Why do women predominate as enquirers into health information?

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Additional Information:

- A Master’s Dissertation, submitted in partial fulfilment of the requirements for the award of Master of Arts degree of Loughborough University.

Metadata Record: [https://dspace.lboro.ac.uk/2134/10331](https://dspace.lboro.ac.uk/2134/10331)

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Why Do Women Predominate as Enquirers into Health Information?

by

Rachel A. Blackmore

A Master's Dissertation, submitted in partial fulfilment of the requirements for the award of the Master of Arts degree of the Loughborough University of Technology

September, 1991

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Department of Library and Information Studies

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ACKNOWLEDGEMENTS

Firstly, I would like to thank Hilary Dyer for supervising my dissertation.

I would also like to thank the staff of the Health Information Service at Lister Hospital, Stevenage, especially Sally Knight for her suggestions and comments. My thanks also go to the members of the Portsmouth City Band, the staff at the Health Centre, Loughborough; and to the staff at the Health Information Centre, Loughborough, for allowing me to conduct my field work on their premises.

Lastly, I would like to express my gratitude to my family for their constant support and assistance throughout my academic career.
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iv</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>1. BACKGROUND</td>
<td></td>
</tr>
<tr>
<td>1.1 Gender Differences in Health Outlook:</td>
<td>2</td>
</tr>
<tr>
<td>A Historical Perspective</td>
<td></td>
</tr>
<tr>
<td>1.2 Gender Differences in the Healing Role:</td>
<td>5</td>
</tr>
<tr>
<td>A Historical Perspective</td>
<td></td>
</tr>
<tr>
<td>1.3 Women and their Social Roles</td>
<td>7</td>
</tr>
<tr>
<td>1.3.1 Women as Carers</td>
<td>10</td>
</tr>
<tr>
<td>1.4 The Health Belief Model</td>
<td>11</td>
</tr>
<tr>
<td>2. WOMEN AND IMAGES OF HEALTH</td>
<td>18</td>
</tr>
<tr>
<td>2.1 Medicalisation of Women</td>
<td>18</td>
</tr>
<tr>
<td>2.2 Sick Roles and Gender</td>
<td>20</td>
</tr>
<tr>
<td>2.3 The Media and Images of Health</td>
<td>24</td>
</tr>
<tr>
<td>2.4 Medical Advertising and Images of Health</td>
<td>27</td>
</tr>
<tr>
<td>3. THE DOCTOR-PATIENT RELATIONSHIP</td>
<td>32</td>
</tr>
<tr>
<td>3.1 Introduction</td>
<td>32</td>
</tr>
<tr>
<td>3.2 Doctor-patient Communication</td>
<td>34</td>
</tr>
<tr>
<td>3.3 Social Class and Doctor-patient Communication</td>
<td>36</td>
</tr>
<tr>
<td>3.4 Gender and the Doctor-patient Relationship</td>
<td>37</td>
</tr>
<tr>
<td>3.5 Doctor Gender and their Attitudes Towards Medical Care</td>
<td>40</td>
</tr>
<tr>
<td>3.6 Patient Perceptions of Male and Female Doctors</td>
<td>42</td>
</tr>
<tr>
<td>3.7 Same-sex Versus Opposite-sex Doctor-patient Consultations</td>
<td>43</td>
</tr>
<tr>
<td>4. THE SURVEY</td>
<td>50</td>
</tr>
<tr>
<td>4.1 Introduction</td>
<td>50</td>
</tr>
<tr>
<td>4.2 Objectives of the Survey</td>
<td>50</td>
</tr>
<tr>
<td>4.3 The Limitations of this Survey</td>
<td>51</td>
</tr>
<tr>
<td>4.4 Methodology</td>
<td>52</td>
</tr>
<tr>
<td>4.4.1 Location</td>
<td>52</td>
</tr>
<tr>
<td>4.4.2 Method of Survey</td>
<td>52</td>
</tr>
<tr>
<td>4.4.3 The Sample</td>
<td>54</td>
</tr>
<tr>
<td>4.5 Explanation of Methodology</td>
<td>54</td>
</tr>
</tbody>
</table>
5. SURVEY RESULTS

5.1 The Sample
5.2 General State of Health
5.3 Importance attached to one's Health
5.4 Health Information Sources
5.5 Where the Most Health Information is Gained
5.6 The Type of Health Information Looked for
5.7 Reasons for Visiting the Health Centre
5.7.1 Reasons for Visiting the Health Information Centre
5.8 Do You Ever Visit Your Doctor?
5.9 Satisfaction with Doctor's Explanation of the Problem
5.10 Seeking Health Information on Someone Else's Behalf
5.10.1 Portsmouth Respondents
5.10.2 Health Centre Respondents
5.10.3 Health Information Centre Respondents
5.11 Those who were Making Enquiries for Themselves
5.11.1 Health Centre Respondents
5.11.2 Health Information Centre Respondents
5.12 Those for whom Health Enquiries are Most Often Made
5.12.1 Portsmouth Respondents
5.12.2 Health Centre Respondents
5.12.3 Health Information Centre Respondents
5.13 Convenience in Visiting a Doctor
5.14 Preference for Doctor of the Same Sex
5.15 Initial Confidant for Health Matters
5.16 Life Threatening or Disabling Illness
5.17 Social Role Stresses
5.18 Concern with Appearance
5.19 Patients' Rights to Information
5.20 Agreement/Disagreement to Patients' Freedom to Make Decisions about their Treatment
5.21 Social Role of Women

6. DISCUSSION

6.1 Gender and Perceptions of Health
6.2 Health Information Sources
6.3 Initial Confidant for Health Matters
6.4 The Type of Health Information Looked For
6.5 Reasons for Visiting the Health Centre
6.5.1 Reasons for Visiting the Health Information Centre
6.6 Attitudes Towards Health-Care Providers
6.6.1 Satisfaction with Doctors' Explanations
6.6.2 Preference for a Doctor of the Same Sex
6.6.3 Convenience in Visiting a Doctor
6.7 Seeking Information on Someone Else's Behalf
6.7.1 Those for Whom Health Enquiries are Most Often Made
6.8 Those Who are Making Enquiries for Themselves
6.9 Life Threatening or Disabling Illness
6.10 Social Role Stresses
6.11 Concern with Appearance
6.12 Patients' Right to Information
6.13 Patients' Freedom to Make Decisions About Their Treatment
6.14 Social Roles of Women
6.15 Social Acceptability of Women to Admit Weakness
7. CONCLUSIONS AND RECOMMENDATIONS

7.1 General Conclusion
7.2 Specific Conclusions Arising from the Survey
7.3 Recommendations

BIBLIOGRAPHY

APPENDICES

Appendix 1: Pilot Study Questionnaire
Appendix 2: Portsmouth City Band Questionnaire
Appendix 3: Health Centre Questionnaire
Appendix 4: Health Information Centre Questionnaire

(iii)
ABSTRACT

The aim of the study is to investigate why women predominate as enquirers into health information. A literature-based discussion followed by a questionnaire survey are the methods chosen for the investigation.

The literature review presents the main areas of contention as perceived by the researcher, whilst the survey attempts to test these theories further. Although much of the data collected were subjective in nature they provided a broad overview of some of the opinions and attitudes which cause women to predominate as enquirers into health information.

It is recommended that further research be undertaken, particularly into how gender affects the doctor-patient relationship and how the medical profession could provide women with greater freedom of choice in their medical care. Finally, it is concluded that if better health care facilities and health information services are to be developed, it is necessary to understand fully why women constitute the majority of clients for health information.
The question 'why do women predominate as enquirers into health information' brings forth a multitude of answers. It is an issue which has been relatively ignored in Britain, though it has received slightly more attention in the United States. In particular, the research that has taken place has been primarily conducted by female researchers, most of whom would advocate a change in women's position in society. The lack of research carried out demonstrates how, generally, less importance is attached to issues primarily of concern to women, than to men.

The growth in consumerism in everyday life which has taken place, particularly in the 1980s, has led to a greater call for consumer information. One of the affects of this upon health care services has been an increase in demand for consumer health information. If developing health information services are to prove effective and fulfil their potential, it is necessary first to understand the nature and demands of their clientele. Since women constitute the majority of health enquirers it is important to establish why this is so and the implications which this has for health information services.

