funded by the NIH so that no longer will we

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have studies conducted on conditions that may affect both men and women. We have the studies done on men only and I could tell you about that because that's my responsibility to make sure that's enforced. The kinds of questions you ask, yes we need studies, we need information to help reinforce or to determine what the state of art of medical practice is. And the state of art of medical practice, in other words, how should your particular situation be handled, what is the way it should be handled, should be based upon the results of scientific inquiry that is research. And we have research going on and those, that research should be what determines and I don't want to comment on particular the particular issues except to say the concerns you raise are the very kind of concerns that women have been asking about their health and their health [unintelligible] that has resulted in more research, more attention to themselves and I would there say for like this one, we demand answers. We ask questions. We don't know. We ask questions. We no longer, I don't as a patient and certainly as a physician I get the answers. You can't tell me as a patient, I can't tell you as a patient you do this because I say you do it. You're going to say well why, and what are the results, what are the outcomes, what does this mean for me. Let's then move on to the Women's Health Initiative or looking at in fact not just the Women's Health Initiative...

**ELIZABETH WURTZEL:** One failed constant I like is this

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the final answer [cross talk].

**DR. VIVIAN PINN:** Well, we don't know because science changes and in fact we often say [unintelligible] fifty percent of what we know today will not be true tomorrow because as science progresses and we get more information we keep learning and we don't want to be stuck in what we think we know today because there's new science, new techniques when information comes available we're going to learn more. That's what research is about and hormones and this whole business about hormones is a good way of looking at that particular issue. It was accepted over the years especially after the book that Dr. Schiff referred to, he didn't give you some of the quotes from that book when it said when women go through menopause their gonads shrivel up and we become useless and all those other comments. That's why we need to be on estrogens. He had some strong quotes. And that was believed by all of us in the medical world, by women, we wanted to stay young and we took it for granted that hormones were going to keep us healthy and keep us young. We have never had a study that has been a long term controlled clinical trial that has demonstrated whether or not in fact what is believed about hormones or believe about Prozac, believed about all these other things we don't have studies to demonstrate whether in fact what we think is the case truly is the case. If we're in the pursuit of truth then we want to know what the scientific information is. We've had

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observation studies which we discussed in the last panel but really you need a controlled clinical trial, which means a trial where you can [unintelligible] a placebo first as a treatment to determine whether or not it helps. And we know that women have had concerns about if I take hormones to prevent, to keep me feeling better, to get rid of the hot flashes and I stay on it because it will keep me young, I won't shrivel up like Dr. Wilson Hope [phonetic] said but will I have an increase in breast cancer? So that's been one of the questions so when the Women's Health Initiative was designed and part of, and there are many other studies. There is a health study that's made observations about breast cancer and other things related to that. We see other observational reports related to hormones and breast cancer and heart disease. So we were waiting for a controlled clinical trial to tell us what are the risks versus benefits of taking postmenopausal hormone therapy. And we like to refer as, instead of calling it replacement therapy, postmenopausal hormone therapy. So with the Women's Health Initiative we don't have estrogen only and the Nurses' Study which is one of the most wonderful studies that's ever been put into place but it's still an observational study, which gives us trends, it gives us information. In the Women's Health Initiative the only part of the study that's in this is the part dealing with estrogen and progesterone alone. And it was shown that there was this

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excess of eight deaths per ten thousand women each year of the study. We're saying that seven excess deaths from heart disease, eight excess deaths, or not deaths, incidents, these are not deaths but cases of breast cancer, seven excess cases of heart disease or heart attack, eight excess cases of stroke. So yes, the absolute number is very small but it demonstrates an increased risk. So then at least with this information we know on combination estrogen progesterone that if you take this as postmenopausal hormone therapy that you then have an increased risk. If to you the importance of taking that medication for some other reason is more important than being exposed to the risk of breast cancer, increased heart disease, or increased stroke then that is a decision you could make called informed decision making. We have other studies going on and part of this study is continuing. We really had planned to take this study out ten years but we stopped because we did not feel that women in the study should be exposed to increased risk. So once we demonstrated increased risk versus the benefit then that portion of the study was stopped. So then you say, "Is this really significant?" I toss it back to you and say, "If you are concerned about your health you have to weigh the risk versus benefit and if you believe the benefits that you would be getting outweigh the risk of taking hormones, then at least you can make an informed decision."

