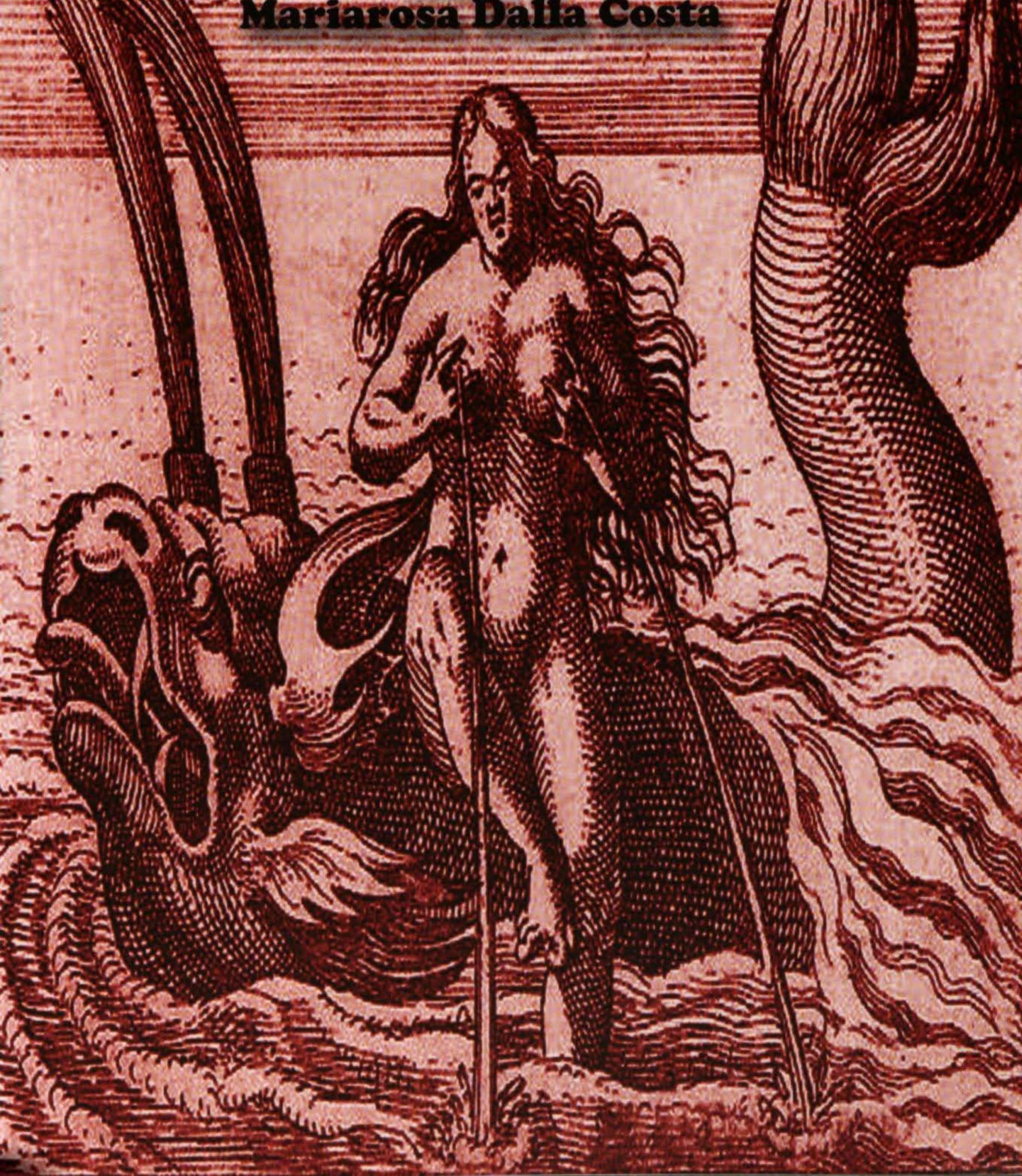
GYNOCIDE

Hysterectomy, Capitalist Patriarchy and the Medical Abuse of Women

Edited by
Mariarosa Dalla Costa



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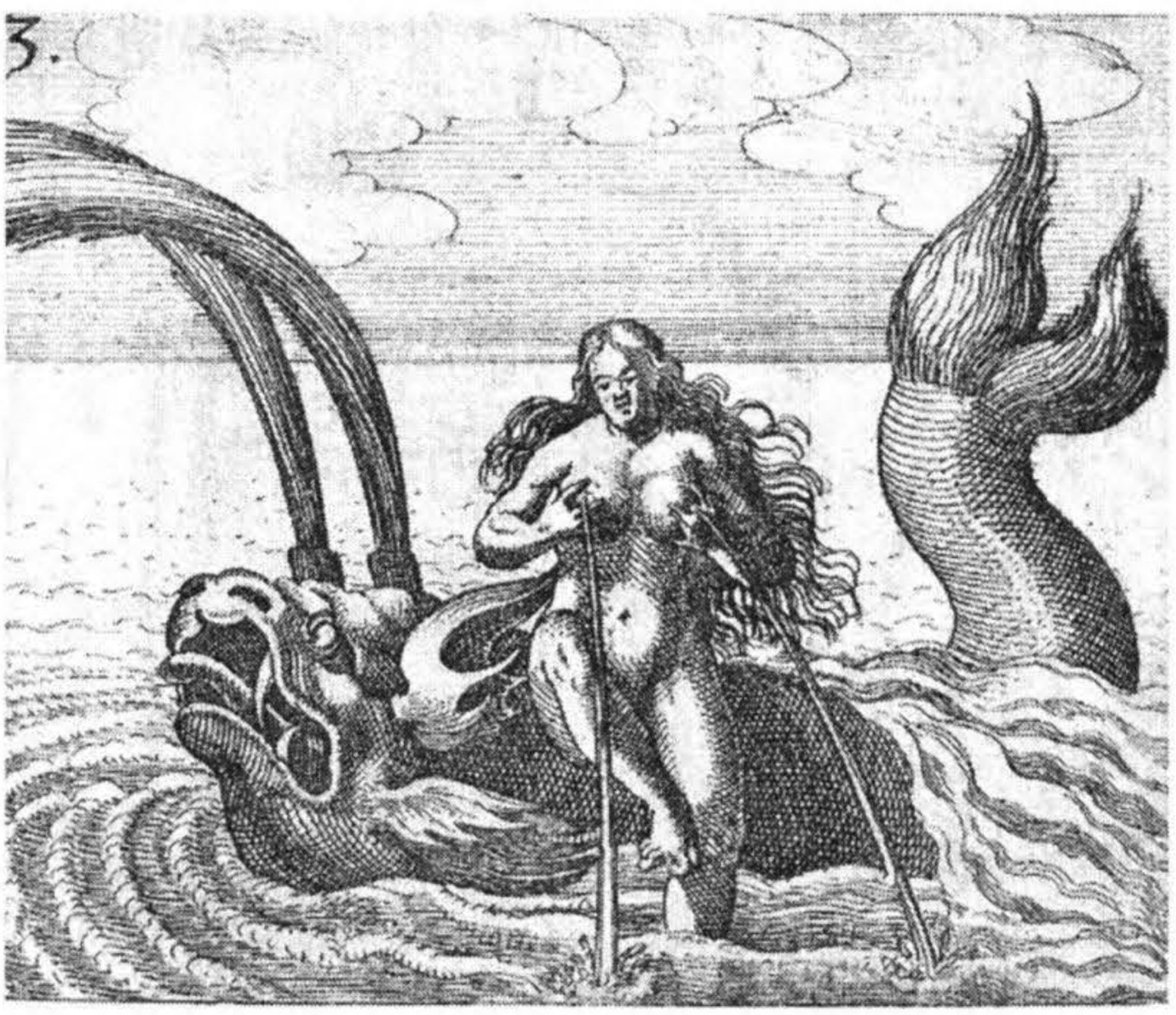

Male midwife using sheets to preserve his patient's modesty,
France, 17th century

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Mariarosa Dalla Costa

Translated by Danila Obici and Ralph D. Church

Autonomedia

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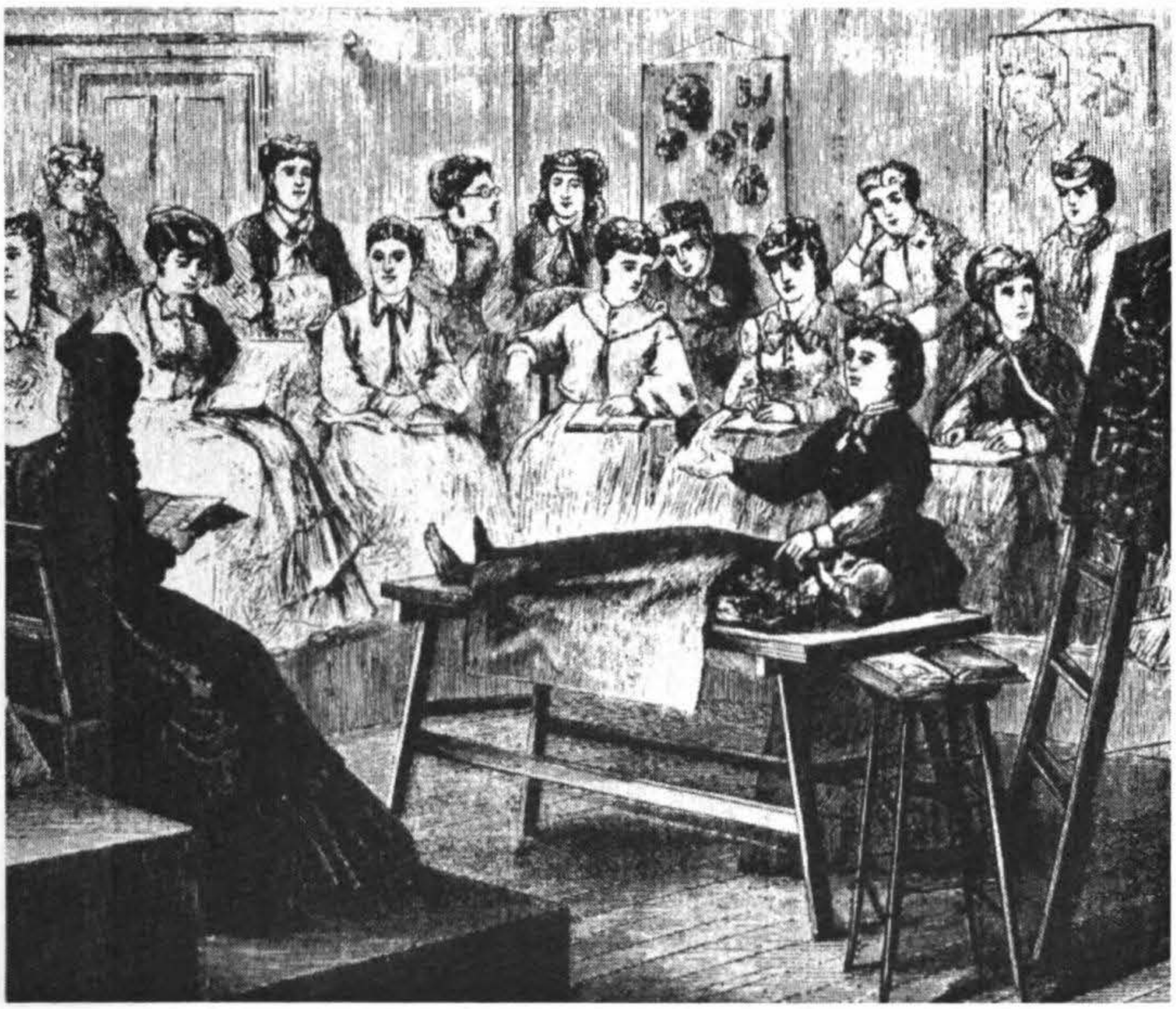
Dedication

To all women and physicians

Acknowledgements

I would like to thank all those who provided their precious expertise and experience and who helped me complete this work. I am especially grateful to Professor Maria Castiglioni of the University of Padua for her elaboration of the statistical information.



Lecture room at a women's homeopathic medical college,
New York City, 1870

Introduction

Mariarosa Dalla Costa

This work is intended to invite discussion on hysterectomy and its abuse, an abuse that is clear from the number of operations performed and from the experience of women in many developed western countries. This abuse did not begin in the last century, but it took on massive proportions. Already in the 1800s, on both sides of the Atlantic—even if on a much more modest scale because of the extremely low survival rates that were offered patients by the surgical techniques of the time—hysterectomy, ovariectomy and clitorectomy were practiced as aberrant surgical techniques for a varied and incoherent range of female problems, which certainly were not due to uterine pathologies. Fundamentally it was used as a means to punish women, a means to control their behavior, to exorcise male fears of the female sex, and to exercise the male will to dominate it.

How much of contemporary medical practice still derives from practice which is rooted in the greatest sexocide in recorded history, the witch-hunt that plagued Europe from the fourteenth to the seventeenth century and burned at the stake, after horrible torture, hundreds of thousands of midwives and healers along with other poor women? All of them were in different ways guilty of not bowing low enough before male authority and the family standards required by the rise of capitalism. Women's bodies and their medical knowledge were burned on those stakes to be replaced by a male "science" and a male gynecological profession controlled by the state and church. Has history run its course? Or, among the many reasons given for hysterectomies, does its abuse still conceal, more or less covertly, a yearning for male domination over women's bodies that reaches this most lethal form of conquest because it expropriates and destroys what makes a body a woman's body?

So the question has been considered from a historical perspective spanning centuries to make people aware of its distant origins, which, because of their centrality to women's history, have already produced fruitful analytical studies by a number of female scholars. Today the anti-female origins of medicine, and

of gynecology in particular, as official sciences are no longer a mystery. But the clock keeps ticking. Women demand always more of their rights, and first of all the right not to suffer needlessly. For this reason we have chosen a debate focused on the present, on what is acceptable and unacceptable today, on today's needless suffering, on today's rights of all citizens, female and male, on the reasonableness of what medicine offers women today. But the clock keeps ticking. The body, not only if it is female and not only if human, is under assault by various "sciences," this compels us to reiterate the rights of a body as a body that is inherent to the individual. The rights that belong to the individual, to every individual and, for our argument, to women as individuals. That is, the rights of the living, the dying and the dead individual within the web of relationships in which they lead their lives, they spend their lives and they bring their lives to a close and the rights of those with whom their relationships are entwined. It is this set of bodies and their relationships, the paths that lead from one body to another, from one individual to another, that we call the "social body." And we claim our *habeas corpus* as the right of individuals to maintain sovereignty over their own physical bodies within the web of their relationships, within the social body, and to maintain possession of their bodies until the solemn moments of passing away, of mourning and of remembrance.

Clearly, as I am about to discuss the unwarranted removal of organs that occurs when hysterectomy is abused, other problems related to the removal and use of human organs or body parts at the moment of death, conception and pregnancy are on my mind. I have committed myself to discuss it with those women and men who are already committed as soon as possible. Meanwhile, I here declare that my *habeas corpus*, here reiterated by exploring the question of hysterectomy, is part of an impassioned and more than legitimate defense, on the basis of human rights and written law, of a human body that is increasingly under siege and threat of expropriation. The body is not a warehouse of organs, or a machine. The body is inherent to the individual who has the *inalienable right* to defend *its integrity while alive* and *bury it whole*.

It follows first that any bill that authorizes the removal of organs based on a citizen's "tacit consent" is unacceptable.

Hysterectomy, in its excess, has become a social problem. For this reason I thought it was opportune to hold a conference at the University of Padua on 12 April 1998, "Hysterectomy: an open question in the relationship between women and medicine," whose proceedings are presented here. The conference hoped to create a place where the voices of female and male scholars, physicians, magistrates, health care providers, and current or future citizen-patients

could be heard. And, during the fiftieth anniversary of the Universal Declaration on Human Rights, it seemed meaningful to dedicate this initiative to the right of all women, like all citizens, to retain the integrity of their bodies as a fundamental and irreplaceable good and to see this integrity adequately protected in medical practice. Over the course of the conference this need became clear and was unanimously shared.

But verifying when and why hysterectomy is performed is a problem that does not concerns advanced societies alone. It is a subject that urgently needs to be included within the question of what is called the "reproductive health" of the female gender, which is considered one of twelve crises areas in the report of the fourth World Conference on Women held in Beijing in 1995. If these critical questions should become the object of special efforts by women's movements and institutions, this initiative, like when this question was raised before a gynecology conference in Palermo in December 1997—at which I was invited to speak and I would like to thank the Italian Society of Gynecology and Obstetrics for the opportunity—is meant to be one of my first steps of action as a feminist and as a scholar. My effort will continue not only through unveiling social problems, but also by facing them squarely and hopefully contributing to their solution as well. While strategies of war and death increasingly loom on the horizon as our lives unfold and research evolves, resisting the production of death, first by refusing to die inside, requires us to think and to act outside the "labyrinth of the inevitable." This is a labyrinth in which many have surrendered rather than raise questions about the subject treated here.

Why is hysterectomy a question? Because, as is recognized in international journals of gynecology, there has been an explosion of hysterectomies, i.e. the surgical removal of the uterus, often accompanied by salpingo-oophorectomy, i.e. surgical removal of the ovarian apparatus, in the twentieth century, which cannot be explained convincingly by an explosion of diseases serious enough to justify the procedure. In this period, with the advances in anesthetics, anticoagulants and antibiotics, the frequency of this kind of surgery has increased, and is recorded in data that raises serious questions. The United States is the leader in the trend to perform hysterectomies. There one woman out of three can expect to undergo this operation by the age of 60 and 40 percent of women under the age of 64. The operation has complications in 50 percent of the cases. This country records remarkable differences among regions, races, and social strata. These differences cannot help but reinforce the doubts. The lawyers of patients attribute these disparities to differences in medical training, professional interest and economic profit. This characterization is cleary recognized. In Europe the rates

are generally lower but incredibly there are noteworthy differences between countries. For example, France and Holland are countries with relatively low rates, while Italy has quite a high one. In our country SIGO (Italian Society of Gynecology and Obstetrics) reports 40,000 hysterectomies per year, which it considers to be too many, especially in a period when less invasive and less destructive techniques have been perfected. SIGO holds that it is a doctor's duty to stay informed of such techniques (minimally invasive operations) like in other countries. For Veneto the data provided by the region reveal a particularly high and increasing rate for the operation: between 1993 and 1996 hysterectomies rose from 5909 to 6685, as a result one woman out of four can expect to experience the operation, twice as many as the national average, which is one woman out of eight based on the same set of data mentioned above.

Nevertheless, I do not think that this surplus, wherever it occurs, should be attributed primarily to outdated training. Alongside the *data* there is the *experience* of women who long ago started to find two approaches to gynecology: one is more holistic and respectful of women as individuals and of their right to defend the integrity of their bodies, represented by physicians who propose hysterectomies (and at times ovariectomy) only when truly necessary; the other, mechanical and reductive, which can also be described as an "age based approach," practiced by physicians who think the ovaries and uterus are superfluous when menopause nears, and recommend this operation more on the basis of age than on the patient's disease. It is this approach, which is found in many areas in Italy or coexists with the other in the same area, that makes hysterectomy a social problem, and a question that we wanted to analyze in our conference and so in the papers in this volume.

It is this approach that has made the recommendation of a hysterectomy a kind of *net* in which middle-aged women's bodies are entrapped, since, by being linked to age (or having had the number of children they desired), it objectively increases the risk for women of being "hysterectomized" simply because of the passage of time and developing a uterine pathology, so leading them to endure, without sufficient cause, an operation which has a severe physical and mental impact on their lives. The outcome of such an approach can be seen in the frequency with which the operation, as recorded in the data mentioned above and reported by the women themselves, has been and is performed that can hardly be traced to pathologies serious enough to justify it, especially when methods of early diagnosis and treatment have been perfected, e.g. for cancer of the neck of the uterus. But most importantly, this approach, as recorded in experience of many women, reveals an extremely defective doc-

tor-patient relationship. We therefore have chosen in this conference to pay special attention to this problem, in the cases in which it occurs, in the hope to help restructure it along more appropriate lines.

More generally, if the abuse of hysterectomy represents the apex of the aggressive and castrating practice of gynecology in relation to the female body, its violence is clearly not confined to this abuse. About a quarter of a century ago, the feminist movement and the women's movement generally criticized needless suffering during childbirth, abortion and in other circumstances when the female genital apparatus needed care. And certainly, thanks to the criticism and actions of those women, many things have changed. Nevertheless, many questions return to the fore, others must continuously be reformulated and even get worse, and new ones arise. Significantly one woman patient, who testified and who will never be able to forget the humiliation and the gratuitous sadism of her childbirths, has come to the conclusion that male gynecologists have used gynecology as a opportunity for revenge against women and deems the abuse of hysterectomy to be the n^{th} expropriation of their bodies that women have endured, the n^{th} form of violent male domination through which male physicians destroy the only power, unofficial but real, that women still have in this society, i.e. their femininity.

In conclusion to these brief introductory observations, I would like to underline how today the aggressiveness of science as a whole, not only of medicine, increasingly expresses a tendency to castrate the reproductive powers of nature in order to create, on the one hand, scarcity, on the other, the capitalization of the reproductive mechanisms of life, so that life is becoming increasingly a good produced in the laboratory. But like Vandana Shiva, a well-known ecofeminist scholar, I believe that when engineering is introduced into the life sciences the ability of life to reproduce itself nears its end.

As for medicine, its aggressive practices cause morbidity, infirmity and unhappiness, and thanks to this create misery because they cause citizens to be increasingly dependent on the market and laboratory, at the expense of their vital creative energies and of their economic resources. This represents the scarcity of good health and the capitalization of the reproductive mechanisms of health that are created by medicine. I hope that the outcome of this conference might be to help people remember that medicine ought to serve citizens and not vice-versa. I also hope that it has contributed to reviving in women the process of learning about their own bodies and constructing basic medical knowledge to allow them to adequately evaluate what medicine offers them and to bear in mind that there is not only one medicine.

Midwife aiding a woman's delivery on birth stool,
Germany, 16th century, woodcut

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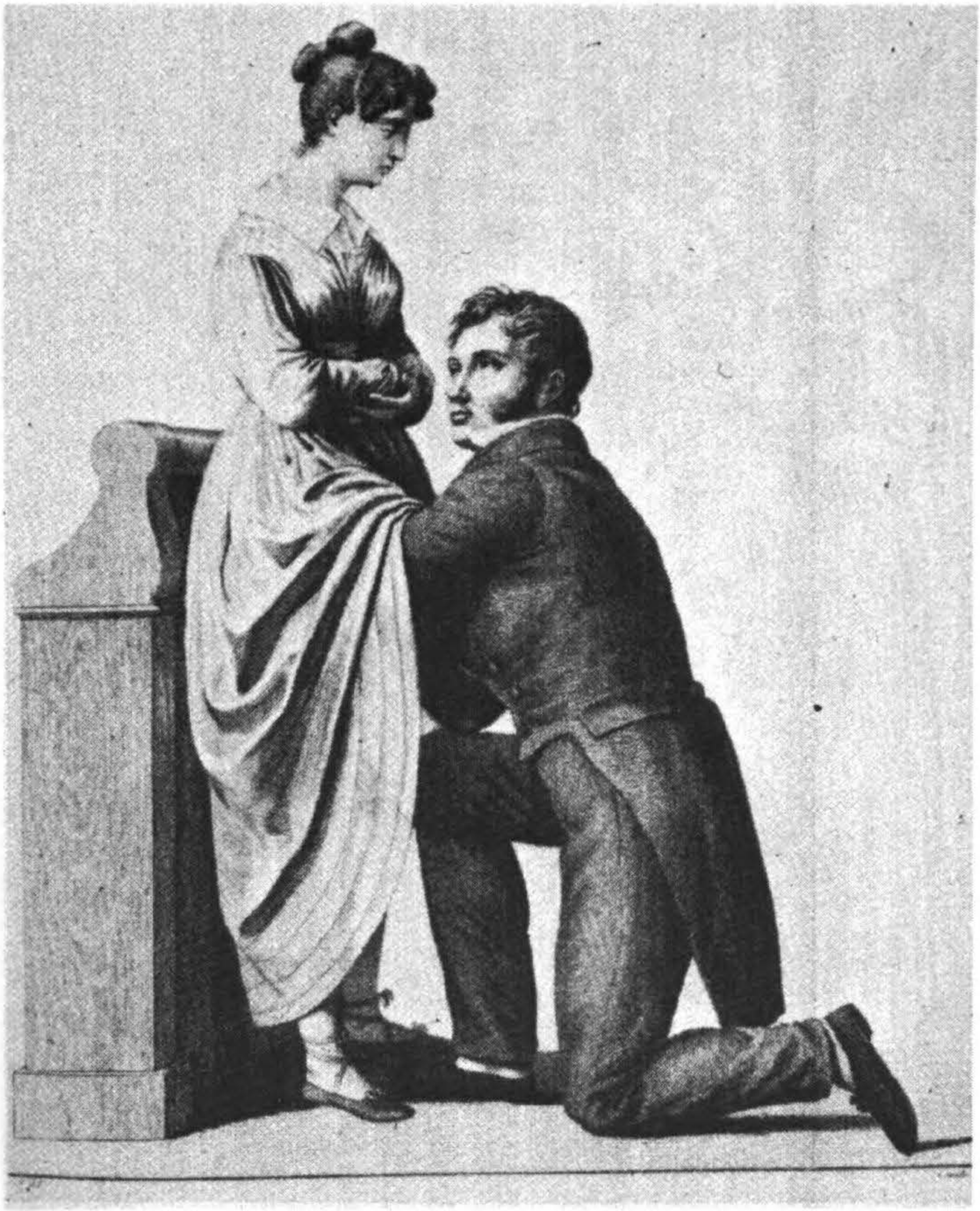

Gynecological exam, "the touch," with no eye contact,
from French text often used in US; Paris, France, 1822

1

*Hysterectomy: A Woman's View of its Medical Facets, Historical Development and Ethical and Legal Questions**

Mariarosa Dalla Costa

Stations along the "Course of Life"

Along my past scholarly and practical engagement with women's issues there have been some *fundamental stages* that I think should be recalled because *they all, more or less directly, intersect with the subject of hysterectomy*. The first one was the discovery that the work of *production and reproduction of other human beings* as ascribed but unremunerated work influences all a woman's life. This work ranges from pregnancy to delivery, and from raising children to caring for adults. Other stages include the analysis of conditions under which this work is performed in crucial moments such as *delivery* and *abortion*. I mention abortion in this production cycle of other lives given that the dramatic decision of having to renounce giving birth to another human being does not negate the prior pregnancy and then the toil and suffering of the abortion itself as a real part of the labor of childbearing. Around these two events, childbirth and abortion, there were struggles and the organizing of the feminist movement and of the women's movement generally that led in the seventies to the regulation of the voluntary interruption of pregnancy (law 194/78) and to more human conditions in the delivery room, at least in some hospitals. Others have regressed, and there are still remarkable discrepancies between facilities only a few kilometers apart. In this case, after

several decades characterized by a distorted approach to gynecology and prevarication to women, it was a question of bringing delivery back to its dimension as a natural, non-pathological event, and to restore to women the role of the protagonist in the event itself, of the actor who, by joining her knowledge, knowledge received from her mother and from other women, with the knowledge of the obstetrician, chooses the kind of delivery, manages it directly and has the right not to be abandoned in her suffering, but to be comforted and assisted by people she trusts. I thought appropriate to mention only these stages in the economy of this tract, since they directly linked to the discourse on medicine and on the ways in which health care facilities and workers operate, especially doctors. Nevertheless, more generally, health has been a pillar in both the debate and the initiatives of the feminist movement in Italy and in various developed western countries during the nineteen-seventies, like it was before in the United States during the nineteenth century.

In Padua in 1974, we opened an independent self-managed center, the "Woman Health Center," followed by others in other cities, with the idea of providing an example of a different "doctor-woman" relationship, of reappropriating medicine for women (historically women have traditionally been healers and midwives), of reappropriating knowledge of our bodies, as an engine for shaping different behavior on the part of doctors and profound transformation in health care facilities.[1]

Also in 1973 in Padua for the first time we transformed a trial for abortion against a woman in a political question, a question that provided the spark for a series of initiatives that led to the law mentioned above. These health initiatives brought together great investigation, denunciation and struggle within public institutions. They were above all about demanding due respect for women, and for physicians to pay adequate attention to their demands rather than a hurried and superficial, and at times vulgar and sadistic, hearing.[2] And furthermore, conditions that would offer protection from absurd deaths in childbirth, from the birth of children crippled by forceps and, word for word from a text of the period,[3] from practices that "have sterilized women because of operations that often did not call for total hysterectomy." Already at that time, it is worth remembering today, we denounced, struggled, wrote and publicized the abuses of hysterectomy, not principally in mature women, but in women fully capable of bearing children. Since I am talking about a quarter of a century ago, which means we were all quite young, we had not had a chance at that time to experience personally how this practice effected mature women. And having raised the question of hysterectomy as an abuse that was

performed even on young women, the illusion spread that, like for the conditions of childbirth and other health questions we had struggled against, the future had to be better. Our minds and our vital energy could be applied elsewhere. But this was not to be. The generation of women who protested about childbirth and abortion, while we saw the fields already ploughed often left untended, we found out that the problem of hysterectomy was anything but solved. Quite the opposite, only with maturity would this generation experience the real size of the problem that formed a new and sizable obstacle along the "life-passages" of the female body. I was one of those who thought I could "dedicate myself to something else." Indeed, if the opening of a debate on the work of reproduction and the female condition led to a series of changes in the social, cultural and legal spheres (for example, the reform of family law and of the law on sexual harassment), in the economic sphere these changes were surely less important, and were unable to make a dent in the well-known problems and dilemmas women encounter along the way. It was this very hard core of the female condition, "the economic question" that, during the eighties, instead of improving, deteriorated further within an overall decline in the quality of life of an ever-increasing portion of the world population that compelled me to take up again the question of development, forcing me, during the nineties, to go through another large and crucial question, "the land/Earth question." The Earth too is feminine and generates.* I would conclude that, against the abuse of "maldevelopment"[4] and its science, laws that presume the spread of hunger, disease and death, *not due to new technological spurts but to the redistribution of land* together with the *reintegration of its reproductive powers and the reallocation and diversification of its cultivations*,[5] women and men could live, could be healthy, could have food, or in the words of a movement that since the nineties has been spreading its network from Latin America to India, to the United States, they could have "fresh and genuine food."[6] In other words, I had come to see, along with other scholars, female and male, that the only way to return to a path free of misery and disease was the re-establishment of and respect for the integrity of the reproductive powers of nature/land, that, not by chance, was matched with safeguarding the reproductive powers of human communities.

I was as a matter of fact going through the land question, so closely tied to women's labor and knowledge in giving birth and child-raising,[7] and so to the production of nourishment as well as medication, when I happened to

* In Italian, *terrra* is the word for both "land" and "Earth" (translator's note).

encounter this strange and bitter affair the female body is subjected to, the question of hysterectomy. Immediately it was clear to me the correlation between the approach of policies that effect and assault nature as land, and the policies that effect and assault nature as woman's body, and the symbiotic destiny that links the land and the woman's body. That is the female body, in its belabored parabola of generating and caring for human life, and caring for the life generated by the land, already denied its knowledge of generating, raising and cultivating, already denied its rights connected to the work it performs, was here again denied, this time even more radically and violently, in the name of that same mechanic-reductionism that sees, on the one hand the female body as an set of parts, rather than as an organism, rather than as a person, on the other hand, it sees the earth not as a living organism of which the human is a part, but as a warehouse of potential goods on which man can draw without limit or restitution, ransacking it and so continuously undermining its life reproducing processes. In fact the struggle against hysterectomy has increasingly seemed to be a new but foreseeable *issue in a series* in which, for *women*, it was and is a question of *defending the reproductive powers of nature* — and therefore the integrity of *their bodies* and of the *land* — as well as *female knowledge* about these powers against a castrating and devastating science and policies.

Paradoxes

I encountered hysterectomy when it was proposed as a solution for a small fibroid that absolutely could not justify it. I have to thank my strong self-image as a person, attained in years of feminist experience, for being able to avoid the arduous and unnecessary operation. But it was in the encounters with various doctors and with many other women that I discovered the extent to which this alternative has become over the years a sort of *net*[8] set to catch the mature female body, a net that waits for it, imprisons it and delivers it to the mutilating and castrating operation, extremely detrimental on both the physical and mental levels, that can be justified only in absolutely exceptional circumstances, when there are extremely serious and otherwise irresolvable problems. But the frequency with which this operation has been and is performed, as is found in the reports of women, who are reluctant to speak because they feel maimed, does not correspond to the probability of disorders serious enough in order to justify it, especially when methods of early diagnosis and treatment as is the case, for example, of cancer of the neck of the uterus, has been perfected. And it contrasts with the problems mentioned by these women, such as

bleeding caused by relatively small fibroids.[9] In a case very close to me, hysterectomy was proposed in the absence of pathologies. The uterus was a little bit larger than normal and "one day," said the gynecologist, "it might cause some problems." The woman refused and, after a brief hormonal therapy, her uterus, within a very short period of time, returned to normal.[10]

It was, as I was saying, while checking the reasonableness of the proposal I had received, and so while formulating my refusal, that I had the chance to speak with many other women and other doctors, male and female. Hysterectomy, normally together with removal of the ovaries, gradually emerged as an issue characterized by a doctor-patient relationship that is extremely unsatisfactory in various ways that I intend to underline, without assuming that this practice is the norm or holds in the majority of cases. But I believe that its frequency must be taken seriously.