This dissertation set out, therefore, to answer, as fully as possible, the question which it posed. By discussing various research studies which have focused on different aspects of women and their health care it was hoped a coherent theory/argument could be constructed. In addition, a survey was conducted in order to test the main hypotheses presented. Much of the data gathered was qualitative in nature. However, it must be stressed that a study of this kind is necessarily subjective. The researcher would suggest though, that subjective data ought not to be treated in a demeaning manner, as subjective attitudes, opinions, and feelings directly influence our actions and behaviour and consequently are an integral part of why women predominate as enquirers into health information.
CHAPTER ONE - BACKGROUND

1.1 GENDER DIFFERENCES IN HEALTH OUTLOOK:
A Historical Perspective

The view that women are 'sick' or defective versions of men, is as old as Eden. Traditionally in Western thought man is representative of wholeness, strength and health whilst woman is a 'misbegotten male', weak and incomplete. "(1)

Through human history women's bodies have been treated as especially threatening to the moral and social stability of society. (2)

Historically, medical science has significantly contributed to sexist ideology by creating the image of women as sick and as potentially sickening to men. (3)

Late 18th century medical commentators were convinced that women were distinct from men because of their anatomy and physiology. Women, it was believed, had a childlike sensibility and were more prone to their passions and emotions than men. This was due to "the great mobility of their fibres, especially those in the uterus; hence their irritability and suffering from vapours." (4)

The prevailing medical theories of the 19th century viewed individuals as having a predetermined amount of energy and vitality. (5) Middle and upper class women were encouraged to concentrate all their energy on their reproductive organs. Any mental stimulation, therefore, would necessarily jeopardize their reproductive capacities. Conversely, since women were primarily reproductive beings, the medical profession tended to view any illness as a result of malfunctioning of one or another of their reproductive organs, often requiring its removal. A woman was viewed as the "product and prisoner of her reproductive system - any imbalance, exhaustion, infection, or other disorders of the reproductive organs could cause pathological reactions in parts of the body seemingly remote." (6)
Affluent women were perceived as inherently sick and were confined to the gentlest of pastimes because of their delicacy. Working class women, however, who spent their lives labouring inside and outside the home, were believed to be inherently healthy and robust. The medical profession ignored the fact that working class women in fact suffered the worst health and advocated that the genteel civilized middle and upper class lifestyles were more health-threatening. In a time of fierce competition for patients amongst the medical profession upper middle class women were the ideal patient: "her illnesses - and her husband's bank account - seemed almost inexhaustible".

Menstrual taboos which serve to protect males from female 'impunity' have long been almost universal in human cultures. From the early 19th Century the functioning of menstruation drew unprecedented medical attention. George Man Burrows in his 'Commentary on Insanity' (1828) stated that "any aberration in the menstrual flow ... must inevitably create an equivalent form of mental disorder." Similarly, strong emotions were likely to cause abnormalities in the menstrual flow which could lead to insanity and death.

Medical advertising in newspapers was specifically targeted for female consumption. They contained lengthy preambles and 'medical' justifications that reinforced the contemporary beliefs of female weakness and delicacy. Men were perceived as capable of exerting self-control over the forces of their bodies while women were totally unable to control theirs. Locock, famous physician to Queen Victoria, claimed that the proper 'performance' of menstrual periods needed to be a constant focus of attention both for the woman and her doctor. Medical surveillance was required, therefore, even under normal circumstances which gives us some idea of the amount of medical intervention middle class Victorian women were subjected to.
The cult of 'female invalidism', a result of the boredom and confinement of affluent women, began in the mid 19th Century. Not only were women inundated with medical advertisements in newspapers but there also began in the 1850's the production of popular home readers by doctors on the subject of female health. Much of the literature emphasized the romantic pathos of illness and death.

It was acceptable, even fashionable, to retire to bed with 'sick headaches', 'nerves' and a host of other mysterious ailments.

TB, an illness mainly suffered by women became surrounded by a romantic myth of the female consumptive. In particular, delicate, pale, porcelain like skin fitted the ideal of the genteel English rose. Men suffering from TB were associated with effeminate imagery.

Not only were women seen as sickly - sickness was seen as feminine.

Doctor S Weir Mitchell stated that "the man who does not know sick women does not know women." In a work entitled 'Concerning the physiological and intellectual weakness of women', the German scientist P. Moebius wrote:

If we wish women to fulfil the task of motherhood ... she cannot possess a masculine brain. If the feminine abilities were developed to the same degree as those of the male her material organs would suffer and we should have before us a repulsive and useless hybrid.

The history of hysteria clearly expresses the subordination of women by medical science and the belief that women had to be regulated in the interests of social order. Foucault (1979) has argued that the female body experienced a major medicalisation during the 18th and 19th centuries. Hysteria was viewed as the result of malfunctioning of the womb and, therefore, an illness peculiar to women. The belief in the physical basis of hysteria is demonstrated by its treatment in the mid 19th Century which often involved the performance of a hysterectomy. For many women the hysterical fit was the only means of an outlet of rage and even of energy. Although some
writers have considered hysteria an act of rebellion, it ultimately led to greater subordination of women as doctors believed it confirmed their view of women as irrational, unpredictable and therefore dangerous. (19)

It is clear that during the 20th Century the Victorian belief in the physical weakness of women has waned but it has gradually been replaced by an emphasis on their psychological weakness. The advent of psycho-analysis and Freud's studies on women meant female sexuality has remained misunderstood and misinterpreted throughout the 20th Century. (20) Instead of sexual surgery, the far more subtle medical 'treatment' of women for their sexuality and restlessness became their assignment to neurotic immaturity and psychoanalysis. Today it is psychiatry, much more than gynaecology, that maintains sexist ideology of "the fundamental defectiveness of women." (21)

The medical view of women has not really shifted from 'sick' to 'well'; it has shifted from 'physically sick' to 'mentally ill'. (22)

1.2 Gender differences in the healing role: a historical perspective

"Women have always been healers." (23) Today, however, health care is almost exclusively the property of male professionals. The myth has often been fostered that male professionals won out due to their greater understanding and development of technology which consequently meant that (male) science replaced (female) superstition and 'old wives tales'. (24)

Witches lived and were burned long before the advent of modern medical technology. They were often the only healers available to the peasant population. It has been argued that the suppression of female witches should be seen as part of the history of the exclusion of women from medical practice. (25) Women healers were labelled as suspect as a consequence of the witch-hunt craze.
In the 13th and 14th centuries, whilst the witch-hunts were taking place in Europe a new male medical profession was being created under the protection of the ruling classes and the Church.

Male upper class healing under the auspices of the Church was acceptable, female healing as part of a peasant subculture was not.²⁶

Witches were, in particular, accused of possessing obstetric skills and there was a strong association of the witch and the midwife: "No one does more harm to the Catholic Church than midwives" wrote witch hunters Kramer and Sprenger²⁷ Consequently, attempts were made to make inroads into mid-wifery, though this occurred at a later stage during the 17th and 18th Centuries.²⁶

Women attempted to provide a professional structure for midwifery but were thwarted at every stage. For example in 1616 the midwives of London petitioned James I for the creation of a society for the development of midwifery but the opposition of the Royal College of Physicians meant the attempt to professionalise midwifery failed.²⁶ By the end of the 19th century the male doctors had successfully imposed a professional control over midwifery on their terms and prevented professional competition from a group dominated by women.²⁶

Additionally, as women were meant to concentrate all their efforts on their reproductive role and avoid any mental stimulation women were barred from entering further education on health grounds. The only avenue open for women into the working world of health care was nursing. During the era of Florence Nightingale, nursing became the domain of the middle and upper class lady. It became envisaged as a "natural vocation for woman, second only to motherhood."³¹ Victor Robinson argued that "woman is an instinctive nurse, taught by Mother Nature."³² Training of the nurses emphasized the necessary way for them to behave rather than the skills needed.

The finished product ... was simply the ideal lady, transplanted from home to hospital, and absolved of reproductive responsibilities.³³
Curing remained the domain of the (male) doctor and was given much greater status and scientific mystic than that of caring which became the woman's domain. Women are still viewed as the carers today both within the medical profession and the private sphere of the home. Medical ideology, therefore, has been successful in two ways. By constructing an image of female delicacy and irrationality women have been excluded as medical practitioners while at the same time qualifying as the typical patient.

1.3 Women and Their Social Roles

It is somewhat paradoxical that despite their greater life-expectancy, women report more illness than men and make more visits to their doctor. It is commonly believed that a person's definitions and values regarding health and illness are socially determined and arise from different life experiences. Social and economic conditions have a major effect upon the patterns of disease and the rates of illness among women differ greatly with their different social conditions. An individual's conception of health and illness is influenced by his/her material condition. In particular, an individual's class position will affect the way in which they assume responsibility for their health and how they define health itself.