**LYNN SHERR:** But if, I think, isn't the question you're

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asking, "has the right study been done and are there more..." I guess the question is and I want to get, ask everybody to be very brief because we're going to questions from the audience. Just hold on one second, Elizabeth, please. That if the issue is we haven't done enough is the question, "Have we done the right study so that you can make an informed decision?" Or what's the answer to this question? What needs to be done now?

**DR. VIVIAN PINN:** This is the best study we have. It does not answer all the questions. We know that it doesn't answer questions about all preparations of hormones - different dosages, different ways of taking it. We need to do more but we'll probably never have a huge expensive study of this magnitude so we need to try to glean as much as we can out of this study. As well as the fact that those in the study will continue to be followed and we'll have the results of the other portion of the study, being estrogen only by the year 2005 to 2007.

**DR. SUSAN WOOD:** And if I could add, there's about, the question that has come up in response to the Women's Health Initiative that broke last summer and all the science that's coming out of it, women very naturally ask the question, "Well, what am I supposed to do about it? When am I supposed to use it? When am I not supposed to use it?" Now as Dr. Schiff mentioned earlier the FDA never approved the drug for prevention of heart disease. However, that was very common

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practice amongst physician practice was to prescribe it to prevent heart disease in the long term. So the big change from the data that comes from the Women's Health Initiative, not necessarily the huge absolute risks that you're going to have. When this study was undertaken it was to show how beneficial the product was. Not that it was risky but that it was good for you. So the first thing you know is that this is not to be used to prevent heart disease and that's what the FDA label that was revised on estrogen products says, that you are not to use these common products, estrogen and estrogen plus progesterone for prevention. Now you are, there are indications for use - for hot flashes and for vaginal atrophy. And for women that have symptoms that need to be treated, these products are indicated for use. They're not, it's not to say it's dangerous, don't take it. It's to say if you need it for these indications, use it. But don't use it for prevention of heart disease. And if you're using it for prevention of osteoporosis [unintelligible] also works. Consider alternatives because if you don't have the other menopausal symptoms there may be other alternatives to prevent your osteoporosis, which would be a better choice for you. But that's not to say you shouldn't use it for these purposes. And there are, there is some guidance in the lack of complete and clear information on all things on what to do and physicians have that now.

**LYNN SHERR:** It does confuse people. It's clearly

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confused Elizabeth. It is confusing to a lot of people and rather than get bogged down on that one subject, which I think we could spend three more days talking about and never come to an answer, let me just briefly go around because we're going to open it to the audience. Let me briefly go around and answer the following question briefly, please. What more needs to be done right now? Judy.

**JUDY NORSIGIAN:** Well, there's so many answers to that. Let me just pick up on one thing because I think tobacco use is a crucial issue. Gro Harlem Brundtland whom many of you know of as the Director General of the World Health Organization, just spent seven years working with many countries to produce an international framework, a treaty on tobacco use. It's going to the World Health Assembly in May. It's a very important document. Find it, read it, go to your policymakers, and make your views known. I think it would be extremely important that this country supports that international treaty. We know a lot. You have to remember that companies like Philip Morris, the largest tobacco manufacturer in this country are, you know, are thinking about their image. They've renamed themselves the out there group. They're concerned about their image. They pay directors five hundred thousand dollars to cover the cost of the set on a movie so that they'll script in smoking when it wasn't originally there. You wonder why there's so much tobacco use. It's because there are these other kinds of infiltration

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into the cultural medium and the mass media that we're exposed to. These more subtle things have to take our attention. They're not only visible. We have to pay much more attention to the role of the media, helping young women to be media literate; to understand that over half of what comes out as news originates in a PR firm now. It's not like it was in the old days. And these are key issues that we have to address.

