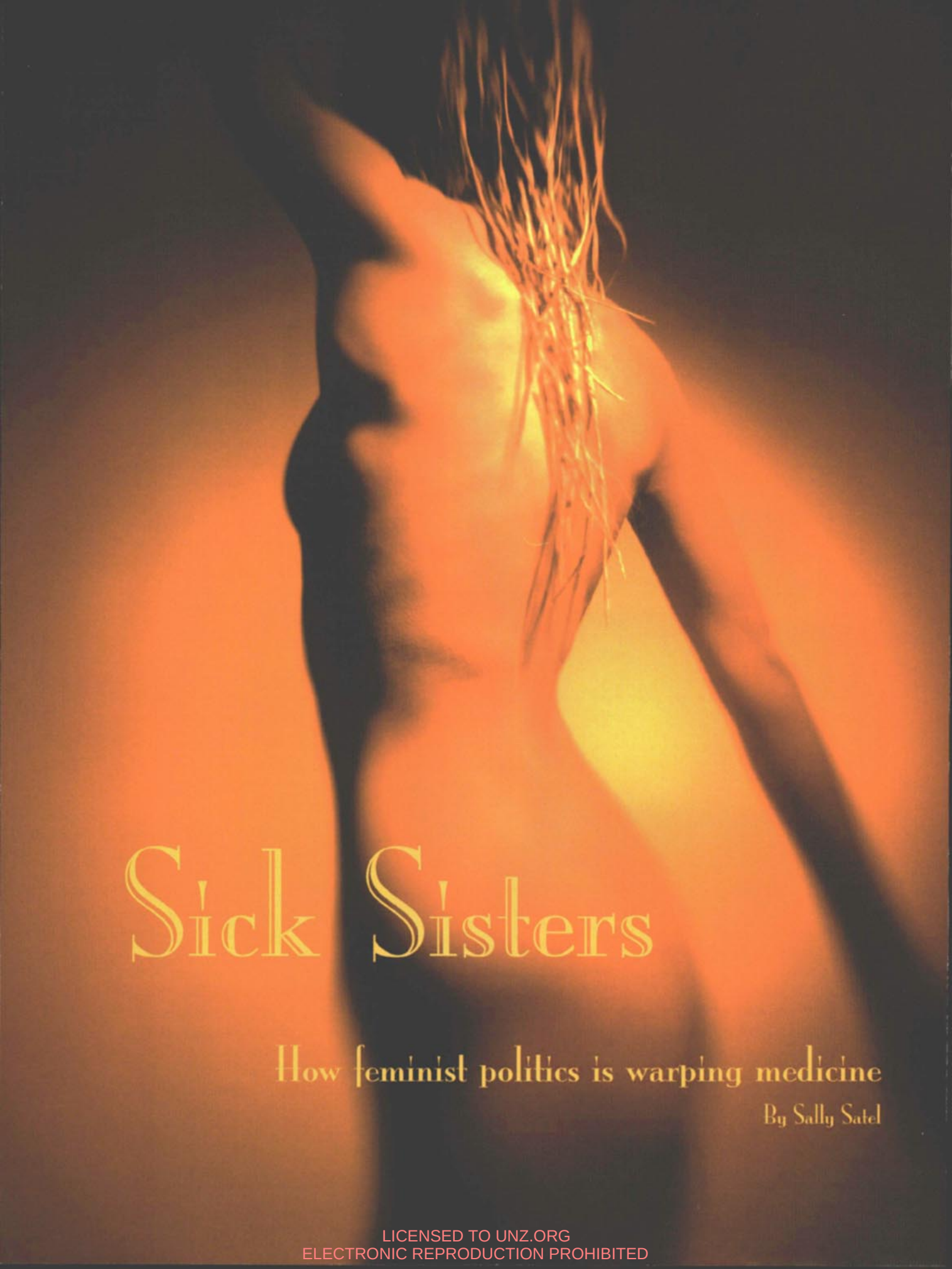


We are now on the threshold of politically correct medicine. P.C. health care is powered by the idea that injustice produces disease, and that political empowerment is the cure. It is a false promise.

Though the activists behind politically correct medicine appear to be fighting for better health, their actions do not prevent disease, alleviate symptoms, or perfect treatments. At best, they create distractions and waste money; at worst, they interfere with effective diagnosis and doctoring. Although the agitators themselves may end up feeling better for having taken part in a "social justice" movement, they undermine the Hippocratic ideal of putting patients first. Instead, P.C. medicine puts ideology first.