It has been argued that the lives many women lead - their position both in the home and in the workplace and the quality of their relationships - may lead to anxiety and depression. The lonely middle-aged housewife whose children have finally left home may feel she has little sense of her own identity or worth. Alternatively, studies have shown how working class women with small children suffer from social isolation and the low value put on their work. The research carried out by Brown and Harris in 1978 on working class women in London showed that five times as many working class women as middle class women were chronically depressed. Working class women were shown to suffer from more 'vulnerability factors' such as
unemployment, poor housing conditions and the presence of preschool children in the home. Additionally, feelings such as helplessness and low self-esteem were conducive to depression unless there was a social buffer, such as a close friend.\(^{(41)}\)

Inequalities in health are often equated with inequalities in standard of living. Different social classes experience differences in accessibility to medical care. Medical facilities in working class areas are often not of a standard found in middle class areas. Additionally, the time and money spent travelling to facilities may prove more costly to those from a lower social class. Members of ethnic minorities are over-represented in manual and working class occupations and they suffer many of the socio-economic disadvantages experienced by the lower classes. However, they also suffer from racism and a lack of services for their own particular needs. For example, facilities dealing with sickle cell anaemia are few and far between.\(^{(42)}\) Also poor communication as a result of cultural differences can lead to confusion.\(^{(43)}\)

Grove and Tudor (1973) confirmed the argument that housewives are more likely to suffer mental illness than unmarried women. They also showed that "the mental health of married women is considerably poorer than that of married men" (Grove W.R.). Marriage is more advantageous for men in reducing stress than it is for women. Grove and Tudor specifically pinpointed five causes for women's emotional problems; housework is unskilled and of low prestige; housewives have no other sources of gratification outside the family; working wives are discriminated in the job market and often have less satisfactory jobs - in addition they continue to perform most of the household chores; evidence suggests that women have a more negative image of themselves than men have of themselves; role expectations confronting women are generally unclear and diffuse leading to uncertainty and lack of control over their future.\(^{(44)}\)
Renne also found that divorced people, particularly women, were "consistently healthier, happier and less isolated than the unhappily married." Oakley has contested that:

> it is the case that many married women do feel unhappy with, or at least in, the situation in which they find themselves and much of this unhappiness goes uncounted in any statistics of health-care use.

Several studies have also investigated how the presence or absence of young children affects women's illness behaviour. Rivkin has shown that among unmarried women those with children are more likely to use medical services than those without children. Also, working women with children use services more, have fewer disability days and suffer more anxiety than those without children. Social class appears to have some bearing on how employment outside the home affects women's health. For instance, among women with children, paid employment seems to be associated with less illness for middle class women but more illness for working class women. Arber et al (1985) have concluded that:

> full-time work for young mothers may be detrimental for their health unless there are adequate financial resources to help with the burden of maintaining the multiple roles, of housewife, mother and employee, or until sexual division of labour in the home changes.

It seems clear that it is not working as such that adds a strain to women's health. Women in higher status jobs, for instance, have been found to suffer from less problems. Rather, it is the many stresses of relatively low status jobs, role expectations at work which include submissiveness and pliability, and heavy domestic burdens which can prove detrimental to women's well being. Waldron (1976) has provided data that suggests that as a group housewives are less likely to regard themselves as being 'in excellent health'.
1.3.1 Women as Carers

The sexual division of labour within the home has also meant that women often take on the role of carers. This has meant that most of the chronically sick and disabled, the mentally handicapped and the elderly are cared for not by paid workers but by women who feel morally bound to take on the role of informal carer.

The idea that women should be responsible for the health of others is not a new one. For instance, mothers were often blamed for the high infant mortality rate in the 19th Century. Much of the rhetoric used today in health education, particularly in the field of child health-care, is geared specifically towards mothers. Paternal responsibility effectively means maternal responsibility as women are encouraged, for example, to breast-feed, give up smoking and attend child-health clinics.

Graham (1985) argues that women's role as health carer within the family involves providing a warm, secure and clean environment to protect against danger and disease and a nutritional diet. Women are also responsible for making sure the home is a happy one, conducive to healthy development. Similarly, women are the ones who teach health care to the family and serve as mediators between the home and outside services.

*Their caring role places them at the interface between the family and the state, as the go-betweens linking the informal health-care system with the financial apparatus of the welfare state.*

It is the wife-mother, therefore, who as the principle carer within the family serves as the gate-keeper between the family and the outside world.
Women are often required to be knowledgeable about health in order to fulfil their role as health educator within the family. Additionally, the role of informal carer has meant that women often came into contact with medical services when they themselves are healthy. The social roles of women today generally carry with them low status and prestige and a sense of powerlessness. The possibility that many women may use sickness as an escape from these oppressing roles cannot be entirely ruled out.\(^{(55)}\)

1.4 The Health Belief Model

The original developers of the health belief model (Hochbaum, Kegeles, Leventhal and Rossenstock) were social psychologists who worked within the public health service. They were concerned primarily with establishing why people avoided preventive measures (e.g. immunizations) and health screenings despite these being provided at little or no cost.\(^{(56)}\)

The health belief model claims that an individual will not take action to avoid a disease unless the following conditions are satisfied:

1) the individual is psychologically ready to take action in relation to a health condition. The extent of readiness is determined by both the person's perceived likelihood of "susceptibility" to the particular illness, and by his/her perceptions of the likely "severity" of the consequences of contracting the disease;

2) the individual believes that the preventive measure is feasible and worthwhile when weighed against perceptions of physical, psychological, financial, and other costs or "barriers" involved in the action;
3) A "cue to action" must occur to trigger the appropriate health behavior; this cue can be either 'internal' (such as symptoms), or 'external' (such as magazine articles, a reminder from the doctor, or illness in the family).<sup>57</sup>

Becker and colleagues<sup>57</sup> revised the original version of the health belief model and added some important factors that they called "modifying and enabling factors." These included primarily the patients' attitudes toward care (including evaluation of health care providers and the treatment facility). Becker et al. were also responsible for adding the variable 'cue to action' to the original model. Additionally, they focused attention on health motivations which include concern about health matters and the individual's willingness to seek medical care (or to avoid it).

The locus of control construct, first introduced by Rotter<sup>55</sup>, describes two general types of beliefs. People with 'internal' locus of control believe that they are in control of their lives and that their decisions and actions shape outcomes. They believe, therefore, that they are responsible for their health and can avoid illness by taking care of themselves. People with 'external' locus of control tend to be fatalistic and feel powerless to influence events. The multidimensional health locus of control<sup>60</sup> has complicated the picture, however, by creating two types of externals; those that rely on fate or chance factors and those that rely on powerful others, such as health care professionals. Generally, it is argued that 'internals' are more likely to engage in positive health behaviour.<sup>61</sup> However, those 'externals' who have faith in powerful others such as health care professionals are just as likely (if not more likely) to conform to medication regimens.

Other factors have also been shown to explain decisions to use preventive health services. Various forms of social pressure can often stimulate an individual into taking appropriate health action. These factors "... can act indirectly by producing beliefs, or they can act directly on the person as a consequence of the socialization process or social group conformity."<sup>62</sup> 'Normative' pressure, which
is inherent in the cultural values available to the individual, can lead that person to make certain decisions. Gender roles can be a major impetus to the kind of preventive health care taken by an individual.

Other factors to be considered are socioeconomic position and education; the value the person places on health, and other situational circumstances, such as being married. Strong associations between socioeconomic status and preventive health behaviour have been shown to exist. Social groups differ both in terms of their norms regarding preventive health behaviour and in their ability to exert pressure to conform to these norms. High socioeconomic status groups norms, regarding preventive health behaviour, are more closely associated with the norms of the medical profession than the norms of low socioeconomic status groups. The approach adopted in the health belief model assumes that the general public as a whole defines health in the same way and that this definition corresponds with official medical definitions. However, Blaxter and Paterson have found that not only do individuals hold a wide variety of definitions according to their social and economic status but that lay definitions sometimes differ significantly from medical definitions.

Many of the criticisms of the health belief model are a result of its high level of abstraction. It is perhaps better described as "a conceptual framework for thinking about illness behaviour than as a 'model'." Furthermore, there has been little said about how much weight should be attached to the key variables which are themselves somewhat elusive. Finally, the major assumption of the health belief model that health beliefs precede and motivate health behaviour may be too limited as it is possible that the reverse may also be true.
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CHAPTER TWO - WOMEN AND IMAGES OF HEALTH

2.1 Medicalisation of Women

The majority of users of the health service are women. This can be partly explained by the fact that there are more women than men in the population and that women tend to be the lay carers and, therefore, more likely to come into contact with the medical profession. In addition, women are subject to 'medicalisation' in that they are treated as patients during natural physiological processes such as pregnancy and childbirth. Also, deviant behaviour in a woman is more likely to be interpreted in medical rather than criminal terms. As already discussed, Foucault (1979) argued that it was the 18th and 19th centuries when major medicalisation of the female body first took place.