**LYNN SHERR:** Thank you, Ellen. What has to be done right now?

**ELLEN MORE:** Well, I think what has to be done is that we have to try and tear our attention away from the war and back to domestic politics because there are horrible disparities in access to care and funding for care among the poor which disproportionately affects women and women with children. In my home state at the moment, of Texas, I'm not a native but that's where I am [laughter] the Children's Health Insurance Program, which is funded through the state is very much endangered because the state, like most states today is suffering from an immense budget crisis. All over the country programs like that are the first to go when there is a shift politically away from commitment of the state to taking care of its citizens. So I would say that the most important thing that we can do right now is to get political again and to realize that the times have changed. [Applause]

**LYNN SHERR:** Byllye.

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**BYLLYE AVERY:** Great segue. I think the most important thing now is that, you know, I'm sitting here thinking we're talking about women's health but our total healthcare system is totally crumbling all around us. It's not working for anyone and so what I would love to see is a women's health movement, which includes all of our organizations and our groups here, trusted, the consumer based, consumer led that, and we are smart. That we gather ourselves together and we develop a healthcare system that delivers services to every single person devoid of my politics, your politics, anybody's politics that makes it so that people have total access to care. And that we learn about healthcare, a human's right, it is our right as we deserve it. And that's what I think we need to do first.

[ Applause]

**DR. SUSAN WOOD:** I hate following Byllye Avery.

[ Laughter] and I'll second everything that's been said but I would on to that that we need to take the knowledge that we do have, make sure it's truly evaluated for whether it makes a difference for women or for men or for kids or for the elderly from all races and ethnicity. That we take that information, we learn from it, and we apply it to the care that's provided to us. One thing we haven't talked about is that of the last ten drugs withdrawn from the market, eight of them had a disproportionate impact on women. So we have the science to analyze that? Sometimes yes, sometimes no. We need to make sure

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that any time we're developing new treatments or medications that we really evaluate it for sex and gender differences and race and ethnicity differences and we not just kind of absorb that information but we turn it into reality and we turn it into care for, for all of our citizens.

**LYNN SHERR:** Isaac.

**DR. ISAAC SCHIFF:** I fully support all, all what we heard but I want to add one other and not necessarily more important or less important but when you speak about women's health one of the important issues is how disease affects a family because it's the woman who actually supplies the nurturing to the family. And if you go to professionals where both the parents are out working, it's always the woman who ends up providing the healthcare to the sick child. It's the woman who assumes the responsibility, not only for her own parents, but for her husband's parents when they get ill and somehow this is all lost in the society. It's an added pressure on women and it's part of the women's healthcare that we have to pay attention to. [Applause]

**DR. VIVIAN PINN:** Honestly, being responsible for research on women's health I concur with all that Susan Wood said and I endorse it and I'd like to stress the importance of needing more research to investment in research so that we have more scientific knowledge to help us answer some of these questions that we don't have a response for or don't have

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questions that we and our healthcare providers can't provide ready answers for. And the second thing is to focus on recognition that better health for ourselves, as well as our communities has two facets. One - what the healthcare system can provide to us and what we can provide for ourselves. Remember prevention, we're seeing a big focus on prevention, what we can do while the healthcare system is coming up with better research and the healthcare system we can expect to survive and deliver better cures, better treatments, we need to remember what we can do to protect our own health in terms of obesity, in terms of physical fitness, in terms of nutrition, in terms of substance abuse, in terms of risky sexual behavior, in terms of smoking to remember it's a two part effort, a collaborative effort. We'll do what we can in terms of science but let's all do what we can in terms of our own behaviors to protect our health. [Applause]

**LYNN SHERR:** Elizabeth.

**ELIZABETH WURTZEL:** I think, that's besides everything everyone has said, that I think actually what we really need is, is more of, of this. What we have here. I think you know women have to be very savvy consumers of what is medically available to them and then you think that that's [unintelligible] know our bodies, our selves. There's so much else that is available. And now there's the whole worldwide web at your disposal but you know to look things up and follow

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things. I think it's just, you know, I think the more you know the more you know. And I think you have to be a consumer advocate on your behalf in dealing with the medical world probably.