According to Patricia Ireland, president of the National Organization for Women, the toxicity of women's breasts will be one of the major political issues of the new millennium. "There are hundreds of synthetic chemicals in breast milk," Ireland pronounced recently on Capitol Hill. "We are poisoning the earth, and women are dying because of it." About 60 women's and health advocacy organizations joined with Ireland to demand more federal funding for diseases that are supposedly killing more and more women. "The evidence—and our bodies—continue to pile up," claim the advocates. A male-dominated medical system, they say, systematically slights America's females. "Women are invisible in the health care system beyond their reproductive systems. The medical model using male science, male body, male culture is still the norm. Women die unnecessarily due to this male perspective," asserts the Foundation for Women's Health.

The foundation's goal is to create a specialty in "women's health" similar to surgery or pediatrics. The American College of Women's Health Physicians is lobbying for the same thing. "Those of us who were exposed to Women's Studies in college find Women's Health a very natural transition and progression," writes Kelley Phillips, president of the college.

It may seem odd that women would need their own specialty. For most doctors (except urologists and orthopedists), treating women patients is the norm, since women make greater use of health care services than men do. Women are especially overrepresented in the age groups that rely most heavily on medical services—the elderly. Indeed, apart from the urological problems that beset old men, geriatrics could reasonably be said to be a woman's specialty, because there are more than two women for every man over age 85.

Nonetheless, the Office of Women's Health at the Department of Health and Human Services (HHS) has been promoting a separate medical school curriculum in women's health. "Curricula in women's health should begin to erase the misconceptions caused by a generation of training physicians in the male model of disease," explains HHS official Elena V. Rios.

These calls for special treatment are rooted in the belief that women are second-class citizens in medicine. Hillary Rodham Clinton complained while First Lady about the "appalling degree to which women were routinely excluded from major clinical trials of most illnesses." During his presidential campaign Al Gore told an audience: "Throughout my career, I have fought for more research funds for those diseases so recently considered less important because they befell only women, such as breast cancer. I pledge to you: Women's health will always be at the top of my agenda."

It is hard to imagine what more Gore could do. Women represented 62 percent of the more than six million participants in ongoing National Institutes of Health-funded research in the latest year. Breast cancer research has received more money than any other type of cancer research each year since 1985, when the National Cancer Institute began keeping track of disease-specific funding. It has always received many times the funding of prostate cancer—about five times the amount in 1997, and triple the expenditure in 1999—even though the incidence of breast cancer in women is less than the incidence of prostate cancer in men. In the latest year's data, 115 women per 100,000 received a diagnosis of invasive breast cancer, compared to 147 men per 100,000 for prostate cancer. Overall death rates are almost identical (though breast cancer victims tend to be younger).

Breast cancer also receives considerable funding compared to other diseases. A 1999 analysis in the *New England Journal of Medicine* calculated that according to the number of years of healthy life lost to a disease, breast cancer was among the five conditions most "generously" funded (the other four were heart disease, dementia, AIDS, and diabetes).

The enormous focus on breast cancer by women's health groups has skewed American women's health fears. Activists have popularized the idea that "one out of every nine" women will get breast cancer. Actually, a 40-year-old woman with no special risk factors has less than a 1-in-200 chance of getting breast cancer, and an even smaller likelihood of dying from it.

Only one in four women recognize that lung cancer is the leading cancer killer among females today. In 1997, about 70,000 women died from lung cancer; fewer than 42,000 died from breast cancer. And the biggest killer of all among women is not cancer at all, but rather heart disease—annual deaths from heart disease exceed deaths from all cancers *combined*. Less than 4 percent of women will die of breast cancer, while about one-third will die of heart disease.

Physician and American Enterprise Institute fellow Sally Satel is a lecturer at the Yale School of Medicine. This is adapted by the editors from her new book PC, M.D.

To say that mainstream medicine caters to men is ludicrous. Women visit doctors much more often than men.

Elaine Ratner, author of *The Feisty Woman's Breast Cancer Book,* is worried that the "fear of breast cancer has reached epidemic proportions, because breast cancer has moved into the spotlight." Having been treated for cancer herself, Ratner says she feels lucky that it was in her breast. "No other body part is as expendable," she writes. But she suspects that many women forgo mammography because their inflated idea of breast cancer's lethality scares them away.

Women's health has recently been a favorite cause in Congress. Dozens of women's health bills were introduced just in the last two years. Free pap smears and mammograms have been made available; minimum hospital stay lengths have been dictated by law; postmastectomy reconstructive surgery has been mandated; the Women's Health and Cancer Rights Act ensures coverage for second opinions and other assurances.