Women's reproductive capacity brings them into the medical orbit in a number of ways. During pregnancy and childbirth, a woman is in frequent contact with the health services. Also women are the most frequent users of fertility control and most female contraception techniques involve some degree of medical intervention. Consequently, women may visit their doctor when they are in fact healthy.

Women are dependent on the medical system for the most basic control over their own reproductivity.

Doctors have monopolised each sexual or reproductive right as soon as it was liberated; not only do they now control abortion but also most reliable means of contraception.

In a study carried out in the United States, Waldron (1983) found that visits for pregnancy, gynecologic exams and symptoms or diseases of the genitourinary system and breast accounted for 79% of the female excess of physician visits at ages 15-24, 60% at ages 25-44, and 31% at ages 45-64. A woman's 'need' for medical intervention is to some extent manufactured. For example, the way in...
which the medical profession deals with pregnancy in our culture, undoubtedly adds false anxieties about pregnancy which "can transform a minor discomfort into an urgent need for medical attention."<sup>3</sup>

Problems specifically suffered by women gain little attention in the medical curriculum taught to students unless they are related to pregnancy and childbirth. Female sexuality, for instance, is still inadequately taught despite all the 'recent discoveries'. Menopause, while no longer often resulting in terminal bed rest, is still described to medical students as "the most serious endocrinological disorder next to diabetes."<sup>10</sup>

The process of childbirth today is one of the most clear examples of the medicalisation of women. Childbirth takes place in hospitals because there are few alternatives. Obstetrics has been successful in creating a monopoly and medicalising a process which in other cultures and countries frequently takes place outside hospitals with little medical intervention. It is often argued that the increased use of technology in childbirth is the most significant factor in the decrease in mortality rate. This obscures, however, the immense importance of factors such as the vast improvements in the general standard of living which have taken place in the Western world. Additionally;

*Scientific evidence lends support to a view of childbirth as a normal 'natural' event that calls for medical intervention only under certain circumstances.*<sup>11</sup>

Despite this evidence, Oakley (1979, 1980) found that 41% of the women taking part in her research project had their labours either induced or accelerated with syntocinin; 52% had an instrumental delivery and 69% said that they did not feel in control of themselves and what was going on during the labour.<sup>12</sup> Other researchers have documented the same problems: mothers having to behave in a passive rather than active manner during childbirth; lack of information about the various obstetric techniques used, the high level of sometimes unnecessary technology; conflict between what the mothers feel and what staff tell them they should be feeling; and failure to
give the social and emotional aspects of childbirth as much attention as the physiological ones. It has been argued that childbirth practices today "systematically undermine the vision, understanding, and power of the childbearing woman."

The medicalisation of women has not only meant that they come into contact with the medical profession to a greater extent than men but has also led to a sense of powerlessness for women. Has that contact with the medical profession resulted in women themselves having a greater interest in their health than perhaps necessary? And/or do women feel they have little control over their own bodies and therefore, actively pursue information and knowledge to 'arm' themselves with? These questions are too subjective and complex to have only one answer but they may be representative of some important attitudes and opinions.

2.2 Sick roles and Gender

In the 1950's the sociologist Talcott Parsons first conceptualised the notion of the sick-role. His concern was to analyse the effect of the social structure on the general features of health. The sick person is regarded as not responsible for his/her illness. He/she is allowed to withdraw from normal social role obligations but is expected to seek competent help and comply with the medical recommendations. However, what Parsons failed to realise was that social and cultural norms often exert a far greater pressure than these theoretical sick-role expectations.

"The way in which we are sick is culturally defined" Whether we define a bodily experience as 'normal' or not varies greatly between individuals, between social groups, and between different countries.

It is crucial to recognise that whether or not people consult their doctors does not depend only upon the presence of disease but also upon how they ... respond to its symptoms
Cultural factors are immensely important to how individuals interpret various symptoms.

Often before a decision is made as to whether or not to visit a surgery an individual will discuss his/her symptoms with others. Freidson (1961, 1970) called this the 'lay referral system' whereby:

the whole process of seeking help involves a network of potential consultants from the intimate confines of the nuclear family through successively more select, distant and authoritative laymen until the 'professional' is reached.\(^{19}\)

It is the lay culture, not the values of professional medicine, which gives meaning to an illness in a social context.

Gender plays an important role in the way people behave when they are ill. The role of women in our society today is generally perceived to be a 'sick' one. There is a sense that to be a 'normal' woman is to be a neurotic human being.\(^{19}\) It has been argued that women are more likely than men to express their problems through anxiety, depression or other symptoms of illness.\(^{20}\) Generally, it is more culturally acceptable for women than for men to admit weakness and seek help, particularly if their problem is an emotional one. Consequently women, rather than men, may more readily take this kind of a problem to a doctor. Additionally, the 'vocabulary of illness' available may differ for men and women.\(^{21}\) In a culture which places greater emphasis on women verbalising their health problems the vocabularies of complaint may be more developed for women.

The fact that psychological weakness is often expected in women can affect a doctor's perceptions. Two doctors Jean and John Lennane (1973) have claimed that many common female disorders are explained away as psychogenic — as 'all in the mind'. This occurs even when there is a perfectly acceptable physical origin for the disorder.\(^{22}\) Additionally, MacIntyre and Oldman (1984) found very different responses from the medical profession to the common
complaint of migraine. They suggest that female sufferers from migraine are more likely to be treated as neurotic females whereas middle class male migraine sufferers are more likely to be diagnosed as suffering from exposure to a lot of stress and tension from demanding jobs.\(^{(23)}\)

Broverman et al. (1970) studied the influence of sex role stereotypes on the professional judgements of mental health. They found that among psychiatrists, psychologists and social workers concepts of mental health differed for men and women and also paralleled traditional sex role stereotypes. While their concept of a healthy adult, sex unspecified, did not differ from the concept of a healthy man, it did differ significantly from their perception of a healthy woman.\(^{(24)}\)

Women are generally perceived as genetically (biologically) more prone to certain kinds of mental illness than men. As already discussed, a view which has developed historically is that women are inherently more excitable and emotionally unstable, primarily because of their reproductive function. Phillips (1964) has argued that women are rejected less strongly than men for exhibiting certain 'emotional' symptoms. He presented data to show that identical behaviour patterns (typical of various mental illnesses) were rejected more strongly when the patient was a man than when the patient was a woman.\(^{(25)}\)

Illness generally causes individuals to be viewed as having more feminine and fewer masculine characteristics than they do when they are well. The characteristics associated with being sick such as dependency, submissiveness and passivity resemble feminine qualities. Women's gender identities, therefore, are apparently not so threatened by illness as are men.\(^{(26)}\)
The historical construction of masculinity is closely associated with Christianity's attitude to the human body which separates the superior spirit from the weak flesh. The history of masculinity, therefore, is the struggle to contain the emotional and sexual self and to recognise the superiority of reason and thought. The struggle for self control is often acted out as control over others. (27) David Jackson (1990) describes in his autobiography how his experience of a serious illness threatened his own masculinity:

It was the first time in my life that my body which I had been holding so firm and tight for so long, had completely let me down. I was scared out of my mind. (28)

He concludes that:

Physical breakdown is a terrifying experience for many men because it connects the masculine body with weakness, dependency, and passivity - all the supposedly 'feminine' qualities they have spent a lifetime defining and defending themselves against. Often for the first time in some men's lives it opens up fearful cracks in the 'hard case' front of heterosexual masculinity. (29)

It is possible to conclude that illness is a more threatening experience for men than for women because it greatly reduces a man's sexual identity. This may account for men failing to report illness and, therefore, enhancing the rate of female reports. But what of the concept of 'health'? Our culture may cause men to equate health with physical fitness, with keeping their bodies 'firm and tight' whilst women more readily equate health with emotional wellbeing. Additionally, if becoming ill is threatening to a man's masculinity then it may be the case that taking an interest in illnesses and what causes them is in itself seen as unsuitable behaviour for men.
2.3 The media and images of health

Within the area of health the advertising industry has had great success in influencing a comparatively well informed public. Advertisers have encouraged the public to either put something on or into their bodies to improve their health, beauty, general appearance, and chances of happiness. Advertisements sell us something else besides consumer goods; they also sell us a way of life, an image for ourselves.