**LYNN SHERR:** And with that we will take your questions. If you want to direct it a specific panelist please feel free. But as you've noticed, they're not shy. They will jump right in. So I'll start over here. Yes, go ahead.

**JOYCE HUNTER:** My name is Joyce Hunter. My question is about women and research and clinical trials. I work in behavioral science at the HIV Center for Clinical Medical Studies and one of the issues that we have there working with Presbyterian Medical Center and some of the other research centers that are doing clinical trials around HIV are going to ACTGICK [misspelled?] the policy cabs [misspelled?], we're finding that it is so difficult no matter what we do and we have a lot of women on the cabs [misspelled?] and people with HIV and a question for us is how come, how come we cannot get enough women into clinical trials because a lot of the medications and the treatments that we are getting are based on treatment and clinical trials based on men. So I was wondering if...

**LYNN SHERR:** Yes, how do you get more women in the clinical trials?

**JOYCE HUNTER:** And I would assume this is probably with

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other trials too but in HIV especially that it's such a rising epidemic among women worldwide and here in New York City I would like to...

**DR. VIVIAN PINN:** The generic response is, as you know we recently had a workshop to reevaluate the progress we've made on inclusion of women in clinical trials and issues that we need to address in the future. And I think Dr. Victoria Cargill specifically addressed some of the issues related to women in HIV/AIDS studies. You're going to hear a lot from Helene Gayle who's in the audience who is, who is one our experts in the country on HIV/AIDS and I'm sure she'll talk about some of [unintelligible] when she addresses it. There are many issues that are related to women going into HIV/AIDS studies that are, that perhaps apply to many other studies. A question about trusting the system, understanding the medications that are being taken, and whether to believe they're really directed towards them. And we have to make, and I could go into many, many other areas, but certainly we'll have to continue to work together on not just AIDS trials, but other trials so that women understand. I, it's interesting that for HIV/AIDS studies and some other studies there is difficulty getting women into trials and then in other areas where people thought it would be difficult to get women, we've found that once women realize that there are trials, that they're anxious to volunteer and they speak that they've never known that they

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had the possibility of getting in. So I could into more theories. Perhaps you might have some suggestions you want to put out about what we can do to help, help and to work with you on that but that could be a whole another hour discussion so let us just bring the attention to the audience to the fact that we need to do all we can to encourage women to participate. It's one thing to have a law requiring the inclusion of women. It is another thing to make sure we get appropriate representation of women in studies, including our populations from different ethnic backgrounds so that we truly can come up with, with distinctions of knowing what the, knowing what the level of benefit is in the study.

**DR. SUSAN WOOD:** I, I would like to add that there are [off mic] many of the studies that we're talking about, they are probably funded by the NIH and fall under the law requiring inclusion and advance planning on how to include them but many studies that we're talking about are either funded by the pharmaceutical industry which is, their trials are regulated by the FDA but we do not have a similar requirement. We require that the studies be generally representative of the people intended to treat but there's no specific rules about how in advance they need to include women. And I think another point is that many of the studies for new drugs are, take place overseas and the United States is a good decade or two ahead of Europe, Japan, and places where these studies are taking place

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in Asia and Africa where both culturally, scientifically, their ethical rules, their laws, their regulations at the moment still actively exclude women from many clinical trials. And it's a, although we've made a huge progress through the NIH funded trials done here in the United States we still face the barriers of getting them in. But that's only a piece of all the clinical research that's done worldwide.