In its 1999 report to Congress and the President, the U.S. Commission on Civil Rights expressed concern about "gender bias" in our health care system. The commission accused medical schools of steering female medical students "toward the more 'accepted' specialties such as pediatrics and general practice," while men are "more likely to enter the richly rewarding surgical subspecialties." The commission presented no evidence whatever for this claim, however, and a fuller picture shows that many women doctors who want to have a family are attracted to specialties with the shortest residencies (family practice, internal medicine, pediatrics, and psychiatry). Surgical subspecialty training after medical school can take up to seven years at a time of life when women are in their prime childbearing years. The culture of surgery, with its brutal hours and strict hierarchy, may not appeal to many women, but those who burn to be surgeons will make it through. And female surgeons are highly sought after by both employers and patients, especially those with breast disease.

The Commission on Civil Rights also leveled a charge of sexism in medical research funding. Noting that women received 22 percent of all research project funding from the National Institutes of Health between 1981 and 1992, and that their grants were, on average, $30,000 lower than grants given to male scientists, the commissioners called this "a blatant civil rights violation." The federal government "must mandate that female scientists are awarded grants at the same ratio as men," they concluded.

Remarkably, these accusers possessed no evidence that quality proposals from women were being rejected at a greater rate than comparable proposals from men. The commission was simply advocating, in effect, that grants be distributed according to the applicant's sex rather than the merit of the proposed research. Ironically, the most recent data show that the percentage of female applicants winning grants (18.3 percent) is actually higher than the percentage of male applicants who succeed (17.1 percent).

The Commission on Civil Rights also alleges that women have been systematically excluded from clinical trials for new medicines and therapies. Many other women's health activists have pushed this same claim, and they've had political effects. "It was my female colleagues and I who led the charge to put an end to clinical trials conducted entirely on men—even for breast cancer," Senator Olympia Snowe (R-Maine) proudly states.

The topic makes great media fodder. "Government-funded Studies Deny Women Key Health Data" was the headline on a May 2000 *USA Today* editorial. "The habit of overlooking women in medical research is deeply ingrained and hard to shake," it pontificated. "For decades, women have been alternatively ignored or overprotected. And the research hierarchy is still largely dominated by the interests and concerns of white males."

In reality, this whole contention is a myth. As Andrew Kadar, an anesthesiologist at the UCLA School of Medicine, points out, those studies that have looked more at one sex than another usually focused on *women* rather than men. That is certainly the case with antidepressants. One of the largest and earliest studies I could find involved 215 subjects—*most* of whom were women (or "housewives," as the 1950s authors called them). Nevertheless, women's health advocates routinely claim, without evidence, that the hormonal fluctuations brought on by women's menstrual cycles led researchers to bar them from antidepressant research.

Have women ever been systematically omitted from clinical trials? Yes, starting in 1977, the Food and Drug Administration excluded pregnant and fertile women from participating in the toxicity testing of pharmaceuticals. The policy, withdrawn in 1993, evolved in the wake of the birth defect tragedies associated with thalidomide and diethylstilbestrol (DES). Women were excluded from the safety-testing phases of pharmaceutical trials to protect fetuses and, to some extent, avoid liability. Though the policy deserved its label of paternalistic, the point was to protect women and babies, not to favor men at their expense. Indeed, men themselves have not been rushing to volunteer for toxicity tests; why else would so many of the subjects who sign up be men from military bases and prisons?

Overall, government surveys have found that "both sexes had substantial representation in clinical trials, in proportions that usually reflected the prevalence of the disease in the sex and age groups included in the trials." Conditions such as depression, osteoporosis, and arthritis have always been *more* thoroughly studied among women—which should come as no surprise, since researchers tend to study the group most at risk. The Office of Research on Women's Health at NIH, created to respond to just

these concerns, found that research subjects for NIH clinical trials funded in 1997 were 69 percent women and 31 percent men.

Still, as late as 1999 advocates like Phyllis Greenberger of the Society for Women's Health Research continued to make remarks like, "It's going to take some time before it's generally accepted that women and men have to be in clinical trials." In the spring of 2000 I received a promotional letter from the *Harvard Women's Health Watch* newsletter telling readers that "nearly all drug testing has been done on men." What will it take to convince these activists of the truth?

Advocates also claim that certain specific medical procedures are evidence of the devaluation of women's health. For instance, the treatment of breast cancer with mastectomy. In her 1999 book *A Darker Ribbon,* Ellen Leopold, a member of the Women's Community Cancer Project in Cambridge, Massachusetts, opines,

> The surgical removal of the breast has to be seen as a violent act. The apparent barbarity of the procedure raises the question of male intent. It is not much of a stretch to view surgery as yet another opportunity to punish a woman for the ambivalent feelings she provokes. The aura surrounding breast surgery reinforced the worst gender stereotypes, attributing all power to the male hero.