Health and beauty advertisements appear to be particularly geared towards women. It has been frequently documented that women in our culture are pressurised by the slenderness ideal more than men. Generally of course, women are also under more pressure from ideals of beauty than men. Women are more likely than men to perceive themselves as "too fat" and to take part in crash dieting, laxative abuse and compulsive exercising. Disturbingly large numbers of individuals, particularly girls and young women, have suffered from bulimia and anorexia nervosa - both serious eating disorders. Peterson attempted to verify whether advertising was responsible in part for eating disorders because of the use of emaciated models and constant images of desirable slim bodies. Although he concluded that the research suggests that exposure to advertisements is not a major contributor to eating disorders, Peterson also discovered that those with eating disorders did react more strongly to television or magazine advertisements than those without eating disorders.

In a study on how physical attractiveness affects happiness and self-esteem, Mathers and Kahn found that physical attractiveness correlated positively with happiness, negatively with neuroticism and positively with self-esteem for women but not for men. The authors suggest that physical attractiveness 'buys' more for women than for men, such as dates and friends and is, therefore, more valuable for women.
Weston and Ruggiero in their content analysis of American women's magazines in the 1970's, addressed the issue of whether popular magazines reflect changes in women's roles and women's issues in health-related areas (for example, women's self-help groups) or whether they reinforce traditional ideas of women as caretakers of the family health and as concerned primarily with physical appearance. The authors compared 'established' magazines with 'new' magazines which started in 1970 or later as a response to the social changes of the 1960's. They found that out of 157 issues in a ten-year sample, there were 203 articles/features dealing with women's health themes. This averaged slightly more than one article per issue overall. The 'established' magazines included more such articles per issue than the 'new' magazines. The highest coverage in the 'established' magazines was clearly given to dieting/exercise/nutrition themes followed by mental health and reproductive health. In contrast, the most widely covered theme in the 'new' magazines was reproductive health followed by mental health and dieting/exercise/nutrition. The authors also reported that many serious health problems actually experienced by women were given little or no attention in the magazines. They concluded that although 'established' magazines functioned largely to reinforce traditional sex role stereotypes by their abundant emphasis on appearance-related topics, the 'new' magazines, while giving more coverage to reproductive issues, still devoted much space to women's appearance.

Another area of women's health which has received wide coverage in the media is premenstrual syndrome. Several studies have suggested that social learning plays a part in the reporting of menstrual and premenstrual distress. If women, therefore, believe that the menstrual cycle has a particular effect on physiological or psychological states, they may be more likely to experience or notice the changes and more likely to label them as caused by the menstrual cycle phase. Stories about premenstrual syndrome in the popular press are shaped by their newsworthiness, which accounts for the negative emphasis of many articles. If women cope well with premenstrual changes then it is not news, but if a woman cannot restrain her
violent urges or becomes too depressed to go to work then premenstrual syndrome is news.

Chrisler and Levy conducted a content analysis of premenstrual syndrome articles in the American popular press. They found that the description of the premenstrual woman was clearly negative and extremely variable. They in fact reported 131 different descriptive terms of the premenstrual woman. No single symptom appeared in 100 percent of the articles. Those symptoms (bloating/swelling, depression) on which there was most agreement were mentioned in only 71 percent of the articles. Opposite descriptions of symptoms were often found. Both good-concentration and difficulty concentrating were apparently signs of premenstrual syndrome. So were good moods and bad moods, increased appetite and loss of appetite. Many of the symptoms were vague, such as "looking crazy", "off balance" or "getting weird."

The authors also found that thirty-five percent of the articles analysed appeared in Beauty/Fashion magazines (more than in any other category examined). Thus, it is not surprising that so many of the symptoms concern changes in physical attractiveness. "During this time you'll be ugly and fat, the magazines warn us, playing right into women's obsessions with weight and beauty." Many of the symptoms support the stereotype of the maladjusted woman. She is, like the premenstrual syndrome sufferer, depressed and subject to headaches, crying spells, and bouts of insomnia. Chrisler and Levy assert that there exists a clear bias in favour of reporting negative premenstrual changes. In addition, biological causes of premenstrual syndrome are most often hypothesized (especially hormonal causes) and biological treatments most often discussed. The authors conclude that generally the description of premenstrual syndrome is negative and confusing. The abundance of symptoms, they argue, means that almost every reader can find herself in there somewhere.
The media, generally, has great potential to influence not only attitudes towards women but also attitudes which women hold of themselves. Therefore, how women view their overall health and their health needs can be influenced by the images constructed by the media in general.

2.4 Medical advertising and images of health

Although advertising in medical journals has changed over the last ten years or so, it has been documented that women are still portrayed as sex objects and in stereotyped roles. Goffman analysed advertisements in popular magazines and newspapers and found gender discrimination was hierarchical ranking: the male doctor telling the female nurse what to do; the male doctor examining a child which is being held by the female nurse. Goffman's work parallels work on portrayals in medical advertisements and suggests, therefore, that medical advertisements reflect those in the popular press.

Hawkins and Aber conducted a content analysis of medical advertisements and found that images of women were both negative and outdated. In contrast, no one ad portrayed a man as a sex object, and very few portrayed men with negative characteristics. Women were often portrayed as consumers looking up at "god-like, father-image physicians." The authors did not find one ad with a woman physician and a male consumer. Additionally, doctors appeared to be the only health care providers able to provide information, for instance: "ask your doctor" and "doctor when will you have my lab results?"

Prather and Fidell, in their study of medical advertisements, found that women are more likely to be portrayed as needing psychoactive drugs, whilst men are portrayed more in ads for nonpsychoactive drugs. Furthermore, vague emotional symptoms were often the cause of women's problems, whilst men suffered anxiety due to the pressures of work or from organic illness. The authors also
found that the correspondence between the rates with which women are shown as requiring the drugs in the advertisements and the rates with which they receive them by prescription was striking. Prather and Fidell conclude that: "Although it cannot be argued conclusively that advertisements cause physicians to prescribe differently for women and men, one can at least speculate upon the possible effects these advertisements may have upon both patient and physician." (81)

Recent studies have found, therefore, that medical advertising presents "women in a doctored world" in much the same light as in the commercial world, as "temptress, wife, mother and sex object ... less intelligent and more dependent than men." (82) The extent to which doctors and patients adjust to the images produced by advertising is yet to be fully investigated.
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-31-
CHAPTER THREE - THE DOCTOR-PATIENT RELATIONSHIP

3.1 Introduction

The authority which doctors possess as professionals means that they can and do control patients' access to and understanding of health information. In a sense, therefore, doctors act as gatekeepers, giving options to some, denying them to others. In the patriarchal society in which we live women have in general been forced to occupy a secondary place in the world in relation to men. As in the words of Simone de Beauvoir; "Woman has always been man's dependant, if not his slave; the two sexes have never shared the world in equality." The expertise and authority invested in doctors creates a similar dominant-subordinate relationship between doctors and patients. Thus;

When doctors are men and their patients are women, both the asymmetry and the reciprocal nature of their relationship is heightened. (2)

The male doctor and female patient relationship, therefore, is a dominant-subordinate one which may not serve the patient's best interests. (3)

Women constitute the majority of NHS patients and use general practitioner, psychiatric, geriatric, and most preventive services more frequently than men. (4) Women now form a significant majority of the elderly in the population. (5) Since the very elderly usually have great need of medical services, women's longer life span is obviously important in explaining their predominance as patients. (6) Women experience more acute conditions and more non fatal chronic diseases than men. However, men have higher prevalence rates for key life threatening chronic diseases. (7) In the USA, women's use of prescription and over-the-counter drugs is about fifty per cent higher than men's. The sex difference for psychotropic drug use (i.e. drugs that affect the mental state), is twofold higher for women than men. (8)
Women also become patients for reasons to do with contraception and child-bearing which men do not. As has previously been stated, there can sometimes be a fundamental difference in perspectives of doctors and mothers on the meaning of child bearing. Graham and Oakley\(^{10}\) found that mothers and doctors disagree on whether pregnancy is a natural or a medical process. Additionally, Doyal and Elston\(^{10}\) claim that pregnant women often complain of unsatisfactory communication with their medical providers who either do not volunteer explanations or give vague or trivial answers when pressed. Graham and Oakley \(^{11}\) in their study of pregnant women and obstetricians found that overt disagreement was rare in doctor-patient interactions. Rather, it was to the researchers that the women commonly reported their dissatisfaction with the care they were receiving.

Todd found in her study that "friendly, submissive behaviour on the part of women was the rule, not the exception."\(^{12}\) However, Todd claimed that although women may take on a passive role in the doctor's office, they appear to take an active role in their healthcare outside the office. Fisher\(^{13}\) reports in her study of women patients in the USA that the patients were often educated and articulate, yet either they did not feel that they had the information with which to make reasonable decisions or could not trust the recommendations their doctors made.