The first feature is *in practice the substitution* of the patient *by the physician* in the decision to perform the operation, by inducing women in various ways into believing that at a certain age total hysterectomy is appropriate, regardless of the pathology that seems to be merely a good excuse. For pathologies that do not justifying it and can be treated with less intrusive and destructive alternatives, such as myomectomy or hysteroscopic resection, if we consider the case of one of the most common reasons, that is fibriods of limited size,[11] physicians argue that at a certain age a total hysterectomy is advisable. Normally, patients are not even made aware of the existence of alternative treatments, let alone evaluate them, and if she asks for information about less intrusive treatments, doctors deny that "at her age" it is possible or sensible. This is not only groundless, it confuses the woman who, normally trusts her gynecologist, without understanding why a therapy is feasible at one age and not at another, ends up accepting the physician's story. In order to further convince her, the woman repeatedly and frequently hears expressions such as, "Madam, at your age, what do you need an uterus for?" And, "Madam, what is the problem? Its destructiveness? A third of the women around fifty you see walking in the streets are without a uterus." If the woman insists in defending the importance of all the body's organs may be made to feel guilty by the physician who objects, "You must be against transplanting organs!" Actually faced with the deep felt horror that a woman experiences at the idea of a hysterectomy, which she suppresses, suffocates within herself, because, if the physician says so, evidently the operation is necessary, this horror is not taken at all into consideration by the physician, because today a human relationship with the patient seems to be a romantic illusion of times past. Furthermore, there is the

horror of the jargon that, in the comments cited above, which are at times repeated during sonograms to reiterate how "natural" it should seem to accept the operation, I have always found to have a Nazi flavor. In fact, the perception of having experienced a sort of "final solution" for the female body emerges from the language used by the women themselves when, speaking with a relative or a friend, they say, "I had everything taken out, I went total." Within his age-centered argument the physician proposes, as has already been suggested above, *generally also the removal of ovaries*, *even if healthy*, given that *the whole apparatus*, *uterus and ovaries*, is about to end its function and therefore *are superfluous*.[12] In order to strengthen his case, *the risk of cancer is greatly emphasized*. The uterus and ovaries might one day be easy prey to it, so — many physicians say — there is one more reason to remove everything. Therefore this operation, in too many cases, is proposed as the only solution, the appropriate solution, of common sense if the patient is of a certain age and has some pathology that needs treatment, it has the advantage of protecting the patient from greater risks. While the risks and the dangers of the operation itself, which become clear from the experience and the testimony of the women themselves, as will be illustrated below, are systematically hidden.

Of the *negative outcomes*, the one that has to be denounced immediately is *the enormous harm* and *violence* of *inducing menopause ahead of time*[13] and *instantly* through a *surgical procedure chosen* by the gynecologist and not because a natural deadline has been reached according to natural rhythms. Normally the passage from regular menstruation to their total absence requires years. The negative consequences of menopause on the physical and psychical condition of women are extremely well known. Nevertheless, these consequences are aggravated and badly combined, or better "mismatched" by the violent change caused by the operation. Therefore inducing the patient to undertake it without a more than adequate reason is the worst service that a physician can provide a female body, and it is combined with rendering her unable to procreate as a result of the operation.

For this reason it is important to highlight how the perplexity and resistance that women try to express about inducing menopause intentionally, in these distorted practices, may be muted by medical arguments that make them feel guilty and transforming it into a natural process, "Madam, you do not want to accept the operation because you do not accept the idea of going into menopause." This procedure *transforms the victim into the perpetrator* like in what women have historically experienced in *typical trials for rape*. And preparing women for hysterectomy and ovariectomy when other alterna-

tives are feasible, is indubitably a serious act of aggression perpetrated by physicians against women.

In my opinion, in a doctor-patient relationship that takes the form described above,[14] that is, one which directs patients towards the most intrusive and destructive operation without adequate grounds, while ignoring, or belittling the alternatives, while not mentioning risks and dangers of the operation, can be characterized not only as uninformed consent, but even worse, as *misinformed consent*. Consent, in these cases, seems to me to be acquired from the patient *through fraud* (*deceptive consent*), who is not free to choose between options that are not even brought to the attention of the patient, but on the basis of some misleading and groundless information (concerning the lack of alternatives and the benefits of hysterectomy with ovariectomy) and other information at is incomplete (immediate harm and future harm, both certain and possible). Paradoxically, while the debate over informed consent has made many steps forward, today most jurisprudence and theory hold that, according to article 32 and 13 of the Constitution[15] and to the law creating the National Health Service 883/78 itself, the right of a citizen to reject treatment even in extreme situations has to be respected, a position maintained in the new code of medical deontology of 1995 (article 29, 31, 34 and 50),[16] in this case, in situations that are not in any way extreme, the practice of proposing/imposing a worse treatment, the most invasive, destructive, crippling, which often leads to other pathologies and need for further operations, is found.

The right to choose is taken away from women, who are once again denied as subjects and are seen by physicians as objects, the objects of their doctors' alternative treatments. Options that seem to be difficult, for situations like those mentioned above or others that can be treatable with less invasive measures, to be based on concern for the well-being of patients. Therefore, if the memory of my juridical studies does not fail me, and, given the above mentioned law, reinforced by the findings of the courts, I think that when a hysterectomy and ovariectomy is performed that is not warranted by serious pathologies that cannot be treated in other ways, which are the only ones that could justify the operation, it constitutes the *crime of extremely serious personal injury* according to article 582 of the criminal code including the aggravating circumstances established by article 583 criminal code, paragraph 2, clause 3, which expressively includes "personal injuries which provoke the loss of the functions of an organ or the loss of the ability to procreate." In this case, in fact compromising the integrity of the body gratuitously, not only organs lose their functions, but organs themselves are "removed," organs which not only performed essential functions before they

were removed, but would continue to have functions after fertility, as is explained below. And this is true even when patients have given their "written authorization." In fact not only are signed authorizations void if they are not the outcome of a process of honest communication in which physicians have really given their patients full information about alternative therapies and operations in order to treat the disease in the best way possible, and they have expressed it in such a manner that patients are really aware of the options they have, despite all this, in my opinion, a "signed authorization" is still void when it "approves" an operation that is more destructive than necessary. And this is so even if, in the extreme, there is full information. The *doctor-patient negotiations* must occur *within a plausible framework*. The doctors on the one hand have to act according to "science and conscience" and so to suggest the remedy that, considering the costs and the benefits, produces the least harm. On the other hand, patients can demand only an operation that goes in the same direction, assuming that it protects in the best way possible their well being. As extreme hypothesis, in the case of self-destructive patients, conscientious doctors cannot accept self-destructiveness. Therefore I hold, as it would be unacceptable for a physician to accept a request from a woman who asks a surgeon to remove both her breasts for fear of breast cancer someday, a request to remove her uterus, her ovaries or both would be unacceptable for the same reasons.

On the basis of the criteria contained in or deducible from article 583 of the Italian criminal code for distinguishing between serious injury and extremely serious ones, I want to make clear that I think that criminal removal, according to article 582 of the criminal code, of the female genital apparatus, is a case of *extremely serious* personal injury according to article 583 of the criminal code, paragraph 2, clause 3, in *all* cases, even if the removal takes place *after menopause*. And this not only because it eliminates fundamental functions that the uterus continues to perform after menopause, in relation to sexual activity, too, but also because the female genital apparatus as a whole has a function, which certainly cannot be performed by other organs, in the foundation and characterization of sexual identity biologically, and so in the biological foundation of the relationship between the sexes. Therefore its removal very seriously could effect the social sphere of a woman. If this thesis of mine does not correspond to *de jure condito* (the actual law), I suggest it be considered as *de jure condendo* (potential law), and from this perspective I also ask fellow jurists to co-operate in its development.

What is said above clearly does not take anything away from the fact that the definition of each one's identity follows innumerable paths. But, for the

evaluation of a crime from a legal point of view, which is what we are interested in here, it seems to me that the general function performed by the genital apparatus, which cannot be performed by other organs, renders its unwarranted removal a crime of extremely serious personal injury. I would consider the removal of a man's testicles in the same manner. Even if, merely as a working hypothesis, one or several of the functions performed by the testicles could be performed by other organs, I would still deem their unwarranted removal a crime for extremely serious personal injury because they represent organs that characterize sexual identity and as such cannot be replaced by other organs. Their removal would certainly weigh heavily on a man's relationships, and not merely his sexual ones.

Going back to the argument we were making concerning the doctor-patient relationship and on the defects in this relationship repeat themselves with unwarranted hysterectomies, the nearly absurd case of a well-informed but self-destructive patient is clearly an extreme case, but one that has to be considered. The fact remains that the abuse of hysterectomy is based on misinformed consent, deceptive consent, and on the practice of the doctor replacing the patient in the decision to perform the operation.

So it is established that this reversal of the roles of the doctor and the patient is unacceptable in the exercise of the *sovereign right* that belongs to all patients/citizens to decide in questions regarding their own bodies and therapies, and to decide based upon complete information about the options, I have to say I am really perplexed, from a legal point of view, as well as from a medical point of view, that the reason frequently introduced in order to justify insistence on the proposal is *to avoid the risk of cancer in the future*. Honestly removing an organ in order to avoid future problems has never seemed to me to be a winning strategy. I find it paradoxical that hysterectomies with ovariectomies are performed to prevent uterine and ovarian cancer. I also find it paradoxical that the tendency to remove the ovaries as well, even when healthy, is sometimes justified by the fact that, as some claim, there is relatively little research on cancers affecting them. So, on the basis of current findings, it is often impossible to intervene in time. But removing healthy ovaries as a form of cancer prevention, even at an age that does not seem to me to be advanced if it begins at 45, and earlier in some cases, only discourages efforts for more studies on the question.

And above all it is not women who should compensate for the lack of research in this field with the sacrifice of their bodies. As for the protection that the removal of the ovaries should provide against ovarian cancer, it is our duty to

recall that other doctors disagree,[17] so it should be studied in order to avoid rendering the sacrifice of female bodies not only unjust, but also counterproductive.

The crucial issue at stake is that doctors so nonchalantly direct patients towards hysterectomy (and ovariectomy), *violating a fundamental and indisputable human right*, that is, the *right to safeguard the integrity of one's own body,* to which should correspond a *criterion of medical ethics* that safeguards above all the body itself as a whole, given the reproductive powers contained within it. Powers directed by nature not only to produce other bodies, but above all to reproduce each individual's body as such. For this reason doctors should operate only when it is really indispensable and using the least invasive means possible. The gratuitous crippling of women's bodies that hysterectomy represents when it is abused in practice, denies a principle that should be a hallmark of medicine, and highlights the adoption of a mechanical and reductive approach, here as called an "age-based approach," abhorrent to female subjects, that undermines both the holistic vision of the body and the conception of women as persons.

But also linger for a moment *within a point of view that considers each organ separately, emphasizing their primary functions.* This seems to be enough to put to an end the nonchalant attitude towards hysterectomy (and ovariectomy), and to the certain negative effects of immediate and violent induction of menopause, and of making procreation impossible. To this can be added the potential damage caused by the fact that, the uterus having an important role in the architecture of the womb, its removal often has negative consequences for the functions the other organs perform. No physician can deny this. I can add that the commitment of women who, in many countries, have started to rebel against this systematic castration of their bodies, and who have decided to analyze more deeply this question, has probably contributed to bringing to light how the uterus is a fundamental part of the female endocrine system and performs important functions even after the age of fertility. For this reason, discussion has begun to spread on its utility, even after its reproductive function has come to an end, since it remains active, during and after menopause, producing hormones and other substances.[18] Among these beta-endorphins, the natural analgesics of the human body, and prostacyclin, a kind of prostaglandin that inhibits the formation of blood clots. Therefore the cause of the increased vascular disease following hysterectomies could probably be the loss of the latter substance, while also it seems that the hypertension many women suffer after surgery may be attributable to the operation. Furthermore, other serious consequences include loss of energy and physical endurance, reduction in sex-

ual secretions and of physical pleasure. Thus extremely onerous negative effects that I have brought to your attention should be examined and the examination should include the reactions of women who have undergone the operation. Outcomes which added to the more notorious ones that affect the urinary system because the bladder looses the support of the uterus and effecting the functions of the intestines which may have problems hardships because part of them tends to fill the void created due to the removal of the organ.

Furthermore, after surgery some women experience a sense of loss, psychological problems, depression, loss of sexual desire, weight gain, fatigue, insomnia, headaches, stiff joints, and vertigo.[19] And most significantly many women, as evermore clear, experience a significant decline in sexual activity. Various studies, including those Ryan (1997) mentions, deal with this problem. Nevertheless this decline seems to be logical if we consider: the changes in the anatomical structure caused by the operation effecting both the vagina and the uterus, which is normally completely removed, that performs an important function through the cervix in the orgasm as is supported by the studies cited below on and as confirmed by women who have had full sex lives; there are a lack of lubrication of the vagina caused by the removal of the cervix and a sudden loss of all the estrogens produced by the ovaries since ovariectomy so often accompanies hysterectomy; the abrupt hormonal alteration provoked by immediate inducing menopause, a change that effects sexual desire and often causes depression that also has a negative influences on sexual fitness.

All the problems mentioned above negatively effect the erotic sphere, because of continued suffering, and of having to deal with other operations or treatments which permeate her mental space, already too filled by working schedules, which should also be reserved for creativity and amorous imagination. We are led to wonder why the doctor does not usually consider the problem of the negative effects on female sexuality, but tends rather to underline the advantage of a sex life free from the risk of unwanted pregnancy that expresses, more or less unconsciously, male collusion. In reality, it is the woman's partner who benefits from the hysterectomy, for his own sexual activity, without any effects of surgery but freed from the need for precautions to prevent pregnancy. This clearly is apart from any consideration of the negative consequences that the operation might have on male sexual activity on the psychological level.

In any case, it seems to me that the set of consequences considered here — some certain, others only potential — are normally not mentioned by gynecologists as negative effects of the operation,along with the certain effects already

mentioned above, of an immediate and violent beginning of menopause and the loss of the ability to procreate. While instead the potential risk of cancer, if the operation is rejected, is repeatedly mentioned, and is more than enough to claim that a woman's real consent is extremely unlikely. Indeed no woman would want to be hysterectomized if it is not absolutely necessary.

Just as, when unnecessary, no woman wants to undergo any operation — and in this case a serious one, given the scars, adhesions, and general physical disruption and various risks — this operation may also require transfusions that — in times like ours, in a period of high morbidity, with old, new and unknown diseases —could become, in an absolutely unforeseen manner, the cause of either disease or death.[20]

It should also be mentioned again that, while at least in Italy total hysterectomy clearly prevails, in the ongoing discussion on the international level on alternatives to hysterectomy — a discussion that includes a series of comparative studies on their costs and benefits (including quality of life) — the opportunity of recovering supracervical hysterectomy (subtotal hysterectomy) is being reconsidered. A study made in Finland highlights a reduced orgasm when the cervix is removed.[21] Others in the United States are planned to verify this relationship.[22] But maybe the result would already be known if what women say after the operation was simply taken seriously. And it is also recommended, when it is really necessary to perform a hysterectomy, to go back to the via vaginal procedure that leaves less scars and is less destructive because it leaves in place, not necessarily but normally, the ovaries and the Fallopian tubes. But other doctors underline that the internal scars of the vaginal procedure may often make it difficult or impossible to recover sexual actitity. We cannot help but wonder why healthy ovaries have been removed, and are removed in via abdominal hysterectomies, when in the via vaginal procedure they are not. We cannot help but wonder why few surgeons are expert in the vaginal procedure, so that most hysterectomies are performed through an abdominal incision, with all the related scars and risks.[23] It should be kept in mind, at a time when the feasibility to go back to subtotal hysterectomy when possible is under discussion, that the vaginal procedure cannot preserve the cervix. Others say myomectomy is technically more complicated than the total removal of the uterus, and requires a more experienced and better surgeon, a fact that explains why the more radical solution is preferred in the operating room.[24] I have verified that in many cases myomectomy is more complicated than hysterectomy. The removal of the uterus alone, leaving the ovaries in place, is a more complicated operation and requires a little more time than the removal of the whole

genital apparatus. But the limited skill or lack of time of some surgeons cannot justify more serious damage being done to the female body, and the serious affront to the woman as a person.

As for the scar left by abdominal removal, the anti-aesthetic effect from a cut running vertically from the navel to the pubes, instead of horizontally along the pubic line, cannot be underestimated. Both kinds of incision bear significant side effects. The horizontal one because it severs the abdominal muscles, and often, during the healing of the wound, an unsightly "flap" effect appears. The vertical one because it is very unsightly, even worse when the sutures employed are unsightly, and negatively affects the perception that the woman and others have of her body, and therefore can negatively affect her relationships, both sexually and in general. In this regard, considering how much the beauty and harmony of the female body still matter in men's eyes, the suggestion by a male doctor to perform hysterectomy, normally performed abdominally, often with a badly sutured vertical incision, seems to be doubly indefensible if there are other solutions. Or are there two kinds of women for some physicians, their own (wives and fiancées) and the others? My doubts have their origin in hearing a gynecologist state publicly at a conference that the wives of doctors normally are not hysterectomized.

Also patients complain that when they leave the hospital they are not given "written guidelines" to inform them about its likely effects, such as the giving way of abdominal muscles, how that problem can be dealt with, or where they could go for help. As usual, it will be easier for patients with higher educations, more resources and more time to focus on these problems and to find solutions. Patients with fewer resources will try to cope for a while before surrendering to their problems, for better or worse, without ever learning, for example, that through appropriate exercise in appropriate facilities, urinary incontinence and muscular deterioration can be prevented. But of course, first they will have to be able to find the time and money.

In conclusion, looking at the organ while forgetting that it forms part of a person, cannot but lead to a form of blindness in surgeons, who risk choosing a solution that drowns the benefits in a sea of troubles that they indeed "do not see."

But let me return to the argument through which I am trying to make explicit all of the negative consequences normally overlooked surrounding the removal of organs that have a complex of physical, psychological, and social functions. That is, above the comments that have been made about *the functions of each organ,* which today seem to be more numerous and varied than

was assumed up to now, and beyond the importance given to each specific function, *the uterus and the ovaries are essential parts of the body.* They are irreplaceable, except in extreme circumstances, because *they play a role in reproducing the body as such, being an integral part of it.* They are part of the *fabric of life woven by and between the organs of the body; they are the reproductive powers of the body itself.* A forest is not only good for the production of lumber. "A forest produces soil, water, pure air" sing the Chipko women in India.[25] A forest provides shade to villages, provides nourishment outside commercial mechanisms, and so guarantees life and abundance. This is also true for the human body as a whole. The balance and strength of a body is expressed through its complex of organs. A person is the product of the history that her/his body — within which her/his mind lives symbiotically with her/his genital apparatus and the full set of other organs — has lived, and is living. A person is her/his body. How can it be imagined that assailing a woman's body in such a significant and characteristic part of her sexual identity would not seriously harm her physically and psychologically, create a deep wound in her person? That is a mechanical view of women, women as merely machines that reproduce other human beings, producers of children, and whose usefulness is limited to this function; a vision that believes, as they near the end of their fertility, that their bodies can be stripped of parts that are no longer thought to be necessary.

I must admit that I have not encountered the same approach among female gynecologists I contacted — even if, obviously, they have not been many. And it has been their explicit suggestion of alternatives that many male gynecologists (though not all) normally do not mention, that on the one hand is a proof of the abuse of hysterectomy, and, on the other, takes us back to the problem of male domination in such an exquisitely female matter as gynecology. This has led to the high price that women have paid, and continue to pay. The reason for the distinct approach of women gynecologists (not all of them), compared to that of many male gynecologists, is the fact that female gynecologists, as women, identify with the female body. Therefore it is hard to imagine that, if they occupied positions of power, they would have so easily promoted a castrating approach. This is not true for male gynecologists.

The female body, for men, is certainly more a territory to conquer rather than a source of identity. And the potential for the doctor-female patient relationship to take on aggressive meanings is, to a greater or lesser degree, latent. This is another reason why gynecologists, aware of the limits that their being

men might represent, should re-examine, in a real and respectful discussion with women, the appropriateness of their proposals.

It is also true that, not long ago, women gynecologists in this context dominated by men, may have modified the model for relating to patients and practicing within it. Some gave up the profession, because they did not find room to practice a different kind of gynecology, and refused to become accomplices in its aggressive practices. In reality, in a medical field in which women are the concern but where, in the recent history of medicine, a female point of view has had few chances of being heard, I find myself repeating something that for me and for most women I believe is "self-evident." That is, that it is wrong to undergo a serious operation if it is not more than necessary; that it is wrong to be forced prematurely and violently into menopause; that it is wrong to be deprived of the ability to procreate, no matter how marginal it may seem at a certain age, while it is right to maintain the integrity of our own bodies and of our own genital apparatus. It is not by chance that neither andrology nor urology has promoted any treatment similar to common hysterectomies. Nor does it seem to me that these are fields dominated by women. Men protect their sex, but in medical practice, as in social practice, they are aggressive too often and too easily towards the opposite sex. Nonetheless, male dominance in the positions of power in gynecology, as well as in many other professional fields, has been made possible by that unjust and not-yet-superceded division of labor in which women bear a greater share of family responsibilities, and so have less freedom to dedicate themselves to a profession. But instead of being grateful to the female bodies which gave them birth and raised them, and through their unpaid toil allowed men to take up qualified and rewarding professions such as medicine, male doctors often rest on their laurels, and do not even pay women back with respect. When male doctors promote aggressive practices, they are responsible for multiplying the drudgery in the lives of women — women patients and women doctors, who have built networks of counter-information in order to promote and privilege gynecological centers that pay greater respect to the female body.

Today there not only seems to be a larger and more open debate on *menopause*, but a growing number of initiatives and resources that should allow this coming historical period to be better. I believe, in this regard, that doctors who remember to act according to the Hippocratic oath — "according to science and conscience" — should first of all stop recommending to/imposing on women the physical and psychological trauma of unwarranted "surgical menopause," which is notoriously an experience much worse than a natural and

gradual passage to menopause, because usually accompanied by fewer negative effects. And, also, to stop recommending/imposing what I call "chemical menopause," by bombardment with synthetic hormones that forever and prematurely suppress ovaries. This represents another violent intervention, and similarly causes serious harm to the female body. I refer to *GnRH* analogs, whose function is to provoke what tellingly is defined as "medical ovariectomy" (Goldfarb and F.A.C.O.G. 1997) in the female body. Some physicians give these in massive doses (more than three injections) to patients they believe are nearing menopause, in the hope that this will bring it on, and stop bleeding caused by extremely small fibromas, for example. And they are really quite effective. Bleeding terminates, but the patient has to bear all the consequences of violently induced menopause. As a result, there is a risk of osteoporosis, and possibly, as has already been established, other extremely negative effects, such as atrophying genitals and the sudden decay and aging of tissues. These effects are somewhat unforeseen, largely because the use of these drugs is relatively recent. But most of all, gynecologists do not have to account for them. Once these effects appear, no doctor, as far as we know, knows how to deal with them. Thus only "a posteriori" do they remember that each body is a case apart, and that, if its balance is upset, no one knows how to react. I do not wish to discuss here the more appropriate and limited use of these drugs, given that small fibromas can be cured through various kinds of treatments or therapies that do not provoke serious harm. I hope instead that these drugs, since they have a significant impact on the body, are used with extreme caution, as all drugs should be. And above all, that new pharmacological research pursues means that do not alter so violently the body's physiological equilibrium.

As for "hormone replacement therapies," I wish to underline that, even if their advantages and disadvantages can be discussed, it is still aberrant when they are offered with one hand, yet on the other they lead women towards unwarranted hysterectomies and ovariectomies. In some circumstances, the availability of these therapies has rather become another reason to nonchalantly propose "surgical menopause," because their effects can then be reduced. With some well-known side effects, and with others which will only be discovered over time, they are still drugs. They are *not* the same as ovaries.

Again with respect to menopause, another highly criticizable aspect of the doctor-patient relationship that I discovered while investigating hysterectomy and ovariectomy is the doctors' *assumption* of a *standard model of a woman who goes into menopause at 52 (others at 49).* While this may be the most probable age, statistically, it counts for little or nothing with respect to the real

age at which that event takes place for the patient. Some women instead go into menopause at age 55. In only a few months, without making any particular effort, I learned of women who entered menopause at the age of 57. I do not know if adequate studies have been performed to state with confidence that the average age of menopause may be changing (as have other stages of the body, which as a whole often now lives longer and stays younger longer). The fact remains that the difference between a later entry into menopause, and the supposed normal age, represents an important advantage in extra years in which the ovaries — rather than drugs — produce estrogens, with the known benefits that derive from them. Why deprive women of these benefits by proposing a hysterectomy (and ovariectomy) because we are nearing (often not *so* near) the age of 52? Here, as well, there is another version, which in my opinion amounts to demanding, yet again, the right to protect the integrity of one's own body. That is, the *right to have our individual age of menopause respected.*

But, on a deeper level — despite the rise of a new medical culture that claims to be more respectful to a new kind of woman, and which these hormone replacement therapies claim to represent — often there remains a feeling that the *standardized age* of menopause *corresponds* to *standardized phases in the life* of a woman and of the *classes of women* in the minds of doctors. There was the time for love, the time for children, followed by the time for maturity and renunciation. Yet this is not so. Not only have biological rhythms been greatly upset by the organization of labor, and by the possibility of different paths of life that contradict the biological clock. But women themselves have created, in spite of new difficulties, a certain degree of independence from these biological rhythms. This not only means not giving up a love life because of aging, but that the unfolding of a love life can take on totally atypical times. One might have been extremely chaste as a youth, because of the stress of having to establish oneself or pursue a career; one may have experienced more rewarding or problematic relationships at a later age. Neither the former nor the latter gain from an intervening "surgical menopause," with its detriments for sexual activity and one's sex life, and with the frequent complications and the need for additional operations and treatments that accompany it.[26] Nor do those who wish to continue to have a good sex life within a marriage, or in another continuous and established relationship, gain from this operation. The same can be said about "chemical menopause."

Another paradox, and not the last, is the fact that while *new techniques in reproduction* have opened new frontiers and experiments in new areas, which allow women to *conceive children at a later age* than what had up to recent-

ly been considered the maximum advisable, hysterectomy, when it is not more than reasonable, *gratuitously eliminates the opportunity*. Leave aside here, for the sake of brevity, any consideration of what is or is not to be hoped for from the possibilities created by these new techniques. Since situations and circumstances in life can change suddenly, throwing away these opportunities seems to me to be a serious thing. One may always be left childless after having had children, and still have a profound desire to have another.

Historical Precedents

I could have mentioned other negative aspects that surround this operation. But even after these first remarks I still feel the discomfort, that I have felt from the beginning, of having attempted to demonstrate the obvious; that is, that a treatment that conserves and is less invasive surgically is better than a destructive and a more invasive one; that doctors are not sovereign over women, but women (like all patient-citizens) are sovereign over themselves, and so sovereign with regard to all decisions concerning their bodies. Citizens, women and men alike, are not property/objects, either of science, or of the state and its health services. What are the reasons, then, that lead medical practice to violate ethical principles and the fundamental rights of citizens (or, better, of *female* citizens)?

A first hypothesis asks how much doctors might remain unaware of the long history of attacks on the female body and on female knowledge, and upon which the origin and development of medicine as an official science was grafted. There are a number of studies on this question, which has flourished especially thanks to the commitment of feminist historians and scholars in Europe and in North America. Among the studies that have led to this noteworthy analytical reconstruction are Barbara Ehrenreich and Deidre English's studies, *Witches, Midwives, and Nurses: A History of Women Healers* (1973a), and *Complaints and Disorders: The Sexual Politics of Sickness* (1973b), which were translated as a single volume into Italian in 1975, and were widely read within the feminist movement during the 1970s on the international level. These studies, which are remembered especially for their insights into the nineteenth century in the United States, first of all shed light on how the primary aim of the budding, official medicine in Europe between the thirteenth to the fourteenth century was not so much the popular knowledge represented by the various healers found among the poor, but rather the knowledge of the well-educated urban healers, with which it competed in acquiring those wealthy

clients who already embodied a consistent demand. The well-educated urban healers were dispossessed, not only by being denied access to nearly all universities, but also by laws that forbade the practice of medicine by those who were not university educated. The case of the famous healer, Jacoba Felicie, cited by Ehrenreich and English, is exemplary: a well-educated woman who attended "special classes" in medicine and, in the opinion of the patients themselves, was more expert than any other physician in Paris, yet who was put on trial in 1322 by the faculty of medicine of the city's university for illegal practice (1973a, p. 18).

This combined strategy of "denying access" and "outlawing" well-educated urban healers in Europe was so effective that by the end of the fourteenth century the campaign by professional doctors against them was practically over. Male doctors obtained a monopoly in medicine for the wealthy classes.

Obstetrics, however, still lay outside their expertise and, despite a wealthy clientele, remained an exclusively female field for another three centuries. Obstetrics later came to face an alliance of the intent of the state, the church and the (male) medical profession, which advocated that this field also be given to the "regular" medical profession, controlled by the state and the church, at the price of the exterminating of the "witches" — mostly midwives and healers who came from and worked among the poor. But this persecution formed part of a complex of social macro-operations that took place in various periods, some already early in the fourteenth century, others generally between the end of the fifteenth and the eighteenth century, and the most famous of which was the *expropriation/enclosure of common lands*. If the latter was used to create the misery necessary for the beginnings of the capitalist mode of production, by making available massive numbers for the workforce, the *witch-hunt* was used instead to *expropriate from women their own bodies*. This was accomplished first of all by depriving women of the knowledge and the power to decide with regard to their reproductive powers, because the reproduction of individuals — from now on, the reproduction of the workforce, as far as it concerned the expropriated and impoverished people — had to be under state control by means of the medical profession. On this subject there are numerous feminist studies, because this process and this historical period represent the foundation for defining the new female individual and her relationships with the professions and institutions. The role of female scholars, with whom I have collaborated since the early seventies, in revising the history of the witch-hunt from a woman's point of view, has been remarkable. I mention first of all the work of Silvia Federici and Leopoldina Fortunati (1984) in *Il grande Calibano*.

Storia del corpo sociale ribelle nella prima fase del capitale. Federici (1984) in particular observes how the witch hunt spread in Europe between the fourteenth and the seventeenth century, reaching an apex between 1550 and 1650, when it is estimated 100,000 women were burned alive, often after vicious torture. The victims were, as I have said, mostly country midwives guilty of knowing not only about childbirth, but also about abortion and contraceptives, as well as healers and women of ill repute. But it was much easier for women to be accused when they were alone, unmarried, old, and above all leaders of urban and peasant rebellions caused by rising prices, by the repeated levying of new taxes, and particularly by the expropriation of land. However, virgins and pregnant women were normally not sent to the stake. This — the greatest sexocide that history has ever recorded — and which represents a fundamental turning point in the history of the struggle between the classes and between the sexes, erased, even if never completely, along with the women who were executed, popular medicine, and especially the gynecological and obstetric knowledge that had been in their hands alone. This knowledge was replaced with an official medicine, controlled by the state and the church, that would need centuries before it was able to replace the void left by the extermination of healers and midwives with something authentically therapeutic. It is worth knowing that while there were witches who had acquired profound knowledge of bones and muscles, of herbs and drugs, the physicians of the time still made their prognoses using astrology. The knowledge of witches was so vast that Paracelsus, who is considered the 'father of modern medicine', in 1527, burned his pharmacology text and confessed that 'he learned all that he knew from sorceresses' (Ehrenreich and English 1973a).