Today we know that radical mastectomy is not necessary for most women. But before the late 1970s and early 1980s it was the accepted lifesaving procedure. A surgeon who did not perform it would have been considered derelict. In hindsight, we can see that many women underwent needlessly aggressive surgery, but there wasn't a gender bias: Men too have been subject to the radical nature of cancer surgery. Thousands of men with positive blood tests as their only sign of possible prostate cancer have undergone needless radical prostatectomies, sometimes involving the removal of pelvic nerves, which destroys the ability to perform sexually. Then, if metastases appeared, men were castrated, since testosterone seemed to promote cancer growth.

In a response to Leopold's feminist interpretation of breast cancer, Jerome Groopman, an oncologist and professor of medicine at Harvard, asks, "Does this mean that urological surgeons were, consciously or subconsciously, acting out as alpha males to dominate and abase the vulnerable men of the tribe?" The development of more conservative operations for both women and men is a continuing priority for physicians, but surgical practice must not be taken out of its historical context.

Contrary to what ideologues ranging from Clinton administration Secretary of Health and Human Services Donna Shalala on down have maintained, there is no women's health crisis today. Women's health research is first-rate. Women are well represented in the ranks of health care administrators. Female consumers have enormous influence in the medical marketplace. In 1999 at least 3,600 programs across the country called themselves women's health centers. There are few comparable centers for men.

To say that mainstream medicine caters to men is ludicrous. Women visit doctors much more often than men. Pharmaceutical companies are advertising vigorously to women. In many specialties women physicians are in high demand. And at the end of the century, 44 percent of the entering class in our medical schools were women.

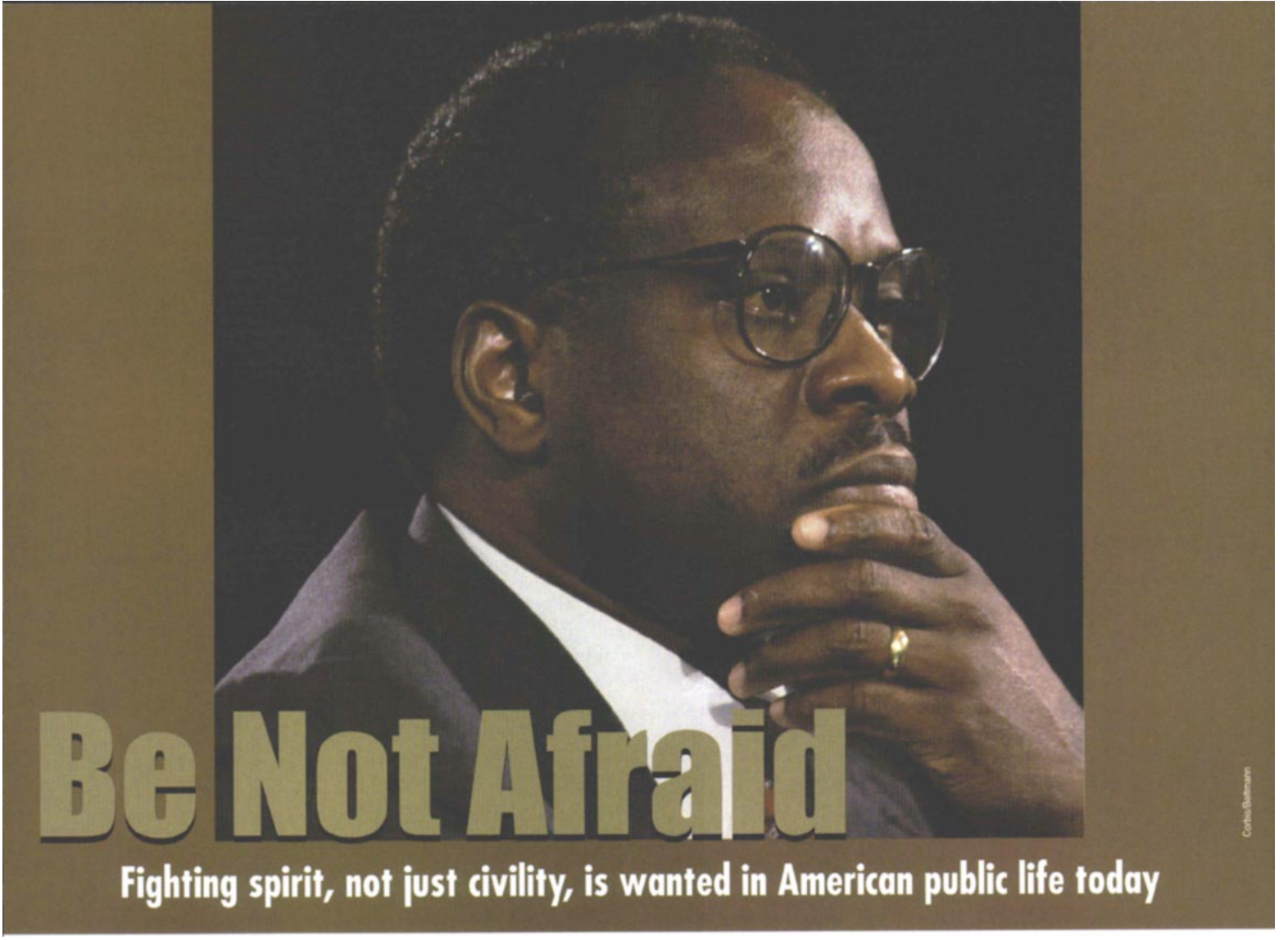
But some will always portray women as deprived no matter what. Except for the tiny Office of Research on Women's Health, "the whole rest of the National Institutes of Health is the men's office," claims Marianne Legato, who directs the Partnership for Women's Health.