**JOYCE HUNTER:** I understand that...

**LYNN SHERR:** I'm afraid; I'm going to take another question. I'm sorry but I'm sure that these ladies would love to talk to you afterwards. It's just not fair to everybody else. Thank you. Yes.

**MINDY LEWIS:** My name is Mindy Lewis. I'm the author a memoir called *Life Inside*, which touches on the questions that Elizabeth we're told brought up. I was an underage adolescent who got caught in the mental health system because my mother who was a single mother was advised by a psychiatrist to have me hospitalized. And I was misdiagnosed and medicated and kept until I was eighteen. And my concern is that in this climate of sort of like the quick fix prescription that parents are often in the position of following the advice of psychiatrists to basically to pathologize and medicate behavior, behavioral problems and mood disorders. And I'm concerned about the long-term effects in terms of side effects from medication, which are real. There's kidney disorder and other things that occur.

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But also on self-concept because especially for young children I mean right now there's been a lot of research studies being done...

**LYNN SHERR:** Let me just get, we're trying, the question you have is are these studies being done or does anybody...

**MINDY LEWIS:** Well, my question is about that it's a very self-contained system so on the studies that are being done on medicating younger and younger children for, for bipolar or depression are being, in other words, what are the alternatives being offered in terms of self-knowledge and other ways of dealing with mood disorders aside from medication, particularly when parents are being to medicate their children Ritalin or what have you.

**LYNN SHERR:** I'm going to, who, Elizabeth, do you want to try to handle this?

**ELIZABETH WURTZEL:** Yeah, I just would say I have this theory that as more adults are, it's like the trickle down theory of medication, I bet there's an incredible correlation between parents on drugs and kids on drugs. Like I bet that an awful lot of the kids who are being medicated have parents who are being medicated. And I've got to say I can't believe they give medication to people who are under eighteen. I mean it really could just be adolescence. I mean you don't really know what it is. And it's very, it's extremely disturbing to me and

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I don't even know what to say about this. I really, I think also as you have parents who are overstressed and you know you have two, you know, a working couple, both people work and they have very limited time to spend with their kids and they don't want to spend that time disciplining them if somebody says to you, "Here's a pill, it will solve that problem." I mean how could you say no and I don't blame the parents for doing that. I really don't. But I think it's really, really frightening. I was going to say we could devote a whole panel to that. I mean I often feel like, I have to say, and this is a separate thing, but as somebody who got addicted to morning Ritalin I can tell you that if you chopped up and powdered Ritalin in front of me and cocaine in front in me, and we did it like the Pepsi challenge, I wouldn't be able to tell the difference and I promise you that there are no parents who would give their children cocaine pills so I don't how parents are so happy to give their kids Ritalin pills. [Applause]

**LYNN SHERR:** Thank you. Yes over here.

**LAURIE BERMAN:** Hi, my name is Laurie Berman and I'm a Barnard graduate and I'm currently finishing up a master's degree in health education at Teacher's College. And I'm, I'm really glad that a number of the panelists have talked briefly about access to healthcare because it's such an important issue. And I just wanted to kind of reiterate that it's not just the poor people in this country but also many people in

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**Panel Two: Women and Healthcare: A Critical Analysis**

4/05/03

the middle class who, whether they have health insurance or not are being denied, incredible how health services are really only available to the wealthy people in this country. I mean I am, I've been working my way through graduate school and on the health insurance that I have, well, I should say that my sister actually died of leukemia and when she was ill she had ill insurance and because of her heart, she had the wrong health insurance. She was denied care at Sloan-Kettering, which we all know is one of the best cancer care facilities in this country. And while she was sick and I was undergoing one of the worst depressions of my life which we call [unintelligible] my health insurance did not provide me access to any of the, I basically, my health insurance provided me with kind of, forgive the term, the bottom of the barrel psychopharmacologist in New York City and it was a really dehumanizing experience. So my question to the panelists is how do we, how can we [unintelligible] for access for everyone to have adequate health coverage in this country, and not just coverage for healthcare but also health education because as I'm student teaching now what I've learned very quickly is that it's the wealthiest communities in this country that have the best health education.

