NOTICE

The quality of this microform is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Reproduction in full or in part of this microform is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30, and subsequent amendments.

AVIS

La qualité de cette microforme dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

La reproduction, même partielle, de cette microforme est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30, et ses amendements subséquents.

ISBN 0-315-56111-4

Canada

The Treatment of Women by the Medical profession: A study of An Alternative - Head and Hands

Linda J. Ramage

A Thesis

In

The Department

of

Sociology

Presented in Partial Fulfillment of the Requirements
for the Degree of Master of Arts at
Concordia University
Montreal, Quebec, Canada

August 1989

Abstract

The Treatment of Women by the Medical Profession: A Study of an Alternative - Head and Hands

Linda J. Ramage

The present study provides an overview of the literature concerning problems and issues faced by women when dealing with the medical profession. Based on the problems detailed in the literature the Head and Hands centre was examined in terms of providing an alternative style of health care for women. It was determined through a questionnaire distributed to clients, interviews with staff members and observation of the centre during routine working hours, that Head and Hands does take a unique approach towards its clientele. The findings also suggest that women do not expect to be treated in an authoritarian manner by their physicians any more so than men. The study also revealed the importance to women of being afforded the opportunity of seeing a physician of the same sex. With regard to the search for improved health care for women the results of this research project suggest that the approach taken at Head and Hands is appealing to women. This approach involves a considerate attitude towards its clients and an emphasis on making sure they are fully informed.

Acknowledgements

I would like to thank Susan Russell for her suggestions and guidance throughout the course of this thesis. I would also like to thank Bill Reimer for his great patience in helping me with all of the computer related aspects of this research project. His input and support was also appreciated.

I would like to thank David Howes for his input.

The information and help provided me concerning Head and Hands by Joe Heillig was invaluable. I am grateful to Joe as well as all of the staff at Head and Hands for being so cooperative and helpful.

Lastly, I would like to thank my parents and my husband for being constant sources of support and encouragement.

Table of Contents

List of Tables

List of Tables in Appendix A

List of Appendices

CHAPTER I

INTRODUCTION

An examination of the literature dealing with women and their relationship to the medical profession quickly reveals a cornucopia of problems and issues. It appears that women have always fared differently than men when coming into contact with the providers of medical services. These problems include a feeling on the part of many women that they are being patronized and treated in an authoritarian manner. Many women have not been provided with adequate information in order to make educated decisions regarding their own well being. The apparent lack of respect traditionally accorded women by the medical profession has led to some very serious consequences such as women being subjected to inadequately tested drugs and procedures. Women are also the recipients of a disproportionate amount of prescriptions for mood altering drugs. It is also disconcerting to discover that nistorically this basic lack of respect is nothing new.

In their search for a more equal society over the past few decades, feminists have isolated many areas where attention must be focused and changes made. The treatment of women by the medical profession is one such area. It is recognized, as is evidenced by the existence of a women's health movement, that women must seek to attain equal treatment here, as they have in the workplace, educational institutions, etc. The dilemma which has arisen however is whether existing services should undergo alterations or if

alternative services should be developed.

For the purposes of this thesis an existing service, Head and Hands, is examined. This is an organization which appears to be an alternative in the approach it takes to its clients. The medical services offered here are conventional, it is the approach taken in their provision which is not. Head and Hands does not portray itself as a women's clinic, nor has it intentionally directed itself towards this purpose. What it has attempted to do is provide all of its services, for it has many, in the most humane manner possible. It has as its goals that it be non-judgemental, informal and non-institutional. It appeared to me when becoming familiar with the approach taken towards clients at Head and Hands, that this style of service would address many of the issues confronting women when dealing with more conventional services. There appears to be a respect accorded to the clientele which involves providing information as fully and completely as possible.

An attempt was made to determine not only if the approach at Head and Hands might address the issues facing women, but also if the approach taken was appealing to women. In order to do this the clientele of the clinic was examined. As Head and Hands considers itself to be oriented towards local youth, it was hypothesized that if the majority of its users were female and of varying ages and income, they must be finding the approach taken at Head and Hands appealing. The

clientele were also examined in terms of education. It was of interest to determine if higher educational levels were represented among the clientele, possibly indicating that an informed choice had been made in coming.

Certain data quoted within the literature, such as the over-prescription of mood altering drugs to women, was compared with that collected at Head and Hands. An attempt was also made to determine if Head and Hands would perhaps have a lesser tendency to prescribe such drugs to women than more conventional services. Another contention held in the literature was that women would prefer to see a physician of their own gender. Another goal of this thesis was to determine if this would indeed hold true for this population.

In view of the assertion that women have been treated in an authoritarian manner by their physicians, an attempt was made to determine if women actually desired to be treated in such a manner more so than men. If this was indeed the case it would certainly influence the outcome of the interaction between physician and patient. Education was then examined in terms of its effect upon the attitudes of men and women vis-a-vis their desire to be treated in an authoritarian manner.

In summation what is to follow is an overview of some of the issues and problems which have confronted women when dealing with the conventional or traditional medical system. Head and Hands is examined in terms of how the approach taken

in the provision of its services addresses many of these problems. The clientele of the clinic are also examined in terms of whether characteristics of this population are typical of those found within the literature.

CHAPTER II

A review of the Literature Concerning Isssues in Women's Health Care

As stated within the previous chapter one of the main objectives of this thesis is to examine a source of medical services which provides women with an alternative to more traditional or conventional sources. Head and Hands provides an excellent example of a clinic where a different approach was taken towards the clientele while the actual medical care provided remained conventional. It is proposed within this paper that the approach taken by Head and Hands appears to provide some solutions or at least improvements to some of the major problems faced by women in the more traditional medical system. One such problem for example, has been that women have not been provided with adequate information by their health care providers on matters which directly concern them. At Head and Hands time is taken and every effort is made to ensure that patients are fully informed and understand the information they are given.

In order to fully understand and observe how the numerous problems faced by women are addressed by the approach taken at Head and Hands, it is first necessary to examine these issues so that we are aware of exactly what they are and of some of the common threads running between them.

The review of the literature to follow in the area of women's health care, illustrates the many areas where women have come up against a sexist medical system. It is also revealed within the literature that these problems are not historically recent. Thus far they appear to be inherent

within the medical system. Described in the literature also, is the eventual advent of a women's health movement whose mandate it is to address these problems.

What is to follow is a review of the literature in this area. The purpose of providing this review is to familiarize the reader with the problems which have been faced by women when dealing with traditional health care services. Following this, it will then be possible to illustrate the ways in which Head and Hands does provide alternatives.

The early seventies heralded the beginning of what was to become a fairly large body of literature and research concerning women and their relationship to the conventional or traditional health care system. The acceleration of the feminist movement a decade earlier and increasing concerns with the health care system in general spurred an awareness of health care issues and problems confronting women in particular.

Women are by far the greater consumers of health care services. According to Ellen Frankfort in Vaginal Politics women make 25% more visits to the doctor than men, consume 50% more prescription drugs and are admitted to hospital more frequently (Frankfort, E., 1972: XXVI).

Diana Scully notes in Men who Control Women's Health that women report more acute and chronic illnesses (even when pregnancy and childbirth are accounted for) and that women seek more psychiatric treatment than men (Scully, D., 1980:

14). C.K. Riessman observes that in addition to the fact that women are a health care system's primary users, women's domestic roles involve health work (Riessman, C., 1986: 200). Women care for the sick and also provide a clean, healthy home environment. Despite women's close contact with health and illness there are many problems experienced by women in dealing with the conventional health care system.

One such problem has been the over prescription of psychotropic (mood altering) drugs to women. Women have also been prescribed inadequately tested drugs such as the Pill and Diethylistilbestrol (DES). As well as being prescribed drugs for which the side effects and long term effects were largely unknown, women have been subjected to inadequately tested procedures such as invitro fertilization. Women also undergo a disproportionate amount of surgical operations. The justifications for the high incidence of many operations which are performed exclusively on women, such as hysterectomies have been called into question in recent years. Another major problem has been the feeling on the part of some women that they are being patronized by their physicians and that their complaints are not being taken seriously. This has resulted in women not being given adequate information to make decisions on their own regarding their bodies.

As stated above, women are indisputably the greatest users of health care services. Although different time

frames and points of reference are used to make this point, almost every piece of literature in this area makes this assertion. There appears to be no disagreement on this. Scully reports that in 1974, women's visits to physicians were 44% higher than those of men and this does not include those visits made for the purposes of accompanying a child (Scully, D., 1980: 14). Ruzek in her book The Women's Health Movement states that national studies of health services utilization reveal that in a given year in the United States, approximately 71% of all women visit a doctor as opposed to 65% of men. Women report an average of 4.5 visits each year while men report an average of 3.6. Hospital admissions each year for women are also greater in that 16 out of every 100 women are admitted. That figure drops to 11 for every 100 men. Ruzek also notes that if we include visits to pediatricians, women have nearly 100% more physician contacts than do men (Ruzek, S., 1978: 13).

It should also be pointed out at the onset that this disproportionate amount of contact on the part of women is being made with a medical profession dominated by men. The representation of women in this field is increasing however, this is a fairly recent phenomenon. Scully reports that in 1970, 93.1% of doctors were male. The percentage of women in gynecology was less than in medicine generally. In 1974, 3.5% of doctors in this area were women (Scully, D., 1980: 14). The reasons posited for this underrepresentation of

women in the area of medicine concerning women exclusively is worthy of note and shall be discussed further on.

That women utilize the health care system to such an extent leads to two possible assumptions. First, that women are sicker than men and secondly, that the health care system, after its repeated exposure to women's needs should be ideally tailored to meet them at this point.

Diana Scully addresses the question of women actually being sicker than men. She notes the paradox in that women would appear the "sicker" sex judging from the disproportionate use of health services, yet women have a longer life expectancy than do men. Scully provides three possible explanations for this. First, she states that the difference between the sexes in the use of health services could merely be a reflection of the greater social acceptance of weakness and help seeking behaviour for women. Secondly, it could be that women display more illness and sick role behaviour because it is more consistent with other female role obligations but is not compatible with those of men. Perhaps it is easier for a woman who works in the home to assume the sick role, than it is for the traditional male bread winner who must report for work outside of the home. As an aside to this last point, it could be pointed out that the proverbial male breadwinner can call in sick to a place of employment whereas a housewife and mother with children to care for cannot as easily remove herself from her work

setting and assume a "sick-role". A new mother soon discovers that this occupation does not allot any annual sick days! Thirdly, Diana Scully presents the explanation that perhaps women are in fact the weaker sex and that this is due to the stresses associated with the female role creating illness (Scully, D., 1980: 14). Scully makes an important point in that regardless of which explanation, if any, you may choose to accept, the fact is that women are more frequently in touch with the health care system. This is especially true during her reproductive years when a woman routinely consults an obstetrician-gynecologist for pre-natal, post-natal and gynecological care, birth control information and abortion services, amongst other asundry reasons.

As stated earlier it would seem reasonable to assume that as women are a health care system's greatest users, the system would have developed into one compatible with their needs. An examination of the research done in this area quickly reveals that this is not the case. The fact that there is a body of literature in this area and that women and the health care system is a topic in itself, reveals that there are major issues to be confronted. The problems are numerous and range from being annoyances to being outright lethal.

One of the more publicized issues in this area over the past several years has been that women appear to be the

recipients of a disproportionate amount of prescriptions for mood altering drugs, mainly tranquilizers.

Ruth Cooperstock delved extensively into the differential prescribing of mood altering drugs in her 1971 study (Cooperstock, R., 1971: 238). She examined the data found through her own research and compared it with existing data in the United States. She found that in both cases there was a higher prevalence of prescriptions going to women. In Toronto (where her own data was collected) 69% of these prescriptions were for women. In the United States, 67% were for women. The percentage of all prescriptions in both Canada and the United States going to women was 60% (Cooperstock, R., 1971: 240). Cooperstock found no clear socio-economic pattern in prescribing. The biggest variable appeared to be sex and whether or not the person was a city dweller, with women and urban residents receiving more. Age was also a factor with older women being the greatest recipients and younger men being the lowest.

Dr. H.L. Lennard in his book Mystification and Drug Misuse quoted a 1967 study where women received twice as many prescriptions as men. 31% of women surveyed had received psychotropic drug(s) while only 15% of the men had. Both in the study discussed by Lennard and in the study by Cooperstock, tranquilizers such as valium, librax and librium along with sedatives such as amytal were most often prescribed (Corea, G., 1977: 74).

A 1975 study conducted on drug usage in a California suburb by Linda Fiddell and Jane Prather of the California State Psychology Dept. found that 53% of women in their sample had used psychotropic drug(s) in the preceding year (Corea, G., 1977: 74). A study discussed in the October 28th issue of the Gazette for 1978 found women taking twice as many of these drugs as men (Schwartz, S., 1978: The Gazette).

In his book Malepractice, Dr. Robert S. Mendelsohn states that in 1978, an American federal official told a congressional committee that 36 million women were taking tranquilizers, 16 million were taking sedatives and 12 million were taking stimulants. Mendelsohn also quotes a federal report as stating that 60% of mind altering drugs, 71% of anti-depressants and 80% of amphetamines are prescribed to women (Mendelsohn, R.S., 1978: 60).

Are women really far more mentally ill than men as a lot of studies would seem to imply? To begin with, men and women differ greatly as to the kind of mental problems they experience (Greenglass, E., 1982: 213). Men tend to be more prone to sociopathic disorders while for women the two major disorders appear to be neurosis and depression. Esther Greenglass found that the presence of children and whether or not the woman was married played a significant role. Married women were reportedly most prone to psychopathology, especially if they are not working outside of the home. While 65% of young wives with children were reportedly

satisfied, this number climbs to 89% when children are absent from a young wife's life (Greenglass, E., 1982: 215).

According to the above psychological view of women, they appear to be more prone than men to minor mental problems which require more out patient care - i.e. the prescription of drugs. But what must be examined now is just who is doing the diagnosis and upon what these diagnoses are based. According to Gena Corea in The Hidden Malpractice, the greater the social distance between participants (the participants being doctors and patients), the worse the therapeutic relationship (Corea, G., 1977: 74). The roots of this social distance appear to be in the messages received by a woman throughout her socialization compared to those received by men. Men are brought up to be very stoic and less expressive whereas society teaches women to be far more in touch with their feelings and pay far more attention to them. Undoubtedly this behaviour leads to furthering her skills as the chief source of nurturance within the family. Being more in touch with her own feelings, she is more understanding and empathetic with those she cares for. This has a reflection then in her relationship with her physician. As stated by Ruth Cooperstock:

> Women have greater freedom than men to express their feelings and hence to recognize emotional difficulties thus enabling her to define her difficulties within a medical model and thus bring them to the attention of her physician (Cooperstock R., 1971: 238).

The difficulty which arises here is that the majority of women attend a male physician who was brought up far more stoically. There is a cultural gap existing between the male physician and the female patient which has been likened to the difference in perceptions of illness between doctors of one country and patients from another. A study was conducted by Zola in 1966 in the eye, ear and throat clinic of the Massachusettes General Hospital, demonstrating such differences (Corea, G., 1977: 80). When seen by American doctors, Italian patients were more emotional and had diffuse complaints while Irish patients were far more stoic and specific. Mood altering drugs were prescribed on a far greater basis to Italians. Gena Corea discusses a 1974 update to this study, again dealing with the Irish and the Italians, finding that if no organic basis for the complaints was determined to exist, doctors tended to describe an Italian as having emotional problems while far more neutral terms were used with regard to the Irish patient (Corea, G., 1977: 80). Women here can be likened to the Italians.

Tuckett et al. in the book Meeting Between Experts attempted to determine the effects of the behaviour of a patient upon the information provided by a physician during a consultation. It appeared that expressing an interest and asking questions definitely invited more information from the physician. However, if the patient expressed his queries or doubts too overtly the opposite would occur and the physician

would feel antagonized and the quality of the consultation would suffer.

> ...patients who presented their explanations of what was wrong with them and their reasons for believing it, those who asked a doctor for his rationale quite overtly and those who asked other questions or aired doubts, were more likely to have their ideas attended to by the doctors or to be given more information more clearly. At the same time it was also apparent that patients who behaved more actively in the ways just mentioned were more likely than others to experience a consultation in which their ideas were evaded and tension was evident (Tuckett et al., 1985: 111).

Keeping the above in mind Tuckett found during the course of his research that although women were only somewhat more likely than man to express doubt, they were almost twice as apt to express their doubts overtly (Tuckett et al., 1985: 110). This would suggest that a woman's openness concerning her feelings may induce what was described above as a consultation in which her ideas are "evaded and tension evident".

In her book Routine Complications: Troubles with Talk Between Doctors and Patients Candace West details the results of her research which indicate that the male doctor female patient relationship is indeed a different relationship from that which exists for male patients. West analyzed 21 video taped consultations between doctors and patients of various combinations with regard to sex (West C., 1984: Chap. 3). What she found was quite telling. West observed that where the doctor was male and the patient female the male doctor tended to interrupt the female patient quite frequently. It

also appeared that in many instances he was not really listening attentively. These interruptions on the part of the doctor decreased markedly when the patient was male (West C., 1984: Chap. 4).