The rising capitalist countries now claimed for themselves — through the science that had to pass through the universities, and so first through the minds of men of the dominant classes, since universities, with rare exceptions, were forbidden to all women — the knowledge, and above all the control, of human reproduction. This murderous expropriation of the patrimony that the women of the people had accumulated and passed on, excluded the poorest strata of the population from all medical care. But most of all, the stake was used to burn away, along with midwives and other condemned women, that medieval model of woman that stood opposed to the new model necessary for the family under ascendant capitalism: the medieval woman, well-represented in many professions and arts, and therefore not only in medicine, who lived in a profoundly social register of life and whose sexuality was not subordinate to procreation alone. But if having a "bad reputation" was already sufficient reason for an

order to be burned at the stake, we have to consider that in the very passage to the new method of production, women were excluded both from land access, through the continuous expropriations/enclosures, and from past professions, yet were also forbidden as well from entering into the new ones (Sullerot 1968). In order to survive, for the first time in history, they had to practice mass prostitution (Fortunati 1995).

In this context the stake, along with the terrorist policy that it represented, meant above all a redefinition of the social function of women. With the purpose of becoming a "machine for the reproduction of labor power," women had to become more and more isolated, sexually repressed, subject to the authority of the husband, the producer of children, with no economic autonomy, knowledge, or decision-making power concerning sexuality and procreation. At the trials against witches, the physician was the expert who was supposed to provide the scientific trappings for all the proceedings, attesting which women could be labeled witches and which maladies could have been produced by witchcraft. Witch-hunting provided, in this way, an easy shelter for the daily inability of physicians: everything they could not heal was attributed to witchcraft. The distinctions between "female superstition" and "male medicine" were actually codified through the roles that the physician and the witch took on at trials (Ehrenreich and English 1973a, p. 19).

Beginning in the seventeenth century there appeared the first male-midwives, and within a century obstetrics passed into male hands (Clark 1968; Donnison 1977). Initially these were barber-surgeons, who showed off a claimed technical superiority because they used the forceps, which was legally classified as a surgical instrument. Women, who had already denounced the dangerousness of that instrument, were excluded by law from surgery. This happened even though many women were already experts for surgical practices like the amputation of prolapsed uteri (Sutton 1997, p. 13). Later on, obstetrics passed into the hands of official doctors, becoming, especially in England among the wealthy, a lucrative practice rather than a neighborhood service.

The United States, in the nineteenth century, provides another meaningful pattern, quite different from the European story, of the confrontation/collision between popular medical knowledge embodied mainly in many women as well as men, with medicinal healers of various ethnic origins (including Africans and Native Americans) on the one hand, and representatives of aspirant, official medical science on the other. The confrontation was completely in favor of popular knowledge, and went so far as to create the "Popular Health Movement," in which women formed the essential framework, a med-

icine emphasizing knowledge of our own bodies, with a strong accent on prevention. This movement — whose most radical members completely rejected the idea that the practice of medicine should be paid for — strongly criticized the "regular" doctors produced by the universities, for their dubious knowledge and for their origins in and identification with the wealthy strata of society at the expense of everyone else. The apex of the Popular Health Movement (1830–1850) corresponded with the beginnings of an organized feminist movement, with which it was largely interwoven. It is important to understand that this popular movement for health had a class-based, feminist point of view, and struggled not so much for better and more widespread medical care, but for a kind of medicine completely different from that offered by the "regular doctors."

While the latter were never able to monopolize medicine in that century, they were given this opportunity at the beginning of the twentieth century, through the efforts of the Rockefeller and Carnegie Foundations. Indeed the United States in this period became the chief industrial power of the world, in which the first financial empires were formed and in which the concentration of wealth was sufficient to organize widespread philanthropy. The philanthropic policy of these foundations aimed to design a new configuration of the social, cultural and political life of the nation, as desired by the dominant class, and which had as its central point "medical reform." It led first of all, beginning in 1903, to massive funding for the regular medical schools, which already enjoyed considerable financial strength and were able, as was required, to initiate the reforms needed to implement the directives adopted by Johns Hopkins (founded in 1893). This school's leading role derived from its having been started by some American physicians on their return from Europe, where they had established contact with the French and German scientists who had developed the germ theory of the origin of diseases.

This theory, for the first time in history, gave a rational basis to the prevention and treatment of disease. Financed by local philanthropists, these physicians made Johns Hopkins the first school of medicine based on the German model. But unlike these more established of the regular schools, the other schools — where the vast majority of women, blacks and poor whites learned — not only went without funding, but were sharply criticized in his 1910 *Report* by Abraham Flexner, who had been entrusted with implementing these philanthropic initiatives. Many of these other schools were soon forced to close.

So medicine became a branch of "higher" learning, accessible only through long and costly university educations, and came to belong almost exclusively

to males of the middle and upper classes. *New laws on university degrees* passed in the various states of the United States confirmed *the monopoly of regular doctors over medicine* and, not much later, *new laws excluded midwives from what had always been their field of expertise*. Midwives were accused as a pretext of being responsible for puerperal infections and ophthalmia in the new-born. But instead of providing them with simple training and cures, such as eye drops for ophthalmia, the progressives preferred to outlaw midwives. This occurred despite a study by a Johns Hopkins professor published in 1912 which revealed that most American doctors were less competent than the midwives of the period. The field of obstetrics was now claimed by professional doctors who were too inclined to use surgical techniques that harmed both the mother and the child. One result of outlawing midwives was that poor women, who could never afford a physician, were left without *any* care. The obvious foreseeable effects on mothers and children have been partially documented (Ehrenreich and English 1973a).

It is in the *"regular" medical profession* in nineteenth-century America that *a kind of medicine* took hold that actually functioned as a *powerful instrument for the control* of women's behavior. It took the form of *aberrant castrating techniques* such as *the ablation of the clitoris* for sexual arousal, which was considered to be dysfunctional in women, and *the ablation of ovaries* for a wide variety of shifting disturbances. Therefore I believe that the time has come for writing a "history of the genital mutilation of women in Western civilization." As for the ablation of the clitoris, according to Ehrenreich and English, writing in 1973, the last operation of this kind in the United States was performed about twenty-five years earlier, on a five-year-old girl who masturbated.

But in nineteenth-century Europe, as well, clitorectomy had its following, even in the leading practitioners of official medicine, such as Doctor Isaac Baker Brown of St. Mary's Hospital, Paddington, London, whose contribution to introducing safer surgical practices has to be recognized. In 1865 he published an article on treating some forms of madness, epilepsy and hysteria by clitorectomy, and he attempted to publicize the success of this practice, for which, fortunately, he was expelled from the London Obstetrical Society (Sutton 1997, p. 10). But how many others, on both sides of the Atlantic Ocean, comfortably committed this medical crime against women?

Returning to the findings of Ehrenreich and English (1973b) on the United States in the nineteenth century, it must be pointed out how the medical profession found an ideal clientele in middle- or upper-middle-class

women. With them, on the one hand, the recurring illness caused by, if not directly identified with, the biological characteristics and traits of the female body could be emphasized. On the other hand, with them could be underlined the need for repeated visits, and for treatments represented essentially in rendering women passive — that is, through isolation and "bed rest" for the patient. According to the so-called "theory of the conservation of energy," which claimed that any energy spent in other activities was a detriment to reproduction, women were simultaneously prevented from doing any intellectual and other kinds of activity. But for the brutal assault on the female body that will lead to *widespread ovariectomy*, on the one hand it presumed the disestablishment of the medical knowledge of women, in the United States as well. On the other hand, it passed through the construction of a male professional science that went so far as to formulate a theory that the authors above have defined as the "psychology of ovaries" (1973b, p. 35). This theory held that the uterus and ovaries dominated the entire female organism, and, as a correlative, that the ovaries influenced the whole female personality. Therefore, any alteration in what were considered the "natural characteristics" of women — alterations that ranged from irritability and madness to the manifestations of sexual desire — could be attributed to ovary disease. Set aside, for the moment, the various abuses perpetrated by the gynecologists of that period on the female body based on this assumption, for it was then common for men to think that female sexual activity was pathological. Let us here emphasize what was the most brutal and widely-practiced procedure by surgical gynecology "for personality disorders," ovariectomy. Thousands of these operations were performed between 1860 and 1890.

A specific theory in this regard was the so-called "normal ovariectomy," the removal of ovaries for non-ovarian diseases, developed in 1872 by Doctor Robert Battey of Rome, Georgia. Doctor Ben Baker-Benfield (Ehrenreich and English 1973b, p. 35) says the operation was thought to relieve "symptoms such as irritability, over-eating, masturbating, attempted suicide, erotic impulses, persecution complexes, simple 'mischievousness' and dysmenorrhea." Among such a wide variety of symptoms, the one for which doctors were most likely to prescribe castration was the presence of a "strong sexual appetite on the part of women."

The patients were normally taken to the surgeon by their husbands, who complained about the lack of discipline in their behavior and, after the operation, according to Doctor Battey, they became more "reasonable, orderly, hard working and clean." Considering the conditions in which the operation was

performed at that time, it is legitimate to ask *for how many women this punitive therapy actually represented capital punishment*. Sometimes the threat of the operation alone sufficed to keep women in line. Some surgeons claimed to have removed between 1500 and 2000 ovaries. In the words of Doctor Baker-Benfield, "they carried them around on platters, like trophies, at medical congresses" (Ehrenreich and English, 1973b, p. 35).

Also in the case of *hysterectomy,* there were medical theories that prescribed it for disorders ranging from hysteria to "menstrual melancholy" — what today is called "pre-menstrual syndrome" (Sutton, 1997, p. 16). It should be pointed out, given the knowledge of that period, that before performing the operation they often did not wash their hands or wear gloves or masks, and the desire to show off their ability led surgeons to transform hysterectomies into social events, to which were invited not only other physicians but also friends and others to see the show,[27] indifferent to the agony of the woman who had to endure alone the inferno of the pain of the lancet's incision from her sternum to her pubic symphysis without anesthesia.

But even after the perfection of the first forms of general anesthesia — for example chloroform — there were surgeons who declared to prefer not to use it, arguing that the tension which patients would manifest during the operation would help them recover from surgery. One such claimant was the eminent Doctor Charles Clay, who gave the name "ovariectomy" to ablation of the ovaries, and who was famous for this operation (he performed 395, only 25 of which were fatal). He performed the first abdominal hysterectomy in Manchester, England in 1843 (unfortunately, followed by the death through hemorrhage of the patient). Clay said he preferred not to use anesthetics because the will power that a woman demonstrated during an operation without anesthesia was a sign of her will to recover as well (Sutton, 1997, pp. 4, 6).

Was this simply an old belief — widely shared by many at the time, and not only in gynecology and obstetrics — that women should suffer?[28] The author of the article cited is surprised by how many women consented to having the operation, despite its high rate of mortality (in particular for abdominal hysterectomies). But we wonder, as in the case of ovariectomy, how much imposition, how much violence, did these women suffer from husbands, brothers, fathers and physicians — as a form of punishment and sadism for some, as a form of sadism and professional interest for others? How much male collusion was responsible for such useless and terrifying suffering by female bodies?

Current Questions

At the end of this first series of considerations concerning — if we may so put it — "the guilt of the ancestors" of modern gynecology, it is more than ever appropriate to raise the question of continuity between this history and the contemporary history of the widespread practice of hysterectomy (and ovariectomy), as forms of aggression against and the expropriation of the female body, and that now opposed what had been the knowledge of the women who provided care without ever even considering destroying the genital apparatus.

It is interesting in this context to know, to consider the possible implications, and to initiate investigations of the reality closer to us. What does Sutton (1997) have to say about the recent United States? In the twentieth century — with the appearance of new safety measures represented by anesthesia, anticoagulants and antibiotics — there was a boom in hysterectomies. So today, within the Union, it is the second most frequent operation, with more than 650,000 performed each year at a cost of about three billion dollars.[29] At the end of the eighties, the author claims, about fifty percent of American women underwent this operation. Sutton attributes such a large number of operations in part to an *abuse* since, as he observes, this occurs in a period in which many technologically advanced alternatives for uterine pathologies were already available.

Given that it is one of the most common surgeries in Western countries, Margaret M. Ryan (1997, p. 21) raises further questions concerning the relationship between pathology and treatment on the basis of the large differences between countries and between social classes. After having reached a peak in the seventies, Ryan notes there has been a decline in various countries. Nevertheless, the author reveals that in the United States the probability of undergoing the operation remains forty percent for women under 64, with lower percentages in Holland. Another estimate (Dranov 1990), in general agreement with various authors, is that, by the age of 60, the expectation of undergoing the operation is one woman in three. It seems to be very significant that some studies — such as the Australian and American ones Ryan refers to for the areas considered — find higher rates for the operation in women belonging to the less affluent and less well-educated strata of the population. Furthermore these results are confirmed by other studies.[30] It is clear in this case — and in how many other cases as well? — it is *the women with less resources and less knowledge for weighing the grounds* for the most frequently abused procedures, who are then *more frequently sacrificed to the interests of the profession and of the health system. But what is more, all cit-*

izens pay the unjustified medical expenses. The author also observes how, on the basis of programs founded on well-informed consent, which certainly are not the norm,[31] the willingness of women to undergo hysterectomy decreases. And since the opinions of the patients in evaluating the positive or negative effects of the operation were not consulted, they were not even considered as "consumers." So from what can be deduced from this article, the "consumer's" point of view is only now taking hold.

Clearly, for official medical science, in the difficult transition from considering the patient to be an object to considering the patient to be a subject, this subject begins to acquire the features of a consumer before those of a citizen, or more simply and essentially of a human being.

In the nineties, the author claims, women begin to demand to know more about hysterectomy: the surgical procedure, the whole recovery process, its benefits and risks, and the alternatives. And this became imperative, she underlines, in all countries.

In reporting these findings, and the reality they describe, I again feel the absurdity that I felt before: of trying to demonstrate the self-evident, this time for having to demand what should obviously be taken for granted. During the long and difficult history of Western democracies, the acknowledgement of the right of women to be informed about the procedure, its risks, the recovery, and above all *the alternatives to genital mutilation* certainly seems to us a significant step forward. In such a context — in which it is so difficult to enumerate rights that should already have been established — it seems important to encourage women, when they are asked to consent to a hysterectomy, to inquire about the organs (especially the ovaries) or tissues that the surgeon wants to remove, to carefully weigh their consent, and to take the time to learn about all aspects before making a decision. Nevertheless, whatever will be the new "guidelines" in Italy for the reorientations of the various schools of gynecology, it must be remembered that nothing can be taken away from a woman against her will. It is also important to ask what kind of incision and stitches will be used. Unsightly scars are an insult to women as well as to the state of the art, and must not be tolerated.

So to return again to the question we raised above, can one find a continuity in the intent to punish, in the sadism, in the negation of women as persons, in a more-or-less-concealed desire for the reprisals of one sex against the other, as may be feared within a history that we have seen to be a struggle between classes and between sexes, and in the reasons underlying the insistence concerning hysterectomy in our own times?

With the abuse of hysterectomy that represents such counterproductive aggression — so clearly counterproductive as to repudiate gynecology itself — what other reasons can be given for this continuation? What the authors cited have said about other countries provides one more reason for investigating its abuse, its real causes, its magnitude, and its procedures in Italy as well.

The number of hysterectomies in Italy is high. The 40,000 operations per year were already described as excessive by the Italian Society for Gynecology and Obstetrics in its November 17, 1997 press release (mentioned above in note 9). For a national female population of 29,515,577 in 1996, the probability that a woman would undergo this operation during her lifetime is one in eight.

At the Veneto regional level, hysterectomies do not appear to be in decline, as one would have expected, given the trend towards decline that took place in many countries after the seventies (Ryan 1997, p. 23–24). Rather, hysterectomies are being recorded at extremely high and growing numbers: 5,909 in 1993, 6,120 in 1994, 6,326 in 1995, and 6,685 in 1996. For this last year, the numbers reveal a particularly steady growth for women between 40 and 69 years of age, with a high frequency for women between 40 and 53. Considering that the female population of the region was 2,278,535, the 6,685 hysterectomies performed in that year means one in four women can expect the operation, which is double the national average.

To raise questions, to exercise extreme care is essential — above all, to develop women's independent ability to evaluate, to think about the issue when faced with such high national and regional figures. These statistics can hardly be attributed fully to pathologies so serious that there were no alternatives. Ever more so in the full context of health care, during which many patients feel very uncomfortable, even suspicious, because there are too many cases when it creates disease, or makes things appear worse or less treatable than they are in reality. In the autumn of 1997, on Italian television, the Health Minister raised a question concerning the potential for a new boom in the removal of tonsils, which had already been performed excessively in the fifties, a boom that would result in economic advantages for hospitals. The abuse of new techniques for assisted pregnancy/artificial insemination has led to suspicions of groundless diagnoses of sterility, and has long been criticized internationally.

These are only two examples, but the dysfunctions of the national health service on the levels of scientific research, on the nature of the service, and of medical practice are widely criticized in the Italian media. Citizens cannot ignore them, regardless of their personal experiences. And given these aspects of deception, of invasiveness, of the production and perpetuation of

diseases rather than cures, for these features which often characterize official medicine, citizens have started to turn to medical alternatives. I hope this will induce the former to really compare itself with the latter, and more generally with real human needs and knowledge, in spite of its birth and development based on their rejection and suppression.

I hope this will lead to abandoning those approaches that have led to operations that are unjustified or more destructive than necessary, following their bellicose logic of destroying in order to replace and to re-intervene. The harm done to the citizen by being transformed into a perpetual patient is physically, psychologically and financially huge. Certainly wars have always supplied the greatest opportunities for reconstruction companies. Today, more than ever, they provide an enormous opportunity as a laboratory for experimentation with the knowledge and know-how about the human body, because they can rely on huge numbers of living/dying guinea pigs (Dalla Costa, 1999a; 1999b, p. 28). But, simply from a human point of view, there is no re-urbanization project or improvement of surgical technique that is worth a war, just like it makes no sense to discover a drug that can save one person, if along the way one hundred have been killed. But war impedes the discovery of a kind of medicine and surgery that are different; not originating from the context of war, they do not share its bellicose logic.

Following the close of the twentieth century, this bellicose logic of opposition between human needs and medicine is strengthened by a market orthodoxy that — in the service of an economic neoliberalism whose aim is the conquest of the last *commons* of humanity — reduces to commodities all human life and the physical and social worlds that surrounds it.

On the international level, the reduction of the commitment of the state,[32] in key sectors such as healthcare, has reduced protection and raised prices for citizens, often with lethal consequences, making even harsher a confrontation in which the positions, options and practices of physicians will be crucial.

In the great battle that the social body is fighting on a planetary scale, in order to place the new millennium on a course for life and health — based above all on the respect for the integrity of the physical body within its relations with the social, and against a millennium of war, destruction and death, against the current policies creating morbidity and invalidity, the disintegration of living creatures, the uprooting of individuals and populations — we hope that many physicians seeking a new humanism and a new dignity for medicine will revolt against their forefathers and ancestors, and, above all, the reigning sovereigns of the market and of war. For their part, women long ago started

their rebellion, and have knit planetary networks of counterinformation[33] and of organization.

They will defend with force the integrity of their bodies from this new narrative of expropriation and violence, will build and teach paths without aggression and destruction. In the same way as in many countries of both the North and South, they will defend and re-establish the integrity of mother Earth, the only one able to ensure nourishment and health to human bodies, rootedness and life to human communities.

Notes

* This paper was originally presented in a shorter version to "The First Meeting for Permanent Training in Gynecology for clinics, the national health service and military medicine" organized by Sigo (Italian Association of Gynecology and Obstetrics) held in Palermo, December 6–8,1997.

1 It was the first independent center in a big city, as is well documented. For a primary source of information and comparison between the experience of the center and of later ones, see Jourdan (1976) *Insieme contro. Esperienze dei consultori femministi* (p. 48–ff.).

2 A good account is offered by Piaggio (1976) *Avanti un'altra. Donne e ginecologi a confronto*. However, the literature on the subject produced during the seventies, based on experience, testimony and moments of struggle, is extremely vast. So on the sadistic behavior of some doctors, see the examples provided in note 3 and in the texts mentioned there.

3 *Dietro la normalità del parto*, (1976), p. 145, edited by the Feminist Group for Wages for Housework of Ferrara. This book brings together a vast number of documents on conditions in some health-care facilities and on the mobilization of women. The death of three women during delivery in the Obstetrics Division of the Hospital of Padua within only a few months was the reason that led to the decision to mobilize by the Women Hospital Workers Group, together with the entire feminist movement. These incidents were anything but isolated in the health service of the time. The text describes exhaustively the conditions of the delivery room in St. Anne's Hospital in Ferrara which led to the birth of many spastic or otherwise unhealthy children (p. 50). Unnecessary sadism, such as curettage and suturing without anesthesia, are recorded here. In the same text, many

cases of death, due to the conditions in which abortions were performed, are reported. Then, as now, it was primarily mothers who already had children and families who decided to abort. This was the case of the 27-year-old woman with two children who died on April 7, 1976 in the Hospital of Padua, whose death provoked the women of the city to organize sit-ins in the places in which gynecology was taught and practiced (university classrooms and university clinics). The day before, in Trapani, Rosa M., a 25-year-old mother of three children, was bounced back and forth between a physician and a obstetrician until, unknowingly, her uterus was removed. Because of it her husband left her. She also was sued, and the court sentenced her to three years in prison for having an abortion.

[4] The term *maldevelopment* is often used in ecofeminist literature on development, from which it has spread to other schools of thought. It intentionally plays with the double entendre of *mal* "wrong" and *male*. So, "It is wrong because it is male?" The interpretation of a particular case is left open to the reader.

[5] This conclusion is shared by many scholars, male and female, who see the expropriation of land and its exploitation commercially, its being defiled by chemicals, biotechnological agents, and warfare, as the first cause of world hunger and poverty. By restoring the reproductive powers of the land, I mean the re-establishment of an agriculture based on ecologically sound criteria which would allow the humus to regenerate. Ownership of land and the preservation of ecologically and economically sustainable agriculture are, in my opinion, the first line of defense for people to have a real chance to gain sustenance and to sink roots in the territory. People who have historically had these rights and opportunities are today expropriated, continuously uprooted and forced to migrate. These questions, together with an analysis of the false assumptions surrounding international debt, are dealt with in a collection of essays I have recently edited (M. and G.F. Dalla Costa, 1999).

[6] Via Campesina, formed in 1992, is today one of the largest organizations of this kind. It links networks of farmers from Central America to India and France. Its inspiring principle is "food sovereignty," meaning the right to use land and to be able to cultivate it according to organic criteria. The "Karnataka Farmers Union" in India, a member of this network, created a center for the procurement, conservation and distribution of natural seeds to the people in order to resist the imposition of laboratory hybrids by big companies. These laboratory hybrids produce infertile seed and render

farmers completely dependent on the "market laboratory" every year. In the United Sates, there have been many people's initiatives during the nineties, from the Atlantic coast to the Pacific coast, to re-establish an organic agriculture that produces fresh food that is free of chemical toxins and is not genetically modified. Nationally for this purpose the "Community Food Security Coalition" was formed on an embryonic level. It has created a network for local distribution at affordable prices of food produced in this way. In the suburbs of Tokyo, similar initiatives began in the sixties. I commented on this question in "Some notes on Neoliberalism, on land and on the food question" (Dalla Costa 1997) in the "Women's Day on Food," held in Rome, November 15, 1996, at the same time as the meeting of the FAO. On initiatives to relocate agriculture and establish it on organic principles, see Mander and Goldsmith (eds.) (1996).

[7] I am referring to the wealth of knowledge acquired and passed down over the centuries, especially among the women of indigenous peoples and more generally women among the South of the world, on how to gain nourishment from the land, but by "taking discretely and giving back" (Shiva 1989) so that land can recover. This is knowledge that continues to be threatened with destruction by the spread of capitalistic relationships and policies to make the land "more productive" and to "multiply" water. But "water is a given, it cannot be multiplied," as Vandana Shiva wisely observed in her *Staying Alive* (1989), in which she analyses the continuous encounter/clash between destructive agricultural mindsets and conservative ones, and the impact of the former on the chances for survival and on the quality of life of peoples. This female author focuses mainly on India, but addresses a world problem that concerns our quality of life in the West as well.

[8] I use the term *net* because as an approach, as is described below, it gives more weight to the age of the patient than the seriousness of the pathology, which objectively increases the probability that she will be hysterectomized simply because the years have passed and she has some sort of uterine problem. Our perception is supported first of all by the data reported in the statement released to the press by SIGO in Rome, November 17, 1997, that says that about 40,000 hysterectomies are performed in Italy each year and claims this is "too many," especially considering the availability of less destructive and intrusive solutions for many pathologies today. An article in *La Repubblica*, March 13, 1997, by Francesco Collenghi finds an extremely high number of hysterectomies in Italy and

throughout the world and draws the same conclusion. The data from foreign countries used are those found in sources in English I cite below. It finds that hysterectomy is the most common operation in the world, particularly in the United States, after the Caesarean section. It does not say which is more common in Italy. Nevertheless, the latest statistics say one woman in six will undergo this operation before the age of 60, compared to one in three in the United States and one in eighteen in France. Collenghi says, "hysterectomy, the complete removal of the uterus, has become so common that gynecologists now prescribe it as a reflex to the first signs of the problems just before or during menopause." Obviously there are also doctors, I have to underline, who have adopted a more acceptable approach because they are more cautious about inflicting needless maiming and harm. However, the article, along with the data, describe a practice that is well-known and too common.

9 Clearly fibroids are one of the most frequent uterine disorders; they can be treated, except in exceptional cases, in various ways, including hormonal therapy or removal through surgery that eliminates the fibroid but preserves the uterus. Often fibroids are reabsorbed during menopause. Nevertheless, in the United States, it is the first cause of hysterectomy, at 33%, while cancer is the reason in 11%. A similar study should be done in Italy as well. For these figures and others on uterine pathologies as cause of hysterectomy, see the table shown in *Hysterectomy and Its Alternatives* (1996), which emphasizes that hysterectomy is necessary when the life of the patient is threatened and there are no alternatives. This is true in only three cases: cancer of the uterus and the ovaries, uncontainable post-partum bleeding, and serious pelvic infection.

10 The questions this case raises leads me to add that the woman, Francesca Rampazzo from Padua, confirmed her story publicly during the conference held in this city, "Hysterectomy, an open question in the relationship between women and medicine," April 23, 1998.

11 I consider this case, which is one of the most common, because if medical practice is prone to hysterectomy in this situation, it is even more likely that it will be used in more serious situations. For instance, in literature in English cited below, in the case of endometrial hyperplasia — which can be treated with hormonal therapy or the removal of the endometrium and other techniques — it becomes a cause of hysterectomy in order to protect women over forty years of age from precarcinogenic transformation of the cells of endometrial lining (P. Dranov, *American Health*, 1990, p. 36,

38–41). Evidently, similar medical practices must have established themselves in Italy as well; the above-mentioned press release of the SIGO (1997) recommends the removal of the endometrius instead of hysterectomy for this disease.

12 After 45, the additional removal of ovaries if the uterus is removed is the undisputed standard practice.

13 I consider first the case of hysterectomy (with bilateral salpingo-oophorectomy) performed before menopause because it is the most frequent. When it is performed after menopause, I will call attention to the negative consequences that it shares with those performed before menopause. That is, the impact of the operation itself, with its scars and unsettling to the architecture of the womb, with the possibility of the need of transfusions and the related risks, and with effects of psychological wounds. In addition there are the negative consequences described in this text, related to the fact that the operation eliminates the functions that the uterus performs after fertility. As for the ovaries, after menopause they continue to produce estrogens for some time although at a lower level along with, above all, androgenous hormones that are so important for a woman's well-being for the rest of her life.

14 The examples of distorted medical conduct and language found generally in the text correspond to what I experienced, and to what I later learned from the experiences of other women.

15 Article 32 of the Italian Constitution states, "No one can be forced to undergo any medical treatment except when established by law..." and article 13: "Personal freedom is inviolable."

16 Articles 29 and 31 respectively deal with informing patients and the informed consent that patients must give in "written form" when there may be consequences on their "physical integrity," so that there is indisputable proof of their intentions. Article 34 states that in cases of necessity and emergency, if patients cannot express their will, physicians shall limit themselves to indispensable treatment and care. Article 50 establishes that physicians shall not impose treatment — for example, in this case, forced feeding even when prisoners refuse to eat — and doctors shall limit themselves to continuing care.

17 Against the first thesis, Dr. Celso Ramon Garcia of the Hospital of the University of Pennsylvania argues that removing ovaries does not protect women from developing a cancer that seems to be identical to ovarian cancer. Some studies have found that women who have had a hysterectomy but kept their ovaries have the lowest rate of ovarian cancer of any group

(P. Dranov, *American Health*, 1990, p. 36, 38–41).

[18] See again F. Collenghi's article (1997) for confirmation of the information reported in this article. But it also can be found in other sources, especially American ones, such as *Hysterectomy and Its Alternatives* (1996).

[19] This is what hysterectomized women report; it is also reported in P. Dranov in *American Health* (1990, p. 36, 38–41), *Hysterectomy* (1994) and in *Hysterectomy and Its Alternatives* (1996).

[20] Nadia Berini died in Padua at the age of 39 on January 7, 1992 because of a transfusion containing the HIV virus that she received in the hospital in Asolo, where she had had a hysterectomy at the age of 34 because of uterine fibroids. While I am trying to come to grips with a problem that affects many women, mention of her case is not only to remember a dear friend, but, I hope, helps to promote an approach of extreme care when dealing with the body of a human being.

[21] See P. Dranov, *American Health* (1990, p. 36, 38–41).

[22] From the AHCPR, Agency for Health Care Policy and Research (October 31, 1996), *Funding Studies on Hysterectomy vs. Alternative Treatment for Uterine Conditions*, press release via web.

[23] See P. Dranov, *American Health* (1990, p. 36, 38–41).

[24] See again Collenghi (1997).

[25] Shiva (1989, p. 219) writes, "With the alternative Nobel prize part of the world community joins the Chipko women in their struggle against this notion of progress and enlightenment. Ten years have passed since when the Henwal Ghati women with their lanterns lit in the middle of the day came to demonstrate to experts in forestry 'the light' (that is that forests produce also soil and water and not only wood and revenue); they are no longer alone in the fight against the exclusive monopoly of the 'light' of western experts."

[26] According to P. Dranov, *American Health* (1990, p. 36, 38–41), who states that in the United States hysterectomy is even more common than in Europe. The number of women who undergo this surgery before the age of 60 is one in three, and there are complications in 50% of the cases. Removal of ovaries takes place in about 45% of the operations to remove the uterus and produces, it is said, more harm than good. *Hysterectomy and Its Alternatives* (1996) reports 500 deaths per year caused by the operation and well describes its drawbacks, such as increased risk of strokes and heart attacks due to the lack of prostacyclin, the hormone the uterus produces that inhibits blood clots. The article reports a reduction in the num-

ber of hysterectomies in the United States, citing the figures provided by the Center for Health Statistics in 1975 (724,000) and 1996 (556,000), but claims they are still too numerous and that 30% are unnecessary. Of these cases, 74% involve women between the age of 30 and 54. By the age of 65, 37% of women are affected. The article underlines the significant differences between areas of the United States, and claims that the lawyers of these patients attribute unwarranted hysterectomies to the fact that either doctors have generally been trained to lean toward this therapy, or that they recommend it for their personal convenience or profit. The article is also a source of detailed information concerning possible alternatives.

[27] The picture of a crowd of men surrounding the naked body of a young woman, laying with her eyes shut as one of the first hysterectomies is about to performed by the gynecologist Pean in Paris, is extremely significant. It has been copied in many feminist texts, and is on the cover of *Avanti un 'altra* by Piaggio (1976), cited above. We provide it here on p. 56, below.

[28] Doubts are raised because James Young Simpson (1811–1870), the inventor of anesthesia for use in obstetrics, "had to defend the use of chloroform against his opponents, who disapproved of it not so much on medical grounds but primarily on moral ones, claiming that 'it would deprive the Lord of the desperate invocations' of women in labor" (Guthrie 1945). Furthermore, in the Middle Ages the church had forbid the use of herbs to reduce suffering during labor (Federici and Fortunati 1984) because the Bible says "you will bear children in suffering." Medicine has continued to respect this precept, given that on the verge of the third millennium, women still give birth in suffering. In the case of Western medicine, epidural injections, whatever one thinks of them, are not part of normal hospital practice. As for Oriental medicine, Chinese acupuncture is able to allow women often to give birth without suffering, so it would be enough for hospitals to hire experts in acupuncture.

[29] This coincides with the figures on hysterectomy provided by the National Center for Health Statistics in 1985 (670,000) and 1981 (674,000). After the seventies the Center has recorded, as was said in note 27, a decrease in the operation, but associations of citizens and doctors with different views still think the rate is still too high. These associations are active in providing women with information about the alternatives (*Hysterectomy and Its Alternatives*, 1996).

[30] According to a 1988 study by the New York Department of Health, non-white women were found to be hysterectomized 39% more often than

white ones. Concerning geographical differences within the country, the South was found to be the region with the highest number of hysterectomies, and regional differences were attributed, in part, to different kinds of gynecological training, in part to financial reasons (P. Dranov, *American Health*, 1990, pp. 36, 38–41). Also the already cited October 31, 1996 ANCPR press release acknowledges differences in the incidence of hysterectomies due to regional, ethnic and socioeconomic factors.