Apparently, such partisans count only the portion of the NIH budget earmarked for diseases specific to women as beneficial to females. But by that barometer, less than 7 percent of medical funding goes to male diseases. So at least 93 percent goes to diseases that affect either women only or both sexes. Pitting the well-being of women against men in this way is not only petty but—considering that women outlive men by six years—rather absurd.

Women are hurt by the half-truths disseminated by the women's health movement and by the righteous indignation it seeks to provoke. People worry needlessly. Patients clamor for procedures that ultimately do them more harm than good. Medical relationships are contaminated with distrust. "When I give lectures on the doctor-patient relationship to physicians, many of the overworked doctors—male *and* female—comment on how frustrating it is to deal with women who come into their office with an attitude of 'Prove that you're not going to take advantage of me,'" says Edward Bartlett, associate adjunct professor at the George Washington University School of Public Health.

Assuredly, there is more to know about the treatment of diseases in women. But it is wrongheaded to confuse the need to know more—an imperative that will always be with us—with the unwarranted and poisonous notion that women are somehow second-class subjects in the world of medicine.

Breast cancer research has received more money than any other type of cancer research since authorities began keeping track.



Be Not Afraid

Fighting spirit, not just civility, is wanted in American public life today

By Clarence Thomas

When I first arrived in Washington, D.C., I thought there would be deep discussions of principles and policies in this city. I expected great debates in the Senate. I expected citizens to candidly and passionately deliberate over what was happening in our country, and to suggest new paths.

I was disabused of this heretical notion in December 1980, when I was unwittingly candid with a young *Washington Post* reporter. He exposed my naive openness in his column about our discussion. I had raised what I thought were legitimate objections to a number of sacred policies—such as affirmative action, welfare, school busing—policies that I felt were not serving their intended beneficiaries well. In reaction I was called names such as I had never been called in my life. I was shocked.

Why were these policies beyond question? What or who placed them off limits? Wasn't it useful for those who felt strongly about these problems and wanted to solve them to have a point of view and to be heard? Sadly, in most forums of public dialogue in this country, the answer on many subjects is no.

On difficult issues such as race there is often no real debate or honest discussion at present. Those with unorthodox views are subjected to intimidation. If you question Washington's conventional wisdom you had better be willing to endure attacks that range from hostile to libelous. The temptation is to retreat, to trim one's sails.

But that is unilateral withdrawal from the field of combat. And an argument diluted to avoid criticism is not nearly as useful as the undiluted argument, because truth is best arrived at through a process of honest and vigorous debate. Arguments should not sneak around in disguise. Dissent should not be treated as sinister.

And people should not be cowed by criticism. Those who challenge accepted wisdom in debates of consequence should expect to be treated badly. Nonetheless, they must stand undaunted. That is required, for bravery is necessary to secure freedom.

Much emphasis these days is placed on who has the quickest tongue, and who looks best on television. Hence, a proliferation of public relations professionals and spin doctors. But this is madness. No car has ever crashed into a mirage. No imaginary army has ever invaded a country.

Nor is high philosophy enough. Obviously, it is important we have ideas and intellect. But it does no good to argue ideas with those who will respond as brutes. Works of genius have often been smashed and burned, and geniuses have sometimes been treated no better.

But there is much wisdom that requires no genius. It takes no education to know that it is best for children to be raised in two-parent families. Yet, those who dare say this are often accused of trying to impose their values on others. This condemnation