Patients and doctors share the same world view and socialization that the doctor knows best. The position of doctors in a healing, helping role, makes it seem inappropriate for a patient to question their help. Those patients that do question the doctor run the risk of being labelled difficult.

Research findings show female patients being taken less seriously than male patients. Gena Corea\(^{14}\) reports that when doctors were asked to describe a "typical complaining patient", seventy-two per cent referred to a woman, four per cent to a man. Stimson\(^{15}\) claims that doctors reported men to cause the least trouble (16%) more often than women (3%). Conversely, women were more
often mentioned as causing the most trouble (14%) than were men (3%). The patients who are the least trouble can clearly present their problem to the doctor. They are those who "... come in; come straight to the point..." and who "...can communicate rationally..." They are to be contrasted with those whose behaviour is typified in this following colourful description:

_Blethering women with verbal diarrhoea who give vast catalogues of irrelevant details and blow by blow accounts of what other doctors have done or said; what colour Aunt Maggie's hat was at Uncle Freddy's funeral._ (16)

### 3.2 Doctor-patient Communication

In the doctor-patient consultation certain actions are expected from both doctor and patient. Friction occurs, however, if the participants define the situation differently, e.g. the doctor views the illness as mechanical and physical, whereas the patient views the illness in a social and emotional context. The greater the cultural gap between doctors and their patients, the less effective they will be in communicating with each other. A working class female will be a greater distance culturally from her middle class male doctor than say a male dentist or chemist. (17)

Bochner (18) states that patients seem to be inhibited from asking for information during the consultation - which would seem the most appropriate time. Bochner claims that this is due to patients lacking the necessary social skills to make a request in the highly stylized medical encounter. Patients enter medical interactions from a position of relative weakness. Doctors, on the other hand, are in their 'home court' using language familiar to themselves but often not to their patients. An important factor in the consultation is the doctor's willingness to release control and recognise the patient's role in the medical process. (19)

Pendleton (20) interviewed patients about their consultations and found that a good consultation was one in which the treatment was
effective or reassuring, the patient was accepted as a person, his/her complaints were taken seriously, the doctor paid prompt attention to the complaint, took his time and showed understanding. A bad consultation was one in which the doctor paid no attention, did not treat the patient as a person, prescribed the wrong treatment, showed no understanding and did not explain.

Waitzkin and Stoeckle report that patients express more dissatisfaction with information they receive from physicians than with any other aspect of medical care. They also found that what a doctor told a patient seemed to depend on what kind of person the doctor was, as well as the characteristics of the particular patient. In a separate study, Waitzkin asked doctors and patients to rate patients' informational needs. In sixty-five per cent of the consultations patients' desires for information were underestimated by doctors. The actual time doctors spent giving information to patients averaged about one minute in consultations lasting roughly twenty minutes. Doctors, however, overestimated the amount of time they had spent in this activity. Waitzkin concludes that a discrepancy exists between doctors' and patients' perceptions of the amount of information needed and given.

Studies have also shown that doctors tend seriously to underestimate their patients' knowledge of health care and their ability to assimilate what information the doctor might give. Those doctors who most seriously underestimate knowledge tend to communicate the least information. Comaroff interviewed general practitioners at length about the amount of information they were prepared to give patients and found wide variations in their attitudes and practice, with doctors varying the amount of information given according to their judgements about the patient's ability to understand.

Byrne and Long in 2,500 doctor-patient interviews found that 'doctor-centred' 'information-gathering' conversations were the most prevalent modes of talk. Medical information was collected by the doctors with little listening or reflecting on the part of the
doctor. Byrne and Long found hardly any allowance for patient-centred concerns to emerge once the initial complaint was stated. Shuy's\(^{26}\) research also shows the doctor-patient consultation to be dominated by the doctor's medical language and perspective. Patients attempted to imitate this talk but invariably failed and returned to their own language. Shuy found the interviews technically adequate and efficient but emotionally or empathetically lacking. Similarly, Korsch et al.\(^{27}\) studying a pediatric outpatient clinic found that consultations were dominated by technical information with little emotion shown. The psychological aspects of patients' lives or illnesses were generally ignored with the doctors asking questions and the patients providing answers.

Stone\(^{28}\) asserts that often either doctors lapse into medical jargon that may seem normal to them but is foreign to the patient or they take on a patronizing, simplistic style that insults the patient. Each route leaves much to be desired for communication and contributes to the patients' feelings of powerlessness. In defence of doctors, it should be recognised that they too have dissatisfactions in their relationships with patients. Doctors suffer from the frustration of this same lack of success whilst exposed to the stress of the public's high expectations.

3.3 Social class and doctor-patient communication

Communication decreases in the consultation as the distance between cultures of the patient and the doctor increases. As doctors are generally middle class it would seem, therefore, that working class patients may experience communication problems with their doctor. There is evidence from work by Pendleton and Bochner\(^{29}\) that many general practitioners volunteer fewer explanations to lower social class patients believing that they require and understand less. This belief is reinforced by the fact that the lower social classes tend not to ask as many direct questions as middle class patients.
Bain, a general practitioner, recorded and analysed 480 consultations in his health centre. He found that more explanations were given to patients of social classes one and two than to patients of social classes four and five. There is quite a lot of data suggesting that middle and working class patients have similar hopes and reactions to their doctors but that the working class patients are more diffident about asking for information.

Buchanan and Richardson found a clear social class gradient in the 'face to face' duration of the consultation from an average of 6.1 minutes for those in social class I (professionals) to 4.4 minutes for those in social class V (unskilled workers). More problems were discussed at consultations with middle class patients than at those with working class patients: an average of 4.1 compared to 2.8. Despite this, however, working class patients were more likely to be very satisfied with the consultation: 91% compared with 70% of middle class patients. Buchanan and Richardson conclude that there is fairly conclusive evidence that middle class patients make more use of preventive services and possibly receive better care.

Lastly, Cartwright and Anderson reported that working class patients were more likely than middle class ones to say that if they were worried about a personal problem that was not strictly medical they would discuss it with a doctor. However, they also reported that there were no class differences in the frequency of consultation for women. It appears, therefore, that other factors may play a greater significant part in women's consultation rate than their social class.

3.4 Gender and the doctor-patient relationship

Roberts argues that a doctor's perception of a patient's gender will affect the diagnosis and treatment as much as his or her perception of other socially significant factors such as class and occupation. Bernstein and Kane also examined the impact of patient sex on the attitudes of doctors. In their sample of 89% male
doctors they found that women patients, in comparison to men, were judged as (a) making more excessive demands on time (b) as having complaints that were more influenced by emotional factors and (c) as having more psychosomatic problems.

Barrett and Roberts in their study of general practitioners and their patients reported that doctors took men's illnesses as well as their life stresses more seriously than women's. The male patients were viewed as hard workers in a competitive world and doctors tended to blame the social situation for their problems. Women, on the other hand, were defined by doctors in terms of the family and home, affected by 'vague and spurious worries', generally psychosomatic in origin. If a woman, suffering from stress, was performing two jobs (one inside the home and one in paid employment) the common response was to advise the woman to give up her job. Doctors were less sympathetic, blaming the individual woman rather than their social situation for their 'unfounded' aches and pains.

Cooperstock focused on the higher incidence of drug use among women, particularly mood altering drugs. She found that doctors viewed women as complainers, enjoying poor health and needing more mood altering drugs than men. Brown and Harris, in their studies of the treatment given to patients by general practitioners, show that 18% of women, as against 10% of men, were given a psychiatric 'diagnosis'; that mood altering drugs were more frequently given to women than men; that in repeat prescriptions, three-quarters were for women (an excessive amount even when women's rates of illness are taken into account), and that 21% of women compared to 9.7% of men had been given a psychotropic drug in the previous year.

One study has provided some tentative evidence that male doctors may discourage communication and information exchange with female patients. Wallen et al. observed the information-seeking behaviour of patients and the responses of the doctors to males' and females' requests for information. They discovered that doctors were more likely to attribute psychological causes to the illnesses of female patients than to those of men. Further, it was found that
though women asked more questions than men, doctors tended to give shorter and less technical answers to women's questions than they were judged to require. The author concluded from these findings that there was a tendency for doctors to withhold medical information from women in order to maintain the male-female power relationship. In contrast, Waitzkin⁽⁴²⁾, who also analysed doctor-patient consultations, found no evidence of less information given to female patients and suggests that the greater number of questions asked by female patients means they received more of the doctors' time, more total technical explanations, more explanations subsequently translated into simpler terms, and more responses at the same technical level as their questions.