31 In the United States, only two states require doctors to inform women about the associated risks and possible alternatives in the case of hysterectomy (P. Dranov, *American Health* 1990, p. 36–41).

32 Here we do not criticize rationalization when its goal is to reduce waste, which weighs heavily on all citizens. But rather when it aims — through questionable decisions on surgery, experiments, and therapies, or through lowering the quality of the service provided, or reductions in the number of qualified workers needed to optimize the service, or through the reduction of guarantees and, above all, through increasing costs for customers — to create a "positive balance sheet" that actually is heavily "in the red" and paid for by all citizens in higher costs, less accessible services (many people are no longer able to afford the service), inadequacy of treatment and reductions in what is supplied generally.

33 On the question of hysterectomy, as for many others, increasing numbers of websites offering medical counterinformation have been established by new or organized groups of women, and many of their experiences have been shared. We hope that the new democracy of horizontal and universal electronic communication will allow women and citizens of the world not only to better defend themselves from abuse, but also to start anew the process of learning about their own bodies, and to build real medical knowledge as a fundamental common good that must be re-established.

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The French gynecologist Pean performs a hysterectomy before a crowd in Paris. Note the absence of gloves and masks.

2

The Evolution of the Doctor-Patient Relationship

Giuseppe Perillo

Outlining in all its details the course and the evolution of the doctor-patient relationship, a complex subject in which medical, philosophical, moral and juridical aspects come together, is an extraordinary venture that may make the effort of those who dare to undertake it seem presumptuous or reckless. I am not this presumptuous, and I do not have the necessary interdisciplinary competence to analyze the subject in depth. Since my specialization is limited to the law, I will treat the subject only from this perspective, and will try to portray it without any pretensions of being exhaustive on the changes that the doctor-patient relationship has undergone from a normative point of view. It is common knowledge that judicial decisions lead to adjusting the law to the new needs of social reality. Therefore, in order to delineate the evolution of the relationship on the legal level, it is first necessary to briefly establish what changes have occurred on the concrete level of the doctor-patient relationship in recent years.

A singular, and in certain ways surprising, fact emerges from the history of the doctor-patient relationship.[1] While medicine acquired great therapeutic means that gave doctors for the first time in history the power to treat common diseases effectively, the doctor-patient relationship grew worse, and threatened to compromise the prestige of the medical profession, a precious asset, especially psychologically, because it is an indicator of the ability of doctors to give patients confidence in their recovery. And this in spite of the fact that these means began to approach the height of success in 1935 with the discovery of sulpha drugs, and, after the Second World War, the successes continued without interruption with the discovery of new and powerful

drugs, such as penicillin, anti-arthritis, and anti-cancer medicines, and, with the aid of new disciplines such as chemistry, and especially biochemistry, that made advances of inestimable importance for the welfare of people and the struggle against disease.

There are several reasons for this situation. Firstly, the abandonment of the physical examination of the patient, traditionally performed by palpation, percussion and auscultation to the patient, and its substitution by a clinical examination, that primarily uses technological means carried out with the aid of computers, laboratory tests and the like, that have led to the depersonalization of the relationship.

Just as significant in its effects on the direction of the change in the doctor-patient relationship, has been the progressive bureaucratization of health care; the process of technocratic and political transformation in the structure of health care; the growing costs caused by long-term and intensive care that have produced a financial crisis in health care; and, consequently, a reduction in service to the disadvantage of the elderly, of the poorest of the ill, and of those who live on the margins of society.

But most significantly, it has been the new and different evaluation of the medical profession in general — that is, the allegiance of this profession to its own aims in order to obtain effective and efficacious care for patients — that has led to a profound transformation in the doctor-patient relationship. Doctors are accused of being arrogant and paternalistic; the utility, efficacy and allegiance to ethics of the new medical treatments are under discussion; "the contingent value of scientific advances, that do not allow for authoritative declarations of truth" (Portigliatti Barbos 1988a) are underlined. The consequence is that a growing number of patients, their expectations of recovery disillusioned by a presumptuous medicine, choose other ways, such as alternative medicine. In the meantime, there are ever-more-frequent claims of malpractice, and lawsuits against doctors and health care institutions are on the rise.

In the center of this critical review, of this wide-ranging debate, that often takes on a harsh and dramatic tone, are the patients, the recipients of medical care, who, with a better education, insistently demand to receive all the information necessary to evaluate the utility and the efficacy of treatments, and to take part consciously and directly in the choices that effect them.

On the legal level, as a consequence of this changing reality, the doctor-patient relationship has become more and more complex. The position of the patient has become prominent and has been enriched by new and different contents that modify its original structure, traditionally based on the legal para-

digm of the intellectual professions, disciplined by the Italian civil code in Article 2221 and the following.

The rules introduced by Italy's republican constitution have played a significant role in the evolution of the contract governing healthcare services, an evolution that has led to a significant revision of the criteria for a doctor's liability.

The choices made by the constitutional law-maker — as defined by careful and progressive developments in jurisprudence and doctrine, open to new instances and new social needs — have privileged, on the one hand, the ethical value and primacy of the human being, conceived of in a Kantian sense as an end and not as a means. On the other hand, they have influenced the exegesis of all the other rules that are involved in the matter. In particular the reference is to the first clause of Article 32, and Article 13 of the constitution, that protect life and the physical integrity of persons, as well as the inviolability of individual liberty, then to the first clause of Article 3, the third clause of Article 27, and Articles 32 and 41 of the constitution, which guarantee the equality and the equal dignity of all the subjects of the law. And, finally, to Article 32 of the constitution, that makes mandatory medical treatment subordinate to the cases foreseen by the law and to respect for individuals.

No less important are the choices made by the ordinary lawmaker, especially in Article 1 of law 180/1978 and Article 33 of law 833/1978 — rules that reinforce the constitutionally relevant principle of a patient's consent as the foundation for the legitimacy of medical treatment.

A regulatory system that is centered on the recognition of the 'sovereignty' of the human being, as a fundamental value from which the principles of the protection of life and of the health of the person derives; a principle that constitutes the basis for weighing costs (damage) and benefits of surgical and experimental treatment, in order to avoid permanent harm from operations that are unwarranted, or are not indispensable for the protection of these goods. From the same principle, it follows as a corollary that this duty is to recognize a patient's consent, and this leads to the exclusion of the existence of a patient's duty to seek treatment — and, conversely, to the recognition of the right of patients to refuse treatment. Some authors go as far as to posit the existence of a patient's right to die.[2] All this points in the direction that if the subject's dissent is informed and resolute, no authority can legitimately substitute its own authority for the lack of the consent of the interested party.

These principles — and in particular the one that is the keystone of the system, that is, the right to healthcare in the context of the right of individual freedom — have to be kept in mind in outlining the stages of the patient-doctor

relationship we are discussing, in determining the content and the limits of the reciprocal rights and duties of doctors and patients, and in delineating the resulting responsibilities, which must be evaluated according to the provisions contained in the criminal and civil codes (Articles 575, 579, 580, 589, and 62 of the criminal code, 1218, 2229, 2043 of the civil code).

As mentioned above, the relation that is established between doctor and patient falls within the realm of contracts for intellectual labor, to which we will now direct our attention, to verify to what extent these constitutionally relevant principles have influenced the code of conduct and the regime of liability of doctors.

It should be pointed out that what will be said about the specific rules that govern a physician's practice and liability hold, with the appropriate adjustments for the various realms of the doctor's civil, penal, and disciplinary liability, because of the tendency within the different judicial areas to promote similarity and assimilation among them. Therefore, when one speaks about liability, about the rights and duties of doctors generally, one is talking about all three realms mentioned above.

In fact, jurisprudence has for some time developed a single body of rules for medical practice and medical liability that is applicable generally, for contractual, extra-contractual, and criminal issues, for both healthcare facilities and private practice, when doctors have to answer to their patients for the unsatisfactory results of their work and their professional services.

According to the traditional view, the obligations of those who practice intellectual professions, such as doctors, include mandatory conduct (called *obligations of means*), obligations in which diligence and expertise in the conduct of the professional are involved, but not the achievement of a result. This is a class of obligations that also characterizes other professions. As an eminent author (Mentone 1988, pg. 181) has said, what is expected from doctors is a treatment that can change a state of illness (the initial condition) to a state of health (final condition). But the expected result, according to the ends of medicine, that is of healthcare "is not recovery, but care that promotes recovery; put succinctly, proper care." That is, a doctor "can only create conditions which are necessary or useful to promote the recovery of the ill; but the success of the therapy also depends to a large extent on other factors, over which doctors have no power."

This principle that recognizes in the field of medicine the predominance of regulation of conduct over regulation of results or ends, has undergone continual and significant change, bringing the obligation of doctors much closer to obligations of result.

First, technological developments in medical treatment have led to an increase rather than a decrease in negligence. In particular, in jurisprudence, the position that claims "in specialized care, that is, care based on specific technical rules, that when not fulfilled, are not only a sign of the incompetence of the specialist but are highly correlated with a lack of success, the failure to achieve the final objective, that is what could have been achieved by following the technical rules, leads to the establishment of the liability of the specialist" has become more important (Court of Cassation, civil case, 11287/1993).

This underlines the idea that following the technical rules leads to the achievement of objectives, and that ignoring these same rules leads to worse results. In short, "The existence of technical rules reduces uncertainty concerning achievable results" (Cafaggi 1988).

Those easily performed medical services, treatments, and operations lead to a more rigorous regime of liability comparable to that associated with the obligations of result. In this case it is the professional who must prove the (unknown) cause that prevented the achievement of the expected result. In fact it is said that, when from a treatment that is easy to perform (such as a routine operation) "is followed by a worse outcome, the final condition of the patient having deteriorated in respect to the pre-existing one, it cannot but be presumed that the performance of the professional service was either inadequate or negligent: a presupposition based on the aberrant outcome alone," (Civil Court of Cassation, 21/12/1978, in *Giur. It.,* 1979, I, 1, 953). In these cases, the obligation of the doctor is not only diligent conduct, the provision of good care, but that the professional shall behave well, so as to achieve the expected and normally achievable outcome.

Furthermore, in the field of aesthetic surgery, the performance of the surgeon is not the object of a simple obligation of means, but the achievement of the result that the other party expected.

An analogous rule is also valid in the sphere of dental reconstruction.

Further significant changes have occurred in the area of discretion, one of the requirements that, together with that of personality, from which derives the fiduciary relationship between doctor and patient, and which characterize a physician's services. According to the traditional view, doctors, like "professionals" and intellectuals, are given a high level of discretion (i.e. freedom) in the choice of how to fulfill their service. It has been claimed that the independence of professionals is substantially the equivalent to immunity from responsibility, but this claim has been significantly tempered in the field of medicine.

First of all the doctor's discretion cannot surmount the limit of the patient's rejection of an undesired treatment. This rule is reiterated in clause 4 of Article 31, of the deontological code, where it explicitly sanctions, "in any case, where there is an explicit rejection of a competent patient, the doctor must cease all diagnostic and medical care because no medical treatment may be performed against the patient's will...." This applies except in those cases of mandatory medical care found in Article 33 of the law that created the national health service. In other words, the discretion of the doctor is reduced by the power of the beneficiary, whose consent is a precondition for the legitimacy of medical care, to intervene in his decision, and so "contributes to the definition and the selection of the options and available alternatives" (Cafaggi 1988).

The discretion of physicians encounters another limit when there are technical-scientific rules. According to the jurisprudence, it is unquestionable that "the set of rules that, due to the shared consensus of the scientific community and consolidated experimentation, can be considered established by science and practice, so as to form required scientific and practical knowledge of the professional.... (This set of rules) has become a limit beyond which the freedom of choice of the professional can never venture..." (Civil Court of Cassation 3044/1972).

In short, increased scientific knowledge reduces the level of uncertainty and, consequently, of the professional's discretion. And so, when a standardized diagnostic-therapeutic protocol exists, the professional who varies from it must give an adequate justification of why. Likewise, he has to give a complete explanation in cases when there are several alternative strategies that allow for a wider range of choices.

To conclude on this point, in decisions of liability there is an important specification to make about how what doctors normally do in carrying out their profession (what is normally called "praxis") is evaluated. According to an approach that can be shared (Cafaggi 1988), medical praxis cannot be considered indiscriminately binding, nor can its observance lead to freedom from liability, because it would be equivalent to giving praxis the value of a "rule insensitive to the evolution of scientific progress, and so creating an incentive for the continued adoption of techniques that, though they are consolidated, may not be the best options for the beneficiary."

This is the case, for instance, for surgery that, although adopted by medical praxis, leads not only to the end of the pathology, but also to significant and irreversible harm to the psycho-physical integrity of the patient, harm that could be avoided by recourse to other operations and treatments that are less

invasive, destructive, or harmful to the patient; techniques that technical-scientific advances and the state of the art consider to be equally fit and appropriate in order to cure the disease.

The conclusion that has been reached may furnish pertinent and useful parameters for answering the questions raised by Professor Dalla Costa about the liability of surgeons for hysterectomies.

But it is the area of information functionally linked to medical practice within the regulatory system that can be deduced from the fundamental charter mentioned at the beginning. This has opened new and important horizons.

It is immediately clear that, in the medical field, where the patient's consent is required, information is both required by the professional and is an essential requirement for the establishment and the development of doctor-patient relationship, destined to affect constitutionally protected interests. It is also clear that the purpose of information is to put the patient in a position to evaluate whether or not to undergo the choice proposed to him (treatment, operation and the like).

However, a few timely clarifications are necessary. Among these requirements for information, we must distinguish the requirements intended to obtain the patient's consent, as well as those intended to allow the patient to adopt precautionary measures. In the first case, the omission or incomplete fulfillment of the requirement affects the recipient's right to self determination in consenting to therapy. In the other case, it impedes the patient's ability to adopt specific measures in order to avoid risks of harm (for example, free and informed reproductive choice; to impede the birth of children with genetic defects, and the like). In both hypotheses, a constitutionally protected right is violated (Articles 13 and 32, paragraph 2 of the Italian constitution).

Furthermore, it is important to clarify that — making explicit the contents we developed concerning a doctor's discretion — the recognition of his discretion has to be paired with a duty of information that justifies the choice he makes.

As has already been mentioned, the requirement of information has the function of making a patient's self determination possible; that is, the opportunity to evaluate both subjectively and objectively the likelihood of the treatment's positive or negative outcome, a cost (harm)/benefit analysis. This implies that information must be detailed and specific, related to the level of comprehension of the addressee. And it must include the purpose of the treatment, the nature of the means used, the outcome of the treatment, and the degree of risk.

After having outlined the nature, content and function of information, it is now necessary to indicate, without any pretension of being exhaustive, what may be the consequences when these requirements are violated. The liability of a professional for violating these requirements — which may coincide with the requirements of the practice itself — is beyond discussion, because it can be criminal, civil-contractual or extra-contractual (a distinction which for our purposes does not require particular attention), and, if the prerequisites exist, also disciplinary.

A judgment of liability is operative, both in cases in which the requirement of information has the purpose of obtaining the patient's consent, and in the cases when it serves the other purpose, of putting the addressee in a position to adopt the necessary precautionary measures.

In jurisprudence, the requirement of information may be construed as a duty of diligence, and so finds the professional liable even if his culpability is slight, since the rule established by Article 2236 of the civil code, which delineates the liability of doctors in especially difficult operations, is considered inapplicable. The lack of, faulty, or inexact information (including untruthful information or information that is revealed to be incorrect *ex post*) — because it creates a situation that has bearing on the patient's decision to undergo the medical treatment (be it clinical or surgical) — renders his consent null and the doctor's treatment invasive, and so the doctor is accountable for subsequent harm. This matter deserves further attention.

The purpose of the requirement of information is not only to obtain the patient's consent, but also to guarantee that the patient, having been made aware of the risks of the treatment, adopts a fitting course of action which clearly includes a personal choice between continuing ill health and its elimination through medical treatment. So a doctor who violates the requirements has jeopardized the patient's opportunity to choose for himself, and is liable. Similar conclusions must be drawn when a doctor fails to give patients complete and specific information on the risks of irremediable loss of health or the dangers of the treatment, and so violates the requirement of thoroughness and clarity. These are events that can be avoided through the use of other treatments, when possible, according to current scientific and technical knowledge, and even if the latter treatments are less effective. Here as well, consent would be considered null and the treatment no longer justified, and hence the unlawfulness and illegitimacy of the medical conduct that consequently would have to be considered harmful and a source of medical liability.

Notes

1 The history of the doctor-patient relationship has been reconstructed thoroughly by Edward Shorter of the University of Toronto in the paper he read at the conference organized by Isfos of Noventa Padovana in Padua in 1991. This paper is the source of most of the information in my article and can be consulted in the Isfos library.

2 This subject is treated fully by Portigliatti Barbos (1988b).

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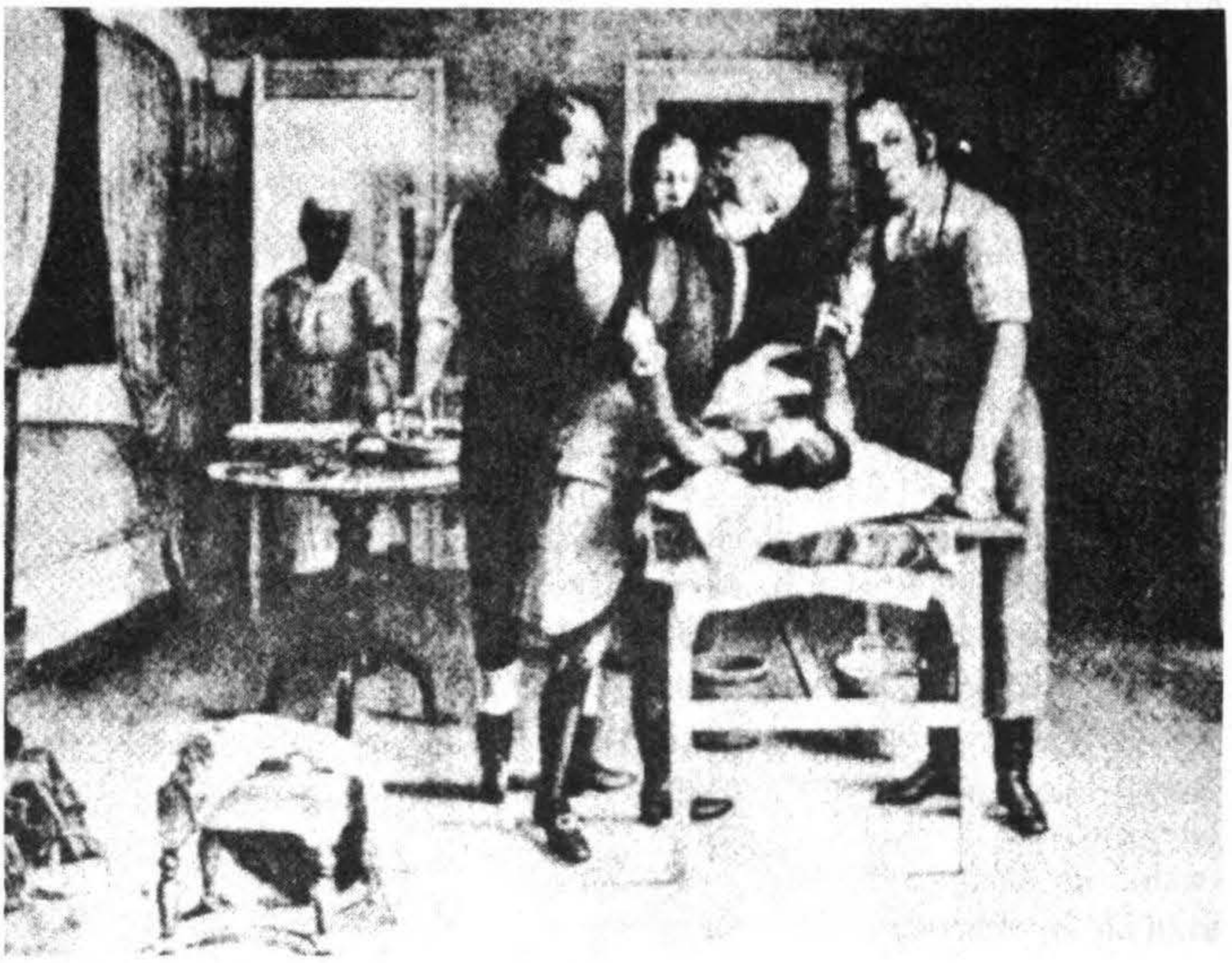

An ovariectomy at the beginning of the 1800s

3

The Evolution of and Current Approaches to Hysterectomy

Daria Minucci

Many people owe their lives to surgery, although it is still risky. Anesthesia, antibiotics, antiseptics, intravenous treatment and transfusions have made it significantly safer. Along with its recent successes, surgical techniques and their technological supports have been rapidly refined and perfected. At the same time, a review and evaluation of the effectiveness and appropriateness of each operation has begun. Progress in scientific research, which is always a source of more alternative medical treatments; the rise of the concept of health as a state of physical, psychological and relational well-being; and the development of data-based medicine, an undeniably modern method, have all lead to better defining when surgery is appropriate. The last twenty years have seen a decrease in the number of many operations that are no longer considered appropriate or which have been replaced by other therapies.

A period of medical reassessment has begun for *hysterectomy* as well in regard to when which surgical technique is necessary and how it should be performed.

The current situation

The urgent need for this review is underlined by the great variations both as to when it is performed, and with respect to the various techniques used in providing treatment around the world.

Throughout the world, hysterectomy is one of the most common serious operations: in the U.S.[1] and in South Australia,[2] one woman out of three over

sixty has undergone the operation; in the United Kingdom,[3] one woman out of five over sixty five; in Italy,[4] according to a controlled case study performed in the area of Milan since 1983, 12.2% of women had been hysterectomized, and for those over sixty the percentage rose from 12.8% for those born between 1900–09 to 22% for those born between 1930–39.

Also the annual rate is varied greatly: at the end of the eighties it ranged from 550 cases per 100,000 women per year in the U.S., to 348 in Finland,[5] and 164 in Norway.[6]

There are also conflicting trends. There has been a continuous, though slow, decline in the U.S. (from 701/100,000 women/year in 1980 to 550 in 1988–93), while it rose in countries such as Norway, where from 1977–78 to 1988–90 it increased by 50%, reaching 164 cases per 100,000 women per year. In Italy, there is little national data on the trend, but it seems to be increasing, at least according to some figures on the regional level.

This disparity in frequency and trends is an indicator that the criteria used as guidelines are more subjective than objective.

Also, the positive criteria and negative criteria used to determine the kind of hysterectomy (subtotal, or total, including surrounding tissue, and so including or excluding the removal of uterine accessories and also the ovaries), the access route (abdominal or vaginal), the surgical technique (traditional surgery, laparoscopy, or mixed) reveal significant differences, not only between countries, but also between surgeons.

In the USA, a study on the criteria used to evaluate the choice of access routes has changed the guidelines in favor of the vaginal rather than the abdominal route, from a ratio of 3:1 to 1:68.[7] But this has been subject to much criticism, some of which comes from Italy. From epidemiological studies, it has been found that hysterectomy is often associated with ovariectomy without there being a significant relationship with either menopause or the number of children.

Nevertheless, the well-being and quality of life for women depends on the greater or lesser extent of the operation and the access route used. For example, the preservation of the neck of the uterus favors sexual activity, while the existence of a visible scar influences women's psychological attitudes and consequently their whole lives. The failure to preserve the ovaries implies, in fertile women, a sudden end in hormonal activity, with a traumatic and precocious beginning of menopause, which cannot always be compensated for through hormone replacement therapy.

The association of hysterectomy with what is called "prophylactic"

ovariectomy is a vexing question, and is often handled more on personal experience than on a scientific basis. In the literature it has often been found, for example, that although the difficulty of ovariectomy is the same when a hysterectomy is performed abdominally or vaginally, it occurs more often in the first case,[8] as if the guidelines for prevention or for evaluation of the situation of the ovaries varied according to access route. Some medical textbooks furnish guidelines based on age — some recommending it for women of age 40, others later — but they agree on its use if the woman is in menopause. The justification in these women is prevention of ovarian cancer,[9] but the epidemiological data furnished to support this claim are approximate and contradictory.[10] *This is the last case in medicine in which healthy organs are removed.* Ovarian cancer is still one of the worst clinical events because of its aggressiveness, and it is usually diagnosed in advanced stages. However, ultrasound tests have made early diagnosis possible; so why should a woman be deprived of a healthy organ and important hormonal support[11] both before and after menopause? *How many ovaries are removed, with well-known consequences, in order to prevent very few tumors?*

The practice of conserving the healthy neck of the uterus in hysterectomies for benign gynecological diseases has had its ups and downs. It was almost always preserved in early hysterectomies because of the difficulties involved in its removal, rather than for objective reasons concerning a woman's health. Its removal before cytological screening, to prevent cancer of the neck of the uterus, may have had some advantages. The neck of the uterus is not a useless organ, and its loss with the consequent alterations in the surrounding nerves can negatively affect urinary and intestinal functions, as well as sexual activity. Furthermore, there may be later complications, such as the prolapse of the vaginal cupola or the presence of persistent granulation tissue.[12]

The neck of the uterus can be removed only for specific reasons. Not all authors agree on these choices. But little of what is said in the literature can be objectively demonstrated, by careful study over the long-term, to make clear what are the real advantages and disadvantages in any particular case, or to determine the ratio of costs to benefits of one choice versus another.

Furthermore, hysterectomy is not free from complications, some of which are linked to the operation itself (hemorrhages, infections, fistulae, disorders of intestinal motility and of the urinary system, etc.). Others are more commonly due to the events that follow the loss of the uterus or the entire internal genital apparatus, which may be hormonal, physical, psychological, relational or sexual in nature.

From the analysis of case studies, the mortality for the operation is between 6 and 11 cases per 10,000 women treated for benign gynecological disease, and between 29 and 38 cases per 10,000 for women treated for complications of pregnancy and labor. Morbidity, including all postoperative complications, in an old study from 1982,[13] was found to be 43% for abdominal hysterectomies and 24% of vaginal ones.

From one of the few systematic epidemiological studies carried out on all the hysterectomies performed in Denmark from 1978–81, it was found that complications, from the moment of operation to six years afterwards, occurred in 2.6% of the cases within the first 30 days, in 3.7% within 90 days, in 9.4% within two years. About 8% needed to be rehospitalized for these complications over the six years.[14]

Among the most significant and well-studied complications are the psychological and sexual disorders, but here as well the results are contradictory. It has to be said that many studies have not been carried out using suitable methodologies, and important variables have not always been taken into account, such as the type of operation, the information given the patient, family support, preexisting conditions, and hormone replacement therapy.[15–19]

Prospectives

Modern medicine, based on evidence — that is, on objective, verifiable and comparable knowledge and experience — requires the evaluation of the efficacy and appropriateness of medical diagnostic and/or therapeutic acts, in relation to the degree they promote and/or restore health good, and the data described above indicate the urgency that hysterectomy be evaluated as well.

All surgery involves risks that can only be accepted when the benefits are greater than the risks. Hysterectomy, in addition to the surgical risk, also means the loss of the ability to have children, and the loss of an organ that has great symbolic importance for a woman's identity.

Therefore hysterectomy as a therapeutic act is justified only when it is the only available means to prevent or repair significant harm to the patient's health. It should be limited to the removal of the smallest part of the uterus possible for the desired outcome, and should favor the least invasive access route.

The concepts of health and disease are not easy to define, once the old organic view is set aside. In 1947 in Alma Ata, the WHO (World Health Organization) defined health as "a state of physical, psychical and relational

well-being"; disease therefore is anything that threatens this condition of well-being. In our case, which uterine pathologies have to be considered diseases, and therefore, require prevention and/or treatment? When is surgery the only alternative? And what is the most appropriate treatment for each of the clinical cases that occur?

From many studies it is found that 10–15% of hysterectomies are performed because of malignant tumor pathologies, while 85–90% occur because of benign pathologies, (mainly fibroleiomyomas, to a lesser degree endometriosis, prolapses of the uterus metrorrhagias or, rarely, because of emergencies such as uncontrolable bleeding or post-partum ingorgement of the uterus, etc.).

Malignant tumors of the uterus and of the ovaries are a serious risk for the well-being of women, and hysterectomy is still the principal therapeutic treatment. However the early diagnosis of many neoplasias in the neck of the uterus and of the ovaries begins to make more limited operations possible in very early stages — for example, limited to the neck of the uterus or to the ovaries alone. It must be added that the screening of tumors in the neck of the uterus — through Pap-tests and the finding of lesions that precede tumors and the removal of them through minor operations that are "radical in respect to the lesions" but which preserve the uterus — have reduced by a third the number of cases of women affected by invasive tumors that require hysterectomy.

Other alterations of the uterus, such as hyperplasia, which is considered a risk for the development of cancers, can often be cured today either through hormonal therapy or through the removal of the endometrium alone.

For malignant tumors, the hope is that research in the not so distant future will produce medical treatment that can replace the need for surgery in many cases. This is the path we need to pursue with all necessary caution, and with all the assurances of experimentation carried out according to rules of proper clinical practice.

All case studies have found that ***benign alterations*** are the reason for most hysterectomies. Of these, uterine fibroids in all their forms are the most common. So it is here that our efforts have to begin, in order to discover a new therapeutic and diagnostic model whose purpose is to focus on the health of the woman as a human being, and not merely on morphological alterations of the organ.

When there is an increase in volume of the whole uterus, or the formation within it of benign tumors with a volume ranging from a few millimeters to several centimeters, and which may range in number from one to many, and which are found in the wall of the uterus or extending from its internal or exter-

nal face, these formations may or may not increase in size, but always shrink when the production of ovarian hormones decreases during menopause. Whatever their volume, number and location, they may or may not produce symptoms, principally, pain and bleeding of various quantities, and harm to the well-being of the woman. Furthermore, in fertile women, they may or may not interfere with reproduction. Often they increase in volume during pregnancy.

When are these formations merely an anatomical change in an organ, and when are they a sign of a disease or a risk of disease? When do they affect or can they affect the physical, psychological and relational well-being of women? The answer to this question is fundamental to verify whether treatment is needed or not, and if so, to choose the most adequate and effective treatment.

What remains lacking is an objective definition of the criteria that determine when a fibroidtosis should be considered a disease. Their harm to the well-being of a woman may derive more from the symptoms and their intensity and from the changes they cause in her sex life or her fertility, and, not least, from how they influence her psychologically and her way of life, rather than from their size or location. This has often led gynecologists to make subjective evaluations based more on their personal experience, instead of on verifiable and comparable objective data, as data-based medicine requires. Furthermore, there is little evidence in the literature to know if the operation is really successful and appropriate. That is, does it eliminate the symptoms and improve quality of life of patients significantly? Furthermore, the lack of an attitude which promotes continual self-assessment and the "passive" acceptance of pre-existing behavior without the necessary critical rethinking can no longer be ignored. This lack has contributed much to making it seem that in this field medicine is far behind schedule.

Similarly in the scientific research there has been a lack of a consistent effort to find the causes that favor the appearance of fibroids, information which is indispensable for preventing and/or treating them successfully without surgery.

The lack of effort in basic research could be due to the fact that they are benign alterations, that they are not always "diseases" according to the definition used above. But this may also point to the fact that hysterectomy is an operation so widely performed and silently endured by women, often without evaluating the relation between it and the intended benefits. This problem has somehow been overlooked.

The search for new diagnostic and therapeutic paths

When fibroids are diagnosed, therefore, it must first be asked if they only require monitoring or if they require therapy.

To accomplish this, a better definition of the criteria used for making a choice based on objective information about its benefits is still needed. Until there are better guidelines and definitions, which yet requires serious research efforts, the old concept must be kept that treatment is useful if there is a real and measurable risk of harm to the health of the patient, or if harm has already begun that the treatment will not worsen.

If a treatment seems to be necessary, the utility of the medical treatment needs to be evaluated first.

As I have mentioned above, in this field there are no drugs that act on the causes and permanently solve the problem. But there are drugs that can eliminate or reduce the symptoms of bleeding that are a cause of anemia, and therefore of the risk of illness, or treatments that can reduce the volume of fibroids, and by so doing reduce the pain or bleeding, and consequenlty restore the well-being of the woman.

If medical treatment is not enough, or if it proves necessary to remove the fibroids — for example, when a pregnancy is forseen — surgery is the only alternative. In this case the first attempt must to be to remove just the fibroids and not the uterus.

In clinical practice, as it has been exercised up to now, it has been held that myomectomy — i.e. the operation that removes the fibroids and preserves the uterus — had to be performed only on very young women, and on those who explicitly desire to retain their ability to have children.