West found that male patients attempted to dominate the encounter when seeing a female physician. The most egalitarian of relationships was observed between female patients and female physicians. West poses the disturbing question as to what effect seeing a male physician has on a woman's health. If the doctor is not truly listening to what the female patient has to say and she is being constantly interrupted this cannot help but reduce the quality of the information she may be giving him. The female patient would also feel far less comfortable and encouraged to ask questions. The way in which West depicts the relationship between the male physician and the female patient cannot possibly be considered conducive to women's health (West, C., 1984: Chap. 4).

Due to an increased public awareness of mental health due to heightened levels of education, people are more aware of symptoms and stresses they may be experiencing. Women also seem to have a greater interest in this area, perhaps because they are more greatly affected, as demonstrated by the preponderance of articles found in women's magazines and talk shows of primary interest to women (Cooperstock, R., 1974: 24).

A study by Parry in 1978 (Cooperstock, R., 1971: 243) revealed that when physicians were asked to describe the typical complaintive patient, 4% described a male, 24% referred to no particular sex and 72% referred to a woman.

The time element in a doctor's schedule is also an important factor. Whether the complaints are diffuse or specific the doctor still wants to do his job and "treat" the patient. Two thirds of all consultations result in a prescription while 59% of all visits are with regard to trivial, non-specific complaints (Cooperstock, R., 1974: 26). By prescribing a mood altering drug, a physician is masking a problem. He is reducing the symptoms of anxiety but he is doing nothing to eliminate its original cause. He is also reducing the anxiety the patient may be causing others. As stated by Lennard, "drugs are abused not only when they negatively affect the taker but when they are giving a greater benefit to the giver" (Lennard, H.L., 1971: 26). Were drugs not so available, pressures for solutions might be encouraged.

Lennard found a strong relationship between the amount prescribed and the physician's need to feel in control (Lennard, H.L., 1971: 33). He found that those doctors who ranked high on an authoritarian personality measurement scale, were doctors who prescribed more and also tended to value assertive and decisive behaviour. This brings the cultural difference again into the picture since women's

behaviour tends to be less assertive and decisive.

Lennard also points out that there is a strong relationship between the patient as a consumer of medical services and a higher rate of prescriptions (Lennard, H.L., 1971: 37). He notes that Jews, as a group, have a higher rate of visits to their physicians and receive a comparatively higher rate of prescriptions for mood altering drugs. Lennard points out that it is only natural, following the argument that doctors don't like to send a patient home without treating them, that since women make more frequent visits to their doctors, they receive more prescriptions.

There is also a preponderance of advertisements in medical journals relating psychotropic drugs to women patients. Men tended to predominate in advertisements for remedies to somatic problems. Dr. R. Seidenberg found a greater number of advertisements for mood altering drugs which suggested their prescription to women whose problems may be related to doing humdrum tasks. He quotes one advertisement as reading "you can't set her free but you can help her feel less anxious" (Corea, G., 1977: 82).

Mendelsohn points out the dangers that the overprescription of these drugs represent. Women, as the highest recipients of these prescriptions, are in particular peril. Mendelsohn states that of the 160 million prescriptions written in the United States in 1979 for tranquilizers, sedatives and stimulants, only 10% of these

prescriptions were written by psychiatrists - the only medical specialists who are specifically trained to recognize their effects (Mendelsohn, R.S., 1981: 60). Studies of valium and lithium reveal that three quarters of the prescriptions are written for conditions inconsistent with the approved use of the drugs. Mendelsohn points out that tranquilizers were in fact never intended to treat simple anxiety. They were originally developed to reduce or replace the electroconvulsive shock treatments and brain surgery being performed on severely psychotic patients in mental hospitals.

Mendelsohn notes that tranquilizers, as a group, are the cause of twice as many hospital emergency room visits by overdosed users than heroine and cocaine users. 90% of the patients seen on these visits are women.

Mendelsohn quotes Dr. Darryl Inama, Director of the pharmaceutical service at the Haight Asbury Free Clinic in San Francisco as saying that people go to doctors because of family or self identity problems and instead of sending them for counselling and dealing with the problems directly, their doctors prescribe pills (Mendelsohn, R.S., 1981: 67).

Dr. Mendelsohn in his book Malepractice presents a very disenchanted view of the medical profession and its treatment of women. He deals with many issues, some of which will be detailed later on in this paper. He finds a basic lack of respect for women and a greed for profits on the part of

doctors and pharmaceutical companies at the root of most of these problems.

> The Chauvinistic belief of most doctors that women are weak, hysterical creatures, given to perpetual anxiety and depression is mirrored in the abuses that female patients suffer. Many doctors relate to women as though they function on the same intellectual plane as their kids. The kids fare better than the women though, because at the end of the office visit they get a free lollipop. Their mothers are handed prescriptions for expensive and risky happiness pills (Mendelsohn, R.S., 1981: 59).

The profit orientation of the pharmaceutical industry has contributed not only to the overprescription of certain drugs to women but also to the problem of inadequately tested drugs being prescribed to women. It does not take a sociologist to explain how a pharmaceutical company will benefit directly by pushing its products. But, as Mendelsohn observes, these inadequately tested drugs could not make their way to patients if doctors were not ladling them out. Mendelsohn states that the pharmaceutical companies and doctors are turning millions of circulatory systems into miniature "Love Canals". It appears also that many of these drugs are exclusively for female use. The questions which arise are why doctors, whose sole purpose is supposedly the health and welfare of their patients, would prescribe such drugs and why women in particular, tend to be the recipients?

One case in point, as provided by Mendelsohn, of an inadequately tested drug for female use being released upon the market with disastrous consequences, is that of the

synthetic hormone diethylistilbestrol (DES) (Mendelsohn, R.S., 1981: 35). Between 1940 and the early 1970's, this drug was widely prescribed to prevent miscarriages. DES had not been adequately tested for efficacy or long-term side effects. It was later revealed that the drug caused cancer of the breast in some of the women, vaginal cancer in some of the female children born to the women on the drug, and genital abnormalities in some of the male children. These side effects are far from being minor. This drug which later proved to be ineffective in preventing miscarriages, was prescribed to women for decades[1].

Although not a drug, a similar case in point is that of the Dalkon Shield (an Intrauterine Device - I.U.D) (Menndelsohn, R.S., 1981: 35). This device was inserted into about four million women between the years 1971 and 1974 when it was banned. This was done despite the fact that it had not received adequate testing. The side effects of the Dalkon Shield revealed themselves very quickly. Two and a half of the four million installed Dalkon Shields were given to American women. In the U.S., 1,100,000 women came down with acute pelvic infections, from which one-fifth became sterile and seventeen died. Mendelsohn states that despite these terrible results, it was not until 1980, after its insurance companies had paid out $55 million to Dalkon Shields victims, with more than 600 court actions and 300 claims still pending, that the manufacturer, A.H. Robins Co.

wrote to physicians urging them to remove the shields from the patients who were still wearing them (Mendelsohn, R.S., 1982: 35). After all of the publicity surrounding the shields, it is unthinkable that it was still felt necessary that a letter be sent to physicians.

The Pill may well be the most dramatic case illustrating not only that many drugs intended for female use are released with inadequate testing but also that large numbers of women are willing to take these drugs even when they are aware of the facts. The Pill has been so widely taken when its long-term effects and side effects were still unknown that it has to be considered unprecedented. Never before in history have so many healthy young women pumped such a potent chemical into their systems for periods of years.

Dr. Herbert Ratner, former Director of Public Health in Oak Park Illinois, comments on how women have willingly left themselves open for drug experimentation:

> Women are the best guinea pigs modern science can find. They take the pill without asking any questions, pay for the privilege of taking it and are the only experimental animals known who feed themselves and keep their own cages clean (Mendelsohn, R.S., 1981: 35).

It may be argued that drug experimentation has not been strictly limited to drugs intended for female consumption only and that perhaps cases could be profiled which involve both men and women. The case of the Pill however must stand alone. The dimensions of its use by women are staggering. As testified by Dr. Phillip Ball, an Indiana internist:

> Modern Medicine, in prescribing the birth control pill for more than a decade, has been conducting a massive double blind, uncontrolled experiment with 50 million women as human guinea pigs (Mendelsohn, R.S.: 1981: 37).

The evidence upon which the American Food and Drug Administration accepted the Pill came from a 1965 study of Enovid. The study took place in San Juan, Puerto Rico, involving 132 women. As Reggie Siegal points out in the article "The Pill - Ironic Liberation", 132 women is less than the number of women that would die that year in the United States alone from blood clots (Siegel, R.,: 11). Blood clots have been found to correlate positively with the use of the Pill.

Strengthening the assumption that this product was safe was the publicity of successful tests in Haiti, California and Puerto Rico. But these tests were for one aspect - efficacy.[2]

The Pill, like DES and the Dalkon Shield, although on a much larger scale, was placed upon the market before adequate testing. The long-term and side effects have proven to be serious.

Gena Corea in her book The Hidden Malpractice demonstrates the different approach taken by researchers in their search for a male contraceptive as opposed to that taken for female contraceptive methods (Corea, G., 1977: 159). There has been special effort made and an unusual stress has been put upon the need when researching male

contraceptives, to find one that would inhibit sperm production without interfering with potency, libido, or causing nausea or headaches. Yet a drug was released upon the market containing these exact characteristics aimed at women. When dealing with women, these were considered annoying side effects to be outweighed by its benefits. Dr. McLeod, one of the leading researchers in male contraceptive methods development today, was pessimistic about the male Pill (Corea, G., 1977: 159). He claimed he was so because any male pill would probably contain testosterone, and according to Dr. McLeod, this would present risks because testosterone is a powerful hormone, and you cannot take hormones without some possible negative effect. Another danger involved with testosterone is that its long-term effects are as yet unknown. Women have been taking potent hormones now for decades without clear knowledge of the long-term effects. Corea quotes Dr. Don W. Fawcett as stating that what is being looked for in the male pill is one that will only affect the target organ and not the entire system (Corea, G., 1977: 74). The Pill affects a woman's entire body.[3]

The tale of the search for a male contraceptive demonstrates very clearly the double standard existing between the approaches taken by the medical profession towards men and women. Somehow it is felt to be acceptable to place women at risk where it would be deigned

inconceivable to place men. Gena Corea also tells of how in 1969, the FDA's advisory committee on obstetrics and gynecology, detailed endless adverse effects associated by various studies with the Pill, yet committee chairman, Dr. Louis Hellman declared the Pill safe in his summary report (Corea, G., 1977: 146). The criteria used is the Keflauver-Harris Amendments which state that a product must be "safe for human health" to be allowed on the open market. Hellman had weighed the health risks to individual women against the risks of over population and determined there was greater benefit in curtailing world population growth. This point is interesting in that this sacrifice of the individual for the benefit of mankind is solely on the part of women.

Gena Corea, author of The Hidden Malpractice which has been quoted widely thus far in this paper, is also the author of a book detailing the inhumanities suffered by women involved with the new reproductive technologies, entitled The Mother Machine. Gena Corea points out that we may tend to regard these new technologies as something apart from the sexist medical system which produced DES and the Pill, etc. This however is incorrect according to Corea. These new developments spring from the same system as all of the others - one with the same low valuation of women (Corea, G., 1985: 3).

A general notion of fertility programs tends to be that they are the product of benevolent, empathetic doctors and

researchers striving to help childless couples. Gena Corea perceives the motives and end results in this area to be something completely different. She presents a view where research and practices surrounding infertility have merely been another chapter in the exploitation of women by a sexist medical profession. It is pointed out at the onset that the majority of reproductive engineers are men and the majority of persons whose bodies are being experimented upon are women. Corea states that the technology used emanates from a science developed by men according to their values and sense of reality (Corea, G., 1985: 6).

For the purpose of providing an example of the types of inhumanities, Corea states are going on in this area, the case of invitro fertilization (IVF) as Corea outlines it, shall be discussed (Corea, G., 1985: 102).

When invitro fertilization research was in its infancy in the late thirties, there was a great need for human eggs and embryos. For gynecologist Dr. J. Rock and pathologist, Dr. A.T. Hertig, two pioneers in this area, the chief source of eggs was from poor women receiving charity medical care at the free hospital for women in Brooklyn, Massachusettes. Many eggs were obtained from organs removed surgically from women. Corea also states that there was an attempt to schedule women's operations around the time of their ovulation. Rather than doing the operation when it was found to be necessary, Dr. Rock had women taking their temperature

and charting their ovulatory cycles for months, so that they (the doctors) could plan the operation for a time when it was most likely that they would find an embryo. Rock and Hertig collected 34 fertilized eggs from 211 women (Corea, G., 1985: 102). Most of these women were Catholic. Corea stresses the fact that these women were charity patients and as such it must be questioned as to whether or not they would have felt free to withhold their consent. Corea tells the story of another doctor who, while performing abdominal surgery, would pierce the ovaries of women and aspirate eggs with a syringe. He claimed that this caused the women no harm. But Corea questions, as in the case where eggs are taken from removed organs, if the consent of these women was ever really obtained.

To provide an idea of still how experimental this procedure was, a look at the success rate is in order. Keep in mind when reading it that the women involved were doing so in hopes of finding an answer to their infertility. By December 1980, of the 278 women who had participated in known experiments with human invitro fertilization, 3 gave birth to test tube babies. The live birth success rate for invitro fertilization was .04% - less than 1 percent (Corea, G., :116).[4]

Like contraception, infertility is a problem shared by both men and women. Infertility research like that being done for contraception again utilizes and subjects to the

possible risks, the woman's body. Corea states that invitro fertilization is particularly useful for women whose male partners are infertile, as in the case of a low sperm count for example. Yet the procedure is performed on women. She, rather than he, is hospitalized, exposed to the risks of repeated anaesthesia, repeated surgery, trauma to the ovaries and uterus, amniocentesis, ultrasonic radiation and the unknown long-term effects of hormones administered to her (Corea, G., 1985: 121).[5]

Another concern which is common in the literature on women and health care is the excessively high rate of surgery performed on women. Operations such as hysterectomies and Caesarian sections are performed on an alarmingly high scale. Diana Scully states that a hysterectomy is the most often performed operation in the United States. It is even more frequent than tonsillectomies and appendectomies (Scully, D., 1980: 17). Scully also states that the American Medical Association sponsored research which placed the hysterectomy and D + C (Dilate and Curretage) among the highest in a group of unnecessary procedures, surpassed only by surgery on the knee (Scully, D., 1980: 17). Scully believes that these aggressive surgical practices are due to an attitude on the part of doctors that female reproductive organs are expendable and even dangerous or dysfunctional outside of child bearing.

Mendelsohn states that in 1977, 5 out of 10 most commonly

performed surgical procedures were obstetrical-gynecological (Mendelsohn, R.S., 1981: 79). Mendelsohn also states that if the present course is continued, one out of two women in the U.S. will lose her uterus before the age of 65 (Mendelsohn, R.S., 1981: 97). Again we could suggest the justification that perhaps women are just that much more sick than men. Mendelsohn states however, that surgeons in the U.S. operate twice as often as those in England and Wales without any significant difference in therapeutic results. Mendelsohn claims that this disproportionate number of women's operations is due to there being an excess number of surgeons. Mendelsohn quotes a 1970 study conducted by two of the surgeons own associations as stating that there were more than 22,000 more surgeons than necessary at that time and that this number has been increasing ever since (Mendelsohn, R.S., 1981: 79). So it appears that women are bearing the brunt of the results of there being not enough necessary operations and too many surgeons available to perform them.

The issues examined thus far are relatively modern and recent. Barbara Ehrenreich and Deirdre English in the book Complaints and Disorders - The Sexual Politics of Sickness demonstrate that although the specific examples discussed thus far may be of our times, the fact that women and men do not fare equally when dealing with the medical profession is nothing new at all.

Ehrenreich and English examine the "weak" upper-middle

class woman of the late nineteenth and early twentieth centuries. There is a stereotype when we envision the victorian "lady" of a delicate creature given to fainting spells and attacks of the vapors. This may indeed have been the case but Ehrenreich and English discuss the role played by the medical profession in shaping or at the very least contributing and encouraging this once sickly and delicate typology of the essence of femininity.

Ehrenreich and English ask the same question concerning these women as we have about today's females - was she perhaps indeed weaker or sicker than men of her time? The life expectancy for women at this time was, as it is today, greater for women than for men, although the difference was not so great. There were health problems however which affected women and not men. Childbirth provided a great many risks for women. In 1915, 61 women died for every 10,000 live births. Two per 10,000 die today. There was no reliable form of birth control so a married woman of child bearing age could expect to be subject to the risks of pregnancy and birth on numerous occasions (Ehrenreich & English, 1973: 19).