However, Fisher⁽⁴³⁾ in her study of family planning consultations argues that doctors do not simply communicate information but also attempt to persuade the patients to a point of view or particular outcome. While persuasion may be regarded as a legitimate action by the doctor it may also be guided by moral and social attitudes which may not be in the patient's best interest. Therefore, studies demonstrating that doctors spend more time with female patients or give them more information may not necessarily mean that a greater understanding on both sides has been achieved or that more rational decisions have been taken.

Tuckett et al.⁽⁴⁴⁾ tape-recorded encounters between general practitioners and their patients and then interviewed patients about their recall, interpretation, and acceptance of the doctors' ideas. The majority (77%) of those with correct recall and interpretation were also committed to their doctors' views. Women, however, were less likely to be committed to their doctors' views than were men.

Hingson et al.⁽⁴⁵⁾ in his review of the literature on why patients do not comply with their medication treatment, maintains that patients are less likely to comply (a) if they believe that they are not held in adequate esteem by their doctors (b) if their doctor seeks information from them without explaining why that information is being gathered or does not explain the patient's condition (c) if
tension emerges during the consultation which is not resolved (d) if patients believe that their expectations are not being met or that their doctors are behaving in an unfriendly way. Fisher reported that the majority of women she interviewed had a low opinion of medical care. Despite the fact that they told of positive experiences with individual doctors and staff, they also had had enough negative experiences to create feelings of discontent.

Todd reported several patterns of relevance in the data she collected on family planning consultations. First, doctors' interpretations took precedence over women's understandings. Second, doctors' more dominant reasoning often led to condescension towards the female patients. Thirdly, the patient would often talk in a social, contextual mode about her health care and her life. The doctor, however, would respond with a medical question, taking the conversation back into the medical domain. Women were often cut off by doctors when attempting to express their concerns. Todd claimed that by not discussing in detail with women all of their contraceptive options, doctors do not give enough technical information for patients to make informed decisions. Additionally, doctors were making contraceptive decisions on technical bases or sweeping social assumptions whereas women tend to consider these issues in personal, contextual terms.

3.5 Doctor gender and their attitudes towards medical care

Although there have been studies which document systematic biases in the way in which health care providers perceive male and female patients and their complaints, few research studies have addressed the impact of doctor gender on the doctor - patient interaction and its outcomes. The lack of research means that no definitive statement can be made that doctor gender has any significant effects on the quality of doctor - patient interactions. However, such effects may exist and are likely to take on a subtle form.
Early sex-role socialization is very resistant to change and therefore, it is unlikely that professional socialization processes will change these sex-role differences among doctors. Female doctors who have been socialized to the traditional female sex-role may be more nurturant and expressive and have stronger interpersonal skills than male doctors. On the other hand, male doctors could be more reserved and less empathetic than female doctors.\textsuperscript{49} The female doctor, however, has broken some stereotypes by becoming a doctor and therefore may impose less traditional views on her patient's behaviour. Thus, the female doctor may make a greater attempt to involve the female patient in decision making than the male doctor would do.

Leserman\textsuperscript{60} found that among senior medical students, women were significantly more likely than men to believe that it is "important to provide health information to patients" and that "social and psychological factors, including empathy, are important in health care." Other research has also documented that female medical students and doctors are more highly orientated toward interpersonal relationships and affectivity in medical practice, while men are more reserved and science-orientated.\textsuperscript{61} Heins et al.\textsuperscript{52} surveyed 182 practising doctors in Detroit, USA about their attitudes on gender role. The study reveals that female doctors have greater gender role sensitivity than male doctors, even when age and speciality area are controlled. It also showed that the women were, in general, more liberal and egalitarian than the men.

However, Broverman et al.\textsuperscript{53} reported that male and female doctors held consistent stereotypes, so the argument could not be made that female doctors would be less likely to stereotype their female patients. Similarly, Bernstein and Kane\textsuperscript{54} asked 225 male and 28 female doctors for their attribution of psychological or organic origins to common complaints in male and female patients. No difference was found between male and female doctors, but male and female patients were judged differently by the doctors. The authors do caution, however, that the findings of lack of influence of doctor
gender is not conclusive because of the small number of female doctors in the study.

In sum, the evidence for doctor sex differences in attitudes and sex biases is mixed. There is consistent evidence that male and female doctors hold different attitudes towards practice and towards women's issues. However, these attitudes may not always translate into behaviour. There is evidence which shows that male and female patients are perceived differently but there is less evidence that male and female doctors differ in their perceptions of male and female patients.

3.6 Patient perceptions of male and female doctors

Patients' perceptions of male and female doctors will result in different expectations being brought by the patients to the consultations with male and female doctors. Shapiro et al. asked male and female patients, medical students and doctors to describe the typical male or female doctor. The women respondents in all three groups tended to see female doctors' behaviour towards patients as "androgynous" ie. having both technical and interpersonal qualities, while male doctors were viewed by all respondent groups as either low in both these qualities or having only technical qualities. The study, therefore, showed that male and female doctors are perceived as behaving differently towards patients but it did not address preferences for male or female doctors.

Engleman, however, surveyed 500 male and female patients in USA about their attitudes towards male and female doctors. While a majority of both men and women (84% of men and 75% of women) stated a preference for a male doctor as their regular doctor, three times as many women (17%) as men (6%) preferred a female doctor. Haar et al. surveyed 409 female patients of both male and female doctors about their attitudes and practices regarding gynaecologists and gynaecological examinations. The authors found that 34% of all women stated a preference for a female gynaecologist. However, 59% of
the women who were patients of female doctors preferred a female gynaecologist. Philliber and Jones found a greater same-sex than opposite-sex provider preference among female adolescent patients seeking family planning services. Respondents were asked how important it was to them to have a counsellor or examiner of the same sex, ethnicity, and relatively close to the same age as themselves. Gender was reported as the most important variable especially in terms of the examiner.

To summarise, there is evidence to suggest that patients tend to attribute different characteristics and attitudes to male and female doctors. It also seems the case that patient preference for female doctors is increased by previous experience with a female doctor. There is evidence that female patients, who have already had contact with a female doctor, prefer female doctors in situations such as family planning and obstetrics-gynaecology. Satisfaction with medical care received may also be affected by the patients' ability to choose a doctor of the preferred gender.

3.7 Same-sex versus opposite-sex doctor-patient consultations

Gender plays a significant part in the creation of social status. Same-sex doctor-patient couples are presumed to result in greater 'status congruence' between provider and patient than would occur in opposite-sex couples. Historically, men have received their medical care from same-sex doctors while women have received theirs from opposite-sex doctors. The result of greater status congruence in same-sex consultations may well be freer communication, more self-disclosure and more joint decision-making. Therefore, both female-female and male-male doctor-patient consultations would be expected to result in a more favourable process and outcome than opposite-sex consultations.
In a study examining people’s willingness to disclose physical and emotional symptoms to hypothetical family practice doctors, Young found that males and females were more willing to disclose symptoms to a doctor of the same sex than to a doctor of the opposite sex, especially when the symptoms were of a personal nature. (1)

Hall (2), in his literature review of gender differences in aspects of general communication, reported that people may be more likely to deviate from the norms for their sex when they are communicating with someone of the opposite sex and behave more stereotypically when they are communicating with someone of their own sex. Thus, male-male doctor-patient consultations might be characterized by stereotypically male communication patterns, whereas the male-female consultations, which most women experience, might be characterized more by one or both participants having to adjust to the communication style of the other. (2) Gender congruence implies reduced social distance between communicators and possibly better rapport and more effective communication.

Wasserman et al. (3), in a study at a pediatric clinic, reported that female doctors provided significantly more verbal statements of empathy (defined as "expression of intellectual appreciation of a parent's situation") than male doctors. Various studies have also shown how male and female doctors appear to differ in the amount of time spent in direct interaction with patients. Langwell (4) shows that female doctors see fewer patients per office hour than male doctors. Interestingly, the greatest gender difference occurs in obstetrics-gynaecology, in which male doctors saw an average of three patients per office hour, compared with 1.73 patients seen by female doctors. Scully also studied consultations in the area of obstetrics-gynaecology and found that female doctors tended to be more empathetic than males in dealing with conditions that are uniquely female and that they themselves have experienced. The author argues that stronger doctor-patient bonds are formed in same-sex couples as a result of empathy. (5)
Zare et al. examined the relationship between a doctor's gender and the content of the doctor-patient relationship in the area of genetic counselling. They report, that with few exceptions, a greater percent of cases seen by female doctors, as opposed to males had in depth discussion of genetic medical issues, although the differences were not always statistically significant. Also, more patients counselled by female than male doctors reported that they were given most of the medical facts they wanted, and were less likely to report failure to ask about their concerns. The sex of the counsellor, therefore, appears to be associated with significant differences in the content of genetic counselling for female patients, particularly in the information given and received, with same-sex consultations achieving a more satisfactory outcome than opposite-sex consultations.