A myomectomy may be simpler or more complex than a hysterectomy, especially in those cases when multiple and voluminous myomas are located in the uterine walls, rendering it long and complicated. In addition, there is a significant risk of the development of new myomas, when the uterus is spared. All these reasons have been the basis for the preference to perform conservative operations only when it was necessary to preserve the ability to bear children.

With new surgical techniques, when necessary, the operation can now be prepared for and accompanied by medical treatment that can simplify it, and prevent the reoccurrence of myomas. The existence of diagnostic instruments for adequate follow-up have favored the choice of conservative operations, whatever the age of the woman.

The endoscopic techniques (laparoscopy and/or hysteroscopy), when appropriate, have considerable advantages, especially when the immediate post-operation period is shorter and less difficult, even if these advantages have not yet been sufficiently demonstrated over the long term.

Truly informed consent is essential so a woman can freely choose between a conservative operation, with a degree of risk of relapse and the need for adequate follow-up on the one hand, and a destructive operation on the other.

In the cases (that now should be few in number) in which hysterectomy is judged to be more beneficial for the health of the woman, the removal of the ovaries and of the neck of uterus, when healthy, does not seem justified.

In addition to fibroids, a similar diagnostic-therapeutic path should be traced for all the benign pathologies. As a result the number of hysterectomies for benign causes, which today represent the majority, should decrease significantly in number. The cases calling for surgery will be fewer, and most of them will be able to take advantage of conservative operations.

In the case, for example, of metrorrhagias, after a careful diagnosis that excludes neoplastic or pre-neoplastic pathologies, medical therapy can be used. If this is not successful, recourse to conservative operations, such as the removal of the endometrium, should produce lasting success in most cases. Today endometriosis — given the numerous diagnostic and therapeutic possibilities of both medical and non-destructive surgical treatment —rarely requires hysterectomy. The prolapse of the uterus that often accompanies other changes of pelvic structure, from urinary incontinence to changes in rectal function, requires careful diagnosis in order to determine the procedures that are most useful in each case. For less serious forms, good physiotherapy may be enough. For others, surgery may be necessary to rebuild the pelvic floor or to restore other important means of support. Only occasionally is hysterectomy required, for example, in the case of an almost total protrusion of the uterus — is a fairly rare event in the kind of lives we lead.

This is a set of paths that, like all choices in medicine, needs to be verified while moving forward both in determining situations in which hysterectomy is required, and for limiting the operation to the removal of what is unhealthy and not of what is sound, using as its sole criterion the recovery of the general well-being and quality of life of the woman over both the short and long term.

The quest for the most effective and appropriate alternatives for the health of women and for the testing and training of medical personnel is a difficult task that the medical world must yet resolve.

Women's role

Since good health is the real and sole concern, continuous collaboration between the world of medicine and women is important. This collaboration should not be limited to establishing new dynamics concerning informed consent, and to empower citizens as actors in their own health care. It must also engage participants in the search for new paths of diagnosis and treatment that are more appropriate, and in the training of medical personnel so that they may learn how to supply better service, and be better able to inform and support patients as they become true protagonists in the promotion and restoration of their own health.

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4

Consent During the Crisis of Doctor-Patient Relationship and Liability in Cases of Hysterectomy

Paolo Benciolini

In the recent past, the evolution of jurisprudence has emphasized the importance of patient's consent in healthcare. The lawmaker in some laws on healthcare, in the recent years, has begun to include the requirement of "informed consent." In addition to the peculiar terminology (which in Italy has unfortunately contributed more to a formal rather than real concern with the importance of consent), it is now clear — even if after so many years — that the second clause of Article 32 of the Italian constitution is not only of interest to jurists but also to doctors. It is not frivolous to point out that, if thirty years (1948–78) were necessary to bring into effect the first clause of Article 32 (at least from a normative point of view), which grants the right to healthcare (also as collective interest), the "discovery" of the second clause — that prohibits medical personnel to give medical treatment to a citizen without consent — was even slower.

2. Another current risk, though justified, of the attention given to consent by healthcare providers today, is the tendency to ignore or underestimate the fundamental *information* process, or better *communication*, that must precede the final expression of willingness, whether contained in a document or not, by which the patient gives his approval (or his disapproval) for the treatment.

The centuries-old tradition of medical practice was anchored in paternalistic attitudes which once may have been comprehensible. But today they are no

longer justified, as is underlined in the most recent version of the deontological code, in which reciprocal trust is placed at the center of the doctor-patient relationship, and so is based not on the imposition of treatment but on the freedom of patients to accept or reject it.

3. The problem of the doctor-patient relationship must therefore be placed under the light of contemporary thought on *human rights,* and, consequently, on whose responsibility it is to guarantee these rights for all. Therefore, in the field of health-care guaranteeing the respect for rights contained in both the first and second clauses of Article 32, this means focusing on the heart of the doctor-patient relationship. This is certainly (and inevitably) an unequal relationship, but one that can only be realized through an adequate "*therapeutic alliance*." To realize it, a valid techno-scientific education alone is certainly not enough. Alongside this "*science*," doctors need to develop their "*conscience.*" First of all, this means being able to listen and to communicate appropriately, which can be neither hasty nor impromptu. This requires training that today is difficult for doctors to learn in the current *curriculum*. The growing importance given to bioethics and to its values and principles is certainly a step in the right direction. This makes it reasonable to hope that a relationship of trust between health-care providers and citizens can be recreated in a manner that protects the latter's rights.

4. The analysis of the subject of this study — that is the practice of hysterectomy — requires two fundamental elements to be verified in order to identify the possible liabilities of doctors: (1) examination of the real clinical-scientific indicators for hysterectomy, and (2) valid consent of the woman who undergoes the treatment.

4.1. As for all other medical treatments, a correct clinical-scientific evaluation of the appropriateness of performing a hysterectomy has to weigh (and compare) the positive indications, the alternatives, and the contra-indications. Among the latter, there should not only be included the physical consequences (which still prevails among doctors today); but also any other repercussions on the women's psycho-physical equilibrium, her affective and interpersonal realms included, have to be examined carefully. It should be remembered that the concept of "*health*" to which our constitution refers in Article 32, cannot differ from that which Italy accepted the year before, 1947, in joining the WHO (World Health Organization) whose charter defines

health as "*a state of complete physical, mental, and social well being*." An excessively organicistic view can therefore lead to choosing a destructive operation, removing tissues considered either potentially or really dangerous, but ignoring the repercussions of this removal on the patient's general equilibrium, serenity, and physical life.

4.2. What has been said above is not enough to make a final decision about the appropriateness of the performance of a hysterectomy. All the elements that are evaluated clinically and scientifically have to be appropriately given to the woman, so that the choice of the treatment can be evaluated by the patient, both in its immediate and long-term effects, leaving the final decision up to her.

However, this approach is not peculiar to hysterectomies. It is simply the application in this particular case of an approach that would have to be shared generally by doctors whenever they propose a treatment. Foreshadowing an approach that today has begun to be more widespread, the law 194/78 already outlined a situation in which technical-scientific competence, even when appropriate and correctly performed, indicates that the doctor (the family doctor, the doctor of the family clinic) has to defer to the woman's choice. This does not mean leaving a woman to fend for herself, but to assist her in acquiring the information necessary to evaluate the decision more thoughtfully, and with knowledge of both its short-term and longer-term prospects and consequences.

5. A hysterectomy is, if the case is of criminal import, a crime of *personal injury*. The provisions of the criminal code are found in Articles 582 (personal injury), 583 (aggravating circumstances) and 590 (unintentional personal injury).

So there are two factors in its classification from the perspective of medical law: firstly, the gravity of the injury; secondly, the psychological features of the crime.

5.1. As for its gravity or seriousness, personal injury is "simple" when the injury caused by the initial deed lasts less than forty days; it is "serious" or "very serious" when circumstances described in Article 583 are present. In the case of hysterectomy, there is no doubt that we are in the field of aggravated personal injury, and the alternatives therefore are either cases of injuries defined as "serious" or those defined as "very serious."

We must distinguish between the consequences of a simple hysterectomy

and those of enlarged hysterectomy, i.e., those that include removal of the surrounding organs (in particular the ovaries).

In the more severe case (hysterectomy with ovariectomy) the evaluation is clear. In fact, among the affects described in the second part of Article 583 (which refers to "very serious" personal injuries) is found the "*loss of the use of an organ.*" It should be said that for criminal evaluation, the concept of "organ" corresponds to its "function."

In the case of the removal of the uterus without other destruction, for a woman of child-bearing age, this must be the same. In fact, among the hypotheses provided for in the second part of Article 583 is the "*loss of the ability to procreate*."

The evaluation in the case of the removal of the uterus alone in a woman no longer of reproductive age is less clear. In fact, in this case it is necessary to verify if in reality a function has been lost or if — despite the destructive act — the organism has retained all its previous functions, albeit at a reduced level. If the latter conclusion is reached, the injury would be classified as "serious" as a case of the "*permanent weakening of an organ*." It bears repeating that the concept of organ in the criminal sense and the concept of organ in the anatomic or morphologic sense are not the same.

This said, a "very serious" personal injury can be recognized in the latter case if the function, although not completely lost, is highly compromised. This criterion, though generally valid, appears to fit the situation examined here particularly well. In fact, relational functions have received (as clearly have sexual functions) particular care from the law-maker, as is expressed in another of the provisions of the second part of Article 583, that is, a "permanent and severe difficulty to speak." I believe that the loss of the uterus, even after the age of fertility, involves a series of repercussions on a woman that influence her relational functions so significantly as to justify — although the evaluation of the particular case is indispensable — the recognition of a "very serious" personal injury even though no function has been completely lost.

5.2. The psychological element of the crime can be seen as *guilt* when, after a valid expression of consent, elements emerge that can be attributed to the execution of the treatment and can be characterized as negligent and/or imprudent and/or inept. In this perspective, the criteria of medical-legal evaluation are no different than those normally adopted in cases of liability due to individual error.

Particular attention has to be given today to the alternative case that considers the requisites of liability because of *fraud*. According to a recent but very authoritative consideration on doctrine, reinforced by a similar approach in jurisprudence (including a fundamental decision of the supreme court), when there is a lack of consent or it is "vitiated" by inadequate information, medical care (and surgery in particular) must be considered (aside from the harm done) "*voluntary personal injury*."

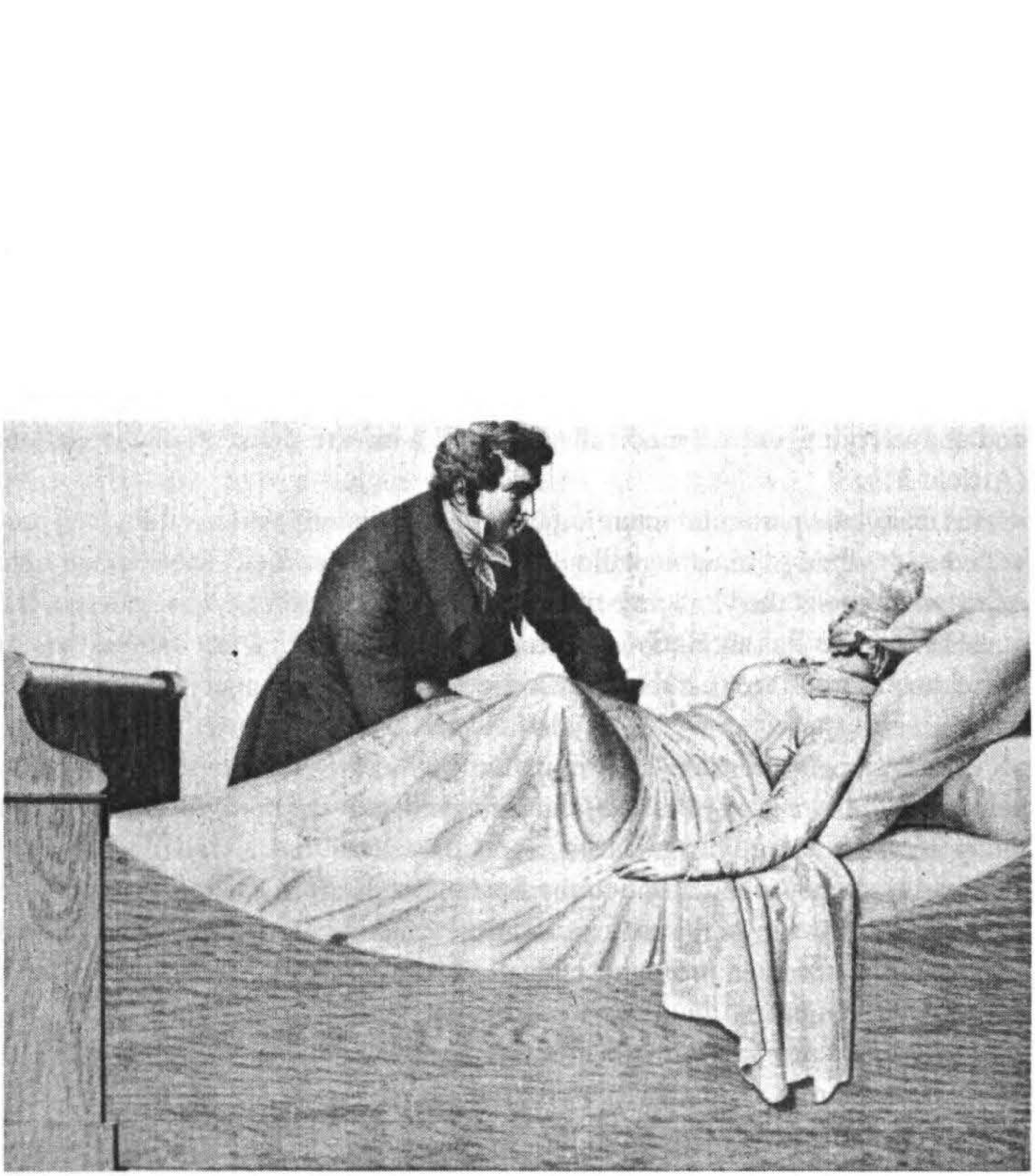
It follows, therefore, that in the absence of valid consent (according to the meaning that should be attributed to it according to the considerations made above) the practice of hysterectomy cannot but be interpreted as voluntary injury, assessed as "very serious" injury or, but only rarely, as "serious" injury.

6. Certainly the main reason that leads us to reflect on the problems of the question under examination is to be sought in the principles that inspire the professional conduct of physicians deontologically and ethically.

The most recent edition (1995) of the Code of Medical Deontology describes well the criteria that must govern proper information (Article 29) and the carrying out of medical treatment with the consent of the patient (Article 31).

Ethically, the particular attention that the question of hysterectomy has provoked in the field of bioethical thought should be underlined. The seminar held a few years ago at the University of Munster and the call for examination of the question by the Italian National Committee for Bioethics are expressions of this concern. I believe that the significance of this multi-voiced meeting on the question of hysterectomy goes beyond the strictly legal issues.

However, reflections on the criminal import of the question should not only be considered as a kind of threat to intimidate health-care providers because of the potential, certainly significant, sanctions described above. In the final analysis, the renewed attention to the fundamental significance of consent as a precondition for the legitimacy of medical care is based on a constitutional principle that contains profound ethical meaning, inspired by a value all can and should recognize.



Gynecological exam: the doctor looks directly into patient's eyes, Paris, France, 1822

5

Medical and Surgical Alternatives to Hysterectomy

Riccardo Samaritani

Though it cannot be denied that the practice of hysterectomy, when performed in cases of real necessity, has saved and will save the lives of many women and frees them of very serious symptoms with significant psychological effects, at the same time it is easy to demonstrate that there are women who have had hysterectomies for no specific and real reason, and today have problems that cannot be easily resolved.

Hysterectomy has been and still is one of the most common surgical procedures. It is interesting to note that the rate of hysterectomy in Western countries varies greatly from nation to nation, reaching its highest levels in the United States and its lowest in Scandinavia.

In order to explain this variation in the number of hysterectomies in different countries, many factors have been considered, among them the characteristics of patients, the availability of medical facilities, as well as the professional attitudes and practice of doctors.

Why is there great interest in the number of hysterectomies performed?

There are several reasons.

First of all, although the risk of mortality after hysterectomy is very low (1–2/1000), the risk of minor complications is relatively high (24.5% for vaginal hysterectomies and 42.8% for abdominal ones), including hemorrhages that require blood transfusions (8.3% and 15.4%), damage to the intestines

(0.3% and 0.6%), to the bladder (0.3% and 1.6), to the ureters (0% and 0.3%), fever (15.3% and 32.3%), urinary retention (15.0% and 4.8%) and prolapse of the vaginal vault (0% and 0.2%).

Secondly, the period of hospitalization — which is 4–7 days in the case of abdominal hysterectomies and 2–4 days in the case of vaginal ones, as well as the period of recovery of 6–12 weeks — has to be considered. Furthermore, hysterectomy is also a relatively expensive procedure. In Italy the average cost for each operation is, in fact, about 2500 euros.

Thirdly, a considerable number of women report a worsening of symptoms or the appearance of new ones after the operation. The most frequent problems after surgery include dyspareunia, a decrease in and at times the disappearance of the libido, hot flushes, loss of appetite, constipation, weight gain, lower-back pain and urinary difficulty.

As for the psychological reaction, while the repercussions of this operation on a psychological level are conceded, it has been the subject of less investigation and remains rather neglected in studies on hysterectomy.

Finally, for many women hysterectomy is a threat to their womanhood, and this is perhaps the most-discussed question, especially in many pressure groups which defend the effectiveness of more conservative surgical techniques.

What are the gynecological conditions that are treated with hysterectomy? Let us consider them one at the time.

Dysfunctional metrorrhagia

Dysfunctional metrorrhagia is bleeding that does not have its origin in organic causes. It is the cause of 35% of hysterectomies.

In the case of real dysfunctional metrorrhagia, some patients can simply be reassured, and will not need any therapy. In most cases, however, the first treatment for dysfunctional metrorrhagia should be medical, and should take into consideration the age of the patient, her use of contraception, its side effects, and, finally, the cost of the treatment.

I divide the treatments into two groups: first choice and second choice.

Progestinic hormones are the treatment of first choice, along with oral contraceptives, inhibitors of prostaglandin synthesis and antifibrinolytic drugs. All the above-mentioned treatments have few side effects, and are tolerated rather well by most women. However other pharmacological remedies are available that can be used in the treatment of dysfunctional metrorrhagia, and because of

their more-or-less significant side effects I define them as second-choice drugs. These drugs are known as GnRH analogues. They are normally given by intramuscular injection once a month, and induce temporary pharmacological menopause. In my opinion these drugs must be used very carefully, because their prolonged use can induce irreversible conditions that range from hypoestrogenicity to menopause itself.

Danazol is also a useful drug in the treatment of dysfunctional metrorrhagia. With a dosage of 200 mg a day, it reduces bleeding by up to 75%. But its usefulness is limited by a series of unpleasant side effects (acne, reduction of libido, oily skin, weight gain, hirsutism and changes in voice).

Furthermore, it has to be remembered that dysfunctional bleeding often reoccurs at the end of the pharmacological therapy. For this reason the therapy should protracted. But this is often not possible due to side effects. The understandable reluctance of patients to continue these therapies, however, favors the use of surgery that very often is not conservative.

A medical treatment that may be both effective and can be used long-term is a medicated IUD. This is a coil that releases very small quantities of progestinic (20 μg/24 h). As this device is a contraceptive, women who want to become pregnant cannot use it. This intrauterine device causes a reduction in blood flow of up to 86% in women with metrorrhagia. It may be responsible for a considerable decrease in the number of patients who choose surgery for their treatment.

Today for the surgical treatment of dysfunctional metrorrhagia there are endoscopic resection techniques. In particular, the removal of the endometrium is a very valid alternative to hysterectomy. The data collected to date show that more than 90% of women who have undergone removal of the endometrium have not had hysterectomies or any other kind of gynecological surgery in the next five years.

The results of three random studies comparing removal of the endometrium and hysterectomy have been published. All these studies have concluded that hysteroscopic surgery is associated with brief operations, low rates of complication, a reduction in the use of analgesics, rapid physical recovery and a return to a normal workload after a short period of time.

Fibroids

Fibroids are next in importance after dysfunctional metrorrhagia.

It has been estimated that between 20–25% of women at the age of 35 have uterine fibroids and most of them are asymptomatic.

The treatment of women with uterine fibroids depends on the association of three factors: symptoms, the age of the patient, and her reproductive status. The therapeutic choices include observation alone, the pharmacological treatment of the symptoms, myomectomy, and finally hysterectomy. When fibroids are small and asymptomatic, they very rarely require surgery. For the treatment of large fibroids, there are conflicting opinions. Often these fibroids do not need therapy because they regress after menopause. However, for many women this natural regression of fibroids does not occur because of the ever-more-common use of hormone-replacement therapy. Another reason that often leads to surgery is the risk, though small, of sarcomatous transformation of fibroids (0.2%). However surgery becomes indispensable when fibroids compress the ureter (a very rare event, however). But this is generally limited to women with very large uteruses (as in the twelfth week of pregnancy).

The medical treatments of fibroids are few. Progestinics, inhibitors of prostglandin synthesis, oral contraceptives, and androgen steroids (danazol and gestrinone) are used in the treatment of metrorrhagia associated with fibroids, but with varied, often unsatisfactory, results.

GnRH analogues can cause the regression of fibroids and relief from the symptoms. Unfortunately the regression is only temporary, and at the end of the treatment the fibroids reappear, adding failure to the side effects which, as mentioned above, may become permanent in some cases.

Surgery becomes indispensable when fibroids are the cause of excessive bleeding that makes patients anemic, or when they cause pelvic pain or compress adjacent organs. Traditionally, hysterectomy has long been the operation of choice, and fibroids are the cause of about 30% of hysterectomies. However, while hysterectomy may be appropriate in the case of large, very bloody fibroids, or when rapid growth of the fibroids themselves occurs, it is certainly not an appropriate procedure for women who are fertile, or for those who simply wish to save their uterus. Today myomectomy and myolysis are surgical alternatives.

Myomectomy is an operation that allows the removal of uterine fibroids while saving the uterus, the possibility of pregnancy, and the menstrual function.

Traditionally, myomectomy is performed abdominally. The intra- and post-operative complications include bleeding which requires transfusion in 20% of cases, infection in 12% of cases, and finally, in 1% of cases, intra-operational conversion to hysterectomy. As an alternative to abdominal surgery, today it is possible to operate laparoscopically and hysteroscopically. These endoscopic alternatives produce very good results, with less risk and fewer complications

for the patient. Generally these two techniques are used principally when it is necessary to remove subserous fibroids (which have formed just below the external lining, the serosa, of the uterus) or submucous (which have formed within the uterus, just below the mucosa). Although comparative studies of endoscopic myomectomies and myomectomies performed using traditional techniques have not been carried out, the evidence suggests that the conservative techniques produce high levels of control of menorrhagia, and fertility clearly improves. In general, for well-selected patients, hysteroscopic myomectomy avoids abdominal operations and so avoids hysterectomy as well.

For fibroids, myolysis is another surgical alternative to myomectomy and hysterectomy. This procedure is based on the heat-induced devascularization of the fibroids, and thus causing its involution due to ischemic necrosis.

Uterovaginal prolapse

Genital prolapse accounts for 6.5% of hysterectomies. The symptoms that accompany genital prolapses include a sense of pelvic heaviness, rectal and urinary difficulty, as well as local distress that ranges from simple irritation to ulceration of the mucosa. Among gynecological pathologies, prolapse is the one that is most difficult to treat with conservative techniques.

Symptomatic uterine prolapse may be treated with pessary positioning, exercises for the pelvic floor, or surgically. The conservative treatments are, as always, appropriate for patients who want to maintain their fertility or who have medical reasons for avoiding surgery. Many patients find long-term treatment of a prolapse with a pessary very difficult; it has to be changed regularly, it interferes with sexual intercourse, and it may frequently provoke inflammation and, at times, bleeding and ulceration of the genital mucous. Often a surgical solution is employed.

Surgery can be limited to the correction of the prolapse of the anterior or posterior vaginal wall, i.e., to correct the prolapse of the bladder or of the rectum and to eliminate problems of urinary and/or fecal incontinence. But when a vaginal prolapse is associated with a uterine prolapse of intermediate or large magnitude, then the treatment should be hysterectomy, in order to maximize the success of the operation. Traditionally, surgery on the pelvic floor is performed vaginally and only rarely abdominally.

Alternatives to hysterectomies have been attempted with mixed results. These techniques for the suspension of the uterus may be used in a few cases.

They are based upon anchoring the round ligaments or the ligaments of the cervix to the fascia of the rectum.

Endometriosis and adenomyosis

Patients who suffer from *endometriosis* can generally be divided into two groups: those who have pelvic pain and other symptoms (two-thirds of the cases) and those who experience infertility (the remaining third). The most common symptoms are pelvic pain, severe dysmenorrhea, dyspareunia and metrorrhagia. Hysterectomy is obviously not recommended for infertile patients, so I will only consider the first group.

As endometriosis is an estrogen-dependent condition, all medical treatments have as their primary aim the inhibition of hormone production. The available drugs are the same ones I have already mentioned concerning medical treatment of dysfunctional metrorrhagia, but in this case they are administered differently. Low-dosage contraceptives, for instance, are prescribed continuously with an interruption every 4–6 months. In this way dysmenorrhea and pelvic pain are drastically reduced. Progestinics induce amenorrhea and block ovulation, hence reducing the symptoms. But they may induce bleeding, weight gain, fluid retention, mammary tension and moodiness. Danazol creates a hypoestrogenic and hyperandrogenic environment that is certainly unfavorable to the growth of endometriosis. In fact, a dosage of 400mg a day inhibits ovulation in 95% of women, thus provoking amenorrhea and the disappearance of painful symptoms. Unfortunately, danazol compliance is very low because it induces acne, reduction of the libido, oily skin, weight gain, hirsutism, and changes of the voice. Also gestrinone eliminates estrogens and causes amenorrhea in the 50–100% of the patients; also, it is poorly tolerated because of its androgenizing side effects. Finally there are the GnRH analogues which — by inhibiting the pituitary gland (hypophysis) in its production of FSH and LH — suppress the production of ovary hormones, and thus create a condition of pseudo-menopause. All these medical treatments have similar degrees of effectiveness. In 80% of cases, they reduce the symptoms and allow surgery to be avoided.

Conservative surgical treatments — based on the removal or ablation of the endometriotic tissue and the consequent replacement of a normal anatomy — are indicated when there are large endometriomas, or when medical treatment fails to control the symptoms or is poorly tolerated.

Medical treatments and conservative surgery can be repeated, especially when the preservation of fertility is sought. But often the psychological consequences of chronic pain, frequent hospitalization, and repeated operations encourage patients to choose definitive surgical solutions. About 4% of hysterectomies are performed because of endometriosis. When hysterectomy is associated with bilateral ovary removal and hormone replacement therapy, it represents the last resort for this chronic disease.

The only real surgical innovation has been that some patients can be treated without laparotomy. In fact, patients with a low degree of endometriosis can be treated vaginally, while patients with severe endometriosis have to be treated through laparoscopy.

Adenomyosis can cause an increase in the size of the uterus, metrorrhagia and dysmenorrhea. Usually, diagnosis occurs by chance, after a histological examination of the uterus. Response to medical treatment is very poor, and the treatment of choice remains hysterectomy.

Pelvic inflammation

Normally a pelvic abscess is treated by salpingectomy or with bilateral oophorectomy. With the recent advances in powerful antibiotic treatments, abscesses can be drained laparoscopically, or through a transvaginal ultrasound-guided technique.

Pelvic pain

Chronic pelvic pain represents an occasional cause of hysterectomy. The syndrome of pelvic pain, as defined by Beard in 1984, is a condition characterized by a venous congestion demonstrated by women with a long-lasting history of pelvic pain, and for whom it is not possible to find an organic cause through laparoscopy.

These cases must be always treated first medically, and only in very severe cases in which medical therapy has failed, should hysterectomy be considered.

Cancer

Genital cancer is the cause of 5.6% of hysterectomies. Hysterectomy is required in the treatment of cases of invasive carcinomas of the cervix, endometrial adenocarcinoma of the endometrium, and uterine sarcoma. It is performed coincidentally during operations for ovarian or fallopian carcinomas, as well as in some cases of non-gynecological cancers. There are no real alternatives in the above-mentioned cases.

Dysfunctional metrorrhagia

Definition:	Hemorrhaging without an organic cause
	The cause of about 35% of hysterectomies
Medical treatment:	Progestinics
	Oral contraceptives
	Prostoglandin synthesis inhibitors
	Antifibrinolytics
	GnRH analogues
	Androgenic steroids
	IUDs medicated with progestinics (20μg/24h)
Conservative surgical treatment:	Removal of endometrium
	Examination of uterine cavity (palliative therapy)
Non-conservative surgical treatment:	Laparotomic hysterectomy
	Vaginal hysterectomy

Uterine fibroids (fibromyomas or leiomyomas)

Definition:	Benign tumours
	The cause of about 30% of hysterectomies
Medical treatment:	Progestinics
	Oral contraceptives
	Prostoglandin synthesis inhibitors
	Antifibrinolytics
	GnRH analogues

Gynecide

Androgenic steroids

Conservative surgical treatment: Laparoscopic myomectomy
Resectoscopic myomectomy
Laparotomic myomectomy
Myolysis

Non-conservative surgical treatment: Laparotomic hysterectomy
Vaginal hysterectomy

Uterovaginal and genital prolapse

Definition: Descent of vaginal walls may be associated with progressive descent of the uterus and of the other pelvic organs (bladder, rectum)
The cause of about 6.5% of hysterectomies

Medical treatment: Pessary, pelvic floor rehabilitation (biofeed back; functional electrical stimula tion) for initial stages of prolapse

Conservative surgical treatment: Suspension of the uterus

Non-conservative surgical treatment: Vaginal hysterectomy +/- pelvic floor reconstruction

Endometriosis

Definition: Pathologic condition caused by dissemination or by growth of endometrial tissue in anormal sites (heterotopia)
The cause of about 4% of hysterectomies

Medical treatment: Progestinics
Oral contraceptives
GnRH analogues
Androgenic steroids

Conservative surgical treatment: Ablation of endometriomas with laparoscopic or vaginal technique

Non-conservative surgical treatment: Hysterectomy with bilateral ovary removal

Pelvic inflammation

Definition: Pelvic inflammatory disease (PID)
Pelvic abscess
Statistically irrelevant for hysterectomies

Medical treatment: Antibiotic treatment

Conservative surgical treatment Laparoscopic draining of the abscess
Transvaginal ultrasound-guided draining of the abscess

Non-conservative surgical treatment: Hysterectomy with bilateral ovary removal or (rarely) laparotomic hysterectomy

Pelvic pain syndrome

Definition: Syndrome characterized by pelvic venous congestion
Statistically irrelevant for hysterectomies

Treatment: Always medical
Hysterectomy should be considered only in very serious cases when medical treatment has failed

Cancer

Definition: Genital cancer is the cause of about 5.6% of hysterectomies

Treatment: An early diagnosis of many neoplasias of the neck of the uterus and of the ovaries may permit less invasive and more limited treatment
There are no effective alternatives to hysterectomy in the case of genital cancer.

Key words

Adenomyosis: or internal endometriosis. Pathological condition characterized by the presence of endometrial tissue within uterine muscle.
Amenorrhea: absence of menstruation.
Analgesic: painkiller.
GnRH analogues: chemical substance that acts like natural GnRH.
Antifibrinolytic: inhibitors of the lysis of fibrin. Substance that helps blood coagulation.
Danazol: drug that inhibits pituitary gonadotropin production.
Dysfunctional metrorrhagia: hemorrhaging without organic causes (for example, fibroids or polyps).
Dysmenorrhea: menstrual pain.
Dyspareunia: pain during intercourse.
Endometrial ablation: removal using rectoscopy of the endometrium (the mucosa layer which internally lines the uterine cavity).
Endometrioma: cyst full of hemosiderin, dark or chocolate colored, the so-called "chocolate cyst."
Endometriosis: pathological condition provoked by dissemination of endometrial tissue in atypical places. It is a disease with particular characteristics that has to be distinguished from inflammation and cancer.
Fibroids: benign tumor consisting mostly of fibrous tissue.
Genital prolapse: it is defined as the lowering of vaginal walls normally associated with a lowering of the uterus inside the vagina. Prolapse of the bladder is called cystocele. Rectum prolapse is called rectocele. These may be associated with genital prolapse.
GnRH: Gonadotrophin Releasing Hormone. Hormonal substance produced by hypothalamus to control the production of pituitary FSH and LH gonadotrophins.
Hypoestrogenicity: reduction of the production of ovarian estrogens.
Hysteroscopy: endoscopic technique that allows observation, through the vagina, of the canal of the cervix and the uterine cavity and the performance of minor surgical procedures on them.
Hirsutism: condition characterized, in women, by an excessive growth of hair in normally hairless places such as the face, chest, abdomen, buttocks, inside of the thighs, etc.
Ischemic necrosis: cellular death caused by absence of oxygen.