Ehrenreich and English state that following a birth, a woman might have a prolapsed (slipped) uterus or irreparable pelvic tear which she would suffer the consequences of her entire life. Tuberculosis was another problem which plagued young women in particular. Twice as many women as men in

their age group died of the disease. This has later been believed to be associated with female hormonal changes associated with puberty and childbearing (Ehrenreich & English, 1973: 19). But Ehrenreich and English state that these factors alone cannot account for the phenomenon of "female invalidism" as it occurred. Ehrenreich and English also state that not only were women seen as sickly but sickly was seen as the embodiment femininity. These inherently ill women were limited to the upper classes; however, Ehrenreich and English state that this myth of female frailty and the overwhelming female hypochondria of the time served the medical profession financially in two ways. Firstly, it kept women out of the healing professions and secondly, it provided them with ideal patients - she supplied the illnesses while her wealthy husband supplied payment.

Ehrenreich and English state the irony in that women of this time were expected to be repelled by the sex act itself yet at the same time, doctors attributed many of women's problems to these very organs. To cure personality disorders, ovaries were removed by the thousands between 1860 and 1890. Doctors also advised women against higher education as it would lead to atrophy of the uterus. It can be seen that medicine was a form of social control of women. Surgery was often performed with the explicit goal of taming a high strung woman (Ehrenreich & English, 1973: 34). This invalidism also increased the upper-middle class woman's

dependence on men - these men being her husband and doctor in particular.

The disease of "hysteria" began to be seen in epidemic numbers. Doctors reacted to this wide scale phenomenon in a very punitive manner. The acumen of the diagnosis of this condition can be called into question since a woman who acted with any degree of independence, could be diagnosed as hysterical. Ehrenreich and English state that this "hysteria" could have merely been an expression of revolt against such a repressive social situation.

> In the epidemic of hysteria, women were both accepting their inherent "sickness" and finding a way to rebel against an intolerable social role. Sickness, having become a way of life, became a way of rebellion and medical treatment, which had always had strong overtones of coercion, revealed itself as frankly and brutally oppressive (Ehrenreich & English, 1973: 42).

As psychology began to emerge upon the scene, it was soon evident that although it was not treating hysteria with surgery, it was nevertheless travelling along the same wavelength as the medical views. Instead of a woman's uterus being the impetus behind a woman's behaviour, Freudians now had penis envy driving her. Women were still "sick" and being a woman was still enough to predispose one to sickness. Ehrenreich and English state that this "survival of the fittest" approach was used to justify these views of women as in the same way it was used to rationalize the poor being inherently less:

> Social Darwinism was also used to explain ill

> health among the poor just as gynecologists found female restlessness to be a symptom of basic ovarian malfunction, so did social observers see the poor as a race afflicted with pathological rebellious tendencies (Ehrenreich & English, 1973: 51).

It is easy to see how medicine was a form of social control for women. Women would assume the feminine role of being frail and weak for if they were to attempt to do otherwise and pursue some independent course of action, their lot could be much worse since they would be defined by certified medical professionals as hysterical, etc. For women of this time anatomy truly was destiny.

According to Ehrenreich and English, the medical system today remains very much an agent of social control and definition. The emphasis has shifted however from women being physically sick to psychologically weak. Doctors still tend to approach normal biological female functions such as childbirth, as physical illnesses and when a doctor cannot quickly diagnose a physical ailment, he is quick to categorize the problem as psychosomatic. Ehrenreich and English quote a 1973 study by Jean and John Lennane. The Lennanes found that doctors commonly attribute such physical complaints as dysmennorhea, nausea during pregnancy, pain in labour and infantile behaviourial disturbances as being aggravated by psychological problems. The Lennanes also state that even though we have ample evidence that there are organic causes behind these ailments, there has been little progress in a search for an effective way to manage these

problems. The Lennanes blame this lack of solutions on the attitude of so many doctors which attribute these organic problems to psychological causes.

> Because these conditions affect only women, the cloudy thinking that characterizes the relevant literature may be due to a form of sexual prejudice (Ehrenreich & English, 1973: 78).

Eleanor Frankfort supports what is stated by Ehrenreich and English in that "women's problems" receive little attention with regard to research for organic causes. She states that very little is known about such things as postpartum depression, menstrual irregularities, failures of contraceptive devices and "other minor plagues of women's daily existence" (Frankfort, E., 1972: 26).

Ehrenreich and English conclude by stating that the medical system has replaced organized religion as a prime source of sexist ideology and as an enforcer of sex roles. Ehrenreich and English view the medical system as a chief target for reform if the feminist movement is to succeed (Ehrenreich & English, 1973: 83). The medical profession holds a unique and powerful place in that its diagnoses and definitions can have tremendous social impact and at the same time, as a profession highly shrouded in technicalities, it retains an omnipotence.

As stated earlier in this paper, few female doctors go in to gynecology. It is worth questioning why this is since this is an area of medicine dealing with women exclusively.

Diana Scully states that a study of medical students conducted at the University of Vermont, revealed that female medical students were concerned about the way this area of medicine related to women. Scully states that they either wished to enter the area of gynocology to change it or were so upset by it that they wanted little to do with it (Scully, D., 1980: 16).

> Until women medical students perceive obstetrics and gynecology as a profession which is genuinely interested in women's problems, they will continue to be more attracted to family practice, pediatrics and psychiatry where their particular humanistic qualities are welcomed (Scully, D., 1980: 16).

Dr. Mendelsohn states that part of the problem of the way in which doctors approach women's health care is the very nature of medical school itself (Mendelsohn, R.S., 1981: 25). Mendelsohn states that medical school differs from other graduate programs in that it strives to keep its students' views narrow. The exercise of judgment is kept to a minimum. Mendelsohn states that "the med student who questions what is being taught will not be a favorite in the race to finish medical school, win a good internship and residency and pass his license exams" (Mendelsohn, R.S., 1981: 25) So in other words, old ideas and stereotypes will be very slow to die here.

Gena Corea states that part of the problem stems from women failing to take responsibility for their own lives and thus their own health. Women have been raised to lean on and

look to men for direction whereas men have been taught self-reliance (Corea, G., 1977: 75). Corea also points out that sexist assumptions not only affect a physicians perceptions of a woman's condition but also how much information he will provide her with. As a case in point, Corea refers to the 1970 Senate hearings on the Pill where several physician's implied that most women would not understand the information even if it was given to them:

> A misguided effort to inform such women leads only to anxiety on their part and loss of confidence in the physician...They want him (the doctor) to tell them what to do, not to confuse them by asking them to make decisions beyond their comprehension...The idea of informing such a woman is impossible (Corea, G., 1977: 77).

Mortin Mintz illustrates the different approach physicians take to men and women by recalling Plato's distinction between the physician of a free man and that of a slave.

> Whereas the slave doctor prescribed as if he had exact knowledge and gave orders like a tyrant, the doctor of freemen went into the nature of the disorder, entered into discourse with the patient and his friends and would not prescribe for him until he had first convinced him (Mintz, M., 1969: 114).

Corea goes on to state that the behaviour of male doctors and female patients is mutually reinforcing. Women have been trained to look up to men for guidance while men have been socialized to be stoic and strong. Corea supports the theory of cultural differences between men and women as discussed earlier. To men, the diffuse complaints of women may appear

to be hysterical while to women, the stoic front put on by her male doctor reinforces her view of him as someone competent within whose hands to lay her fate.

A common thread throughout the literature in this area is the emphasis upon the importance of women having access to doctors of their own gender. As stated in an emphatic manner by Corea:

> It is a most basic violation of our civil rights for the group that is not at any risk from reproduction (male) to control the group that is at risk (female) (Corea, G., 1977: 14).

Corea uses, as a case in point to demonstrate the importance of women having access to other women, a family planning clinic in Torrance, California which experienced a 500% increase in patient visits after female paraprofessionals trained in contraceptive fitting and cancer screening began working at the clinic (Corea, G., 1977: 84).

Corea states that the majority of men never see a female doctor about an intimate part of their anatomy. As of 1974, there were only 9 female urologists in the United States. Corea also states that gynecologists themselves admit that many women may be avoiding health care due to the discomfort they experience when dealing with a professional of the opposite sex on such highly intimate matters. Corea demonstrates how dangerous this can be by using cervical cancer as an example. She states that cervical cancer is 100% curable if detected early through a pap smear. Yet,

approximately 7,700 American women die of it each year. Corea says that as of 1970, only 12% of women were having regular pap smears (Corea, G., 1977: 85).

Sheryl Burt Ruzek, author of The Women's Health Movement states that a movement for reform in health care for women emerged in the late 1960s and early 1970s as a result of women's self-concept changing due to the feminist movement and also due to concern over health care. Ruzek states that a lot of women's contact with the medical profession occurs when she is well rather than sick. A well person does not require an authoritative, powerful figure in these situations. Such authoritative behaviour has been considered justified in institutions dealing with acutely ill people and it is in this manner that women have been dealing when they are really in search of "well" care. Ruzek presents a rather radical view which appears to be the basis of much of the suggested reforms as stated in the literature in this area, which is that "routine health care should be deinstitutionalized, deprofessionalized, and reintegrated into female culture" (Ruzek, S.B., 1978: 14)

What the movement is advocating is more self-knowledge when it comes to biological issues. An example in practice of what is being proposed is the book Our Bodies, Ourselves by the Boston Women's Health Collective. Ruzek states that in the spring of 1969, a group of women who had attended a conference on women's health issues at a women's conference

in Boston, met to examine the issues and to do something about doctors who had been condescending, paternalistic, judgemental and non-informative (Ruzek, S.B., 1978: 32). They decided that they would have to make themselves informed and wrote articles on anatomy, physiology, sexuality, venereal diseases, birth control, abortion, pregnancy and child birth. This collection of research papers became the book Our Bodies, Ourselves.

The goals of the women's health movement are to teach women to be more independent in terms of assessing their health needs. It is emphasized that women should come to their own decisions and should question what they are told. They should then refuse services they find unacceptable (Ruzek, S.B., 1978: 145).

Ruzek states that there has been a debate within the movement over whether it is preferable to attempt to improve the present institutions and practice or to provide alternative services. The problem which has been found with merely providing alternative services, is that it takes the pressure for change off the existing ones.

Diana Scully presents a list of elements for humane care from Jan Howard's essay "Humanization and Dehumanization of Health Care." One of these elements is that patients must be viewed as holistic selves and not as a specific medical ailment. Other elements are that all humans must be viewed as equally valuable, unique and irreplacable; a patient's

freedom of choice and full access to information must be ensured; regardless of educational level, patients must have the right to be fully informed and to participate in decisions about their care; and practitioners must strive to achieve empathy (Scully, D., 1980: 249).

The preceding literature review was an attempt to provide an understanding of the issues and problems confronting women when dealing with the traditional or conventional health care system. Dangers such as the overprescription of drugs and the use of procedures under false pretence or without adequate testing have been provided in hopes of illustrating the reality of the situation. The existence of these dangers however reflects and illustrates attitudes and ideologies prevalent throughout the entire medical system from the research lab to the doctor's office. The evolution of a women's health movement was a logical occurrence at a time of civil rights awareness. The feminist movement recognizes the social importance played by the medical profession in role definition and maintenance and recognizes it as a strategic institution for women's liberation.

It may be argued that many of the strategies which would remove certain aspects of health care from the medical domain are denying the technical expertise only attainable through highly specialized exposure and training which is fundamentally the essence of medicine as a profession. Regardless, there are crucial elements however, such as

attitude and approach which beg to be corrected.

In a search for improvements in women's health care it becomes essential to examine sources of medical attention which deliver care in a manner which provides women with an alternative. If we can examine such services in practice we can hopefully determine if therein some solutions may be found. An examination of one such clinic, Head and Hands shall be the focus of this thesis. As well as an examination of the clinic as an alternative source of health care for women, this thesis shall also examine data concerning the clientele of Head and Hands to determine if many of the findings within the literature hold true for this population.

It is hypothesized that most of the findings within the literature will be supported by the data collected at Head and Hands. Specifics shall be provided in later chapters. Also it is hypothesized that women of today are aware of the health issues facing them and that this awareness positively correlates with education. It is also projected that Head and Hands, being a holistic service, will be less likely to reach for stop gap measures such as the prescribing of tranquilizers.

CHAPTER III

What is Head and Hands

As discussed in the preceding chapter, there are many problems faced by women in dealing with the conventional or traditional health care system. Patronizing attitudes on the part of physicians towards their female patients, women not being adequately and fully informed by their doctors of issues directly concerning them are but two. As was also shown in the previous chapter these attitudes can result in consequences of great significance to women's health. With awareness of these problems being heightened over the past couple of decades the search for solutions has begun. Those in the women's health movement have proposed many changes for improvement. The question has been raised as to whether or not improvements made to existing institutions will be adequate or whether alternate sources of health care must be established. A clinic exists in the Montreal area, Head and Hands, which is unique in its approach and although it was not designed specifically for this purpose, would appear to offer solutions to many of the problems predominantly faced by women within the health care system. First some background information on the clinic will be provided and then it will be shown where its services and overall approach warrant close examination since it appears to be ideally suited for a progressive, quality approach to women's health care. What is to follow is a description of Head and Hands. In chapters to follow it will be examined as an alternative approach. The clientele of the clinic shall also be

examined.

Head and Hands in N.D.G. opened its doors in 1971. Its primary services at this time were aimed towards helping drug abusers. The centre is still going strong today, although its main focus has shifted. Today the services offered at Head and Hands are many and varied. Head and Hands offers such services as personal counselling and referrals, legal information with lawyers available, a "do it yourself" divorce clinic, "Sunday in the Park", health education, a job bank, a baby sitting skills course, a baby clothing exchange, a tiny tots play group, a summer day camp, a Christmas basket project and a life skills course geared towards young people moving out onto their own for the first time. As well as the above mentioned projects, the centre offers extensive health and medical services. There are daily medical clinics monday through friday staffed with a doctor and nurse team. The medical clinic includes gynecology, referral to specialists and birth control and pregnancy counselling.

Head and Hands is a unique and contributing member of its community. The fact that such a myriad of services is offered in one place is not only singular but the philosophy behind the rendering of these services is also different. As can be seen from the type of services offered, Head and Hands takes a holistic approach. The centre deals with a whole range of aspects of modern life from legal services to medical care to "Sunday in the park". Head and Hands also

attempts to be as informal as possible. Accompanying the informality, a non-institutional setting is strived for. Head and Hands also attempts to be non-judgemental in its approach. A special effort has been made to achieve an organization where people who would otherwise be uncomfortable or intimidated in a formal setting, will not be so here.

The democratic character of Head and Hands is also a unique aspect of the centre. No one employee's job is judged to be more important or valuable than the next. Everyone from the administrator to the receptionist, who meets the client at the door, is viewed as playing an equally important part and has equal input at weekly staff meetings and in the decision making process. All who work at the centre receive the same salary, save the doctors who are not actually employed by Head and Hands and are paid by Medicare. Those who work at Head and Hands do so because of a belief in the centre and its goals.

Head and Hands is primarily staffed by women. This has not been due to a conscious effort on the part of the centre but is probably due to the majority of the jobs being traditionally female dominated occupations. This was the claim of Dr. Pierre Tellier, a director of Head and Hands and a physician there.

With respect to the medical services offered at Head and Hands it is not typical of most health services available.

It is different from the government run C.L.S.C.s (Centre Local de Services Communitaires) and private group practices. Head and Hands is open all day and every evening, except for weekends and it is not completely funded by the government. Another distinct aspect of Head & Hands is that a lot of time is given to each patient. When a woman comes to be fitted for a diaphragm, for example, she is first instructed on its use by a nurse. Following this, she is then instructed again by a doctor. The woman is then requested to make a follow-up visit at a later date to demonstrate that she is using the device correctly. Although this is probably the ideal approach to the prescribing of such a birth control method, which requires more technical knowledge by the user than taking the Pill, it would rarely be seen in most medical settings due to time constraints. Head and Hands is also one of very few locations in the Montreal area where a woman can obtain a cervical cap. This is also due, in part, to the fact that instructions on its use are time consuming.

Dr. Tellier explains that the centre does not consider or present itself as an organization aimed specifically at women. Dr. Tellier also feels that the medical approach taken at Head and Hands is not particularly non-traditional. He considers himself to be fairly traditional in his approach and not necessarily an advocate of alternative forms of medicine. So why then are we interested in examining Head and Hands in terms of providing some alternatives to

conventional women's health care?

The answer lays not in the medical care itself but in the style or approach taken when providing it. As mentioned earlier, Sheryl Burt Ruzek in her book The Women's Health Movement, highlights the fact that there has been a debate within the movement over whether it is preferable to attempt to improve the present institutions and practices or to provide alternative services (Ruzek, S.B., 1978: 169). Head and Hands would appear to present an example of an improved existing service.

Head and Hands admittedly adapts to meet the needs of an ever changing community and an intrinsic part of Head and Hands are the medical services which it provides. With heightened awareness of feminist issues more and more women have supposedly become more conscious of what they should and should not expect from health care services. Head and Hands does provide health services in a manner which is conducive to answering many of the complaints women have had regarding their treatment. Head and Hands attempts to be informal and provide a non-institutional setting. This along with the non-judgemental philosophy applied at Head and hands allows a woman to feel less intimidated than she otherwise might have. She can feel less nervous and therefore will probably feel freer to ask questions regarding her health and is in a better frame of mind to retain the answers. Every effort is made at Head and Hands to inform patients and a considerable

amount of time is spent talking to them.