**LYNN SHERR:** Let me ask Byllye to respond to that.

**BYLLYE AVERY:** Well, I'm the organizer here and so you know we'd have a real problem here. And so frequently just make a decision, and you want to pull people together right where

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you are. You want to get [unintelligible]. There are a whole bunch of people over there who have the same idea that you have. Organize some kind of forum where you come together and you start to talk about it and like minds meet each other's and you start to work on this. It's not going to happen waiting for somebody else to do it. We all have to start right where we are. [Applause] And you have to start.

**LYNN SHERR:** I'm going to go over here now. Thank you, Bylllye.

**RULA PATEL:** Hi, my name is Rula Patel [misspelled?] and I'm a Barnard student after 2004. Do the panelists in discussing providing healthcare to the public and more specifically about the time that a physician spends with the patient and I guess the lines of communication before administering treatment. My question as a pre-med student trying to be a physician, is how can you reconcile the disparity between providing good healthcare by spending more time with patients versus providing as much healthcare to as many patients as possible?

**LYNN SHERR:** Tough question. Who wants to take that one? Nobody wants to take that one. Ellen. It seems like you. [Laughter]. Oh okay, we'll give it to a little bit...

**ELLEN MORE:** It's certainly, it's a certainly a, what we would call a tragic choice. In short we don't want to settle for that kind of choice. So that would be the first place to

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start. The second place to start is to realize that if you do proceed into medical school you will be urged all the time to do everything and then to do it faster. And that's how it's being addressed at the moment. And it's being addressed that way of course in part, not just because of the access issues, but because of the reimbursement issues. So again it becomes a political question and one in which physicians themselves today are increasingly aware that they need to take a political stance and that they're not outside of politics but they're within politics. So I would echo what Byllye says. Physicians themselves need to start organizing themselves and obviously funding, the funding of critical public health programs and community health is the best key but we have to remember that physicians aren't the only providers of primary care services. We have nurse/practitioners, we have nurse/midwives, we have physician assistants. We have other providers of care who can in some cases do a better job of primary care delivery and we have to make sure that we've, when we get into those settings we're ready to organize. Just like you said. I know HMO's where physicians were told; "You're going to get a ten minute limit from here on". They organized as a group of physicians and said, "Ahh, there's going to be no ten minute limit. You need to fire all of us or you let us practice medicine the way it should be practiced." You have to be ready to organize when you get those kinds of constraints; they're really bad for

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providing good care, whether you're a physician or a nurse/practitioner or whoever. And so we ought to remember that healthcare is now very political no matter what else it is.

**LYNN SHERR:** Let me just get one more answer from an actual physician and then we'll move over here and then we're going to have to go.

**DR. ISAAC SCHIFF:** You bring up a very important point because we're approaching a crisis and the crisis comes from many different areas. For example, in Florida the malpractice rates are for a obstetrician gynecologist is two hundred, excuse me, two hundred and fifty thousand dollars a year so that's one type of crisis. Another crisis is in my own state due to budgetary constraints they've removed people from the Medicaid list. So these folks have no money. They can't go to the physician. They wait until they're really sick and then end up in the emergency room. So now the emergency rooms in hospitals are crowded beyond means because these illnesses are the advanced illnesses that could have been avoided had they had some preventive care. So it's multifactorial but there's no leadership. There is no leadership that's dealing with this as a crisis. All it is is patchwork and every so often people solve an issue to a week or a month but it is coming down to a crisis from many different areas.

**LYNN SHERR:** Lots of things to look forward to when you get to medical school, okay. I'm unfortunately being given a

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time signal. I'm going to take two more questions, one from over here and then one from over here. Please make your questions brief.