Laparoscopy: endoscopic technique also called celioscopy that allows inspection of the pelvic and abdominal organs and the performance of diagnostic and therapeutic operations on them.

Laparotomy: surgical opening of the abdominal cavity.

Menorrhagia: excessive menstrual blood loss

Metrorrhagia: bleeding, at times heavy, that occurs between menstruation, post-menopause or before puberty.

Myoma or *leiomyoma*: benign tumor prevalently composed of muscle tissue.

Pessary: Plastic or rubber doughnut shaped device that is used to keep the uterus in place.

Progestinic: synthetic hormone with characteristics similar to progesterone.

Prostaglandin: term used for the first time by Von Euler to define a factor in the seminal liquid presumably secreted by the prostate gland; today it means a particular group of substances synthesized from essential fatty acids.

Resectoscopic: using resectoscope.

Resectoscope: surgical instrument used especially for endoscopic treatment of myomas, septas, adhesions, and for endometrial ablation.

Round ligament: anatomic structure whose purpose is to sustain the uterus.

Salpingectomy: removal of an oviduct or a Fallopian tube.

Sarcoma: malign tumor of connective tissue.

Transvaginal: through the vagina.

Ultrasound guided: sonography used to locate a precise anatomic point.

Testimonials

Lucia Basso, President of the Veneto Women's Projects Center,
Auser. Healthcare provider and Coordinator of RSU
(Unified Union Representation) of the Hospital of Padua

Diverging Practices Concerning Hysterectomy and Its Consequences on Women's Lives

I would like to thank Professor Dalla Costa for her desire to reopen a wide-ranging debate on such an old but at the same time pressing question as the relationship "women and medicine," and by raising such a delicate question as hysterectomy.

Based on my experience — both personal and from many years of voluntary work for the Veneto Women's Projects Center — I can say that the removal of the reproductive organs of a woman changes the quality of her existence irreversibly. It influences and denies her intimate needs and rights, her rights of choice, her claim to an autonomous sexual subjectivity, and rights over her own body.

Therefore I believe that procedures other than hysterectomy should be used whenever possible in order to conserve reproductive organs as often as possible.

After a hysterectomy, women ask the Veneto Women's Projects Center for help because their affective and sexual relationships with their partners change completely.Women need to understand what has happened, because they lose touch with their own sexuality, and they want to be able to recover their psycho-physical well-being and their relationship with their man.

In direct contact with women, you immediately learn how much the power over one's own body and on one's quality of life is limited by fear of and dependence on physicians, by the inevitability of reliance on science and med-

ical practice. This limit is also caused by specialization, and by a certain nonchalant and at times even brutal manner that women experience when these problems are treated.

We know the answer some gynecologists give to women who rely on their care. "Madam, we'll clean it all up," terminology that alludes to the idea that there is something "dirty" inside you, that your organs are "unclean."

However, the violence of the mutilation is reflected in the language women themselves use when they say, "I had everything taken out," or "I had a total." It is easy to imagine the consequences in terms of depression, of the absence of sexual desire, of the perception of having suffered irreversible harm.

On the question that is being discussed today, I can also add my personal experience. At the age of 33, about seventeen years ago, I was diagnosed with multiple uterine fibromatosis and, given their size, they said it was necessary to remove my uterus. At the time they emphasized that, for a similar problem, my mother had undergone a hysterectomy at the age of 42.

I remember the feelings and the doubts I had then. Even if I was afraid and anxious because we were dealing with new formations of an "uncertain nature" and, therefore, the "lesser evil" had to be chosen, the possibility of giving up motherhood was extremely hard for me.

In the state of desolation and fear in which I found myself, I had the luck to meet a physician, the gynecologist who would operate on me, who believed in a "conservative philosophy." He believed that a 33-year-old woman could not and should not have to change her life and the quality of her reproductive choices. And so the formations were to be removed and the organ, the uterus, preserved intact. This is how I learned about an alternative to hysterectomy, and I could not believe I was going to try it.

What have I gained from my own experience and the experiences of others?

That women ask of medicine something extremely simple: to be able to get beyond the news of the disease—full of fear, anxiety and suffering—through the provision of good information which allows them freedom of choice and, as far as possible, the restoration of psycho-physical harmony and well-being.

Therefore we need to overcome the exasperated specialization of treatment of the body and on the reproductive organs of women, which sadly seems to be always more "invasive," by providing adequate and humanized information that enhances the power to decide and the possibility of choice.

It is necessary to restore elementary human values, to recognize the autonomy and initiatives of women, to consider the integrity of everyone's body as a precious resource to preserve jealously during our lifetime.

Francesca Rampazzo, 54-year-old Housewife, Padua

I want to tell you my story. I am 54 years old. I'm not a doctor, I am only a housewife. Despite this, my uterus is not worthless. At least I believe that is the case, and anyway it is rather important to me. I was nearing the age of menopause when, during a regular check-up, my gynecologist found a thickening of my uterus. Not very much, it was explained to me, but, in time, it could have given me trouble, and thus we should consider removing it.

My time for untroubled childbearing had passed, and so I was offered the opportunity of a "definitive operation" from which I would have only benefits. I would be able to avoid using the pill and the possibility of late pregnancies.

I resisted. I wasn't convinced at all that the "solution" was so logical and inconsequential. Faced with my refusal, my gynecologist fell back on a minor hormone treatment that made my uterus return to its normal size, just like in the drawing on his charts. "It's incredible," he said, "if I hadn't seen it with my own eyes, I wouldn't have believed it!" For me, it was a stroke of luck.

Now I believe that I really had a close call! I remember at that time that this organ, so important for a woman's well-being, was treated like something to get rid of, because without it things would go on as before. Instinctively, I felt that this wasn't the case, and so I resisted. And now, here, I understand even better that I did the right thing. In addition, I am learning now that future doctors are taught how to relate to patients, as if it were a branch of medicine to be more human.

And so, to understand the pain of others, I want to tell you about when, upon giving birth to my first son, just after the delivery, I was left cold and shivering, waiting for the doctor on duty to come to sew up the tears from my labor. When he arrived, after what seemed like an eternity, he began to sew me up without anesthesia. Because the pain was killing me, I screamed a little, and I flinched. I remember that I was gruffly scolded because I didn't stay perfectly still, and I complained.

I hope that women are no longer subjected to such a lack of humanity — or better, sadism — when they decide to entrust their well-being to the hands of qualified people.

C. P., 33-year-old Housewife

A year ago, in the sixth month of breast-feeding of my third son, I felt very strong abdominal pains, and I went to the emergency room where I was diagnosed as having a second-degree uterine prolapse and a policystic ovary. And so abruptly, without even saying "excuse me, we are sorry you are only 32 years old," without explaining exactly what they were alluding to, they suggested a "definitive operation" with no mention of alternatives, "so we can tidy thinks up a little; you already have three children."

Since I am a hard-headed woman by nature, I did not give up, but still today I get upset when I think of it all. And speaking with various people who have had problems with prolapses, I discovered that they had solved the problem through exercise similar to prenatal exercise, which was not mentioned in the hospital. I ask myself, why didn't they say anything? Why didn't they inform me of the fact that sometimes in these cases exercise is sufficient to improve the situation?

Later my personal gynecologist told me: "It's all right, you aren't perfect, but you can carry on, after all you have already had three children."

Well then, as for informed consent, I want to know this. If an anesthetist is informed that an asthmatic patient who needs an adenoidectomy is allergic to a drug (atropine), and then you discover from his medical chart that this drug was given him anyway, inducing brachycardia and tetany with spasms so intense they had to open his airway with a rigid tube since "his jaw was locked so tight that air could not get through..." Then who (if anyone) is responsible? I want to point out that after the operation, the family was told that everything went all right, but there had been "a minor inconvenience" when the patient came to.

Maurizio Borsatto, Family Doctor, Padua

The Crucial Role of the Family Doctor In the relationship Between Medicine and Patients

I begin by noting the current crisis of the health service and its members, because an ever-more-prepared citizenry demands that its needs be the top priority.

Never before has there been the opportunity to take advantage of a health service that is well-distributed territorially, nor can it be denied that the quality of life has clearly improved in recent years, at least in terms of the quantity of goods and information available (I am obviously speaking of the Western world).

In spite of this — or better, because of this — little by little the important role, at least in the memory of earlier generations, of the family doctor is being lost. A role based at that time on a paternalism that was exercised through advice and recommendations that left little room for the opinions of the patient — who, however, felt reassured within the relationship. What has happened?

In my opinion, two particular realities have coincided and produced the crisis in this relationship: (1) the breakdown of the earlier model of the family, and the related disaggregation (at least in cities) of its members (the nuclear family), and (2) the proletarization of family doctors within the professional market and within the medical profession itself, and hence their greater vulnerability in the social order.

This role, besides being devalued, is poorly integrated with the other side of the medical profession, that which is identified with hospitals and medical specialization.

However, we might say thanks to this loss of authority, the family doctor today is in closer contact with common citizens and the problems that they bring daily into his office. Both of them are included in that homogenization and standardization which characterize our era. Both risk being entrapped in a relationship of dependence in which both are expropriated.

Expropriated of the will power to make decisions about the increasing complexity of civil living, and impatient for answers and solutions to all problems, often losing sight of the significance of individual problems, and as a result of their relative importance. Complexity and impatience have caused a radical change in the behavior of entire social groups. The example of the aged is enough to make the point. Extricating ourselves from this dynamic is ever more difficult, both for doctors and mere citizens. Still, the difficulty of distinguishing between values and needs has radically changed the way family doctors relate to patients. This relationship has to change radically if we want to keep the role of the family doctor alive.

I have stated these premises because I think that the question we are dealing with, hysterectomy, exemplifies effectively the complexity of the social and interpersonal dynamic that influences us daily in the family doctor's office. During my professional training, primarily in wards of obstetrics and

gynecology, I was able to gauge the size of the problem. I did not find a single good reason to explain why there were so many hysterectomies. I still have my doubts today about the need to intervene so radically and so often. And since then I have asked, and continue to ask, women (and only women) who visit my office for an answer.

All of them have told me either an anecdote about themselves or other women and about hysterectomies they considered useless or in someway harmful. But what has made me think the most is that they all had critically produced an accurate assessment of the problem of keeping themselves intact physically and psychologically, even after menopause. Many of these women had had uterine fibroids diagnosed, and so had had a hysterectomy, and perhaps the removal of the ovaries and fallopian tubes, recommended to them. Many of them today, after menopause, still live with their larger or smaller uterus that someone told them was useless and cumbersome after a certain age.

In the light of this experience, I think acceptance and recognition of the likelihood that natural physical changes occur over time is one of the most important problems that a family doctor faces in daily practice. And this is true whether they are dealing with physiological processes linked to the passage of time, like menopause, or if they are dealing with pathological processes, whether serious or minor.

In this regard two patients come to mind, both of whom have neoplasias that originated genitally, and with whom in recent months I have shared a reciprocal relationship based on acceptance and recognition of their disease and the problems that accompany it. What I have learned from these relationships has been particularly useful in my professional practice, which is so often characterized by hurried and impatient dealings with people who often have difficultly carrying on with minor problems. Nevertheless, the phenomenon should not be underestimated. It is rooted in the widespread social discomfort in which interpersonal and workplace relationships have lost their intersubjective nature, to be replaced by increasing interdependence. For this reason we should be reminded that these relationships, and in particular the doctor-patient relationship, uses the spoken language as its fundamental tool, along with the metalanguages that automatically are used when speaking and that reinforce it. So we need to remember that the patient may misunderstand a word with a complicated meaning, poorly explained or inserted in a dialogue at an inappropriate moment. Every single word has a precise meaning and, given the poverty of spoken language that has characterized recent years (think of the example set by some politicians), we, as doctors, must be very careful about what we

say to our patients. We should exercise our patience and learn to listen. We must even invite and prod our patients to express their problems more fully.

Doing so, even if it is not always easy for me, I have found some doubts in patients who had already been told they need a hysterectomy, doubts raised by patients that have been transformed into responsible and rational choices. It is much more difficult to settle doubts left unsettled after a hysterectomy has been performed.

I have dwelt on only a few aspects of the problem. I want to conclude by saying that every doctor-patient relationship has to be very complete and thorough, that both parties in the relationship have to feel responsibly free within the relationship. Only in this manner can they reach a satisfactory understanding.

Norberto Perin, Nephrologist, First-level Doctor of the Hospital of Padua, Member of the CGIL (General Italian Confederation of Labor) Secretariat for Doctors

I would like to thank Prof. Dalla Costa who, by involving me in the preparation of her paper on the question of hysterectomy for what concerns my area of expertise, allowed me to see the enormous importance of the operation not only in the relationship between women and medicine but for women in general.

I confess that I once shared the surgical and chauvinistic biases concerning hysterectomy. Some time ago, in fact, when my partner, a bit over forty with uterine fibroids (whether it was one or two I don't remember), asked me for my medical opinion after her gynecologist recommended a conservative treatment, I answered, "Remove the uterus, what good is it to you?"

So I think it is beyond doubt that there is a male-chauvinist bias regarding hysterectomy.

On the other hand, hysterectomy is the chief operation or the most important surgical DRG (Diagnosis-Related Group) in gynecology, and so it can be claimed that there is a surgeon's, in addition to a male chauvinist's, bias to recommend hysterectomy.

On the basis of a low level of understanding or an underestimation of the consequences of hysterectomy on the female body, and on the basis of recommendations of the operation seriously influenced by surgical and male bias, I thought I should know, if only as a union member, how many hysterectomies have been performed in Veneto in recent years, and to see if it has been used

"excessively" for benign reasons like uterine fibroids and fibromatosis. From the data there emerges, in addition to a high number of hysterectomies in Veneto, a tendency to increase, from 5,909 in 1993 to 6,685 in 1996. But they also reveal another important fact, supported by my own research: whether they were performed for benign and malignant reasons, they are recorded statistically in the same manner (ICD – 9 — CM – 68.40).

I think it would be appropriate that the Veneto region (and the same can be said for the data collections in other regions and nationally) use a code that, even if based on the international one, makes a further distinction between hysterectomies performed for benign and malignant reasons. I also think it is important to know the age of patients on which hysterectomies are performed. So a request has been sent to the region to know the rate of hysterectomy in relation to the age of women.

In conclusion, it is more than plausible, based on the data collected, to infer that they indicate an excess of hysterectomies for benign reasons. This excess can be attributed to surgical, male, and privatized institutional biases.

I want to say two things about "informed consent" and the "evolution of the doctor-patient relationship."

First of all in the national health service, if it is reorganized along corporate lines, the customer/patient will not be in a position to evaluate the product offered, even if offered on the basis of informed consent. In this general framework — in which only the conscientiousness of the doctor, or lack thereof, can insure that the patient follows a route of greater benefit or greater harm — it seems to me (and in this I agree with Prof. Dalla Costa) that the evaluation and so the refusal of an unwarranted hysterectomy by a woman is a goal that women can nevertheless pursue on their own. And this can occur on the basis of the collective efforts of women, potential patients, together with women, healthcare providers, that will enable them to acquire the basic information on the alternative treatments for the principal uterine pathologies.

Secondly, I think that a doctor-patient relationship that in any case seeks a positive result, will induce doctors to decide based on "legal medicine" (obviously, a flawed version of it) and so to make his choice not based on what is best for the patient based on current scientific knowledge and fundamental ethical values, but what is safest for him. That means what is least dangerous for him "legally." The high number of Caesarian sections in the United States seems to me a good example of this "legal medicine."

But the high rate of hysterectomy cannot be explained in this way because, in comparison with other gynecological operations, it is the most invasive, and

is full of negative consequences. So only the three reasons mentioned above are left to explain the excess.

Carmen Meo Fiorot, Psychopedagogue, Director of the Institute of Alternative Educational Dynamics CRS–IDEA, Padua

I am here not as a director, or a psychopedagogue, or an instructor of mental dynamics, but as a woman who has suffered unutterable pain because of the question being discussed here today.

I played the mother for eight brothers (the youngest of whom was eight months old, and for two girls of three and five years and so on). My mother died at age forty when I was sixteen-and-a-half, and I took the reins of my family in hand. When I married at 24, I ardently wanted my own children. Teaching, studying pedagogy, and the long experience with my younger brothers and sisters had all prepared me to be a perfect mother. But then the troubles began. One, two, three, and more miscarriages. Check-ups, tests, everything was all right, the doctors said. But not always are check-ups and tests correct. During a salpingography — a test in which an iodine-based contrast medium is injected into the fallopian tubes, (anyone who has undergone it knows how painful it is) — because I had a natural reaction to the pain, a doctor slapped and crudely insulted me.

Only after the sixth miscarriage did it dawn on them to test to my husband and me for the Rh factor. I am Rh negative, he is Rh positive. This was why my pregnancies didn't last more than three-and-a-half months. But, with every pregnancy, I prepared cradle and wardrobe.

It was a long, very painful ordeal. During the day I tried to hide my psychological state, but every night I dreamt that I went down into the graves of my unborn children, I brought them toys and we played with them. Then, when I made love with my husband, inescapably there appeared an apple tree. The apples were lovely, but they were quickly transformed into many tiny skulls. Real torture. But I kept on hoping, kept on trying. I would have given twenty years of my life to have one child.

Certainly the fact that I had others miscarriages (five more unfulfilled pregnancies) was my responsibility. On the other hand, my doctors were responsible for the enormous quantity of lutein and folliculin that they gave me needlessly. I am not a doctor, but who can tell me that the fibroids and cysts, for

which I was repeatedly operated on (with the extra bonus of hepatitis from a transfusion) and that twice brought me near death, were not due to these massive hormone levels? And then, the arrogance of the doctors. I was the victim of real psychological terrorism on their part. I regret talking about doctors like this. My brother is a doctor, but he treats his patients with great love. At that time he was young, he worked on respiratory diseases, and he had complete faith in the work of his older colleagues in other fields of medicine. But I have never had a single word of explanation from the doctors who cared for me, so that I imagined that I might have had some malignancy. But the fact remains that when I was not yet thirty, they removed my first ovary and then the other one and a part of my uterus.

In conclusion, when very young I was hysterectomized and ovariectomized, and for a long time I have lived in complete desolation, which became somatic on all levels. As I wrote in my book, *Energia mentale e pensiero positivo* (Demetra, 1993), my brother used to say that I was a walking pathology handbook.

Women who have had a hysterectomy feel castrated. They are terrified that they are not only finished as mothers, but also have had their sexuality diminished. Their world caves in on them. They fear they are no longer loved because their body has lost its sumptuousness. Emotionally, they become unstable. They desperately need medical explanations from doctors and a lot of psychological support. Instead, in my case — and as far as I know generally as well (there are obviously exceptions; I ask to be forgiven by them and I hope they understand that I am not speaking about them) — the doctors did not offer a word of support, nor of explanation, nor help of any kind. There was no trace of psychologists, at least in my times, in the hospitals.

I had to go to the United States to know something more specific about my case. I went for check-ups to the Bethesda National Institute of Health and the George Washington University Hospital. I received the same answer in both hospitals. Professor Tamagna, I still remember her name, told me, "Don't worry. The fibroids and cysts were benign. The fact that your uterus was saved in part is the confirmation." But she added, "Maybe they could have saved your ovaries as well, but probably they wanted to get things over with."

"How good they were," I say, "in removing everything from a woman who was not yet thirty, without even trying to save the organs that could have been saved."

On the psychological level, I helped myself. In America, as a Fulbright fellow, I visited clinics in which depressed people used creative visualization.

They were made to relax and were invited to picture themselves as calm, satisfied and happy in a comfortable house, and so on. In this way those people slowly modified their self-image and overcame their crises.

"Why don't I do it too?" I asked myself. Fortunately I met a certain Marcello Bonazzola, who had created a course in mental dynamics. I attended the course and I realized that the methodology could be very useful both to reinforce one's self image, and because they give you a series of techniques to feel better psychologically and physically. (We now know how the two are intimately connected; who is not to say that some uterine pathologies for which women are hysterectomized occur more easily in people who are in psychological crisis?)

I was so happy about the help the methodology of mental dynamics had given me that I decided to found, with Marcello Bonazzola and a small group of strong-willed people, the European Academy CRS – IDEA (Research and Study Center – Institute of Alternative Educational Dynamics) whose scientific director is Sabino Samele Acquaviva.

This Academy is today a moral organization recognized by the state. It has the goal to work on various levels and in a wide range of activities for the recovery of personal strength, for equilibrium between the mind and body, to improve techniques that teach participants to set goals calmly and to live them mentally, as though they had been achieved through synthetic experience, to make them aware of the law of compensation according to which who loses an organ has others that either work better or as a substitute, in order to give strength, dignity and hope to people, especially to women, and in particular to those hysterectomized or who were the victims of any kind of physical or psychological violence, (and which today, unfortunately, are innumerable).

Made strong by my experience, I want to conclude my testimony with a message for hysterectomized women:

"Let go of your earlier suffering. Project yourself in a future of well-being. Live the here and now intensely, creatively. Decide to do something for you. Learn to love yourself. Take care of yourself. Attend a course to reinforce your personality. Also attend courses in order to express your creativity in different areas which like I have done. Creativity means, if this way does not work, I will take another, or yet another. Even if I they have hysterectomized me, I know that my sexuality is in my head, in my mind, I know that it depends on my creative ability and so I will continue to live it, more fully and better than before. If I have retired, I will do whatever I like that perhaps I wasn't able to do before."

Since I have retired as the director of instruction, I have given myself to many other activities. Finally I create art, how and when I want to. I write books. I am a pychopedagogue; I direct the Institute of Alternative Educational Dynamics. I conduct courses of mental dynamics and creativity around the world, and I also conduct another kind of course that lasts a week during which there is the time to bring out all an individual's problems. And, to the great shame of the whole male sex, systematically it comes out that at least half, and some times more, of the women in the course have been abused, often when very young.

With a life spent helping others, especially women, I am ever more aware that all over the world we are still objects of abuse and torture. (In twelve years directing schools for girls in Africa, I have seen many kinds of abuse against women; still today, when I think of infibulation and clitorectomy, I am horrified).

And in closing, as for myself, I have to say that if for half of my life I cried because I did not have any children, now I have thousands of them all over the world. I have learned that there is not only physical motherhood, but there is a spiritual one. I am 72 years old, and I live on all levels like a thirty-year-old. I am happy, serene, joyful, at peace with myself and others, with the whole world, even if I still support struggles against injustice and abuse.

Hysterectomized women, you have had a rough time, as I well know. But do not stop to cry. Pick yourselves up, and start living joyfully again. I did it. You can do it too.

Giuliana Mareglia, Psychologist at the Family Counseling
Center of Monterotondo (Rome) Local Health Unit Rome G

Psychological Impact on Women of Experiencing a Hysterectomy

My presentation is organized in five parts: (1) how woman come to accept having the operation based on my personal experience; (2) why removal of the uterus is not the same as removal of a kidney; (3) information drawn from some studies on the consequences of hysterectomy on women; (4) the experience of psychological counselor with the question; and (5) some thoughts about what can be done to help women who have to undergo the operation.

Healthcare providers present hysterectomy to women as the only alternative that will free her of a uterus that has become too troublesome. It may either be

enlarged, or contains fibroids, either it weighs on the bladder and causes urinary problems, or it does not contract properly and causes long and abundant menstruations and consequently anemia and fatigue.

They repeat that the uterus in reality is only an organ for having children. Only if they have not had one, is it worth doing everything possible to preserve it. Otherwise it is better to get rid of it, since it is an organ with a risk of cancer.

When it is all over, she will feel much better, she will not have to worry about getting pregnant, and she will be able to enjoy her sexuality freely.

To get away physical discomfort that limits her relationships, the woman accepts the operation.

Let us now look at why, from a psychological point of view, undergoing a hysterectomy is not like undergoing any other operation.

Psychoanalytic studies have shown that in the course of life the structure of the ego and personal identity are based considerably on bodily sensations and awareness.

While men live their bodies exteriorly, the image that women have of themselves is built around a "central cavity" that is animated, fantasized, symbolized, as well as experienced, that renders experience and the structure of the body differently in the various phases of life.

This empty space is prone to be filled: the dynamic of full and empty, of union and separation, is expressed in women especially in the transitions supplied by biological signs ranging from menarche to the menstrual rhythm, from pregnancy to menopause, as well as in sexual activity. So the female psyche is dominated by awareness of an internal genital space that can take or preserve, but which at the same time produces and creates, i.e., an interior space in which vital processes are linked with sexuality. The specific nature of the female identity is the ability to feel the internal rhythm of the body and its cyclical language. In the fertile age of life, the rhythmic pulsing of the internal genital space represents vitality. So its harmony, its corporal equilibrium and cyclicality are the basis of her sexual identity. Its meaning is challenged continuously. Menstruation and pregnancy carry an organizing, stabilizing, and integrating meaning.

A hysterectomy thus may initiate in women an intense psychological problem centered on the removal of an organ to which different symbolic functions are attributed, such as the protection of her sense of womanhood, her ability to reproduce, and the completeness of her own body. After experiencing a hysterectomy, her image of her body is impoverished and debilitated. Since its synchronization with the other events of adult life is no longer respected, and its

bodily rhythm and experience are traumatically altered. The cessation of the menstrual flow can provoke a harsh emotional reaction, because of the symbolic and affective significance of menstruation. According to Deutsch (1944–45) the narcissistic ego of a young girl may welcome menstruation as a satisfying step towards adulthood. It is associated symbolically with pregnancy and fecundity and acts as an organizing factor of womanhood. Not only the pain but also the nature of the menstrual flow itself — the regularity of the period, the installation of regular habits in body care — contribute to the stability and wholeness of the psyche. According to studies on hysterectomized women carried out by Dullich and Bieber, (cited in Ceccato et al., in Genazzani and Facchinetti 1988), it was found that menstruations are considered to play a vital function in cleansing and expulsion. To be components of the vital rhythm, their occurrence is seen to be necessary because of their regularity for staying healthy. It is on all this that lie the anxieties of a woman who has to undergo the operation, and who has to face a new balance that may cause disruption in her sexuality, periods of depression, somatic symptoms and maladjustment with her partner and family.

It was Richards who in 1974 defined the "Post-hysterectomy syndrome" which he characterized using two groups of physical and psychological symptoms: on the one hand, asthenia, cephalalgy, hot flashes, vertigo, tachycardia, dyspareunia, insomnia, decreased libido, on the other hand, a depressed mood. Among the 56 patients examined by Richards, depression occurred in 70% of the cases in the three years following the hysterectomy, while in the control group it occurred only in 30%. The average duration of the disorder was 12 months and 9 days for the first group, versus 4 months and 2 days for the second. Hot flashes occurred both in patients with total and partial ovariectomy as well as in 35 patients without ovariectomy, so the cause of these is unclear.

An American study carried out by Dennerstein et al. in 1977 (cited in Amore et al. 1988) focused on the deterioration in the sex life that occured in 37% of the hysterectomized and ovariectomized women and which, at times, involved the husband as well, producing a post-operative syndrome in the couple. It may be that men find it difficult to accept the mutilation of their partner.

Other studies have highlighted depression as the most important post-hysterectomy complication.

Medina and Forleo, in a 1980 study using a sample of 109 women, found, in addition to depression, the reinforcement of what they called psychosomatic disorders which were already present before the hysterectomy (this would confirm the thesis that some gynecological disorders can have a psychosomatic basis).

However there are other studies in which an increase in depression is not found in comparison to the control group. Sometimes the operation is followed by a improvement in mood, which is attributed to the hysterectomy eliminating the somatic disorders or, according to a psychodynamic interpretation, the operation could represent a valid means for expiation of past wrongs — that is, "now that I have paid, I can rest easy."

A study carried out at the University of Bologna (Amore et al., 1988) on twenty women who had been examined before hysterectomy through clinical interviews and examinations, found that the most significant psychopathologic reactions occurred in patients with disturbed personality traits (serious neurotic, psychotic or borderline traits). So it may be that the patient's personality structure is the decisive factor in the development of psychopathologic reactions to the operation. A study carried out at the University of Modena (Rigatelli, M. et al., 1988), on the psychosocial stages of mastectomized and hysterectomized women, defines better what may be the variables that determine the response to the operation. The ethnic and cultural factors of the social context to which the patients belong (religion, education, the importance given to the role of the woman), personal factors (previous pathologies, age at the onset of the disease, the nature of the disease, education level, type of personality) and external factors such as the information received, the family structure in which the patient lives, and the type of social support offered were all found to be very important. Some variables are considered unfavorable for the consequences of the operation, such as, for example, youth, low social-cultural level, and the lack of a stable relationship.

My twenty years of experience as a psychological counselor confirms what has been highlighted in the studies I have described. The women who come to the counseling center on their own after having a hysterectomy are few. They complain about being depressed, a sense of emptiness, "a kind of a loss," difficulty in having sexual relations or in finding satisfaction from them. Women who have a good relationship with their bodies and sexuality mention a change in how they experience orgasm that, according to them, loses "intensity," as if the uterus before the operation had performed the function of a "sound box."

This is confirmed in the most recent American studies (The Hysterectomy Association, 1998) that record how some women report the same feeling, and that this might be determined by the fact that not only the clitoris is involved in orgasms but also the uterus and the cervix — "contractile muscles that come into play in the experience." Obviously their absence could explain the experience reported by these women.

Master and Johnson (1966) in their research had already pointed to a direct involvement of the uterus and the cervix in sexual tension and orgasms. The former "rises" in the pelvis in the phase of excitement, and this rise is complete only when the plateau phase has been reached. During the orgasmic phase it "participates" through contractions that come to the end with the phase of resolution. Its size may increase, and often does increases during the cycle of sexual response, because of a notable increase in the liquid part of vasocongestion. This reaction is clinically more marked when the phase of excitement and plateau last longer and the subject is a woman who has given birth.

The cervix participates during sexual response through the opening of its external orifice, and this opening seems to be positively correlated to the intensity of the orgasm reached by the woman. This process is more evident in women without children, as the uterus has not undergone the trauma of the delivery.

However, I believe that the involvement of the uterus and the cervix in determining the intensity of the orgasm deserves further study, perhaps through more focused research. It would be interesting, for instance, to study a group of women who were able to gain confidence in their sexuality, to live it in freedom by using oral contraceptives, and who had the misfortune to have a hysterectomy. Probably, changes in orgasmic experience would be easily documented in many cases.

At our family-counseling center discussion groups for hysterectomized women have been organized to help them scrutinize their loss. Unfortunately they have not been a success because participants had often undergone the operation some time before, so that it had probably been sufficiently coped with. Most of them, in fact, only attended a few meetings and then stopped coming.

In collaboration with the local hospital, we started to invite women as they were discharged (in our hospital they do about sixty operations a year and have a total of twelve beds). The results confirmed what was found in a study of the University of Turin (Piccioni et al. 1988): "patients tend to deny their problems, not only the physical ones, connected with the operation," because the women did not come to the meeting to create the support group.

To conclude, I think that hysterectomy is an event with a particular existential meaning that may be lived in an intense emotional and affective atmosphere. Each individual, because of her personality structure may react in her own way to it because it is "unique for her."

However, a hysterectomy is a severe loss for a woman and reactivates on a symbolic level the way she has learned through out her life to deal with loss and change.

Finally to act preventively, if hysterectomy is "really" the only practicable route, psychotherapy or pre-operative support for the individual or the couple is called for — especially for those women who already are instable psychologically. (And here all the authors who have looked into the question agree).

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Erminia Macola, Professor of Spanish at the Faculty
of Political Science, University of Padua

I want to begin from another point of view, asking myself: why do women so often have problems with the reproductive apparatus?

This disease could be one of many symptoms of the uneasiness of our civilization. Doctors resolve the problem by eliminating the cause of the uneasiness without questioning it too deeply. This has inspired me to analyze the phenomenon of hysterectomy, which is too easily performed, alongside another symptom of our times: the fall in the birthrate.

Statistics report that in Italy and Spain the rate of fertility is 1.2, while it would have to be 2.1 to ensure that one generation would replace the other. In our civilization something is dying, and this is troubling. I will leave aside sociological interpretations of the phenomenon to get to its core, the relationship between the individual and science in our times, which is not foreign to the subject of this convention.

We can see then that science is replacing the human potential with machines. First of all it replaced physical power, then it replaced intellectual power with computers, thanks to which we are experiencing a great loss of memory compared to earlier generations.