As discussed by Diana Scully in Men Who Control Women's Health one of Jan Howards elements for humane care is the emphasis on a holistic service (Scully, D., 1980: 249). Head and Hands is a holistic service.

It is also expressed in the literature that some women would feel more comfortable with a doctor of the same sex. Due to the majority of doctors being male most women are seen by a male doctor. Being seen by a doctor of the opposite sex is something few men ever experience. Head and Hands is staffed by both male and female doctors. As will be elaborated upon later in this paper, observation of the centre during routine working hours was among the research techniques employed in the data collection for this thesis. One point of observation was that when a client called and solicited information regarding medical services, the information supplied included the gender of the physician on duty that evening. When the centre became aware that part of the research for this thesis would involve examining personal preferences of clientele concerning this issue, they were very interested in the results in order to maximize the meeting of their clients needs.

Head and Hands, therefore, becomes of great interest and worthy of examination. Its non-judgemental and informal approach along with its sincere attempt to keep up with the needs of its clientele present a climate which would appear

to alleviate many of the problems traditionally experienced by women when dealing with medical services. Although not designed with this consciously in mind, it provides an interesting arena in that it combines traditional medical care with an open-minded humane and holistic approach. It would logically follow that in a setting such as this, if emotional causes were believed to be at the root of a woman's problems, this would probably lead to her being referred to a counsellor at the centre rather than being handed a prescription.

What becomes of interest as well is the clientele of such a centre. The demographic characteristics of those coming to Head and Hands is worthy of inquiry. With the advent of the women's movement, increased public awareness of various issues and the demand on the part of women for improved services, it is possible that it is not merely local youth of limited resources seeking the services of Head and Hands as it might once have been. It may prove to be informed women who like and can feel comfortable with the approach Head and Hands has to offer.

The attitudes towards health care held by those who come to Head and Hands are also of interest. As found in the literature, women relate differently to physicians than men. The result is that they are treated in a more authoritarian manner. It becomes a matter of concern then as to whether women, more than men, desire to be treated in such a manner

and are those who arrive at Head and Hands expressing that they do not? Dr. Tellier is of the opinion that people will gravitate towards an atmosphere of service with which they are most comfortable. If this is correct then the atmosphere of Head and Hands should reflect the attitudes of the clientele.

It is the object of this thesis to obtain profiles of the centre and its clientele, both demographically and attitudinally. This shall be accomplished through the use of a questionnaire distributed to clients of Head and Hands, observation of the centre during routine working hours and conversations with staff members. What is being examined is an existing organization using traditional medical practices which has adopted an innovative humane and sensitive approach towards its clientele. For women who are dissatisfied with traditional health services, the examination of such an organization as Head and Hands, should be of some contribution in the search for improved health care for women.

CHAPTER IV

Discussion of Hypotheses and Research Methodology

The major purpose of this thesis is to examine Head and Hands, an organization unique in its approach, in relation to women and their requirements for an improved health care system. To accomplish this, in addition to examining the centre and its mode of operation, the clientele also must be examined in terms of their attitudes and demographic make-up. We must look at who is coming to Head and Hands and for what reasons. This also allows us the opportunity of determining if certain aspects which the literature indicates are important to women, such as being able to see a doctor of the same sex for example, are actually of significance to this population.

By drawing a profile of the clientele of Head and Hands we are determining exactly which groups are attracted to the services of such an organization. With regard to the interests of this thesis one of the first factors to be examined is what proportion of the clientele are female and what proportion are male. Does Head and Hands hold a greater attraction to one sex more than to the other? It is expected that women will predominate in this sample. Based on women being the largest consumers of health care services, (Frankfort, E., 1972: XXVI) as stated by the literature and medical services being a major service at Head and Hands, it is logical to make this projection.

Another area we wish to examine is the types of services that each sex is seeking when coming to Head and Hands. The

use of medical services is of primary interest but examining the proportion of each sex using other services will be useful for comparative purposes. It is again hypothesized, for the same reason as listed above, that the majority of the users of the medical services will be female.

The income levels of those coming to Head and Hands will be examined. It will be of interest to see if Head and Hands is attracting primarily low income earners. Since the centre considers itself to be youth oriented one would expect this to be the case. Also, the presence of a food bank would appear to indicate this. If higher income groups are coming to Head and Hands it could be concluded that the approach taken and style of service at Head and Hands provides an attraction. It is hypothesized that it will not only be low income groups attending the centre. The sexes will also be compared with regard to income levels. If the higher income groups are proportionately more represented by women this is again evidence that it is the approach of Head and Hands which is attractive. It is again hypothesized that this will indeed be the case. This prediction is based on the assumption that women have become more aware of health issues concerning them and of what they have a right to look for in terms of alternatives.

The representation of the clientele at various educational levels shall also be examined. It will be interesting to note if higher educational levels are

represented thus perhaps indicating, if we assume that higher education leads to greater awareness and openness to new ideas, that in choosing Head and Hands an informed choice was made. It is predicted that particularly in the case of women, these higher levels will be represented.

The representation of men and women in the different age groups is also of interest. Head and Hands considers itself a youth oriented centre. We again have an indication of a preference on the part of the clientele for the approach taken at Head and Hands if age groups other than the very young are well represented. This will prove to be an especially important indicator as to whether or not Head and Hands does hold a particular appeal to women. If the proportion of women in older age categories is significant, this will show that in spite of the clinic being oriented to a different age group, the approach it takes is attractive to women.

A considerable area of interest for this thesis is whether or not it is important to the women coming to Head and Hands that they be able to see a physician of their own sex. The literature states quite emphatically that the under representation of women in the medical profession has been a major contributor to the problems which women have experienced. It is felt that seeing a doctor of the opposite sex can be an uncomfortable experience which few men have endured due to the majority of physicians being male. After

determining if the literature is supported, it will be interesting to examine the preferences of males in this area. Whether or not attending a physician of the same sex is as vitally important to men as it is to women, will be interesting to examine. If an analysis of the data collected reveals that women prefer to be able to see a physician of the same sex, then this is important to know when looking at features which attract women to a particular source of medical care.

Another factor which will be of interest when looking at the preferred sex of a physician, is whether or not the age of the clients is of any significance. Whether it is more important for a woman to see a doctor of the same sex the older or younger she is could indicate that factors other than feeling more comfortable are at work. For instance, if it were revealed that proportionately more older women prefer male doctors, this could indicate a stereotype at work and that these women have more confidence in male professionals, whereas perhaps younger women, being reared during the feminist movement, would not be subject to these perceptions. It is predicted that all women, regardless of ages, will prefer a doctor of the same sex, supporting the contention found in the literature.

Level of educational attainment will also be examined in light of the preferred sex of a physician. This could be of particular interest when examining the male population. It

will be interesting to note whether high educational attainment correlates positively with a more liberal attitude on the part of men towards having a female physician.

Another point made within the literature, as recalled earlier, is that women frequent their physician's office more than do men. The validity of this statement will be tested with this population. It is predicted that the literature will be supported and that the women of this population will not differ from those in other studies. It is predicted that they will state that they see a doctor more often per year than will the male portion of the sample.

The disproportionate amount of psychotropic drugs prescribed to women has also been a point of major importance when considering issues concerning women and health care. It is therefore an area which shall certainly be dealt with during the process of this research. A centre such as Head and Hands, as stated in the previous chapter, could be expected to be less inclined to prescribe mood altering drugs. This is due to the holistic nature of the clinic. Counsellors and social workers are working out of the same facility. An attempt will be made to determine if the clients of Head and Hands are typical of other populations discussed in the literature, where it was revealed that a disproportionate number of women have been prescribed mood altering drugs as compared to men. Also, the sources of these prescriptions will be examined. It is predicted that

women will outnumber men in terms of the percentage of them who have received prescriptions for these drugs. It is also predicted however that few of these prescriptions will have emanated from Head and Hands but will have come from other sources.

Some factors will be examined in regard to those who have received prescriptions to see if there are any patterns or commonalities. Age for example, will be examined to determine if certain age groups have received more of these prescriptions.[6] The living arrangements of these cases will also be examined to determine if the presence of children in the home correlates positively with one's chances of being prescribed such drugs.[7]

A final area which shall be examined involves attitudes towards the manner in which medical care is given and whether different attitudes exist via-a-vis men and women. The types of attitudes to be examined are those indicating how authoritarian an approach the patient expects a health service to take. The literature indicates that women have been typically treated in an authoritarian manner. This is evidenced by patronizing attitudes on the part of physicians towards their female patients and women not being provided with complete information from their doctors. If women actually do expect this attitude then this would logically be a contributing factor to their receiving treatment in this fashion. Thus, this study will seek to determine if there

are differences between men and women of this population, in terms of the expectations they have of a health service. The effect of education on these attitudes will also be examined. Should it prove that women more than men hold positive attitudes towards authoritarian treatment on the part of their health practitioners, then it would be expected that this attitude should negatively correlate with education.

Methodology

The approach used to gather data for this research project was three fold. A combination of 1) a questionnaire distributed to clients, 2) an interview with a director and physician at Head and Hands as well as discussions held on an informal basis with an administrator, and other staff members at Head and Hands and 3) observation of the centre during routine working hours. Therefore the analysis will be both quantitative and qualitative in nature.

The questionnaire consisted primarily of questions used in a previous questionnaire which was distributed at Head and Hands in 1979 and again in 1983. A few additional questions, applicable directly to the research at hand were added. Some were worked directly into the body of the existing questionnaire and others were placed on a separate page at the back with a note explaining that they were for a separate research project and not being directed by Head and Hands. This was done for questions such as one dealing with mood altering drugs. It was felt by Head and Hands that this

topic was clearly not related to the operation of the centre and that there was no need to confuse the clients in this regard.

Two of the questions which were added were for the purpose of contributing to a demographic profile of the clientele. These two questions involved income and educational attainment. It should be noted at this juncture that Head and Hands had taken great care with the previous questionnaire to ensure that the questions were very informal and uninhibiting, coinciding with the approach of the centre. The questions which were added were designed to merge with this style. For instance, the question dealing with income was worded thus:

> Last year I earned about: -
>
> (If you are living as a couple, please estimate roughly what you both earned together).
>
> Less than $10,000 ( ) $30,000 - $39,000 ( )
>
> $10,000 - $19,000 ( ) $40,000 - $49,000 ( )
>
> $20,000 - $29,000 ( ) more than $50,000 ( )

This was considered to be much less inhibiting than a more formally structured question such as: Please approximate your income for the previous year.

On the final page, to be asked apart from the body of the questionnaire, were five questions. The first question inquired as to how many times per year the respondent visited a doctor. In order to control for pregnancy and child

bearing, the respondents were asked not to include these visits.

The second question inquired as to the preferred gender of a physician and the third inquired as to the sex of the physician usually seen by the respondents at Head and Hands.

The fourth question provided a list of mood altering drugs and asked the respondent to indicate if he/she had ever been prescribed any of them. A space was provided for respondents who knew that they had received a drug of this type but could not remember the name. Also, a space was provided for those who had received a prescription but the drug was not included on the list. In this case the category "other" would apply and they were asked to please specify the drug. The purpose of providing a list of drugs was to act as a memory aid to the respondent. This list was taken from the results of a thesis entitled "Women's Health Care: Who Cares?" written in 1982 by Barbara Nathan Marcus, with the addition of two drugs, these being surmontil and imipramine. For those respondents checking "other", they were asked to specify the drug. This was done so that it could be determined if the drug prescribed was indeed a psychotropic agent. This proved to be of value since some cases did emerge where the affirmative response to the question was disregarded since the drug was not of the pertinent class. There was a possibility of errors occurring where respondents indicated "Do not know name". Errors could result as there

is no way of knowing whether these drugs are those of a mood altering class. It was assumed that the proportion of these misunderstandings would be negligible and as mentioned above, safeguards had been applied to ensure the accuracy of all other categories.

The importance of the word "prescribed" was emphasized within the question by underlining it. Since it is the interaction between medical professionals and patients that is of primary interest for this study, if the respondent obtained these drugs by any other means, it would be of no relevance to the results of this research project.

The final question inquired as to the origin of the prescription. This was done in an attempt to determine how Head and Hands would fare when compared to outside agencies. It is recognized that since a respondent has had his/her entire life to receive prescriptions and may only have been frequenting Head and Hands for a recent period, this would not be a good indicator of Head and Hands' prescribing patterns. In an attempt to improve the validity of the results obtained, all those cases which had responded in the affirmative but had also indicated that it was their first visit to Head and Hands or that they had only been there once or twice previously, were excluded from the data for this question.

The questionnaire consisted of two styles of questions, these being multiple response and open ended. The

questionnaire consisted of 43 questions occupying 7 pages. It was recognized that it was lengthy and rather time-consuming to complete but this was not considered a major problem in that usually there is some waiting involved at the centre and this provided a way to put in time. Also in some cases, rushed clients were allowed to take the questionnaire home. Many of those who were attending the weekly "do it yourself divorce clinic" for example, picked up the questionnaire one week and returned with it the next.

Seventeen of the questions were attitude statements where the respondent was required to indicate either agreement, disagreement or that he/she did not know. It was from this body of questions that those indicating an attitude either positive or negative towards being treated in an authoritative manner by a health professional were chosen. The four questions which were felt to be of significance in this regard were as follows:

- It is important to me that a health centre looks business-like.
- I think you should be able to tell by the way they dress who the staff people are, and who the clients are in a health centre.
- I want the doctor (or lawyer) to spend time explaining my situation so I can make decisions for myself.
- Since the doctor (or lawyer) has the professional knowledge, he/she should make the decisions for me.

If a respondent indicated agreement with the first, second and fourth of these statements and responded

negatively to the third, this was taken as indicating that the respondent preferred to be treated in an authoritarian manner. Those responses opposite to these would indicate that a more egalitarian approach was preferred. The results produced from the examination of the responses to these statements would be analyzed as a composite creating a profile of a general attitude. These responses would then also be examined on an independent basis.

The questionnaire was distributed over three weeks during the months of March and April 1988. During the day, the questionnaire was prominently available on a table in the waiting room. The receptionist aided in the dispensation of them when time permitted. During the evenings, the questionnaire was monitored by myself. This was to ensure that each client entering the waiting room was given the opportunity of completing it. The questionnaire was available in both french and english. Both questionnaires are located within the appendix of this paper.

It should be explained at the onset that before commencing with this research I was required to present the research proposal to the staff of Head and Hands at their weekly staff meeting. The data received from the questionnaire would be supplied to them. In exchange for my collecting the data, coding it and supplying them with the results, I would be permitted to utilize the data for the purposes of this thesis. The staff was very helpful and it

was one of the nurses who provided the names of two additional commonly prescribed drugs for the question dealing with mood altering drugs.

Having my attendance at this meeting as my introduction to Head and Hands, p oved beneficial in two ways. First of all it made the purpose of my presence in the centre over the next few weeks known and introduced me to the staff. I felt this facilitated them in being able to provide me with pertinent information wherever possible. Secondly, I was able to observe, if only briefly, the interaction between the staff members. The democratic nature of Head and Hands was very apparent. All present appeared to provide input freely and were accorded equal respect. The hierarchy of positions which exists in traditional organizations was not evident at this meeting.

I spent each evening over a three week period in the waiting room at Head and Hands monitoring questionnaires. As stated earlier, the majority of the clients were very obliging. Many stated that they were happy to do something which might contribute to the centre.

The waiting room at Head and Hands definitely reflects its philosophy. It is very warm and comfortable. It is lit with table lamps during the evening, as opposed to fluorescent lighting which you would find in most institutional settings. The receptionist was the individual I primarily saw and she was extremely helpful and informed in

matters concerning Head and Hands. She answered questions and also voluntarily supplied me with information which she deemed might be useful.

While monitoring the dispensation and collection of the questionnaires I was able to observe the functioning of the centre. The purpose of observing routine activities at the centre was to take note of the interactions between clients and the staff of the centre. It was expected that this would prove illuminating in terms of illustrating the approach of the centre and its reception on the part of the clientele. In general, it was felt that the different atmosphere of Head and Hands should reflect itself in practice and that this could be noted through observation.

In summation, through the use of a questionnaire, observation and interviews, it was anticipated that a portrait of Head and Hands and its clientele would emerge. From the data to be collected, it was hoped that it would be possible to determine if the approach taken by Head and Hands was one of particular appeal to women. The chapter to follow outlines the results of this research project.

CHAPTER V

Analysis of Results

This research project proved quite fruitful in terms of the data provided. Many of the clients at Head and Hands were very obliging in donating their time and thoughtfully completing the questionnaires. In total 137 questionnaires were completed. The staff was also very helpful in terms of answering any questions which I may have had concerning the operation of the centre and in encouraging clients to fill in questionnaires. It was possible from the data provided to get a clear overview of the clientele both demographically and attitudinally. From some of the comments received on the questionnaires, from observation and from speaking with staff members, I did get the indication that many clients were at Head and Hands because they had been less satisfied when using other services. In this sense many had chosen it as an alternative. Many of the predictions, as discussed in the preceding chapter, were supported. The clinic is frequented predominantly by women, for example. Also, although the centre is youth oriented, many age groups are well represented. Other aspects such as sex differentiation with regard to the proportion of prescriptions for psychotropic drugs did not support the findings of previous research as discussed in Chapter II. There are explanations as to why this occurred with this population which shall be described later in this chapter. Overall the data revealed many interesting findings, the analysis of which in some instances, led to questions which had not previously been

posed.