**ANITA:** Hi, my name's Anita. I'm a Barnard senior and I'm also part of the Rollerman [misspelled?] program. My question I guess is not directed to any one person but any one who wants to answer it. Do you feel that there's a problem with the value that's given to the life, the body, and the health of a woman especially with regard to legal measures and stances that have kind of been taken with this current administration? Yeah, I mean for me personally I feel like there's kind of silent intrusion in my status here as a woman with things like you know insurance being extended to a zygote I may be carrying or the fetus I might have but not being given to me and the Administration not supporting me as a pregnant woman should that happen? [Applause]

**LYNN SHERR:** Who wants to take it. Judy, do you want to try this?

**JUDY NORSIGIAN:** Let someone else take that.

**LYNN SHERR:** Let someone else take that. Well, give it a shot.

**JUDY NORSIGIAN:** Well, I agree with you and I think that there are some major problems with what is happening in this Administration right now in terms of addressing the needs of women as we have been over the years. I am one of those

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people that believe that a truly woman centered perspective really does allow for a range in choices, not choice for choice's sake. I'm not someone who believes in human germ line genetic manipulation. That we should design our babies like James Watson suggests we should. I am, I am someone who believes there are appropriate controls on things like procreate and liberty. I am someone who thinks we have to go back and say, "What about asking younger woman to have their eggs extract for the purposes of embryo cloning or for even in IVF clinics, do we know enough about all the risks involved?" I want to us to go back and ask the questions that Vivian and others have been saying. But if, I'm a feminist, and I use that word very proudly and I think it does mean that you have to embrace the great variety of women and women's needs, cultural backgrounds, we are doing a great disservice to many Muslim women in this country right now by the way we are treating women. I can give you examples which I won't right now but I think that we have to remember this is just a dental story that Byllye that there, racism is alive and well, particularly for women and that women are burdened with so many responsibilities. And although I do know young men who do take that responsibility of being the nurturer and the carer, they're not always just the woman. I'd like to see more of us supporting it. I don't see this Administration supporting that nurturing role in men that the women's movement has been so

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long in calling for and some young men are rising to the occasion in doing that. But are they getting support? I don't see it from this Administration. That's just a little bit of what I want to say.

**LYNN SHERR:** Last question. Go ahead.

**GOTSHAB MACRAD:** My name is Gotshab Macrad [misspelled?]. I'm an undergrad at Colombia and Judy touched on environmental impacts on public health and the lack of research funding and I was wondering what research is currently being done to support these efforts and what can we as students, citizens, scientists, and public policy makers do to encourage funding for this kind of research?

**DR. VIVIAN PINN:** Judy, I noticed when you mentioned that I wasn't quite sure exactly what you were referring to because maybe you want to explain exactly what you meant and we'll keep it short.

**JUDY NORSIGIAN:** [off mic] but I do just need, I'll lead to the Collaborative On Health And The Environment and then also the Science and Environmental Health Network, which is that great website. There's a lot of research, NIEHS, National Institutes of Environmental Health Sciences. There's also other research that's going on. All I would say is the balance isn't quite right. We need to have more such research but it's going on. And I have to say under the Clinton Administration we saw a resurgence of interest after

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[unintelligible] well, I won't get into the alphabet soup, but there were three or four agencies in the federal government that lost so much of their funding. We, during the Reagan era saw very little attention. Then we began to give it more attention and now I feel with the exception of some public health advocates who have been really hammering away, we're losing some ground there. That's why I raised the issue and I want to focus on that more.

**DR. VIVIAN PINN:** Let me just end by saying we do have as Judy referred to at the Institutes of National, National Institutes of Health a institute specifically focused on environmental health research and that particular institute is focusing on women's health. It's budget has been for sure because NIH has been very fortunate to have it's funding continuing and we can see that it's a doubling of the NIH project which we're very happy about. And in terms of women's health, we're looking at environmental issues. That institute is in fact, is in fact focusing a lot of effort in that area but there's always more we can do and so I think that maybe should be the bottom line about all of this. Where we don't have the answers, research whether it's NIH research, whether it's general research some other way, can help us get that information and we all...

[ END]