We can now see, to our great bewilderment, that even the reproductive system can be replaced. Artificial insemination, in vitro fertilization, rented uteruses, and — why not? — an artificial uterus. So the natural uterus will no longer be needed, so what should we do with it? We are already experiencing part of this new reality through sonograms, when we see that what is internal can be seen externally, it can be projected on a screen and as a result what before was a mystery, a surprise, a gift, is now known, programmed, and managed by women and doctors of procreation.

The complex relation between sexual desire and the desire to have children has become estranged, while before when a woman conceived she felt simultaneously both a future mother and more a woman. Everything that used to have an important role is fading away or changing, and giving birth is always more overrun by technology.

Widespread infertility is one current reaction to this problem. I feel that this leads us closer to uterine disorders, which I also consider to be a complex and inexplicable uneasiness. In both can be seen a violation of the covenant of sol-

idarity between two essential sources of feminine identity, that of being a woman and that of being a mother.

In my opinion this violation should be attributed to the role of women who have become entrepreneurs of their desires and of their bodies; to capitalism, which commands that everything should be produced, except children who interfere with production; and to science, which is a cause of changes greater than all our powers to recognize ourselves within it.

Cristina Zuppel, Psychologist, Padua

My name is Cristina Zuppel and I would like to tell you about Nadia Berini, a dear friend of mine who was hysterectomized when she was 34 years old, in 1986 at the Asolo Hospital, and who died in Padua in January 1992 of AIDS. The disease was a long ordeal that Nadia contracted from a blood transfusion because of her hysterectomy.

Nadia was a woman aware of the condition of women and women's rights. She had fought for women's rights; she was a fighter with a strong will to live. I remember that it was March when a frightened Nadia called me. She had a violent stomach ache and very abundant menstrual bleeding, enough to fear a hemorrhage. We ran to the gynecologist who found her uterus had doubled in size. There were two possibilities, either Nadia was three or four months pregnant, despite her menstruations, or there was something "more serious" going on. After tests and sonograms, the diagnosis was multiple fibroids. Nadia could not stand the idea of suffering any longer the terrible pain that arrived every fifteen or twenty days. She asked what could be done to solve the problem and, obviously, only one solution was proposed — a radical operation. Nadia had already had an ovary removed a few years before, for a problem with ovarian cysts. She was told that, because of adhesions caused by the earlier operation, her uterus could not have been removed vaginally, and that furthermore, as the state of the other ovary was unknown, it was possible that she might have to undergo an ovariectomy during the operation as well.

Nadia asked for more information; she wanted to know about the consequences. The doctor who operated on her in Asolo told her about the psychological problems due to being without a uterus and, in her case, perhaps without ovaries as well, and the fact that she would no longer be able to give birth. However, he did not mention any alternatives.

Nadia took time to think it over, but when the pain returned, she decided she was strong enough to face a life without children and without her uterus. But Nadia was not told about the physical consequences that removal of her uterus and ovaries implied — i.e., an abrupt and violent entry into menopause; the severe imbalances due to the loss of hormones fundamental to the organism; the risk, even if only the uterus were removed, of intestinal or bladder problems. If Nadia had known all this, she might have waited; she might not have had the operation so hastily. But, most importantly, Nadia had not been informed of a fundamental aspect of the situation, that is, that an operation of that kind might involve blood transfusions. This was at a time when the Ministry of Health had sent a protocol to all hospitals advising they use blood transfusions only in the case of extreme necessity, given the serious risk of units of blood being infected with the AIDS virus.

Nadia's case was not an extreme case. She was only very anemic after the operation, an anemia, according to qualified medical experts who were consulted later that could have been treated with a simple iron supplement.

The first thing Nadia asked me when she woke up after the operation was: "Did they remove everything?" Fortunately no, the other ovary was saved. She was happy; somehow she felt less disfigured. In April she came home from the hospital. She did not feel well, she was losing weight and was not recovering. In September, after several tests, the death sentence: "Madame, you are HIV positive." And the inquisition began, the interrogations, the insinuating questions about her private life, about her sexual habits, suggestions that she might not know everything about her husband's life. From victim, she was transformed into a suspect. Those were years, but maybe it still happens today, in which AIDS meant being labeled a homosexual or a drug addict by many people, so "different," blameworthy, meriting exemplary punishment. Nadia and her husband did not give up, they spoke with their friends about it, they sought solidarity, they did not become isolated. They traced, on their own, the unit of blood used for Nadia's transfusion and discovered that the donor was HIV positive and that the hospital knew it, but had remained silent. Why didn't they warn her? If the disease had not developed quickly, she might have infected her husband as well. After months of desperation, Nadia decided to fight and sued the hospital. She has received merely the appearance of justice, but only after death. All this for uterine fibroids, a disorder — and here today it has been widely confirmed — that can be treated without being forced to undergo destructive operations and consequences that unalterably and cruelly ruin the quality of life of too many women.

R.B., Pediatrician, 54-years-old

I underwent a hysterectomy thirteen years ago. I had no children and I did everything to avoid it, because as a doctor I was aware of the loss I would have experienced. To save my uterus I would have risked another operation with no regrets, but this was not possible because my uterus was fibromatous and had endometriosis. And so they removed my uterus and an ovary.

I remember the terrible post-operative phase, although I left hospital after five days. The experience I had can be compared to "mourning." As a doctor I tried not to complain, and I thought that I did not have an oncological problem, and so I would not have to undergo chemotherapy.

Fundamentally, I missed the rhythm of menstruation. Even if I had suffered metrorrhagia, I felt a great loss. I tried to react by keeping in touch with the menstrual rhythm, by trying to sense the symptoms of ovulation in the days corresponding to the period, and in this I can say that I was successful. This, I realize, was a mechanism to offset the lack of menstruations, and I believe, as a doctor, that it would be the first thing I would tell women forced to undergo a hysterectomy.

Despite the fact I had a Pfammerstirl, I had great difficulty accepting the surgical scar; I felt ashamed. The fear of weight gain led me to greater control of my diet, and my feelings about what had happened my body caused me to be more careful about my physical appearance to compensate.

I reinitiated sexual intercourse as if it were therapy, because I experienced it as an obstacle to overcome, with the consciousness that it would be very different. I could not get over the idea that scar tissue had replaced my cervix and uterus. I started over as a gesture of will power; at the same time, I feared unconscious rejection by my husband even though, fortunately, it did not occur. On the contrary, I must say that I received his support and understanding and it assisted my recovery. If this had not occurred, I would have let him go to choose his own way because I would have justified his choice and I would have permanently stepped aside.

Despite having had a severe form of endometriosis that made intercourse painful, I had coped well. There was pain during intercourse, but it was bearable. After the operation what I felt made me long for the former situation. The new situation that I found myself experiencing was that I felt my abdomen without a uterus and the related vascularization as an empty sound box that no longer resonated. The change in the quality of my sex life was certainly great

and, even if I have been able to reinitiate my sex life with my husband's help (but differently), I am always aware of the loss I have experienced.

Since I could not present in person for professional reasons, I have given my testimony to this convention in writing, because this aspect of impoverished sex lives caused by hysterectomies is not normally communicated to patients by gynecologists who recommend the operation. Patients run the risk of discovering it as a bitter surprise, afterwards. On the contrary, it is another serious reason why gynecologists should recommend this operation only when there are no alternatives. Women have to be very careful, and check every single thing before giving their consent.

M.D.C., Teacher, 55-years-old, Padua

I never needed special gynecological care. I was healthy and a naturalist in how I conduct my life. I had chosen a gynecologist suggested by a common friend because, when he was a student, our friend had seen him study a lot to stay abreast of the latest developments. For me, he was just someone to fall back on if I had a real problem. But, as I had decided not to have children, since I had always refused to take birth control pills and I had never used an IUD (I used the diaphragm instead), my relationship with genecology was rather rarefied.

When I was 48-years-old, I began to have excessive menstruations. I was diagnosed with a small fibroid of three centimeters in the rear sub-mucosa, which grew to four centimeters after five years of the usual hormone therapy with progesterone ten days per month for a cycle of several months.

At the end of five years, the doctor told me that the growth of the fibroid — which caused the bleeding to get worse and left me always more exhausted — was due to taking the drug as well. Since uterine fibroids are the most common pathology, I continue to wonder why no better drugs have been developed, since the one I took has so many negative side effects. I have the feeling that there have not been adequate efforts both on the origin of fibroids and on the development of effective remedies with no side effects. After my experience I have my doubts that everything has been left as it is because fibroids are considered the halfway house to hysterectomy.

However, from the very beginning, I had asked my doctor whether my fibroid could be removed; he had always said it was impossible. I wonder to myself, if such a small fibroid cannot be removed, which ones can be removed?

What he said sounded strange to me, but since he had been my doctor for many years, I trusted him and believed him. Then, I learned that a relative of a friend of mine in Rome had completely solved a case of fibroids similar to mine through a new vaginal technique (I did not know yet that it was called hysteroscopic resection), and thus without an external incision. I talked about it with my gynecologist. He said that "in my case" it was absolutely impossible.

In reality he led me astray after the solution had been found. To those who would tell me to verify it, my answer was that it would have been absurd to telephone people who I did not even know if my doctor said it was impossible. He certainly knew better that I did where my fibroid was located. Still, two years after the first time I had talked to him, and worn down by the excessive bleeding for which I had several series of iron injections, I asked him the same question again. I give him the name of the hospital in which such a procedure had been done, and the name of the doctor as well, because it seemed to me that, if there was a real chance, two doctors would be able to understand each other, to communicate.

The answer was the same. He proposed a total hysterectomy with the removal of the ovaries as well, reiterating that he, as he had already recommended, would have done it five years earlier, and that he would have given me a skin patch. At the time of that discussion I was 53-years-old; my menstrual cycle had been perfectly regular. Thus he would have sent me into a surgical menopause when I was 48-years-old for a three-centimeter fibroid. All this sounded a little absurd, since he did not think it wise to undergo replacement therapy for more than five years. In fact, at age 53 I would have already exhausted all my resources and be without ovaries and without a patch. He describes the operation to me as a very normal event at a certain age, and I would say "more up to date" than keeping one's own organs with their defects, given the new hormone replacement therapies available. This is an attitude that I later found in others. The drawbacks? None.

I felt my heart freeze, even though I did not know anything about the operation or anything else, because I always have been wary of letting anyone lift a scalpel near me. I dared to express my timid concerns about any kind of operation. Is there not a risk of adhesions and of feeling the wound when the weather changes? He smiled, "Absolutely not." I tried to explain the importance that the body's organs seem to have for me. I even appealed to the example of Chinese medicine, based on the flow of energy through those organs.

Organs cannot but be important. From that moment on, my desperate resistance began. I tried to gather information on hysterectomy by talking with

women who had undergone one. The operation, even though I still knew little about it, seemed to be more serious and filled with negative consequences than I had been told. He tried again to blame me, and accused me of not accepting the operation because I refused to accept the idea of entering menopause. It was my problem. Continuing to blame me, he came up other reasons. I continued to reject the operation, and I reminded him that once he had mentioned injections that could "put my ovaries in standby" for three months. He recalled it half-heartedly, underlining that it was not worth considering any longer because injections now cost a lot. This, too, seemed absurd to me. In place of an operation...

But he did not me give any information about it. To put my ovaries in standby for a while seemed sweet to me. I discovered only after having had the injections that in reality they are a massive dose of synthetic hormones that influence the hypophysis and the ovaries, and that, for this reason, other doctors use them with great caution and in exceptional cases. In reality, when I went to the appointment for the first injection he told me, syringe already in a hand, that he hoped to send me into menopause because that is what often happens after a certain age. Yet another act of aggression. Why did he not tell me before, so that I could think it over and learn something more? I would have had to jump off the table. I was confused. I thought I would be inappropriate to leave. I wanted to think that it would not happen to me because I always had regular periods. I had five injections, not the maximum of three recommended for fibroids. It had the intended effect. My menstruations disappeared, and it seemed to me that they had pulled my plug. I was completely estranged and disturbed psychologically. I felt like I was someone else. I felt like I had been catapulted into a situation over which I had no control. What are the consequences of such a violent onset of menopause?

After a few months, I had to go back to him for a checkup after having a sonogram. While having it done in hospital, I asked another doctor if in her opinion the fibroid could be removed without removing everything else. Certainly, she answered, but those five injections had hardened it, and they may cause osteoporosis. So she said I should get a lot of sun.

I asked my doctor why he lied to me. He shook his head, as if I pretended to know something that was beyond me. However, he told me that a new medical instrument had arrived in Padua that could remove fibroids vaginally, but, "naturally," I would have to sign a form authorizing removal of my uterus if necessary. In fact, he told me that something could go wrong with the new procedure, making it necessary to remove the organ. Practically, he told me that I

had to exonerate the surgeon from any liability and dig my own grave. I felt my heart grow cold again.

It seemed to me to be a well of cynicism and bad faith. "So this is the instrument I had talked about and that they used in Rome," I said. He, in the mean time, began to write the letter, which I have to this day, with which he intended to send me to his colleague, the surgeon. It reads, "Dear... I'm sending you this woman ... who does not want to undergo a hysterectomy..."

Evidently that was still the first option from his perspective. For whose good? I answered, "No doctor, at this point I'm going to Rome." In fact, I wanted to remove the fibroid to avoid the serious consequences that I was afraid of as a result of a traumatic passage into menopause, for which I would need a replacement therapy to keep these consequences under control. But this therapy, while I still had the fibroid, could lead again to excessive blooding.

I underwent the hysteroscopic resection successfully at San Carlo of Nancy Hospital in Rome, where I experienced respect and sensitivity in the way doctors treated patients. With but one exception. Two nights before the operation I had a very severe abdominal swelling and some pain. I did not know why; an attack of appendicitis, or maybe the hospital food? In the evening I was searching for a doctor for his opinion because the operation was imminent and I did not feel comfortable. I needed to tell him that in the last few months occasionally I had a bit of swelling but never so severe and never with pain.

"In my opinion your belly is old," was his diagnosis, "whatever it is I will come have a look soon." "I do not think it is my age," I replied, "but the hospital food." He examined me. He excluded appendicitis, but did not mention his sado-scientific diagnosis in front of the head of the ward. I avoided any suspicious food at lunch and dinner and I did not have a relapse. Every pond has its ugly duckling, I think, but this one will never turn into a swan.

In fact, after a few months I had a series of very serious side effects as a result of the chemical menopause. I used a hormone replacement therapy for six months, but I understood that the damage could no longer be treated in this manner. I stopped taking the hormones. I had no intention to be dependent on any drug or doctor. My body — which I had protected by not even forcing birth control pills on it — would find its own way to somehow get over the aggression it had undergone.

In the town where I live, I would experience more violence. During a check-up that I had to have in the hospital after the operation, the doctor told me that at my age it would not have been a bad idea to have a total hysterectomy instead of the hysteroscopic resection. He was almost complaining about it.

One less operation. Three nurses or student nurses were there as observers. I hope that my answer taught them a lesson.

I would like to add that, a short time afterwards, I experienced some heaviness in my legs and a certain difficulty to sitting, I went to have my veins examined. The doctor who did the Doppler pronounced that I had to have both saphenous veins removed. I replied, "But nowadays don't you try to do what can be done to save them, through other treatments? They could always turn out to be precious in heart or other surgery."

"If they're not healthy, they won't be useful today or tomorrow," he answered. I looked at my legs surprised. Looking at them they did not look so bad. But maybe he saw something with the Doppler. I decided to go to a famous angiologist. He told me that my legs were all right, that I did not need anything, and that I did not have varicose veins. I could improve my circulation by learning how to massage my ankles regularly with a cream that he suggested. If I continued to feel the heaviness I could take a few injections. He prescribed them, but only if felt I needed them. I understand that these troubles had some cause, perhaps connected to the recent operation. I did not take the injections and my problems disappeared on their own. Since then my legs move across the world with ease, looking for the good guys and unmasking the bad ones.

A.D., 57-years-old, Housewife, Padua

I had my uterus scraped in 1992 and, as I could read in the document the hospital gave me, it was on re-examination of the cavity of my uterus that the fragments with cystic glandular hyperplasia of the endometrium were found. For the following two years, I was given hormone therapy, but it was not very successful. So in 1994 I was hospitalized for metropathia hemorrhagica.

The doctor decided to remove my uterus and ovaries, but I do not remember whether he described any of the negative consequences of the operation. He only mentioned the necessity of a "bit of rest" for a short period. I should be leaving the hospital after about ten days.

Instead, my operation was followed by complications. After about eight days I got a fever. I never knew exactly what were the complications. In the end, I was hospitalized for seventeen days. Just before being released, the head-nurse told me that I would have to rest for at least one month. Why are you not told these things before, so that a woman can look for someone who can help her — if she can find someone — during recovery?

I had a family, two daughters and a husband who were waiting for me, a home to look after, my husband's work in which I used to lend a hand. I had not made adequate arrangements — which would not have been easy to find — to be able to rest and not lift even a shopping bag for a period that, in my opinion, would last two months for an operation without complications, and if there were complications much longer.

It is absurd that they do not warn a woman in time, and that they think it easy to find a solution on the spur of the moment.

In reality, it was almost impossible to rest completely for the prescribed time, even if the doctor warned me of the risk of a prolapse of the bladder or the stomach, or intestinal complications. All these were risks I had never heard of before.

For two or three months after the operation I suffered a little phlebitis. But four years after the operation, I still suffer the negative consequences of the operation. I have difficulty in my sex life too, even though I can count on a good relationship with my husband. I still feel pain during intercourse, and I do not know whether it depends on the operation itself or its complications (perhaps adhesions to the cupola?).

But other negative consequences were a result of my recovery lasting for years. The first year after the operation I really felt its effects, and I was less firm than before. I was so terribly tired that it was very difficult to face the housework and to help with my husband in his work. I greatly regretted that I was not always able to put all the energy I wanted to into raising my second daughter. I can say that only after some time did I regain my psychological balance. I suffered a degree of disorientation, but I tried to keep it to myself to keep peace in the family and my commitment to my nearest and dearest. However, I never regained the energy I had before. In reality I get tired more easily.

Based on my story — and having experienced it in the first person, the number of unexpected and expected results with long-term consequences that the operation may induce, if I think about it now — the frequency with which it is recommended to women as a nearly normal result of diseases that afflict the female genital apparatus seems strange to me. Probably, in my case, there were no alternatives. However, many important features of the operation were not mentioned before the operation; I had to discover them, to my bitter surprise, afterwards. But in many cases, as I have learned during this conference, there probably are alternatives. So when gynecologists recommend women unwarrantedly to face all the serious consequences and the risks of the operation, they

behave irresponsibly. I also want to say that my mother entered into menopause when she was 57 years old. So perhaps it is not so rare.

G.T. 52-years-old, University Student, from the Province of Venice

Since I was a child I have always liked to read and study. But my family was not very interested in my studies because I was a girl. They did not think it was useful for me to study, since, sooner or later, I would get married. Later moves of my family, for economic reasons, made it inconvenient to continue school, eliminated my slim hopes of doing so, and justified my parents' bias. My disillusion was terrible, and was made worse because I could not disassociate it from the underlying prejudice related to the fact that I was not a boy. This injustice has made me very sensitive ever since to the different ways it is expressed, and, later, it allowed me to see how extensively it is intertwined in our everyday lives.

As an adult, married and a mother with well-defined commitments, but with complete freedom of choice, I knew that the time had come to do what I had always dreamed of doing, and that it depended only on me, and on my ability to organize everything. So I began, with great effort and not without opposition, a series of night schools that step by step brought me nearer my goal and has led me, a mother of two children, to university. In this context, since I am very interested in women's issues of all kinds, I have taken part in the conference on hysterectomy with great interest. Since I have not been able to offer what I would have liked to, because of the number of papers, I thought it useful to offer my observations afterwards.

I would like to add to the discussion on hysterectomy what I have found to be the attitude of several friends and acquaintances in regard to the idea of undergoing the operation. First of all, based on their experience, from the very beginning when the first uterine problem appears, although the doctor prescribes a temporary solution, he lets them know that sooner or later a definitive solution will be necessary. In this way the woman is gradually given a sense of inevitability about the operation, since the female reproductive system will become diseased as she ages and it will have to be eliminated.

To reinforce this option, the doctor often underlines the fact that the uterus and ovaries no longer have a purpose with the coming of menopause, and that these organs are no longer useful if she has had the number of children desired. This last reason, in particular, can lead the woman to consider the option rea-

sonable even at a young age, around forty, I have observed. But in my opinion also the reasoning based on being "near" menopause can in reality lead to operations that come much earlier than that period.

I believe that medical encouragement for the most drastic solution from the very beginning is not to a woman's advantage. She is, in reality, deprived of organs essential to her womanhood. In fact, these organs cannot be seen merely for their reproductive purpose. They must be seen, in the context of a woman's body, as a part *for* the whole and not as a part *of* the whole.

In fact, a woman deprived of her uterus or ovaries or both, experiences various effects. First of all, physical and psychological ones which undermine her health and her role within her family, and in intercourse with her partner. But also at work where — as those I have spoke with have told me — her "image" is diminished; she is no longer a competitor with the other women. And finally, these changes affect the whole social sphere in which she plays roles.

According to male logic, women have value for their beauty and youth and for their reproductive potential. When she is deprived of one (because of the age) or of the other (after being disfigured) or of both of them, a woman as such, according to this logic, no longer has any value. So I see this medical practice as defrauding and castrating of the female being, as an almost unconscious desire to negate and thus remove the only unofficial but real power that women still have in our modern society: their womanhood.

In reality, I believe that women today still undergo, as they have many times in their social history, an unwarranted expropriation of their bodies. In fact when gynecologists pursue, in relation to hysterectomy, an approach like the one described above, they betray the trust that patients have in them. They carry out a violent form of male domination of women's bodies.

On the eve of the year 2000, I do not see, other than a great deal of talk and of paper declarations, real equality between men and women. In this regard, it is enough to note the lack of women in our highest institutions. But I believe that to see this parity only as the equality of rights between men and women is limiting. Both of them, but especially women, need to be able to live by administering freely and fully their natural differences.

A diversification, thus, that includes every aspect of an individual and her personality, and that should be considered not only as personal wealth but also as a social value, and as such protected by every institution, and their functionaries, which were created to protect goods and values as a citizen's fundamental right. And so in the first instance by doctors, as an instrument for ensuring human health and so being responsible for it.

On the relationship between women and gynecologists, I think what I experienced when my daughters were born is useful.

From the point of view of medical information, I recall my first pregnancy and delivery with only one certainty: the total uncertainty surrounding it. Since my periods had never been regular, neither my gynecologist, nor my doctor, nor the obstetrician of my town at the time, the nineteen-seventies, were ever able to give me a delivery date.

My gynecologist, who had a great reputation at the time, said, when I was already pregnant (but I did not know it, because I was waiting the test results), that if I were to have children, I would have to "have special therapy and be very patient."

The night I was to give birth to my first daughter, the local midwife — who was called when the first labor pains occurred to know if it was time for the delivery — said that I could relax because it would be three or four days before the delivery.

In the hospital (where I went thanks to feminine intuition), besides the extremely repellent hygiene, I remember the easygoing imprecision of the obstetrician who assisted me during delivery. She was a practical woman, but not without a certain human warmth in performing her duties.

On the contrary, I have a burning, permanent memory of the cantankerous doctor who — on sewing me up without anesthesia after the delivery — told me to stay still because he was working, even if I was obviously doing my best not to move. I answered him that I was not a piece of cloth but a living person, and that I was doing my best. But to this day I ask myself, why this sadistic practice of stitches after delivery without local anesthesia — which I consider to be one more example of gratuitous and unwarranted suffering — while dentists always use anesthetic for even the smallest cavity.

At the birth of my second daughter, which was much more painful than the first, about eight years earlier, I distinctly remember the doctor who very roughly, and in an untimely manner, examined me, making me suffer even more than I already was. He insisted on examining me right in the midst of a contraction, even though I asked him to wait a few seconds.

Fortunately, chance would have it that, at the same time as my delivery, the whole hospital staff was busy with an emergency in the operating room. So during my labor and delivery I was looked after by the obstetrician alone, the same one as eight years before. I say fortunately, because the stitches were done by the obstetrician, even if without anesthesia like the first time. And I again ask: why did the obstetrician, despite being more human than the

doctor, not call someone to give me a little anesthetic? Instead she warned me, "I'm sorry, but now you'll have to be very brave because I'm going to make you really suffer." Is it so taken for granted that woman must suffer gratuitously?

The developments that followed this delivery were caused by inconveniences connected to a strike which had just ended; by being assigned to the gynecology ward instead of the maternity ward (with significant problems because of our different needs in both sleep patterns and for breast feeding); by the invasiveness and length of the visits of the relatives, which ran up to and past ten at night; and by the fact that these people smoked in the room because it was the gynecology and not the maternity ward.

What sticks in my mind then is that nothing was offered to relieve the pain of delivery and the pain in the days after delivery. In fact I learned then, and at my own expense, that during the birth of a second child the labor pain is almost always much more intense than the first.

As a woman I believe it both inconceivable and uncivilized that today, at the beginning of the third millennium, women must still give birth not only with great pain, but also amidst nearly total indifference and resignation.

In effect — apart from the positive aspects of the joyful event of the birth of a child — what remains is an awareness of the human loneliness in which a woman finds herself in one of the most important moments, not only of her own life, but also for the community in which she lives, and this despite the fact of having her relatives near her.

Analyzing this objectively, I believe that my hospitalization after deliveries has been, from a human point of view, compared to others, the absolute worst for several reasons. In fact, in my other stays, although I do have some complaints, I did not leave with the sense of humiliation and severe harm to my dignity as a human being that characterized the course of my hospitalization for giving birth. I decided that I would never return to give birth "in their clutches."

Generally, when you are hospitalized you are considered a "number," and not a human being with your own individuality to be protected and defended. However this is never as true as during childbirth, when a woman is vulnerable physiologically and more predisposed, and because she has always been prepared to bear the indescribable pain with its Biblical origins: "in sorrow you shall bring forth children."

All this makes me think about our civil society and about the fact that in every social position, whatever it may be, there is always a "code" of

behavior, sometimes unwritten, but which still has to be obeyed. As in the factory, the office, the classroom, the theatre or the parlor, all these places have more-or-less strict rules for how we can express our presence and personality. And so hospitals require an implicit kind of behavior of patients in general and, in our case, of maternity patients. According to this rule, the woman who bears the pain with few complaints, or even stoically, is implicitly more worthy of admiration and respect than one who gives in completely to her pain.

Adhering to this "code" and overcoming her dignity requires considerable effort of the patient, rewarded only by the fact that she can "enjoy" her victory over herself during her stay in the hospital in terms of admiration and respect. Therefore, the doctor who blames the woman for not being still enough while he is stiching her up without anesthesia wants to expropriate the merit she gained "in the delivery room" by humiliating and subjecting her to rough, sadistic male pseudo-professionalism, and thus not fulfilling the deontology and complexity of the duties that the profession requires.

And so, based on my experience, I conclude that male doctors use gynecology as an opportunity of revenge against women. If this was not the case, their attitude would certainly be different.

Anna Arvati, 58-year-old Retired Social Worker at the Civil Hospital of Padua

When I was 38 I had a fibroid the size of a cherry. At age 39, it was the size of a walnut. At every annual checkup it grew geometrically until it reached the size of a grapefruit. "Let's hope that menopause comes, so that it might regress; otherwise we will remove your uterus, if hemorrhaging begins." "And my ovaries?" "We leave them." At 47, hemorrhaging began. "Let's remove it." "Okay."

When I was admitted, they asked me to sign, "I authorize the removal of the uterus and of the ovaries." I objected. "No, not the ovaries, only if you find a serious disease," and I wrote it out on the form. The young female doctor became hysterical, but I was inflexible.

My surgeon arrived in the pre-operating room, the one who had followed my case from the cherry to the grapefruit and, *when I was already half pre-*

pared, he told me, "We have to remove the ovaries as well. You know the clinic has approved a protocol that it is better because of the risk of ovarian cancer. The statistics..." At that point, in that condition, I had no other opportunity to resist.

That decision, I know, is now often debated on a scientific level. I wonder how warranted it was at that time. They probably deprived me of eight years of my youth, and certainly of the healthy equilibrium of my body. In fact, my mother entered menopause when she was 55, as did my sister, and probably that was my time as well.

After a year I asked for replacement hormone therapy, because my bones were 24% more decalcified than normal. I had hot flashes and insomnia as well (obviously, with 4–5 hot flashes per hour at night). Because I worked in the hospital, it was easy to enter a phase of a clinical test to establish a protocol for hormone doses to be taken after surgical menopause. Sixteen different types of lab tests, the same number of medical examinations and two months of my dogged perseverance were not enough to determine if I were suitable to enter their study. I decided not to trust them. Today I am 58-years-old. I have a hormone patch, osteoporosis, constant bone pain, I lose a drop of urine occasionally, and I have constipation, all of which I did not have before the operation. I do not have either my uterus or my ovaries. I often remember what my mother told me when she left the hospital after a mastectomy. Before her breast was removed, the surgeon made an incision without a drop of anesthetic and ripped out the malignant nodule for a biopsy. She told me about the terrible, unforgettable pain, and she said, "You know, I do not know if I will ever feel or be like I was before; not because I am without a breast, but because it was all so incredibly violent!" My mother, on coming home, would experience more violence. Our family doctor, while examining her said, "Poor Elia" (her husband), "what will he do with only one tit?" My mother, who had always been strong as a rock, never overcame the violence of that operation.

Like her, I have never again felt the same.

And I think that perhaps — if this medicine were not so violent, if these doctors served people instead of institutions and their careers, if my job had meant something when facing them (but, we know, secondary professions in these institutions count for little) — perhaps I could have saved my uterus and my ovaries, and who knows how many belonging to other women?

At this time I want to mention a widespread need, one shared by many patients. That is, to have not only a written statement saying "what they will be doing to you" (a need only partially resolved by "informed consent," which is

worded in a way that is convenient for doctors to be able defend themselves legally, and so that they feel authorized to communicate even less with patients), before the operation. But also to have a complete written list of the public and private resources and services that are available based on their needs and the possible consequences of the operation when leaving the hospital.

Gina Piccin Dugo, Poet

(Poem contributed by the author as a sign of participation in the conference, published in her book *Ridatemi l'infanzia*, Rebellato, 1984)

AND IT WAS THE LACERATION OF HOPE

I, who to the enchantment and sweetness
of motherhood
will have shed rivers of tenderness,
underwent the violence of its denial.
Never my young plant,
made sterile by pitiless shears,
will give its blossom.
Never from my deep well
will I draw the water of life.
My flesh cried its own mutilation,
bent my heart on the shipwreck of expectations
and the empty hands gripped convulsively
'til hope was lacerated.
I bind my wounds
with the smile of the children of other mothers
but bitter is my consolation.
The path of loneliness in two
follows a route of courage. And painful
is the embrace of our common cross.
We found again
I and the father of my children unborn
the forgotten music.
And new was the song.
But the voice has the low subdued, deep tones

of the accumulated tears.
And always a chorus of children's voices is missing
in our little concert...

Piera, 59-year-old Housewife, Padua
(Submitting a copy of her clinical record and the tests performed)

When I was 47, I was diagnosed a uterine fibroid that did not cause any significant problems for me. But my gynecologist told me that it would be necessary to remove everything as soon as possible, pointing out that at my age my uterus was no longer of any use. I was not very convinced that my genital apparatus was so useless, and I let a few years go by. Although I had no particular problems at each check-up, I was pressed to make a decision "before it was too late." In reality I had nothing "malignant" or serious in any sense of the word. They explained that they would make a small, nearly invisible, horizontal incision along the line of my pubis, and it was based on this that in the end I made the decision to let them operate on me. This occurred in a public institution in the town in which I live.

When I woke up, I discovered that I had a horrible, badly sutured, vertical incision running from my navel to my pubis that disfigured my stomach. From that time on, my husband no longer wanted to have intercourse with me. He never succeeded in overcoming the trauma of the mutilation I had suffered, and he left me. So, all at once, I found myself deprived of my genitals, physically maimed, psychologically destroyed, and without a husband. That operation, symbolized by the scar, prevented me from establishing a relationship with another man afterwards. Sometimes I have thought of going to a plastic surgeon but, as I have been left alone, I don't have enough money and I fear facing new risks and new suffering.

Loredana Callegaro, 50-year-old Housewife, Padua

I have been in surgical menopause for nineteen years. In 1970, when I was 22-years-old, because of severe pain caused by a cyst in my right ovary, I was admitted to a hospital in the province of Padua and had an emergency operation. In my case the operation really had to be done immediately, and the ovary could not have been saved. When I was 32, I developed another cyst in

my left ovary. Because of this pain, which was not as severe as the first time, I was hospitalized for tests. They decided to operate, and my second ovary was removed. Unlike the first time, the total removal of my ovary was unnecessary. All the doctors I consulted afterwards agreed that it had been very "foolish" because of the very severe damage I had to endure. Over the years, I have suffered greatly for my physical and psychological condition. However, the gynecologist I went to for the seven years after my second operation, despite being considered competent and human, did not prescribe replacement therapy. He used to say that hot flashes had become a mania, and he did not know what to do for my anxiety and depression.