As stated above, the greater proportion of the clientele, according to the results of the questionnaire, were female: 26.3% (36) of the respondents were male and 72.3% (99) were female. Two respondents did not reveal their gender. With regard to the utilization of the services at Head and Hands, medical services were the reason for the majority of the female clients being there. The primary service being sought on the part of males was the lawyer. The results for all of the services by sex can be viewed in Table A-1 of the appendix. 59.8% of the services being sought by women were medical. 36.1% of males were there for legal services. It should be noted that it was possible for a respondent to have a multiple response for this question since they may have come to utilize more than one service. The lawyer ranked second for women with 13.1% of them being there for legal services. For men, medical services placed second in the reason for them being there, with 27.8% indicating this service. To this point what was predicted in the previous chapter has occurred. The majority of the clientele are female and the most popular service being sought by women is medical. Or to put it another way, the majority of the medical services are being used by women.

When examining the data provided by the question asking the respondents how many times a year they see a doctor, women again emerge as being greater users of medical

services. Table 1 contains the data regarding this question. If we examine individual responses, the majority of females (25.5%) see a doctor twice a year. For this question, respondents were required to write a number in a blank indicating the number of visits. The most dramatic difference can be seen between males and females in this regard, if we group the responses together for those who indicated seeing a physician three or more times a year. 31.2% of males reported doing so while 50% of females did so. It is very evident that females are the greater consumers of health care.

TABLE 1

Percentage of clinic clients by the frequency with which they visit a physician per year and sex.

Visits per year:	Males	Females
	%	%
0	6.2	--
1	40.6	24.5
2	21.9	25.5
3 or more	31.2	50.
	(32)	(94)

The majority of the females in the sample were between the ages of 19-25. Table A-2 in the appendix depicts the relationship between age and sex. 45.9% of the women were in

this age group. Interestingly, the age group with the second largest representation is for those over 31 years of age with 27.5% of the sample being in this age range. Third is the 26-30 year olds with 14.3% being in this group and lastly is the 13 to 18 years age group with 12.2% It is clear that Head and Hands is attracting more than the very young, in fact, their smallest age group is 13 to 18 years. Those falling into the 19-25 year age range could possibly be attracted to Head and Hands by its appeal as a youth centre but certainly this explanation cannot apply to the over 31 age group which as stated, makes up 27.5% of its female clientele.

For males, the largest age group represented was again older than m ght have been expected. The largest representation, 47.2%, were over 31. Second for men was the 19-25 age group making up 25%, third was the 26-30 range comprising 16.6% and fourth was the 13-18 age group making up 11.1% of the male population.

It is of significance that although the largest age group for women is between 19 and 25 years, a sizable proportion is older than this. Such a finding is consistent with our prediction that Head and Hands is providing an alternative for women. If we combine the two age groups over 25 years of age, we are looking at 41.8% of the female clientele.

What is also of interest is that the majority of men coming to Head and Hands are over 31 years of age. What may

account for part of the high representation for both sexes in this higher age group is that the majority age group for those seeking legal services was in this older category. 22 respondents in this age group were seeking legal services while there were 44 respondents over 31 years of age in the sample. A table providing a list of services in relation to age of respondents utilizing them is located under Table A-3 in the appendix. Since these legal services are free of charge, this may account for part of the attraction. It must also be remembered that the service most sought by men at Head and Hands is the legal service.

When examining the educational levels achieved by the clientele, both sexes appear fairly well educated. It must be pointed out however that the wording of the question which deals with this aspect inquired as to what level the last completed year of school was. This means that if a respondent indicates university, this does not mean that they necessarily completed a degree. This vagueness could be considered as a criticism of the questionnaire if specific levels were required. In this instance however, the data serves its purpose in that exposure to university, this involving its courses and discourse with teachers and other students, could have a broadening affect.

The majority of women in the sample (36.1%) reported high school as being the level of their last year of education. Table A-4 in the appendix depicts the relationship between

sex and educational levels attained. There was however a sizable representation within the CEGEP and university categories. 22.7% reported CEGEP, 25.8% reported university and there was even 4.1% who reported having done post graduate work. This representation within educational categories greater than high school is considerable. When census data is consulted, it is revealed that 33.12% of the population of Montreal have post secondary education. If we combine those women of this sample who have CEGEP, university and post graduate education, we discover that this group comprises 52.6% of the females in this sample. When compared with the population at large, it is still evident that the female clientele of Head and Hands are well represented within post secondary levels of education.

For the male portion of the sample, the results are very surprising in that the majority of the men coming to Head and Hands have had at least some university education. 38.8% reported having university. The second largest group was that reporting CEGEP at 27.7% and the third largest group was that reporting high school at 22.2%.

With regard to income, the majority of the women in the sample (47.4%) had earned less than $10,000 the previous year. Table 2 contains the data concerning the income ranges reported by the clientele. A considerable percentage however, had earned between $10,000 and $29,000. Although the second category for income did contain a sizable number

of cases, it would have to be concluded that the majority of women coming to Head and Hands are of lower income.

What was very surprising was that for males, all of the income groups were fairly well represented. The majority (38.7%) were earning less than $10,000 but 29% were earning over $30,000. Similar results for women were expected if the contention was to be supported that Head and Hands was being viewed by women as an alternative clinic. If women had been represented within all of the income groups this would suggest that Head and Hands was attracting women from groups other than those for whom it was actually targeted., As was discussed above however, this did not prove to be the case. When census data collected for the Montreal area is consulted, it is revealed that these results reflect what is occurring within society at large. The average income for women is $13,068. while for men it is $23,463. This census data represents only those members of the population over 15 years of age with income. The data for Head and Hands includes respondents younger that 15 and did not require that the respondents be employed to be included. The census data reveals the same disparity between the incomes of men and women that we have found at Head and Hands. Had the census data included respondents younger than 15 years of age and those who were not employed, it is probable that the average income for women in the census report would be below $10,000. as was the case with Head and Hands.

TABLE 2

Percentage of clients by income and sex.

	Males	Females
$	%	%
Less $10T	38.7	55.3
$10T-$29T	32.2	36.5
$30T & +	29.	8.2
	(31)	(85)

With regard to attitudes, one of the questions which was asked concerned the preferred sex of a physician. This yielded very significant results both in terms of indicating the preferences of the majority of women but also in terms of showing how men's and women's attitudes on this subject differ. Table 3 on the following page contains the results for this question. The majority of women (64.8%) would prefer a female physician. Second in preference at 26.4% came "either" or "did not care". Although "either" or "did not care" was second, it represented a significantly lower percentage of the women. Lastly came a preference for a male physician at 8.8%. It is apparent from these results that as suggested in the literature, it is of importance to women to be able to see a physician of the same sex.

The majority of males (40%) chose "either" or "did not care". Although a preference for a male physician came second with 33.3%, surprisingly 26.7% of the males in the sample would prefer to see a female doctor. One explanation

for so few women preferring a male physician and the majority of males not having a preference could be that very few men would ever have had occasion to have been seen by a physician of the opposite sex whereas the majority of women would have had this experience. It is interesting however that such a percentage of men would actually prefer a female physician. Perhaps this is due to a perception of women as being more nurturing.

TABLE 3

Percentage of Clients by the Preferred Sex of a Physician and Sex.

	Males	Females
Preference:	%	%
Male	33.3	8.8
Female	26.7	64.8
Either	40.	26.4
	(30)	(91)

When age is examined in terms of whether or not there is a preference for a physician of the same sex, some clear patterns emerge. The data illustrating the relationship between sex, age and the preferred gender of a physician is in tables A-5A and A-5B within the appendix. Females under the age of 31 prefer a doctor of the same sex. For those

females 31 years of age and over, there is a tie between those preferring a female physician and those indicating "either". For the 13 to 18 years age group, 75.1% prefer a female doctor. For those between the ages of 19 and 25, 66.6% prefer a female physician. The strongest preference for a female physician appears in the 26 to 30 age group with 84.6% preferring a female doctor. Over 31 years of age, both the female preferred and the "either" categories received 42.7%. For none of the age groups is a male doctor preferred. In fact, in two of the age groups, that for those between 13 and 18 and that for those between 26 and 30, no respondent indicated a preference for a male physician. The 42.8% split between the preference for a female physician and not having a preference is quite a drop from the "female preferred" category. The next highest group is 66.6% for the 19-25 age group. It would appear that after women reach the age of 31, they become far less concerned about having a physician of the same sex. One explanation for this could be that women in this older age group were exposed to male physicians to such a large extent due to the female doctor being such a rarity in the past. Perhaps some, after having become accustomed to seeing a male doctor, do not have a preference in this regard. This would be especially true of those having had positive experiences with a male physician.

For males, the results for this question were very revealing. For males between the ages of 13 and 18, a doctor

of the same sex is preferred. 75% of males in this category chose a male physician. The second choice was a female physician. None chose the "either" category. As we move into the 19 to 25 age group, a male physician is still preferred; however, with less of a majority. 62.5% of males in this category preferred a male physician. The second choice at 25% was a female physician. Third with 12.5% was the "either" category. Within the 26 to 30 age group, the "either" category was chosen by the majority with 50% of the respondents choosing it. Second with 33.3% was the preference for a female physician. Surprisingly, the choice of a male physician ranked third for this age group with 16.6% choosing it. A preference for a male physician ranked last again with 8.3% of the male sample in the group for those over 31. The majority (66.6%) in this age group chose the "either" category. It is very interesting that for every age group of the female portion of the sample, the preference for seeing a physician of the opposite sex was the category least often chosen, yet for males this category was ranked second within each age group. Within two of the groups, the choice of a female physician was selected more frequently than a male physician.

It is obvious from the above that it is far less desirable for women to see a male physician than it is for men to see a female physician. This illustrates the importance of providing women access to female physicians.

When considering health services for women the gender of the physician(s) to work there becomes an important issue. With regard to women, the data supports what was suggested within the literature. The only anomaly was for those women over 31 years of age. However, even in this age group, the preference for a female physician was chosen as frequently as the "either" category and the choice of a physician of the opposite sex was selected least frequently.

With respect to the males of the sample, it is logical that between the ages of 13 and 18, a physician of the same sex would be preferred due to this being a period of adolescence and accompanying insecurities. It is also understandable that the "either" category would be a first choice in the next three age groups following adolescence. A female being preferred over a male within the next three age groups is surprising however. As stated earlier, perhaps a logical explanation for this lies in the perception of women as being the more compassionate gender.

It should be stated that when answering this question the respondent was given a choice between male and female. The third category indicating "either" was comprised of those who had written in "either", "do not care" or something to that effect. Had this category been provided on the questionnaire as were "Male" and "Female", perhaps it would have had an even larger representation.

When education is examined in relation to the preferred

sex of a physician, an interesting finding reveals itself with regard to women. Tables A-6A and A-6B in the appendix provide the relationship between sex, educational attainment and the preferred sex of a physician. Although over 50% of the female respondents with high school or CEGEP indicate a preference for a female physician (high school - 62.5%; CEGEP - 54.5%), there were still some respondents within these groups preferring to have a male physician (high school - 9.3%; CEGEP - 18.2%). Once we reach those with university however, there are no respondents preferring to have a male physician. The same occurs with those women in the sample having post graduate level education. If the number of female respondents for those having university and post graduate level education is combined, there were 29 women in this group. 27 women in this group responded, so the portion of the overall sample we are examining is significant enough to be indicative of attitudes of women at Head and Hands at this educational level. For women, higher education appears to correlate positively with a preference for having a physician of the same sex.

For males, the majority of those with a university education indicated that they had no preference (50%). This was followed by 28.6% indicating that a female physician was preferred. For males there is no clear indication however, that higher education correlates with more liberal attitudes in this regard since those with high school prefer a female

physician (42.8%) while those with CEGEP preferred a male (57.1%). We do however see a lack of a preference among those who have a university education which could indicate that university possibly contributes to the disintegration of stereotypes regarding sex and the proficiency of professionals.

Another attitude examined in terms of differences between males and females was whether an authoritarian approach was expected from a health service. As outlined in the previous chapter, the responses to four questions were examined concerning this aspect. Respondents were requested to state that they agreed, disagreed or did not know concerning their attitudes towards the following statements:

1. It is most important to me that a health centre looks business-like.

2. I think I should be able to tell by the way they dress who the staff people are and who the clients are in a health centre.

3. I want the doctor (or lawyer) to spend time explaining my situation so I can make decisions for myself.

4. Since the doctor (or lawyer) has the professional knowledge, he/she should make the decisions for me.

It is suggested that a response of "agree" to numbers 1,2 and 4 and a response of "disagree" to number 3 would constitute a profile of someone preferring that an authoritarian approach be taken on the part of those delivering health services. A series of responses opposite

to the above would indicate that a non-authoritarian attitude was expected. It was proposed in the previous chapter that perhaps women have a more positive attitude towards an authoritarian attitude on the part of physicians and that perhaps this contributes to perpetuating their being treated in this manner. The results revealed that very few members of the sample of either sex fit this profile. If we look at these four factors as a whole, all of the clients expect a non-authoritarian approach to be taken by their health service regardless of sex. For women only 4% (4) fit the profile while for men only 2.7% (1) fit. 97.2% (35) of men did not fit it and 96% (95) of women did not. So although 3% more of the women than men did fit the pattern, these dirrerences are so small as to be negligible.

Following the examination of the data resulting when responses to these four statements were looked upon as a totality, the results to each statement were examined individually. All data received for these statements on an individual basis are provided in Tables 4, 5, 6 and 7 to follow.

With regard to the statement concerning whether a health centre should look business-like, the majority for both sexes disagreed. The data collected for this question is located in Table 4. 58.8% of males disagreed while 69.5% of females disagreed. A larger percentage of males agreed with the statement (29.4%) than did females (23.1%). This difference

is only 6% however so, it does not lead to any strong indications. The results of a T-test yielded that this difference was insignificant.

In examining the results for the statement regarding the manner of dress of the staff people in a clinic, 22.4% of women agreed with this statement while only 15.1% of men did. Table 5 contains the results for this question. There does appear to be stronger agreement among women on this issue. A larger percentage of females than males also agreed that the doctor or lawyer should make decisions for them. The responses to this question are outlined in Table 7. This difference is once again small however with 14% of females agreeing and 7.4% of males agreeing. The results of a T-test reveals that this difference is not significant. When we examine the results for the statement that the individual should be supplied with information so that they can make decisions for themselves, more women agreed than did men which would appear to contradict the above findings. The data for the responses to this statement is located in Table 6. 87.5% of men agreed with this statement while 89.5% of the women did.

TABLE 4

Percentage of responses made by clients to the statement:

"It is most important to me that a health centre looks business-like"

	Males	Females
	%	%
Disagreed	58.8	69.5
Agreed	29.4	23.1
Do not know	11.8	7.4
	(34)	(95)

TABLE 5

Percentage of responses made by clients to the statement:

"I think you should be able to tell by the way they dress who the staff people are, and who the clients are in a health centre."

	Males	Females
	%	%
Disagreed	75.7	73.5
Agreed	15.1	22.4
Do not know	9.1	4.1
	(33)	(98)

TABLE 6

Percentage of responses made by clients to the statement: "I want the doctor (or lawyer) to spend time explaining my situation so I can make decisions for myself".

	Males	Females
	%	%
Disagreed	9.4	6.3
Agreed	87.5	89.5
Do not know	3.1	4.2
	(32)	(95)

TABLE 7

Percentage of responses made by clients to the statement: "Since the doctor (or lawyer) has the professional knowledge, he/she should make the decisions for me".

	Males	Females
	%	%
Disagreed	81.5	83.9
Agreed	7.4	14.
Do not know	11.1	2.1
	(27)	(93)

The responses to these statements were then examined in relation to levels of education in order to determine if more education led to more negative attitudes towards being treated in an authoritarian manner. These results were

compared by sex. The complete data gathered for both males and females with regard to attitude towards the above discussed statements as it relates to education, is provided in the appendix under tables A-7A through A-10B.

With regard to the statement that it is important that a health centre look business-like, for women the largest percentage agreeing with this statement had a high school education. The data for the responses of female clients to this question by education is located in Table A-7B of the appendix. 26.5% of respondents with a high school level education agreed. The percentage of women agreeing with this statement declined with CEGEP and university levels of education. 20% of those with a CEGEP education agreed with the statement and 20.8% of those with a university education agreed with it. Higher education for females in this instance did lead to a less authoritarian viewpoint. The results of a chi squared test yielded these results to be insignificant however.

When female answers are examined in response to the statement indicating that it should be evident by the way the staff dresses that they are the staff, higher education again appears to correlate with a negative attitude towards being treated in an authoritative manner. The data for the responses of females by education is located in Table A-8B of the appendix. 55.9% of those with high school education disagreed with this statement. When the category containing

the responses of CEGEP educated females was examined, 86.4% disagreed. The percentage disagreeing rises to 88% when we examine the responses of university educated females.

When the responses to the statement indicating that respondents would like to have information supplied to them so that they can make their own decisions are examined, again we find a positive correlation for women between a university level education and a desire to be treated in a less authoritative manner. The responses made by females to this statement by education are located in Table A-9B in the appendix. The difference in percentages representing those females who agreed with the statement is not as dramatic as in the previous statement but still appears nevertheless. 90.6% of respondents with high school education agreed with the statement. This number decreases to 86.4% for those with CEGEP and rises again to 91.7% for those with a university level education. If we combine those with a university education with those who had done post graduate work, this number increases to 92.8%. The results of a chi squared test of statistical significance yielded these results to be insignificant as well however.

When the responses are examined for the statement indicating that the doctor should make the decisions, those females with university level education agree with this statement the least. The data regarding the responses to this statement is located in Table A-10B. 8.3% of those

female respondents with a university education agree, whereas 14.3% of CEGEP educated females agree and 16.9% of high school educated females agree. These results were also found to be insignificant by the use of a chi squared test of statistical significance.

It would appear from the data discussed above that for females, a university level education correlates positively with the desire to be treated in a non-authoritative manner thus supporting the hypothesis. However, it must be emphasized that in two of the three instances where this clearly occurred, the percent differential was very small.

With regard to male respondents, the responses to the statement indicating that a health centre should look business-like were in contrast to those of the female respondents. The responses of males to this statement are located in Table A-7A. The degree of agreement to this statement increased with increases in educational level. 25% of those with high school agreed with the statement, 33.3% of those with CEGEP agreed with the statement and 38.5% of those with a university education agreed.

An examination of attitudes for males to the statement that the staff should be dressed distinctly yielded no clear correlation with educational level. The data for this statement is displayed in Table A-8A of the appendix. 25% of those with high school agreed with the statement, while none of those with CEGEP did and 15.4% of those with a university

education did. Although a relationship is not clear, those with a university education agree less than those with high school.

An examination of the responses of males to the statement indicating that the doctor should provide information so that the respondent could make decisions for himself again, as with the responses to the first statement, negatively correlates with increasing levels of education. The data collected in response to this statement is located in Table A-9A. 100% of the sample with a high school education agreed. This figure remains at 100% for those with CEGEP and drops to 76.9% for those with a university education.

When the responses of males to the statement that the doctor should make the decisions is examined, the degree of disagreement correlates positively with higher levels of education. Table A-10A in the appendix provides the data collected regarding males for this statement. 75% of those males with a high school level education disagreed with the statement; 100% of those with CEGEP disagreed and 84.6% of those with a university education disagreed. If the single post graduate respondent is added to the university level respondents, the degree of disagreement rises to 85%. Although there is an increase in the percentage of respondents who disagreed for those with a CEGEP education, the number drops for those with university. Those with a university education still disagreed to a significant extent

when compared to those with high school.

It would appear from the above that for males a clear pattern does not emerge concerning an increase in education and a desire for less authoritarian treatment with the response to two of the four statements correlating negatively and two correlating positively. It would appear that for women, a university level education is more related to a negative attitude towards being treated in an authoritative manner by their source of health care. Perhaps this is due to women having experienced this authoritative attitude more so than men and when they do attain the realization that they do not have to accept this manner of treatment, they respond more negatively to it. Following this logic, for males who have not experienced an authoritative attitude on the part of their physicians, the catalyst of a university education leading to a greater degree of independent thought would not affect them as strongly in this particular regard.

When examining the data in response to the question inquiring as to the receiving of a prescription for a psychotropic drug, the findings clearly did not support those found within the literature. More male respondents in this sample had received prescriptions than female.

19.7% (27) of the total sample responded that they had received a prescription for a drug of this class. 18.8% (18) of females in the sample had received prescriptions and 22.22% of the males had. This difference was not found to be

significant however, based on the results of a T-test. This is in direct contrast with the results of studies discussed in the literature where women received more prescriptions than men. Dr. H.L. Lennard for example, quoted a 1967 study finding that women received twice as many prescriptions as men (Lennard, 1971: 36). A study discussed in a 1978 issue of the Gazette also found women taking twice as many of these drugs (Montreal Gazette, October 28, 1978).

One major factor which contributed to the data revealing that a greater percentage of males had received prescriptions than women was surmised by myself through observation at the clinic and was later confirmed by Dr. Tellier. Late in the evening a few men would arrive at the clinic for coffee and to talk to one another. I was informed that these men were psychiatric patients. These respondents would have undoubtedly been among those responding in the affirmative to having received some of these prescriptions. Head and Hands operates as the medical arm for a drug treatment program called Alternatives. In addition to this, psychiatric patients from a neighborhood treatment centre, who are also ex-psychiatric patients of Head and Hands, often dropped by. These factors would account for there being a disproportionate number of men receiving prescriptions.

When age was examined in relation to those who had received prescriptions, the results became very interesting. The data with regard to age, sex and having received a

prescription for a mood altering drug is presented in Table 8. For both males and females, the majority of those who had received prescriptions were over the age of 31. 50% (4) of the males were in this age group and 44.4% (8) of the females were. The majority of males in the total sample fall into this age group so this could account for the majority of those receiving prescriptions being in it. 47.2% (17) of the males fall into this age group. For females, the majority are between 19 and 25 years of age. 45.4% of the total female portion of the sample falls into this age group. Only 27.2% (27) of the female were over 31 years of age. This would support Ruth Cooperstock's finding that older women were the greatest recipients of these drugs (Cooperstock, 1971: 240). Another possible explanation however could be a flaw in the research tool. The question relating to the prescription did not set a time frame, thus the older a respondent is, the greater the opportunity they have had to receive a prescription.

TABLE 8

Percentage of those who responded affirmatively to having been prescribed a mood altering drug by age.

	Males	Females
Age:	%	%
16-18	25.	11.1
19-25	--	22.2
26-30	25.	22.2
31 +	50.	44.4
	(8)	(18)

When examining the origins of these prescriptions, all those respondents who had stated that they had received prescriptions but also responded when asked how frequently they came to Head and Hands, that it was their first visit or that they had only been there once or twice before, were eliminated from the data analysis. It was the prescribing patterns of Head and Hands which were of interest so including the sources for those respondents who were not regular users of Head and Hands services would bias the data. Upon discounting these cases, 8 female cases remained. 3 of these women had received their prescriptions from Head and Hands. 3 male respondents remained, none of whom had received their prescriptions from the centre. Due to the small size of the male group at this juncture however, this does not provide a very valid base for a comparison.

Dr. Tellier was asked if he felt there was a different approach taken at Head and hands regarding the treatment of emotional problems. He stated that there was a recognition that the prescribing of drugs to young people should be kept to a minimum. Since there are so many years ahead of them, there would be a danger of more and more drugs being prescribed. As Head and Hands orients itself to young people, this could suggest a general attitude towards prescribing over all. It is plausible that this attitude would spill over when seeing clients of other age groups.

With regard to the presence of children being related to an increase in psychological problems, this was not supported when examining the living arrangements of those who had received prescriptions. There appeared to be no relationship whatsoever. Tables providing the data for both living arrangements and the relationship between living arrangements and the rate of prescriptions is provided in tables A-11A and A-11B in the appendix. As an aside, when Dr. Tellier was asked for his thoughts on the issue of women receiving more tranquilizers than men in most research, he replied that he felt that the role occupied by females in modern society was more stressful than for men. He explained that when the average male in our society returns home after a stressful day, he has outlets to release the day's tensions. He may go jogging or whatever. For most women, the end of a stressful work day means making dinner and caring for a home and

children. According to Dr. Tellier, this logically leads to a greater amount of "burn out" among women.

An analysis of the responses given to the open ended questions in the questionnaire supported the contention that women view the approach taken towards clients at Head and Hands in a very positive way. The responses to the following four questions were examined: (9) If "yes" why didn't you go back this time? (this question followed one asking if the respondent had ever used any of a list of neighbourhood services such as a C.L.S.C.); (17) How would you describe the surroundings at Head and Hands? a) The waiting room (b) The receptionist (c) The nurses (d) The doctor (e) The counsellor or social worker (f) The lawyer (g) Other people you've had dealings with; (20) What do you think of the professional skills of the people you're seeing here, compared with other doctors, nurses, lawyers or social workers you have dealt with? and; (21) Other comments or suggestions. As this thesis primarily concerns itself with women and the approach taken at Head and Hands, it was the responses of female clients to the above questions which were of primary concern.

47 women responded to question 9 inquiring as to why they had not returned to the source of service they had previously used. 12 of these women (25.5%) clearly indicated that they had been dissatisfied with the personal treatment they had received elsewhere. One of these women remarked that it had

been due to there being no female gynecologist at the previous service. It is noteworthy that only 2 male respondents (10.5% of those responding to the question) indicated that they had been dissatisfied with the personal treatment they had received. It appears that either women are treated less well than men at these services or that their treatment was of greater concern to women. The following are some examples of the kinds of responses made by women indicating dissatisfaction in the way they were treated:

- Because I'd much rather come here. The way people deal with you here doesn't make you feel like a number.
- This time I need a lawyer but I prefer the care we get here when we see a doctor. They take the time to answer questions and inform you so I come here when I can.
- They don't care.
- I did not like it there. The people were very rude.

With regard to question 17 asking the respondent to describe the surroundings at Head and Hands, particular attention was paid to those answers given in response to (c) The nurses and (d) The doctors. The adjectives friendly and caring were used quite frequently by women. Several of the women also commented positively upon the communication between the nurses, doctors and patients. Below are examples of these comments:

- c) very informative and caring
- d) knowledgable, listens, understanding

- d) very good in explanations

- d) polite, helpful with important questions.

The responses provided by women to question 20 regarding the professional skills of the staff at Head and hands as compared to those encountered elsewhere were very telling. Many women tended to make note specifically of the good interpersonal skills of those who were dealing with them. This is interesting in that women were asked to comment upon the "professional skills" of those they were seeing not necessarily interpersonal skills. This could be taken as indicative of women placing an importance upon these skills, perhaps in part due to a lack of respect being encountered in their dealings with other services.

Of the 57 women responding to this question 18 (45.6%) specifically commented positively on the interpersonal skills of those they were dealing with at Head and Hands. What was also of interest was that when the age of the women making these comments was examined there appeared to be a positive correlation. 42.8% of those females between the ages of 16 - 18 commented positively, 42.3% of those between the ages 19 - 25 did so, 44.4% of those between the ages of 26 - 30 did so, and 53.3% of those women over the age of 31 commented positively. It would appear to be fair to conclude that the interpersonal skills of the staff at Head and Hands were not only appreciated by the women but were increasingly appreciated with age. Perhaps this is due in part to older

women having had more experience in dealing with other services than younger women. It was also observed that many women commented upon the amount of time spent with each of them at Head and Hands. The following provides an example of some of the responses of women to question 20:

- The people I have seen I find are very professional. They talk and answer questions that you ask so that you can understand them, instead of leaving mind boggled, you leave with a peace of mind. (19-25).

- Very good. I feel safe with them. To my story they listen carefully and you feel more at ease. (31 -).

- Very comparable professionally. Added attentiveness that one does not usually find at another institution. (19-25).

- The professional skills here are excellent - particularly on the level of interaction between patient and doctor or patient and nurse. (26-30).

With regard to the responses to question 21 asking for comments or suggestions it is noteworthy that 4 female respondents complained that the waiting time at Head and Hands was too long. This could be taken as indicative of the great demand for the centre's services. The following is an example of such a response:

- The only thing I dislike is the waiting time but it doesn't keep me from coming. I'd rather wait the extra time than be treated like a number.

As can be seen from the preceding analysis of the responses to the open ended questions the approach taken by Head and Hands in dealing with its clients is indeed attractive to women. It would appear that Head and Hands treats its clientele with an added degree of respect which

involves affording them greater time for the provision of information than can be found with other providers of similar services.

CHAPTER VI

Conclusion

Overall, many aspects of the hypothesis were supported. The majority of the users of Head and Hands are female and the majority of the medical services offered are used by females. Also, women of this population are typical of those in the literature in that they see a doctor twice as often as do males.

Although Head and Hands is youth oriented, the majority of women coming are between the ages of 19 and 25. When other age groups are combined, we find that 41.4% of the women coming are over 25 years of age. With regard to education, although the majority of women had high school education, a sizable representation had CEGEP and university level educations. It was hypothesized that if Head and Hands were viewed by women as an alternative source of services, Head and Hands would find itself attracting older and more educated women than it was targeting for. This aspect of the hypothesis was supported by the results. It was also hypothesized however that it would not only be women of limited financial resources frequenting the clinic. As the majority of women earn less than ten thousand dollars per year, this was not supported.

It was hypothesized that being able to see a physician of the same sex would be of great importance to women. This was proved overwhelmingly correct. Head and Hands offers this service. For males, this was not a major concern. Keeping in mind the findings of Candace West with regard to the

dynamics of a male physician - female patient relationship, it is not surprising that it should be more important to women to see a female physician. What would be of interest for further study would be to discover if those women who had had experience with a female physician were more adamant upon seeing a doctor of the same sex than those women who had only had experience with male physicians.

It was not found that women have more positive attitudes than men towards being treated in an authoritarian manner by a health service, but perhaps this is a reflection of the attitudes of those women opting to go to Head and Hands. A university education did correlate positively however for women with negative attitudes towards authoritarian treatment. This relationship did not appear to exist for men. Since there is a sizable representation of university educated women coming to Head and Hands, this could suggest that an informed, conscious choice was made in coming to the centre. These differences between educational groups were not found to be statistically significant however.

The data relating to the prescription of psychotropic drugs did not support the literature in that more men than women responded that they had received prescriptions. This could be due in part however to ex-psychiatric patients frequenting the clinic to visit as well as Head and Hands' connection with Alternatives.

An analysis of the responses to the open ended questions

in the questionnaire also supported aspects of the hypothesis. The responses indicated that women found the approach taken by Head and Hands to be appealing. It was also found that this was particularly true for older women.

Women particularly appreciate the time that the professionals at Head and Hands are willing to spend with them. This time allows women to have their question answered and for information to be provided to them. This sharing of information allows women to play a more active part in making decisions which concern their own health.

Overall it was felt that the contention of this thesis was supported in that Head and Hands does provide an alternative style while providing traditional treatment practices. Women are attracted by this approach as is shown by the representation at the clinic of a primarily female clientele, many of whom are over 25 years of age and are university educated. As the centre is consciously targeted towards no particular sex and considers its orientation to be aimed at local youth, it would appear that its informal, non-judgemental, humane approach is attracting more than just this group. This approach appears to be very attractive to women.

As is stated above, Head and Hands targets itself towards no particular sex but perhaps the approach taken at this clinic could be taken as a suggestion for those centres who do wish to target their services towards women, and who wish

to provide an alternative to more conventional systems.

Endnotes

1. A study was eventually conducted revealing devastating findings. Over two thousand healthy, pregnant women were given DES and told that they were taking a vitamin. With regard to efficacy, the drug proved to have no effect upon the rate of miscarriages. By 1972, however, the long-term side effects of the drug began to surface (Mendelsohn, R.S., 1981: 35).

2. At this juncture, let's examine what dangers and risks the Pill has been found to pose. In 1967, the FDA announced that the probability of a woman suffering from a clotting disease was seven to ten times greater for a woman on the Pill (Mintz, M., 1969: 21). The chance of clotting becomes increased in the legs, pelvis, lungs and brain. The peak danger time of clotting for a woman is preceding pregnancy. This is due to the increasing tendency of the blood to clot during pregnancy. A woman on the Pill is delivering once a month. Also there is an increase in blood supply to the pelvic vascular system, but for women on the Pill, there is no enlarging of the uterus to utilize the increase.

   In 1965, Dr. Sadusk, one of a group of London Physicians and D.A. Cahal, Britain's medical assessor for Britain's committee on safety of drugs, reported four times the amount of stroke related deaths in women between the ages of 15 and 45 on the pill (Mintz, M., 1969: 59). The Archives of Opthimology in 1965, warned of possible eye damage.

   The Pill is also capable of producing a stunt in the growth of young girls taking it. Other asundry side effects include nausea and vomiting, inter-menstrual bleeding, edema, varicose veins, tension and irritability, breast discomfort, acne, muscle cramps, emotional change and changing libido (Duffy and Wallace, 1969: 90).

   As examination of the research done on the Pill during the 1960's reveals very shoddy work at best. The Pill was released upon the market in 1965. An example of one such piece of research was that conducted by the Wright Committee. Set up in 1962, the Wright Committee came out with the conclusion that there was no relationship between the Pill and clotting. This was what was widely publicized as emerging from the committee. But there were three major factors the Committee recognized, making its statistics unreliable. 1) There was no documented well-collected proof of how many women were at risk.

2) They did not know how to consider women who had been on the pill less than one year and 3) It was acknowledged that many women on welfare were receiving the Pill and either giving them away or selling them. All leading to an unreliable sample. They suggested a further study. The FDA did not take up the suggestion and other areas of government never pressured them (Mintz, M., 1969: 49).