Basically, he did not believe me, or he minimized it, leaving it up to me to solve the problems, as if it were a question of will. The surgeon who had operated on me only knew how to ask me demeaningly what I was looking for. I had to understand that I was in menopause. Married, and with a son, I had enormous difficulty continuing my sex life because of vaginal dryness, frequent infections, and ulcers. And so my marriage went to pieces. After seven years I found myself with severe osteoporosis. I had 32% less calcium than I should have had. My gynecologist, instead of prescribing a therapy to compensate for it, kept on giving me birth control pills. Eight years after the second operation I was no longer able to walk. It was at this point that I met a doctor, not a gynecologist, who took my case to heart and began to take care of me.

I no longer want to hear anything about gynecologists. From my experience, they do not know anything. Today, I am in touch with the Menopause Center of Padua and I like it. And on my body, I, too, bear the sign of this ugly story: a long, badly sewn scar that crosses my belly. And when I go to the sea, I wonder for how many women a one-piece bathing suit is the required choice — to cover up the useless and frequent disfiguration of their bodies — and so leaving the sign of this abuse endured unseen. Like me.

Afterword: One Year Later...

Mariarosa Dalla Costa

A child born of woman, this book too grows, particularly in the awareness and the communication that it has created among women and among doctors of goodwill. The frequency of hysterectomy in Italy during the nineties was even higher than what had been recorded by the Italian Society of Gynecology and Obstetrics. The figures that I received later from the Ministry of Health recorded 68,000 hysterectomies in 1997, so that one woman out of five could expect to undergo the operation, versus 38,000 in 1994. The 40,000 hysterectomies per year announced by Sigo in the 1997 document was then a figure closer to the 1994 levels.

Both the frequency of the operation recorded in these figures, and its astonishing rise (keeping in mind that in 1994, not all hospitals reported to the regions the number of operations performed within the deadline) reveal a truly alarming situation. If in fact the only risk is that the figures are too low, this means that the past and present reality may be still more horrifying. For Veneto, too, the updated figure, including those reported late by hospitals, increases the number of hysterectomies for 1996 from 6,685, as was reported in this work, to 6,977.

There is no justification for such a high rate for this operation, and even less for its notable increase. This contrasts, as mentioned above, both with the tendency of the rate to decrease that has been reported in other developed countries since the nineteen seventies, and with the improvement in diagnostic and therapeutic alternatives and in minimally invasive surgery, which has long been available in many Italian hospitals, based on a conservative rather than a destructive approach to the female genital apparatus. But it has to be kept in mind that often no surgery at all is needed.

In neighboring France, the figures reported by Credoc (Centre de reignseignement et de documentation) of the Ministère de la Santé record a rate of one woman in twenty nationally and one woman in twenty-five in Paris and the

surrounding area (with a population of about twelve million) who can expect to undergo the operation. When compared to the Parisian figures, about 80% of Italian hysterectomies seem to be unwarranted. Furthermore, in France as well, the tendency is for the rate to decrease.

Other stories fell into my lap. It is enough to listen patiently to these stories — testimonials of absurd hysterectomies and ovariectomies with the serious harm and needless suffering that accompanies them — for them to arrive with an obsessive frequency. A relative, a neighbor, a woman you have just met and who has read an earlier edition of this book and identified with the consequences frequently described as due to the operation, but which she had never fully expressed and explored. She did not know that the same consequences had happened for many other women, and that maybe there was something better to do than just put up with it. Or perhaps she encountered an attitude from caregivers that minimized or even denied her complaints and her need for care. Certainly, I feel better when a son or a daughter of a woman who was told she needed an operation tells me that they recommended that their mother read the book, get more information, and evaluate the alternatives, instead of passively accepting surgery.

Collecting more testimonials does not require special effort. Unfortunately, they are all around us, and collecting them is like picking daisies in a field in springtime. But each one of them always has something special, so I would like to publish them all. Maybe one day I will. Each of them is unique as a slice of life and of how that life has been changed by the operation. Here I decided to make public two more of them, the stories of Piera and of Loredana Callegaro that I have added to the testimonials from the first edition. Piera's story was to be read by another woman at the convention in Venice, 2 January 1999, but in the end it was not because of lack of time for everyone.

Unfortunately, this terrible practice of the unwarranted removal of a woman's uterus and ovaries continues in recent months. Both earlier and more recent precedents of the mutilation of women's genitals in Western civilization and medicine have revealed themselves to be more widespread than I thought. From the beginning of the nineteenth century to the nineteen sixties, clitoridectomies were performed in psychiatric hospitals (but there were also cases in non-psychiatric hospitals) in Europe, including Italy, and in the United States, for no medical reason, but principally to punish women and their sexuality.

I am grateful to Doctor Angelo Righetti of the Department of Mental Health of Palmanova, Udine, who told me about this, and who brought to my attention the book *La ragione del più forte* by Bernard de Fréminville, published by

Feltrinelli in 1979. Concerning the widespread and current form of mutilation of female genitals — that is, the abuse of hysterectomy — in my efforts to try to stop it in various ways, I have met other healthcare providers who have taken the trouble to denounce the excess, its strange variants, and to raise women's awareness. One of them is Doctor Gianfranco Domenighetti, Director of the Health Services of Canton Ticino, as well as Professor of Economics at the Universities of Lausanne and Geneva, who with others (Domenighetti et al. 1998) published in *The Lancet* the results of a study in the canton carried out between 1977 and 1986. They found that, after a good campaign to inform the public, the rate of the operation decreased, unlike in other cantons where there was no education campaign and where, during the same period, there was an increase instead. Furthermore, the decrease was more significant in non-teaching hospitals than in others where teaching took place.

It emerged that the spread of information through the media to the population at large about the regional frequency of the operation, and about when it was necessary, could change medical practice. In the same issue of *The Lancet* (p. 1417), the same author, together with the economist Antoine Casabianca, reported on the results of other studies they carried out. These found that women physicians and lawyers' wives were less hysterectomized than other women; that the women most affected are those with the highest insurance coverage and the lowest levels of education; and that women gynecologists perform about fifty percent fewer hysterectomies than their male counterparts.

On the basis of these findings, they concluded that it cannot be excluded that "gynecologists exploit women for personal profit or that they find some hidden pleasure in the operation." In the Italian case — in addition to reflecting on possible hidden aspects of the male psyche and private profits — we should ask ourselves how much some aspects of the national health service system may promote unnecessary, or more destructive rather than warranted, operations and to what extent — as the lawyers of American patients have suggested — professional as well as teaching interests may be involved.

I learned about the existence of Gianfranco Domenighetti's articles (and other important material that I am now examining for future studies) from the gynecologist Roberto Fraioli, representative of Andria, national coordinating committee of gynecologists and obstetricians, both female and male, and president of the Study Center for Natural Birth, as well as a member of the editorial board of *Istar, rivista multidisciplinare sulla nascita* published by the Center. Other material has come from the journalist Antonella Barina, founder and director of the journal.

I have enjoyed seeing that these new networks of relationships — created around the right of a uterus to exist, to be respected if it becomes diseased, or which simply has some problems because of age or for poorly understood reasons — have come together with the networks of women and men that were formed around respect for the uterus' reproductive function and the respect for natural childbirth. Other physicians, both women and men, who work in gynecology or in other sectors, who have to face the consequences of the abuse of hysterectomy and ovariectomy, have contacted me. They are a real help, bringing to my attention positive and negative developments and joining their efforts with mine. Professor Mario Trivellato, director of cardiology at the Geriatric Hospital of Padua, is also a creator and director of the hospital's "Path for women's health," a program that — by taking advantage of the resources and technology that the hospital possesses — offers prompt diagnostic and therapeutic care for menopausal or post-menopausal women. Based on his vast experience with the question, he has underlined the extreme importance of the hormonal role of the ovaries in a multifaceted perspective, and so the importance of keeping them intact. And most importantly, for a healthy heart, since the risk of cardiovascular disease has grown greatly in recent years for menopausal women, until it has become the first cause of death for post-menopausal women. I recall that in recent years Italy has experienced a great increase in the number of women who have had hysterectomies as well as ovariectomies. It seemed natural to me to ask him to separate from the others in his studies his findings about cardiovascular disease effecting post-menopausal women, and those who experienced surgical or pharmacological menopause.

In fact, the literature I have read claims that the ovaries play a fundamental role. Their removal in surgical menopause eliminates the production of hormones that would have continued until physiological menopause and beyond (as happens with pharmacological menopause, in which the ovaries are practically destroyed). But the uterus also plays a fundamental role, with its production of prostacyclin, mentioned above. I brought this to Trivellato's attention for evaluation because, in times when hormone replacement therapies are so much discussed, I believe the medical profession should encourage protecting women's genital apparatus as much as possible, due to the "natural therapies" they provide.

Professor Rodolfo Scarpa, chief of geriatrics at the hospitals of Chioggia (Venice) and Piove di Sacco (Padua), and president for the Triveneto of the Italian Society of Geriatrics and Gerontology, brought to my attention several

problems concerning older women, and several consequences that this operation has in various social contexts in which women live. Doctor Giovanni Degani, an obstetric gynecologist in Padua and formerly secretary of the medical association, now retired, after having doing his work with extraordinary humanity and professionalism and having never been sued by a patient, has always supported me. To him and to his late wife Marialuisa — who would have loved to continue discussing several aspects of this problem — goes my gratitude. To all those who in so many ways helped me, go my thanks, for having contributed to promoting this cause which is still not as widely debated as it should be and which risks in some ways to still become worse.

In fact, during these months my "impression" that hormone replacement therapies have become, in bad practices, yet another reason for performing unwarranted hysterectomies and ovariectomies — and, even worse, on women only 40-years-old — is confirmed by the highly-questionable wording of certain "informed-consent forms" given to patients in some hospitals. And my impression is confirmed by those cases (to which I can personally attest) in which women "near menopause" with small fibroids and no pain are prescribed a patch with a high dosage of estrogen as hormone replacement therapy, and when the foreseeable consequence of the enlargement of the fibroid — a hysterectomy and ovariectomy — is recommended so that they "will be able to keep using the patches." In such cases, one has to think that they are not due to ignorance, but rather to pressure from pharmaceutical companies.

Doctor Fiorella Gazzetta and Doctor Filippo Bianchetti, both family doctors in Varese, contacted me saying they were glad to hear that the problem of the abuse of hysterectomy had been raised, as well as that of the risk of excessive and distorted use of hormone replacement therapy. All these questions they already faced in their practices, and had long concerned them.

Doctor Bianchetti, confronting a situation he tentatively described as "epidemic hystero-ovariectomy," in August 1997 decided to post in the waiting room of his office, and personally hand to his patients, a "Letter To a Climacteric Woman," in which he described the typical situation in which a woman was likely to be told that she should have her uterus and ovaries removed because of common uterine pathologies. In this letter, a list of alternative solutions to be preferred over the more drastic ones was included. In this manner he informed his patients of alternatives, and encouraged them to discuss their own cases not only with their gynecologist as a specialist but also with him as a family doctor. In this letter I loved his spirit of responsibility as a family doctor whose duty is the holistic care of a citizen's health instead of

delegating everything to specialists, and his facing up to the problem of checking up on their work, since the health of the patient is first of all in the hands of family doctors. I think it is extremely important that the letter provided information on the physiology of the body that not all women have. As, for example, the fact that keeping one's ovaries — if removal of the uterus becomes necessary — allows for physiological menopause. I also appreciated the sense of responsibility that emerges by his clearly spelling out that undergoing the operation is the most dangerous alternative, due to the risks of surgery and anesthesia, and that there is no evidence that removal of healthy ovaries is useful (and so if they were healthy he, as doctor, would not remove them). I decided to reproduce here the full text of this "Letter To a Climacteric Woman," so that it can provide useful introductory information to many women outside Varese, and perhaps, as an example of proactive and responsible behavior, for other family doctors who are more rushed and less concerned about the well-being of their female and male patients.

Doctor Gazzetta, instead, when she learned about the existence of this book, sent a letter to a newspaper. But during recent months there have been so many things drawing the attention of the media (principally war), that she does not think it was ever published. What she says seems to me to be extremely important and I believe of real value. I consider it to be a great example from a woman family doctor who was determined to publicly denounce this harsh reality in order to try to save women from the ominous destiny of gratuitous mutilation. For this reason I have decided to include her letter in this work as well.

During the year after the publication of earlier editions of this book documenting the work of the first convention on this issue in Padua, the Green Party Council member, Michele Boato, interpellated the Veneto Regional Council on the problem, since this region has a rate of hysterectomy that is even higher than the extremely high national average. Deputy Valpiana of the mixed group of the Chamber of Deputies initiated a parliamentary inquiry on the same question. There have now been two more conventions attended by varied audiences of women, including men somehow effected by the problem, extremely qualified representatives of various levels of the national health service, of human rights organizations, of the social sciences, of activist and volunteer groups in the region. The first meeting, "Hysterectomy and the Right of the Woman to the Integrity of Her Own Body," took place in Venice, Labia Palace, on January 22, 1999.[1] The second, "The Abuse of Hysterectomy: Violence against Women and Harm to Health, Possible Alternatives and Different Realities,"[2] took place

on May 7of the same year, in Rome, at the Congress Center of the Faculty of Sociology. From these meetings the possibility of furnishing women with detailed and thoughtful information on alternatives to the destructive solutions for the various pathologies of the female genital apparatus gradually became apparent. In order to illustrate these alternatives, I thought it was extremely important to add here one more medical essay.

I believe that the fulfillment of this great awakening depends mainly on women, to whom this book is primarily dedicated. They are becoming aware of the enormity of the abuse they have suffered, and they are not tolerating continued suffering. They are re-appropriating the medical knowledge that, faced with unwarranted recommendations of mutilation, allows them to recognize its groundlessness. They are rejecting these abuses, demanding accountability, and hopefully reviving, with proper indignation, the démodé expression: "How dare you?"

Notes

[1] Organized by the Center of Studies and Education for the Rights of the Person and of Peoples, by the Postgraduate School of Institutions and Techniques for the Protection of Human Rights (SDU), by the European Master in Human Rights and Democratization (MEDUD), all institutions of the Faculty of Political Science at the University of Padua. The convention was attended by authoritative figures in medicine, psychology, epidemiology, law, human rights, and from the national health service and the regional government. Gilberto Muraro, vice-president of the High Council of Health, Amalia Sartori, president of the Veneto Regional Council, Maria Trentin, president of the Regional Commission for Equal Opportunity greeted the convention. The lecturers were Antonio Papisca, full professor of International Relations at the University of Padua and Director of the Postgraduate School (SDU), who analyzed the implications of the abuse of hysterectomy in light of the international human rights documents; Bruno Paccagnella, full professor of Hygienics and Public Health at the University of Padua who compared the phenomenon with analogous phenomena involving other operations; Eleonora Capovilla, psychologist and psychotherapist at the Medical Oncology Division of the Hospital of Padua and regional coordinator of the Italian Psycho-oncology Society, who analyzed the problems of hysterectomy within a framework of oncological disease.

The medical aspects of the problem, their fallout and possible alternatives, were examined by Daria Minucci, professor of Oncological

Gynecology and chief of the autonomous service of hospital oncology of the University of Padua, by Riccardo Samaritani, assistant of gynecology at the St. Charles of Nancy Hospital in Rome, and by Lucio Massacesi, president of the Italian Hospital Obstetric Gynecologists Association, and former member of the board of directors of the Italian Society of Gynecology and Obstetrics. I outlined the problem. The journalist Milva Andriolli coordinated the work. The Region of Veneto, the Veneto Regional Council and the City of Venice approved the event. The Regional Commission for Equal Opportunity gave its approval. The Minister for Social Solidarity Livia Turco sent a telegram in support of the initiative and apologizing for not being present because of other pressing commitments.

[2] The conference was organized by the Faculty of Sociology of the University of Rome. Enzo Campelli, full professor of Methodology of Social Sciences, opened the proceedings by welcoming the participants to the Faculty and commemorating them to the late Gianni Statera, full professor of Sociology and dean of the Faculty, who had immediately understood the urgency of the problem and agreed to host a meeting dedicated to it.

Gaetano Congi, professor of Sociology of Development in the same faculty, introduced and coordinate the sessions. The medical problem and medical and surgical alternatives were outlined by Doctor Riccardo Samaritani, assistant of Gynecology at the St. Charles of Nancy Hospital of Rome, while Doctor Dominique de Clery, gynecologist, endocrinologists, and gerontology, professor of Endocrinology at the University of Paris VI described the more conservative approach practiced in France. Doctor Giuliana Mareglia, psychologist at the Family Counseling Center of Monterotondo, Rome, Local Health Unit, Rome G, analyzed the possible consequences of hysterectomy on the psyche of women and of couples. I outlined some medical and juridical problems. The Ministry of Health, the Ministry of Equal Opportunity, and the Ministry for Social Solidarity approved the event. AVO (Hospital Volunteers Association) of Rome supported and assisted in organizing the meeting. The Minister of Health, Rosy Bindi, sent a telegram hoping the meeting would be a complete success and apologizing for not being able to attend because of other pressing commitments.

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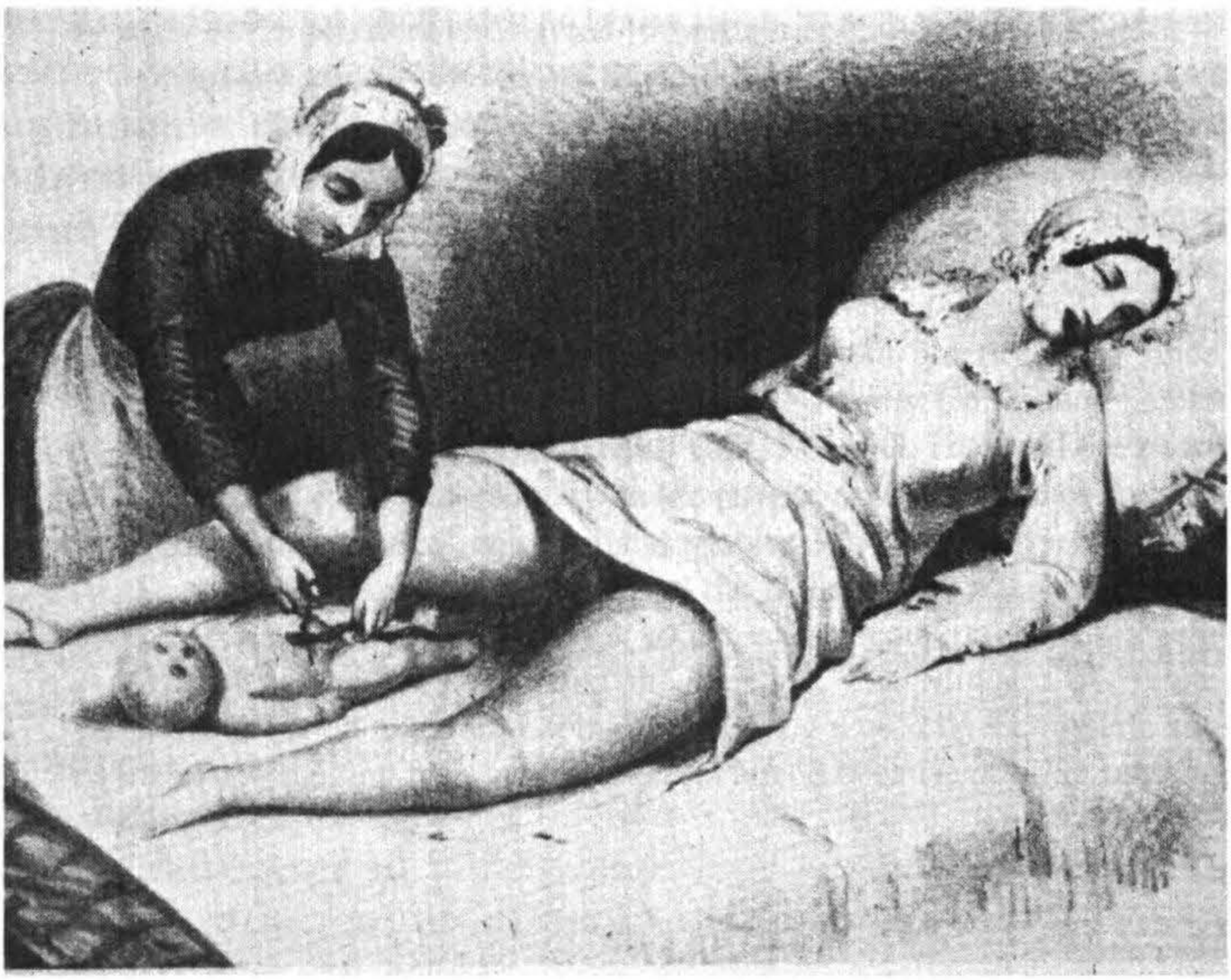

Midwife aiding delivery, from a text for eclectic (alternative) physicians, New York, 1847

Open Letter

Dr. Fiorella Gazzetta

[Editor's Note: This letter was sent to a newspaper by Doctor Fiorella Gazzetta, a general practitioner from Varese, who was pleased that with the publishing of this book the question of the abuse of hysterectomy would be more widely discussed.]

... For a long time I have been committed to opposing, challenging and reducing the predominant behavior of my colleagues who recommend to my patients hysterectomies and ovariectomies (accompanied by an "educational informed consent form" illustrating the benefits of ovariectomy followed up by estrogen replacement therapy!). I am a family doctor who works as a doctor of general medicine, I deal with what I call "basic gynecology." I worked for years without pay as an intern in gynecology until I decided that I was not interested in, but instead was frightened of, becoming part of the hospital system and accommodating myself to it, and that I could do better (so to say) by working in the field in direct contact with ordinary people to prevent, to educate, and to inform my patients about their everyday problems.

Too many times I have seen women who are now between 50 and 60 and who have been without uterus, and often without ovaries as well, for 15–20 years. Too often I see recommendations for ovariectomy for women between 40 and 50 years of age without there being a real need to undergo such a radical operation.

The reasons for the operation are so impersonal, so "manly" and "unhealthy," to always be scandalous (even though nowadays nothing scandalizes me any more). Consequently I experience as personal abuse the abuse they want to inflict on women by condemning them to a treatment of physical and psychological amputation. Yes, because every time a woman is told her uterus will be removed, she is not only told to have an organ removed, but a piece of

her life, a symbol of her womanhood. To forget this or to ignore it is a crime, ethically unacceptable, and has to be condemned.

Too many women still live what they become (and the way they are) after the operation as their fate; too many women have lived with the depression and anxiety of its aftermath, an aftermath that suddenly makes them 'autumnal' according to the current disgraceful but fashionable portrait of menopause that is used to justify the pressure of the "mass media," of pharmaceutical companies, and of many schools of science, so that women will use estrogens during menopause. Old, grey, depressed, sterile, asexual, disturbed, this is a woman in menopause who does not use hormones, with the sword of Damocles of the risk of heart attack, stroke, Alzheimer's, and osteoporosis hanging above her head.

I see so many beautiful women in their seventies and eighties who are whole, happy, and satisfied with their womanhood even if they do not take hormones.

We have to defend our right to womanhood, resist the sense of guilt "for not having done all we could have" to prevent the dreaded fact of menopause. We must demand that our own situation is explained to us clearly and completely, so we can decide what to do when faced with the prospect of treatments that are not very natural, often unnecessary, and postponable, and, if needed, we should actively participate in the therapy by being aware of what is going on and of what will go on in the future. True democracy ought to respect the free choice of individuals who are aware and informed about the need for the treatment on their bodies, its collateral effects, its consequences, and alternative treatments. Individuals, who are dominated, frightened, humbled by dread of the disease, and, perhaps, family or social blackmail because of unconfirmed risks, because we have made a choice different from the one proposed, are certainly not put in a position to choose freely. To forget about all this, or to ignore it, is a crime, is ethically wrong, and is disgraceful. As woman, I revolt against the abuse; as physician, I am ashamed.

Letter to a Climacteric Woman

Dr. Filippo Bianchetti

These comments were prepared by Doctor Filippo Bianchetti, a family doctor from Varese, and were posted in his office in response to the high rate of hysterectomy in the town.

Hystero-Ovariectomy Epidemic?

Over the last few months I have seen various gynecologists in my city make several recommendations for bilateral hystero-ovariectomy due to bleeding caused by uterine fibroids. The gynecologists never mentioned any alternatives, and several were irritated when I sent a patient back for further explanation. It was this irritability that raised my suspicion and made me recall that I had read about great differences in hysterectomy rates in several countries.

Is it merely a fad?

I thought I should write the following "Letter to a Climacteric Woman" (I beg Don Milani's forgiveness) to post in my waiting room or to give patients when appropriate. The "case" is compiled from five or six real cases, while the woman addressed is obviously fictitious.

Dear Mrs. Sanguinetti [i.e., "Mrs. Bleeding," — ed.]

I would first like to recapitulate the situation, then to give you my opinion on your case, in the hope it can help you in deciding what to do. Remove your uterus or try to save it?

The situation: for months you have had heavy, irregular and frequent periods, so you have become a little anemic (three months ago your hemoglobin level was 11; the minimum is 12). At 48 years of age, a period of premenopausal hormonal irregularities, and with a slightly enlarged uterus (though not that much: 10 x 6 x 7 cm) because widespread fibroids, a very common situation.

From your recent trans-vaginal sonogram, your ovaries seem healthy, there is no prolapse or problems with micturition.

You are generally healthy and do not show any particular risk factors, even if lately you have been extremely tired and a little depressed for well known reasons. It is obvious that if the excessive flows persist, you will become more and more anemic and grow weaker. The treatment must then be directed to compensate for your loss of blood, while you continue to take iron orally, as I had already recommended, and, most importantly, to stop the excessive bleeding.

For this reason the gynecologist suggested you immediately have both your uterus and ovaries surgically removed abdominally. As you told me, the ovaries are to be removed even if they are healthy, and the gynecologist said "since we are in there and you no longer need them, we will no longer have to worry about tumors."

My opinion: besides taking iron, and blood tests (a hemagram) about once every three months, I think that it would be better to follow a gradual strategy, from the simplest treatment to the decisive (and riskier), but only if they are necessary.

Menopause might indeed be around the corner, and with it the problem would disappear because it will lead to hormone scarcity and a natural reduction of the fibroids.

For this reason it makes sense to buy time.

What follows is a list of possible therapies, that we can discuss as the need arises:

treatment with progestinic hormones alone: one pill a day for 10 days a month, from the 16th to the 25th day of the cycle, it does not have any particular complications and may regulate your period;

treatment with estrogen and progestinic hormones: a real "pill," with an extremely low dose of estrogen, to be taken for 21 days out of 28. It may be more effective than the progestinic alone and has the effects of a contraceptive;

treatment with gonadotropin inhibitors: one injection per month for three months. It temporally induces menopause and provokes a shrinking of the uterus; it might cause climacteric problems and is expensive;

endometrial ablation: a microwave probe is introduced into the uterus and the mucosa covering it is permanently destroyed, stopping the bleeding;

removal of the uterus: through a Caesarean-like operation, it can also be performed vaginally if the uterus has shrunk by treatments. It is the only truly

definitive choice, but obviously it is also the most dangerous because of the risks of surgery and anesthesia. When only the uterus is removed, the ovaries continue to function and menopause occurs—quietly—when it was supposed to happen. But if the ovaries are removed, menopause occurs immediately; in addition, there is no proof that the "precautionary" removal of healthy organs is useful (therefore I would eliminate this alternative).

By considering this general information and after further discussion of your case with me, your doctor, and with the gynecologist who bears the delicate responsibility of providing specialized care, I now believe you can better evaluate the path you want to follow.

Your family doctor

About the Authors

Mariarosa Dalla Costa is Professor of Political Sociology, specializing in "Globalization, Human Rights and Promotion of Women's Condition" and in "Globalization: Questions and Movements" at the Faculty of Political Science of the University of Padua, Italy.

She has been a well-known exponent of the feminist movement at the international level since the early 1970s, and since then she has dedicated her theoretical and practical commitment to the question of women's condition within a continually up-dated reading of capitalist development. Since the 1990s she has also focused her study on problems concerning human reproduction analysing the correspondence between policies affecting land and policies affecting the physical and social body. In this perspective she has raised and discussed the question of hysterectomy in this book (which has already been translated into Japanese by Impact Shuppankai, Tokyo, 2002).

She has dedicated many writings to movements for the maintenance of the organic relationship between crafts and the safeguard of biological resources such as basic commons, namely movements for peasant agriculture, for traditional fishing and for alternative food policies with particular attention to women's role in them. Her writings have been translated into many languages. A large collection of them are soon to be published with Akal, Madrid.

Among her better known works are: with S. James, *The Power of Women and the Subversion of the Community,* Falling Wall Press, Bristol, 1972, *Riproduzione e emigrazione* in A. Serafini et al., *L'operaio multinazionale in Europa*, Feltrinelli, Milan, 1974, 2nd ed. 1977, *Famiglia welfare e stato tra Progressismo e New Deal*, FrancoAngeli, Milan, 1983, 3rd ed. 1997, and with M. Chilese, *Nostra madre Oceano,* DeriveApprodi, Rome, 2005. A collection of her essays has been published in Japanese, (Impact Shuppankai, Tokyo, 1986, 2nd ed. 1990).

She edited with Giovanna F. Dalla Costa, *Paying the Price. Women and the Politics of International Economic Strategy*, Zed Books, London, 1995 (Japanese translation Impact Shuppankai, Tokyo, 1995) and they also co-edited *Women Development and Labor of Reproduction. Struggles and*

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Giuseppe Perillo, magistrate, currently performs his duties as Counsellor to the Court of Appeals of Venice. During his career he has dealt with, among other things, controversies concerning civil liability in the practice of the intellectual professions, including healthcare. He contributed to the study of various questions, which are reflected best in the following articles; "La centralità delle norme," in *Si, Rivista di studi sociali nel Veneto,* 4th Year, n. 14, 1992, "Aspetti applicativi delle norme introdotte della L. 26.6.1990, n. 162 sulle tossicodipendenze. Alcuni punti essenziali" in *Si, Rivista di studi sociali nel Veneto*, 3rd Year, n. 11, 1991, "La responsabilità dei dirigenti degli Enti locali" in *Ente locale e società,* 1988, "Le linee generali del sistema sanzionatorio penale ed urbanistico-edilizio, contenute nella L. 28.2.1985, n. 87" in *Ente locale e società,* 1986, "Considerazioni generali sul ruolo della logica nel diritto" in *Verifiche,* 1983, "La decisione secondo equità" in *Scritti in memoria di Patrizia de' Mozzi,* Cleup, 2nd vol., 1993, 1995.

Daria Minucci is professor of Oncologic Gynaecology and is chief of the Autonomous Service of Gynecologic Oncology and Cytodiagnostics of the University of Padua. In 1973 at the university, she organized the first Special School for Colpocytology dedicated to the preparation of cytotechnicians for the screening of carcinoma of the neck of the uterus, a school she later directed, and that in 1995 became part of the university degree for Biomedical Laboratory Technicians, where she now teaches; in 1987, she recommended the creation of the first course of specialization in Colposcopy and Cervical,Vaginal and Vulval disease for medical school graduates to be held every year and which she now directs. She has lectured to a number of nation-

al and international conventions and published some 180 works mostly on the physiopathology of reproduction and principally on questions of preventive gynecological oncology. She is member of the Italian Society of Gynecology and Obstetrics, of the European Gynecological Oncology Society, and of the Italian Society of Colposcopy and Cervical and Vulval Pathology.

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How much of contemporary medical practice still derives from a practice rooted in the witch-hunts that plagued Europe from the fourteenth to the seventeenth century, and burned at the stake, after horrible torture, hundreds of thousands of midwives and healers along with other poor women — the greatest sexocide in recorded history?

Women's bodies and their medical knowledge were burned on those stakes to be replaced by a male "science" and a male gynecological profession controlled by the state and church.

Has history run its course? Or, among the many reasons given today for hysterectomies, does its abuse still conceal, more or less covertly, a yearning for male domination over women's bodies that reaches this most lethal form of conquest because it expropriates and destroys what makes a body a woman's body?

The powerful essays (and accompanying glossaries and testimonials) collected in *Gynocide* examine the historical, legal, ethical, psychological and medical aspects of deeply sexist practices in defining and treating these issues of contemporary women's health.

Contributors draw on the important theoretical insights and perspectives developed in recent decades by radical Italian feminism, revealing the complicity of widespread assumptions about the structures and roles of gender, the nuclear family, educational practices, and the state.

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