Searle pharmaceutical company was behind a study entitled "The 25 Month Club" (Mintz, M., 1969: 64). It claimed to be the solution to the Wright Committee's proposal. Dir Irwin C. Winter (Searle's Vice-president) presented the study. It was very favourable. It supported prior claims that Enovid was safe for long-term continuous use. On the surface, the study appears quite Credible. It consisted of 10,000 participating women. It was done with the knowledge of the FDA. Only eight of 5,000 developed thrombophlebitis. There were again several flaws in the research. First of all, there was no adequate control group and secondly, in order to be enroled in the program, a woman had to have been on Enovid for at least two years. Thus the study automatically eliminated the crucially important drop-outs who stopped using Enovid for whatever reasons. The vast majority of the cases which had precipitated the need for a conclusive study, had experienced problems within the first six months.

3. An interesting piece of information concerning the development of a male contraceptive can be found in an article in a 1982 issue of Chatelaine magazine by Ann Charney (Charney, A., 1982: 92). She states that when the world health organization had to drop one of its task forces due to lack of funds, it was the one dealing with male contraception.

4. Another step along the path of this particular research which again demonstrated questionable ethics, was performed by a Dr. R.G. Edwards (Corea, G., 1985: 104). Sperm cannot simply be added to an egg with a fertilized egg being the end result. The sperm requires "conditioning" first. This normally occurs in the genital tract of the female. So the research question to be answered before invitro fertilization could become a reality, was how to accomplish this and yet still have the fertilization occur outside of a woman's body. Dr. R.G. Edwards, in his attempt to solve this problem, created a porous chamber, placed the sperm inside it and then placed the chamber overnight inside women volunteers. Theoretically, secretions from the woman's womb would pass through the chamber "conditioning" the sperm, but without letting the sperm escape. In reality,

Dr. Edwards was not at all certain that the sperm would not escape and impregnate some of his volunteers! As the research progressed, childless couples who were in search of an answer to their infertility problems, became the objects of experimentation. The research in this area was not advanced enough and the odds of these couples actually being helped were very slim. The most they could realistically hope for was that they were contributing to research which would someday help future childless couples. Corea states however that most of these couples did not really understand this. They considered themselves as patients not experimental subjects. Corea states that there is evidence that the women in the English, Australian and American invitro fertilization programs did not understand the situation (Corea, G., 1985: 112). Corea quotes Kass as stating the inhumanity of this:

> There is a question whether the women were told that the surgery being performed on them would be applied to other infertile women in the future and not they themselves. If not then this false generation of hope is cruel and unethical (Corea, G., 1985: 112).

Edwards and Steptoe began human trials of invitro fertilization without following usual research procedure and performing the procedure on a large number of animals first. The safety of invitro fertilization had not been verified in primates before it was attempted on women. Corea states that before the birth of Louise Brown in 1978, the number of animal species and the total number of animals born following invitro fertilization and embryo transfer was extremely low: fewer than 200 rabbits, 200 mice and 50 rats (Corea, G., 1985: 114).

5. Gena Corea states fears reminiscent of Aldous Huxley's Brave New World when contemplating the possible future of invitro fertilization. Corea states that invitro fertilization makes the application of animal husbandry to human beings possible. Corea states that once the embryo is formed in the petri dish, there is no technical necessity for the embryo to go into the uterus of the woman who produced the egg. Corea states that this process could reduce women to breeders while a centralized group of white men control who is to be born (Corea, G., 1985: 123).

6. Ruth Cooperstock (Cooperstock, 1971: 240) found that age was a factor correlating with prescribing patterns. Older women were the greatest recipients of prescriptions and younger men were the lowest.

7. This prediction is based upon the findings of Esther Greenglass (Greenglass, Esther, 1982:213) who stated that the presence of children and whether or not a woman is married plays a significant role in indicating whether or not a woman is prone to psychopathology.

Bibliography

Canada Census - 1986

Charney, Ann "The Politics of Contraception" Chatelaine April1982.

The Citizen - "M.D. is Patronizing" April 8, 1978.

Cooperstock, Ruth "Some Factors Involved in the Increased Prescribing of Psychotropic Drugs" Social Aspects of the Medical Use of Psychotropic Drugs. House of Lund, Toronto 1974.

Cooperstock, Ruth "Sex Differences in the Use of Mood-Modifying Drugs: An Explanatory Model" Journal of Health and Social Behaviour volume 12, 1971.

Corea, Gena The Mother Machine: Reproductive Techniques from Aritificial Insemination to Artificial Wombs, New York, Harper & Row, 1985.

Corea, Gena The Hidden Malpractice William and Morrow Inc., New York 1977.

Djerassi, Carl The Politics of Contraception Norton & Co., London 1969.

Ehrenreich, Barbara and English, Deirdre Complaints and Disorders - The Sexual Politics of Sickness, The Feminist Press, New York 1973.

Frankfort, Ellen Vaginal Politics, Quadrangle Books Inc., New York 1972.

Globe and Mail - "Women at Home Taking More Pills" April 25, 1978.

Globe and Mail - "A better Way than Valium" May 29, 1978.

Greenglass, Esther A World of Difference - Gender Roles in Perspective, John Wiley & Sons, Toronto 1982.

Harrison, Michelle, M.D. A Woman In Residence: A Doctor's Personal and Professional Battles Against an Insensitive Medical System, Penguin Books, New York 1982.

Howard, Jan "Humanization and Dehumanization of Health Care" from Humanizing Health Care by Jan Howard and Anselm Strauss, John Wiley, New York 1975.

Lennane, K. Jean and Lennane R. John "Alleged Psychogenic

Disorders in Women - A Possible Manifestation of Sexual Prejudice" In New England Journal of Medicine 1973, page 288.

Lennard, H.L. Mystification and Drug Misuse Jossey-Bass Inc., San Francisco 1971.

Marcus, Barbara Nathan "Women's Health Care: who cares?" Concordia University Thesis, 1982.

Mintz, Morton The Pill: An Alarming Report Beacon Press, Boston 1969.

Mintz, Morton "The Pill and the Public's Right to Know" Child and Family volume II no. 2, 1972.

Mintz, Morton "Annals of Commerce: Selling the Pill" Washington Post February 8, 1976.

Nadelson, C.C. & Notman, M.T. The Woman Patient Plenum Press, New York, 1978

Riessman, Catherine Kohler "Medial Knowledge About Women: Beyond Bad Doctors" Contemporary Sociology volume 15, the A.S.A. 1986.

Ruzek, Sheryl Burt The Women's Health Movement - Feminist Alternatives to Medical Control. Praeger publishers, Praeger Special Studies, New York 1978.

Schwartz, Susan - "Passive Role Makes Women Sick" The Gazette October 24, 1978.

Scully, Diana Men who Control Women's Health Houghton Mifflin Co., Boston 1980.

Segal, R. "The Pill - An Ironic Liberation" Women, A Journal of Liberation.

Stage, Sarah Female Complaints W.W. Norton & Co., New York 1979.

Tuckett, David et al. Meeting Between Experts: An Approval to Sharing Ideas in Medical Consultations Tavistock, London, 1985.

Vaughan, Paul The pill on Trial Coward - McCann, New York (1970).

Vaughan, Paul "The Pill Turns Twenty" New York Times Magazine June 13, 1976.

West, Candace Routine Complications: Trouble with Talk Between Doctors and Patients. Indiana University Press, Bloomington, 1984.

APPENDICES

TABLE A-1

Percentage of clinic clients by use of service and sex.

	Males	Female
Service:	%	%
Lawyer	36.1	13.1
Doctor	27.8	59.8
Counsellor	19.4	9.3
Nurse	11.1	11.2
Info.	2.8	2.8
Job Bank	2.8	--
Tutor	--	2.8
Youth worker	--	.9
	100%	100%
	(36)	(107)*

* There were 99 female respondents to the questionnaire but this question allowed for multiple responses.

TABLE A-2

Percentage of clinic clients by age and sex.

	Males	Females
Age:	%	%
13-18	11.1	12.2
19-25	25.	45.9
26-30	16.6	14.3
31 +	47.2	27.5
	(100%)	(100%)
	(36)	(98)

TABLE A-3

Percentage of clinic clients by use of service and age.

Age:	13-18	19-25	26-30	31 +
Service:	%	%	%	%
Lawyer	--	3.6	10.	44.9
Doctor	55.6	75.	50.	24.5
Counsellor	11.1	5.4	25.	16.3
Nurse	22.2	12.5	15.	4.1
Info.	--	1.8	--	6.1
Job Bank	--	--	--	2.
Tutor	11.1	1.8	--	--
Youth worker	--	--	--	2.
	100%	100%	100%	100%
	(18)	(56)	(20)	(49)

Note: This question concerning use of service allowed for multiple responses.

TABLE A-4

Percentage of clinic clients by educational level and sex.

	Males	Females
Education:	%	%
Elementary	--	6.2
High School	22.2	36.1
CEGEP	27.7	22.7
VOC/TEC	5.5	3.1
University	38.8	25.8
Post-Grad	2.7	4.1
Other	2.7	2.1
	100%	100%
	(36)	(97)

TABLE A-5A

Percentage of male clinic clients by age and preferred sex of a physician.

Age:	13-18	19-25	36-30	31 +
Preference:	%	%	%	%
Males	75.	62.5	16.6	8.3
Females	25.	25.	33.3	25.
Either	--	12.5	50.	66.6
	100%	100%	100%	100%
	(4)	(8)	(6)	(12)

TABLE A-5B

Percentage of female clinic clients by age and preferred sex of a physician.

Age:	13-18	19-25	26-30	31 +
Preference:	%	%	%	%
Males	--	11.1	--	14.3
Females	75.1	66.6	84.6	42.8
Either	25.	22.2	15.4	42.8
	100%	100%	100%	100%
	(12)	(45)	(13)	(21)

TABLE A-6A

Percentage of male clinic clients by preferred sex of a physician and educational level.

	Elem	HS	CEGEP	VOC/TEC	Univ.	Post-Grad	Other
Preference:	%	%	%	%	%	%	%
Males	--	28.6	57.1	--	21.4	--	100
Females	--	42.8	14.3	--	28.6	--	--
Either	--	28.6	28.6	100	50.	--	--
	0	100%	100%	100%	100%	0	100%
		(7)	(7)	(1)	(14)		(1)

TABLE A-6B

Percentage of female clinic clients by preferred sex of a physician and educational level.

Preference:	Elem	HS	CEGEP	VOC/TEC	Univ.	Post-Grad	Other
	%	%	%	%	%	%	%
Males	--	9.3	18.2	50.	--	--	--
Females	60.	62.5	54.5	50.	78.3	50.	100
Either	40.	28.1	27.3	--	21.7	50.	--
	100%	100%	100%	100%	100%	100%	100%
	(5)	(32)	(22)	(2)	(23)	(4)	(2)

TABLE A-7A

Percentage of responses of male clinic clients to the statement:

"It's most important to me that a health centre looks business like".

by educational level

	Elem	HS	CEGEP	Univ.	VOC/TEC	Post-Grad	Other
Attitude:	%	%	%	%	%	%	%
Agree	--	25.	33.3	38.5	--	--	--
Disagree	--	62.5	66.6	46.1	50.	100	100
Don't know	--	12.5	--	15.4	50.	--	--
	0	100%	100%	100%	100%	100%	100%
		(8)	(9)	(13)	(2)	(1)	(1)

TABLE A-7B

Percentage of responses of female clinic clients to the statement:

"It's most important to me that a health centre looks business like".

by educational level

Attitude:	Elem	HS	CEGEP	Univ.	VOC/TEC	Post-Grad	Other
	%	%	%	%	%	%	%
Agree	16.6	26.5	20.	20.8	33.3	--	--
Disagree	66.6	64.7	80.	75.	66.6	75.	50.
Don't know	16.4	8.8	--	4.2	--	25.	50.
	100%	100%	100%	100%	100%	100%	100%
	(6)	(34)	(20)	(24)	(3)	(4)	(2)

TABLE A-8A

Percentage of responses of male clinic clients to the statement:

"I think you should be able to tell by the way they dress who the staff people are, and who the clients are in a health centre".

by educational level

	Elem	HS	CEGEP	Univ.	VOC/TEC	Post-Grad	Other
Attitude:	%	%	%	%	%	%	%
Agree	--	25.	--	15.4	50.	--	--
Disagree	--	62.5	87.5	76.9	50.	100	100
Don't know	--	12.5	12.5	7.7	--	--	--
	0	100%	100%	100%	100%	100%	100%
		(8)	(8)	(13)	(2)	(1)	(1)

TABLE A-8B

Percentage of responses of female clinic clients to the statement:

"I think you should be able to tell by the way they dress who the staff people are, and who the clients are in a health centre".

by educational level

Attitude:	Elem	HS	CEGEP	Univ.	VOC/TEC	Post-Grad	Other
	%	%	%	%	%	%	%
Agree	33.3	35.3	9.	12.	66.6	--	50.
Disagree	66.6	55.9	86.4	88.	33.3	100	50.
Don't know	--	88.2	4.5	--	--	--	--
	100%	100%	100%	100%	100%	100%	100%
	(6)	(34)	(22)	(25)	(3)	(4)	(2)

TABLE A-9A

Percentage of responses of male clinic clients to the statement:

"I want the doctor (or lawyer) to spend time explaining my situation so I can make decisions for myself".

by educational level

	Elem	HS	CEGEP	Univ.	VOC/TEC	Post-Grad	Other
Attitude:	%	%	%	%	%	%	%
Agree	--	100	100	76.9	100	100	--
Disagree	--	--	--	15.4	--	--	100
Don't know	--	--	--	7.4	--	--	--
	0	100%	100%	100%	100%	100%	100%
		(8)	(8)	(13)	(1)	(1)	(1)

TABLE A-9B

Percentage of responses of female clinic clients to the statement:

"I want the doctor (or lawyer) to spend time explaining my situation so I can make decisions for myself".

by educational level

Attitude:	Elem	HS	CEGEP	Univ.	VOC/TEC	Post-Grad	Other
	%	%	%	%	%	%	%
Agree	83.3	90.6	86.4	91.7	100	100	50.
Disagree	16.6	6.2	4.5	4.2	--	--	50.
Don't know	--	3.1	9.	4.2	--	--	--
	100%	100%	100%	100%	100%	100%	100%
	(6)	(32)	(22)	(24)	(3)	(4)	(2)

TABLE A-10A

Percentage of responses of male clinic clients to the statement:

"Since the doctor (or lawyer has the professional knowledge, he/she should make the decisions for me".

by educational level

	Elem	HS	CEGEP	Univ.	VOC/TEC	Post-Grad	Other
Attitude:	%	%	%	%	%	%	%
Agree	--	12.5	--	7.7	--	--	--
Disagree	--	75.	100	84.6	--	100	100
Don't know	--	12.4	--	7.7	100	--	--
	0	100%	100%	100%	100%	100%	100%
		(8)	(8)	(13)	(1)	(1)	(1)

TABLE A-10B

Percentage of responses of female clinic clients to the statement:

"Since the doctor (or lawyer has the professional knowledge, he/she should make the decisions for me".

by educational level

	Elem	HS	CEGEP	Univ.	VOC/TEC	Post-Grad	Other
Attitude:	%	%	%	%	%	%	%
Agree	--	16.1	14.3	8.3	33.3	--	50
Disagree	83.3	80.6	85.7	91.6	66.6	100	50
Don't know	16.6	3.2	--	--	--	--	--
	100%	100%	100%	100%	100%	100%	100%
	(6)	(31)	(21)	(24)	(3)	(4)	(2)

TABLE A-11A

Living Arrangements of clients by sex.

	Males	Females
	%	%
With parents	25.	24.2
Several friends	11.1	5.
Another adult + 1 or more children	5.5	5.
Foster Home, group home or shelter	2.7	2.
Alone	19.4	19.2
1 other person	30.5	36.4
Alone with 1 or more children	--	8.
No permanent home	5.5	--
	(36)	(99)

TABLE A-11B

Percentage of clinic clients having been prescribed a mood altering drug by living arrangements and sex.

	Males	Females
	%	%
With parents	25.	11.1
Several friends	12.5	--
Another adult + 1 or more children	--	11.1
Foster home, group home or shelter	12.5	5.5
Alone	25.	27.5
1 other person	12.5	38.8
Alone with 1 or more children	--	5.5
No permanent home	12.5	--
	(8)	(18)

head
&
hands inc.

services communautaires de n d g et environs
community services in west-end montreal

2304, av old orchard
481-0277

adresse postale / mailing address
c p / p o box 446
bureau de poste n d g post office
montreal, que H4A 3P8

PLEASE TAKE A FEW MINUTES TO HELP HEAD & HANDS ...

Would you please take a couple of minutes to answer this questionnaire? While there is no obligation on your part, the information that you provide will be a big help to us in our requests for funding.

It is particularly useful for us to know why people like you prefer to come to Head & Hands rather than to some other organization. We are also anxious to know what you like and what you don't like about our services, so that we may try to improve them.

So we're asking your help in assuring the continued survival of Head & Hands, as well as the quality of its services.

COMPLETELY CONFIDENTIAL

As you can see, neither your name nor any other identification appears on this questionnaire, nor should you sign it. We have taken all steps to keep the information you give us completely confidential.

Your completed questionnaire will be placed in the sealed box, which won't be opened till next week. So you can feel quite comfortable about answering all the questions anonymously.

Thank you so much for your help.

HEAD & HANDS

1. How did you first hear about Head & Hands? (please put a tick beside one of the following?)

( ) A friend recommended you.
( ) I picked up one of your leaflets at a booth.
( ) A teacher or guidance counsellor suggested I come here.
( ) I heard about you in school.
( ) A doctor or hospital referred me here.
( ) Passing by, saw your sign.
( ) Someone in another agency
( ) At Sunday in the Park.
( ) Other (please specify)_____.

2. Who did you come here to see today?

( ) Nurse ( ) Youth Worker ( ) Counsellor
( ) Lawyer ( ) Tutor ( ) For Information
( ) Doctor ( ) Job Bank ( ) For Food

3. ( ) This is my first time here.
( ) I come here every few months.
( ) I've been here once or twice before.
( ) I come here every week.
( ) I come here every few weeks.
( ) I've been coming here for years now.

4. In past visits I have <u>also</u> seen: (Tick none, one, or several)

( ) Nurse ( ) Doctor ( ) Counsellor
( ) Lawyer ( ) Youth Worker ( ) Receptionist

5. Why did you come to Head & Hands? (you may tick more than one)

( ) Convenient to get to.
( ) People are caring here.
( ) Convenient hours
( ) I trust the service I receive here.
( ) Confidentiality
( ) To see a particular doctor.
( ) Comfortable atmosphere.
( ) Has a service I can't get elsewhere.
( ) A free service I'd have to pay for elsewhere.
( ) Other_____
_____

6. Which district do you live in? (Please tick one of the following)

( ) NDG	( ) Cote St. Luc	( ) Ville St. Laurent
( ) Westmount	( ) Hampstead	( ) Town of Mt. Royal
( ) Montreal West	( ) Snowdon	( ) Ville St. Pierre
( ) Downtown	( ) West Island	( ) Chomedey
( ) Verdun	( ) Lachine	( ) Outremont
( ) Cote des Neiges	( ) St. Henri	( ) Pt. St. Charles
( ) La Salle		

7. Are there any of the following services in your neighborhood? (please tick <u>each</u> of the following questions)

	YES	NO	Don't Know
A CLSC?	( )	( )	( )
A medical centre?	( )	( )	( )
A hospital emergency department?	( )	( )	( )
A social service centre?	( )	( )	( )
A hospital out-patient department?	( )	( )	( )
A legal aid office?	( )	( )	( )

8. Have you ever used any? ( ) Yes ( ) No.
If "yes", which ones?

_____

9. If "yes" why didn't you go back this time?

_____

10. My age is between:

( ) 13 - 15	( ) 19 - 21	( ) 26 - 30	( ) 41 - 50
( ) 16 - 18	( ) 22 - 25	( ) 31 - 40	( ) Over 50

11. I am: ( ) Male ( ) Female

12. My living arrangements are:

( ) Live with my parents	( ) Live alone
( ) Live with several friends	( ) Live with one other person
( ) Live with another adult and one or more children	( ) Live alone with one or more children
( ) In foster home, group home, emergency shelter	( ) No permanent home

13. My work or school situation is:

( ) Now in high school ( ) CEGEP

( ) In University ( ) Vocational School

( ) Working full time ( ) Working part-time

( ) Not working at the moment ( ) Not at school at the moment

( ) On U.I.C. ( ) On welfare

14. The last year of school I completed was:

( ) Elementary ( ) High school

( ) CEGEP ( ) Vocational or tech.

( ) University ( ) Post-grad

( ) Didn't complete elementary ( ) Other_____

15. Last year I earned about:-
(If you're living as a couple, please estimate roughly what you both earned together)

Less than $10,000 ( ) $30,000 - $39,000 ( )

$10,000 - $19,000 ( ) $40,000 - $49,000 ( )

$20,000 - $29,000 ( ) More than $50,000 ( )

16. My three favorite radio stations are:-

1._____ 2._____ 3._____

If you have been to Head & Hands before, we would very much like to know what you think of the service you receive here. It's important to us to know what you don't like, as well as the good things -- so don't be shy to criticize. Remember, this is an anonymous questionnaire, so we won't know who you are.

17. How would you describe the surroundings at Head & Hands?

    a. The waiting room_____
    b. The receptionist _____
    c. The nurses_____
    d. The doctor_____
    e. The counsellor or social worker_____
    _____
    f. The lawyer_____
    g. Other people you've had dealings with_____
    _____

18. Is the time you have to spend in the waiting room before seeing someone too long ( ): about what you'd expected ( ): shorter than other places ( ) (please check one)

19. Do you find there is a little or a lot of forms and red tape here compared with other places you know about?_____

20. What do you think of the professional skills of the people you're seeing here, compared with other doctors, nurses, lawyers or social workers you have dealt with?_____
    _____
    _____
    _____

21. Other comments or suggestions_____
    _____
    _____
    _____

Please put a tick in either: "Agree", "Disagree", or the "Don't Know" column beside <u>each</u> of the following questions.

		AGREE	DISAGREE	DON'T KNOW
22.	Its most important to me that a health centre looks business like.	( )	( )	( )
23.	I think you should be able to tell by the way they dress who the staff people are, and who the clients are in a health centre.	( )	( )	( )
24.	If the doctor can just fix me up, most other things in my life will be pretty good.	( )	( )	( )
25.	It's important to me that I don't have to go through 2 or 3 people before being able to talk about my problems.	( )	( )	( )
26.	I want to be given lots of time here to talk about what's bothering me.	( )	( )	( )
27.	I would rather talk to a social worker who isn't too formal.	( )	( )	( )
28.	A health centre doesn't have to look businesslike as long as its comfortable and "homey" looking.	( )	( )	( )
29.	It's important to me to be able to see doctors, counsellors and lawyers all in one place.	( )	( )	( )
30.	I don't want my family to know that I'm coming here.	( )	( )	( )
31.	Social workers are busy people so I expect to have to make an appointment for some later date.	( )	( )	( )
32.	People come to Head and Hands because they have a lot of different problems in their lives all at once.	( )	( )	( )

		AGREE	DISAGREE	DON'T KNOW
33.	A person shouldn't have to give his/her name and address to a clinic if they don't want to.	( )	( )	( )
34.	I figure I'll have to talk to 3 or 4 people here before I get to someone who can help me with my problems.	( )	( )	( )
35.	I need help but I'm not sure what kind.	( )	( )	( )
36.	I want the doctor (or lawyer) to spend time explaining my situation so I can make decisions for myself.	( )	( )	( )
37.	Since the doctor (or lawyer) has the professional knowledge, he/she should make the decisions for me.	( )	( )	( )
38.	I expect to have to fill out a lot of forms before I can see a social worker.	( )	( )	( )

And ... would you please take a minute to answer these additional questions? We're doing this survey in co-operation with a researcher who is studying health care issues. Your answers to the following questions will be most helpful.

Thank you.

39. About how many times a year would you say that you visit a doctor? (not including visits made during pregnancy)

About_____ times a year.

40. Do you prefer to see a male or a female doctor?

Male( ) Female( )

41. When you come to Head and Hands are you usually seen by a male or a female doctor?

Male ( ) Female( ) Not Applicable ( )

42. Have you ever been <u>prescribed</u> any of the following mood altering drugs:

___ Valium
___ Diazipan
___ Ativan
___ Dalmane
___ Protenzin
___ Amytal
___ Chloropromazine
___ Elavil
___ Equanil
___ Librax
___ surmontil
___ Don't know name
___ Mellaril
___ Meprobamate
___ Phenobarbital
___ Seconal
___ Serax
___ Stelazine
___ Thorazine
___ Tranzene
___ Vivol
___ Librium
___ imipramine
___ other (please specify)_____

43. If you answered YES to any of the above, who gave you your prescription?

My family doctor ( ) A hospital clinic ( )
A Medical Centre ( ) Heads & Hands ( )
A CLSC ( ) Other _____

AURIEZ-VOUS QUELQUES MINUTES POUR AIDER HEAD & HANDS?

Pendant que vous êtes dans la salle d'attente, pouvez-vous prendre quelques minutes pour répondre à ce questionnaire? Il n'y a aucune obligation de votre part mais les informations que vous pouvez nous apporter nous seraient d'une aide précieuse lors de notre prochaine sollicitation pour financement.

Il nous est utile de savoir pourquoi les gens comme vous préfèrent venir chez Head & Hands plutôt qu'un autre établissement. Nous voulons aussi savoir ce qui vous plaît et vous déplaît chez nous pour pouvoir améliorer la qualité de nos services.

Alors nous vous demandons votre aide pour réussir à assurer la survivance de Head & Hands ainsi que la qualité de ses services.

Comme vous pouvez le constater, ni votre nom, ni votre adresse n'apparaît sur le questionnaire. Vous n'avez pas besoin, non plus, de signer le questionnaire. Nous avons essayé de tout prévoir pour conserver l'anonymat total. De plus, le questionnaire, une fois rempli, sera déposé dans une boîte scellée qui ne sera ouverte que la semaine prochaine. Ainsi vous pouvez vous sentir à l'aise pour répondre aux questions. Personne ne saura qui vous êtes.

Head & Hands Inc.

Veuillez cocher la case appropriée

1. Où avez-vous entendu parler de Head & Hands, la première fois?

( ) Un(e) ami(e)
( ) J'ai vu un de vos feuillets dans un kiosque sur la santé.
( ) Un professeur ou un conseiller en orientation m'a conseillé de venir ici
( ) A l'école
( ) J'ai vu l'enseigne, en passant.
( ) Un docteur ou hôpital
( ) Dimanche au Soleil
( ) Dans une autre agence
( ) Autres (précisez) _____

2. Qui êtes-vous venu(e) voir aujourd'hui?

( ) Infirmière
( ) Avocat(e)
( ) Médecin
( ) Pour de la nourriture
( ) Travailleur(euse) Jeunesse
( ) Tuteur(trice)
( ) Centre d'emploi
( ) Conseiller(ère) pour des informations

3. ( ) Ceci est ma première visite.
( ) Je suis déjà venu(e) une ou deux fois.
( ) Je viens à toutes les quelques semaines.
( ) Je viens régulièrement à toutes les semaines.
( ) Je viens à tous les quelques mois
( ) Je viens chez Head & Hands depuis des années.

4. Lors d'autres visites, j'ai <u>aussi</u> rencontré (cochez une ou plusieurs cases si approprié)

( ) Infirmière
( ) Avocat
( ) Médecin
( ) Travailleur Jeunesse
( ) Conseiller(ère)
( ) Réceptioniste

5. Pourquoi êtes-vous venu(e) chez Head & Hands (vous pouvez cocher plus d'une case).

( ) C'est près de chez moi
( ) Les heures d'ouverture me conviennent
( ) L'atmosphère est confortable
( ) Le caractère confidentiel
( ) Les gens s'occupent vraiment de vous.
( ) J'ai confiance en la qualité des services.
( ) Pour voir un docteur en particulier
( ) Donne un service que je ne peux retrouver ailleurs.
( ) Donne gratuitement un service pour lequel je devrais payer ailleurs.
( ) Autres _____

6. Quelle région habitez-vous?

( ) N.D.G.	( ) Côte St. Luc	( ) Ville St. Laurent
( ) Westmount	( ) Hampstead	( ) Ville Mont-Royal
( ) Montréal-Ouest	( ) Snowdon	( ) Ville St. Pierre
( ) Centre Ville	( ) West Island	( ) Chomedey
( ) Verdun	( ) Lachine	( ) Outremont
( ) Cote-des-Neiges	( ) St. Henri	( ) Pte-St.-Charles
( ) Ville LaSalle		

7. Les services suivants existent-ils dans votre quartier? (S.V.P. cocher pour chacune des questions)

	OUI	NON	NE SAIS PAS
C.L.S.C.	( )	( )	( )
Centre Médical	( )	( )	( )
Service d'urgence (Hôpital)	( )	( )	( )
Centre de service social	( )	( )	( )
Clinique externe (Hôpital)	( )	( )	( )
Bureau d'aide juridique	( )	( )	( )

8. Avez-vous déjà utilisé certains de ces services?

( ) Oui ( ) Non

Si oui, lesquels_____

9. Si vous avez répondu oui à la question 8, pourquoi n'êtes vous pas retourné(e) à ce service aujourd'hui?

_____

10. Quel âge avez-vous?

( ) 13 - 15	( ) 19 - 20	( ) 26 - 30	( ) 41 - 50
( ) 16 - 18	( ) 22 - 25	( ) 31 - 40	( ) Over 50

11. Vous êtes:

( ) homme ( ) femme

12. Quel est votre mode d'habitation?

( ) J'habite chez mes parents
( ) J'habite avec plusieurs ami(e)s
( ) J'habite seul(e)
( ) J'habite avec un(e) autre adulte et un ou plusieurs enfants
( ) J'habite avec une autre personne
( ) J'habite seul(e) avec un ou plusieurs enfants
( ) J'habite dans un foyer de groupe, un foyer d'adoption, une auberge de transition.
( ) Pas d'adresse permanente

13. Quelle est votre situation scolaire ou de travail?

( ) Présentement à l'école secondaire	( ) Au CEGEP
( ) A l'université	( ) A l'école d'art et métier
( ) Travaille à temps plein	( ) Travaille à temps partiel
( ) Ne travaille pas pour l'instant	( ) Je n'étudie pas présentement
( ) Reçoit de l'assurance chômage	( ) Reçoit du Bien-être social

14. Ma dernière année d'éducation est:

Elémentaire ( )	Ecole Secondaire ( )
CEGEP ( )	Formation Professionnelle ou technique(
Université ( )	Etude de second Cycle ( )
N'ai pas complété l'élémentaire ( )	Autres_____

15. Mon salaire de l'année dernière :
(Si vous faite partie d'un couple; s'il vous plaît estimez le salaire total)

Moins de $10,000 ( )	$30,000 - $39,000 ( )
$10,000 - $19,000 ( )	$40,000 - $49,000 ( )
$20,000 - $29,000 ( )	Plus de $50,000 ( )

16. Mes stations de radio favorites sonts

1._____ 2._____ 3._____

Si vous avez déja visité Head & Hands, nous aimerions connaître votre opinion sur les services offerts. Il est nous de connaître tant vos critiques négatives que positives.

Nous voulons vous rappeler encore une fois que ce questionnaire est anonyme. Alors soyez sans crainte!

17. Comment décririez-vous l'apparence de Head & Hands?

La salle d'attente_____

Que diriez-vous des gens et de leur façon d'agir envers vous?

La réceptionniste _____

Les infirmières_____

Les médecins _____

Les conseillers ou travailleurs sociaux_____

_____

Les avocat(e)s_____

Les autres (précisez)_____

18. Le temps que vous avez dû passer dans la salle d'attente, vous a-t-il semblé:

trop long( ). à peu près ce à quoi vous vous attendiez ( ).

plus court qu'ailleurs ( ).

19. Trouvez-vous qu'il y a beaucoup de bureaucratie et paperasserie chez Head & Hands comparé à ailleurs?_____

_____

20. Que pensez-vous de la compétence des gens que vous avez rencontrés par rapport à ceux que vous avez vu _____

_____

_____

21. Si nous n'avons pas couvert un aspect dont vous désirez parler, n'hésitez pas à inscrire vos commentaires._____

_____

_____

_____

Veuillez cocher soit D'ACCORD, PAS D'ACCORD, NE SAIS PAS, pour chacune des questions suivantes.

		D'accord	Pas D'accord	Ne sais pas
22.	Il est très important pour moi qu'un centre de santé ait une apparence professionnelle.	( )	( )	( )
23.	Les employé (es) devraient s'habiller de sorte qu'on puisse savoir qui sont les employés et qui sont les clients.	( )	( )	( )
24.	Si le médecin peut m'aider le reste de ma vie sera assez bien.	( )	( )	( )
25.	Il est important que je n'aie pas à passer par 2 ou 3 personnes avant que je puisse parler de mon problème.	( )	( )	( )
26.	Je veux qu'on m'accorde beaucoup de temps pour pouvoir parler de mes problèmes.	( )	( )	( )
27.	Je préfère parler à un(e) travailleur(euse) social(e) qui n'est pas trop solennel(le).	( )	( )	( )
28.	Un centre de santé n'a pas besoin d'avoir une allure professionnelle si on y est à l'aise et que c'est accueillant.	( )	( )	( )
29.	Je ne veux pas que ma famille sache que je suis venu(e) ici.	( )	( )	( )
30.	Il m'est important de pouvoir consulter les médecins, conseillers et avocats dans un même endroit.	( )	( )	( )
31.	Les travailleurs(euses) sociaux sont des gens occupé(e)s alors je m'attends à être obligé(e) de prendre rendez-vous pour un autre jour.	( )	( )	( )