Biener studied counselling of clients in a drug treatment programme and found that female clients were more likely to keep a screening appointment if they had been interviewed first by a female counsellor rather than by a male counsellor. For male clients, the sex of the counsellor made no difference in subsequent appointment-keeping.

It would appear, therefore, that there is tentative evidence that same-sex doctor-patient consultations may result in greater rapport, in greater symptom disclosure and exchange of information, and in greater empathy expressed by the doctor. The patient, consequently, benefits from a greater level of giving and receiving of information. Women take a more active role in their health care than men which results in their greater utilisation of health care services. However, when the relationship between a female patient and her health care provider is an unsatisfactory or unequal one this may act as an impetus to the patient to actively seek health information from sources other than the medical profession.
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CHAPTER FOUR - THE SURVEY

4.1 Introduction

Having conducted a literature review and attempted to examine the main theories and opinions on why women predominate as enquirers into health information, it became evident that there is a lack of empirical research in this area. If the researcher is to discover the answers to such a complex polemic it is necessary, in part, to record and analyse the feelings and opinions of people in general. Thus a survey was undertaken for this final part of the study.

4.2 Objectives of the survey

The survey attempted to discover how gender affects important issues related to health and health information. In particular, it tried to discover how gender influences people's feelings about their health generally; what factors influence the giving and receiving of health information; and what sources of health information are used and by whom. Moreover, the survey attempted to discover how gender affects people's attitudes towards the importance of health information.

The specific aims of this survey were as follows:

1. To see if gender roles influence a person's belief in the importance of their health.

2. To discover where people gain their health information and to see if differences by gender exist.

3. To see what different aspects of health people seek information on, and to see what affect, if any, gender has on this.
4. To see if generally gender affects attitudes towards healthcare providers.

5. To see if gender affects seeking health information on someone else's behalf.

6. To see how convenient it is for people to attend their doctor.

7. To see if gender affects a person's 'lay referral system' i.e. who a person turns to first when they are ill.

8. To see whether social role stresses, such as running the household, influence health care behaviour.

9. To see if gender affects a person's concern with his or her appearance.

10. To see if gender influences beliefs in the amount and type of information a doctor should supply to a patient.

11. To yield information on how some social roles of women affect their seeking of health information.

4.3 The limitations of this survey

It should be stressed that this survey is not intended to be an in depth analysis of gender and health information seeking. Rather, it attempts to examine some of the main areas of contention which have been raised in the preceding literature review. An area of study so subjective as this requires much more research and analysis than the researcher had time or financial resources to undertake. Much of the information gathered in this survey describes the respondent’s feelings and opinions, so consequently most of the results are based on subjective data. There is no way to test, in objective terms, the accuracy or validity of the subjective answers given by the respondents. However, the results do give people's
perceptions on matters with which the researcher is concerned. When dealing with such a subjective area of study there are few 'facts'. Instead there exists feelings, attitudes and opinions which lead to particular actions and behaviours or possibly vice versa.

It was found that for useful results to be obtained from cross tabulations the overall sample size needed to be much larger. In particular, as three different samples were used and not all questions were answered by all respondents the sample sizes were very small in some instances (see 4.4.2). Therefore, this study does not present cross tabulations of results.

4.4 Methodology

4.4.1 Location

The survey for this study took place in three separate locations. These were:

1. At rehearsals of Portsmouth City Brass Band in Portsmouth, Hants.

2. At the Health Centre, Loughborough.

3. At the Health Information Centre, Loughborough.

4.4.2 Method of survey

The survey involved the distribution of questionnaires in the three locations cited. The researcher approached people asking them if they would be willing to fill in a questionnaire about seeking health information. If they accepted, they were given a questionnaire and asked if they could return the questionnaire, once completed, to the researcher.
Although the questionnaires distributed in each location all contained the same core questions there were variations between the questionnaires to account for the different circumstances and sample within which the questionnaires were being distributed (see appendices 2-4). It is clearly labelled in the results as to which sample each individual question has been addressed.

One of the aims of the survey was to determine whether gender plays a part in our individual's concern with appearance. In order to do this all respondents were asked a series of four questions to measure their concern with appearance (see questions no. 13 - no. 16, appendix 2). The responses were coded: not at all important (1), not very important (2), neutral (3), important (4), very important (5). The four items were added together and divided by four. The higher the score the greater the concern with appearance. This method originates from Diane Hayes and Catherine E. Ross (1987).

A small pilot study in which 16 questionnaires were distributed to colleagues originally took place. The main study in which 89 questionnaires were collected took place at:


2. The Health Centre, Loughborough on 1st July, 1991 between 10am and 12pm, and on 2nd July, 1991 between the same times.

3. The Health Information Centre, Loughborough between 4th July and 10th July (excluding Saturday and Sunday) from 9.30am till 5pm.
4.4.3 The Sample

The respondents were chosen on a purely haphazard basis. Only a small proportion (16%) of the people approached refused to answer questions. However, of the people approached at the Health Information Centre 23% refused to answer questions, all of whom were women. Had these women formed part of the respondents there would have been a greater proportion of women to men than that which the researcher received.

The overall sample was composed of three separate samples. At Portsmouth there were 27 respondents; at the Health Centre, Loughborough there were 35 respondents; and at the Health Information Centre, Loughborough there were 27 respondents resulting in a total of 89 respondents.

Three samples of respondents were chosen for the questionnaire in order to gain a cross section of opinion of people who may or may not actively seek health information. The Portsmouth sample consisted of respondents who may or may not use health care services and may or may not use health information resources. The Health Centre sample was composed of those who use health care services but may or may not use health information resources. The Health Information Centre sample consisted of respondents who use a health information resource but may or may not use health care services. By employing these different samples more objective and better balanced results could be achieved overall.

4.5 Explanation of methodology

It was decided to carry out a questionnaire survey because:

1. Questionnaires serve as a useful and practical way of collecting data.
2. As Parmeggiani states:

Questionnaires give quantitative answers to people's subjective judgements. This is one under-rated source of information; subjective judgements, in many instances, are more sensitive, more accurate and faster than equivalent objective measures.

Questionnaires, however, do have weaknesses. The wording of a question can be interpreted differently by different respondents resulting, therefore, in subjective responses to questions.

Additionally, if respondents are limited to ticking only one choice of answers this choice may not necessarily truly reflect the respondent's point of view. As explained earlier the survey produced subjective data showing opinions and attitudes rather than objective 'facts'.

To overcome, to some degree, the problem of respondents having to tick one of a limited choice of answers respondents were given the option of ticking 'other' where appropriate. If they ticked 'other' they were then asked to specify their answer (for example see question 3 of the main study questionnaires in Appendices 2-4).

After the pilot study had taken place some alterations were made to the questionnaire design. Many of these alterations were simply to clarify its wording. In the pilot study, however, there had been a group of questions designed to measure health locus of control (see section 1.3 and appendix 1, no.3-7). These were then tested to see if gender had any discernible affect upon health locus of control. No connection was found between gender and locus of control. Despite the small size of the pilot sample it was felt to be justifiable, therefore, to omit these questions from the main questionnaire (see appendices 1-4). The pilot study was not used in the main study as the respondents were not part of the three samples chosen.

The survey results are presented in the next chapter.
REFERENCES

CHAPTER FIVE - SURVEY RESULTS

Introduction

This chapter presents the statistical results of the survey. Discussion and evaluation follow in the next chapter.

5.1 The Sample

All 89 respondents were asked for general details about status and background. Their responses are shown in Table 1.
## TABLE 1
Sex, Marital Status, Social Class, Age and Ethnic Origin of Respondents

<table>
<thead>
<tr>
<th>SEX</th>
<th>No OF RESPONDENTS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>36</td>
<td>40.4</td>
</tr>
<tr>
<td>Female</td>
<td>53</td>
<td>59.6</td>
</tr>
<tr>
<td>TOTAL</td>
<td>89</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>15 (41.7%)</td>
<td>11 (20.8%)</td>
<td>26 (29.2%)</td>
</tr>
<tr>
<td>Married</td>
<td>19 (52.8%)</td>
<td>33 (62.3%)</td>
<td>52 (58.4%)</td>
</tr>
<tr>
<td>Widowed</td>
<td>1 (2.8%)</td>
<td>3 (5.7%)</td>
<td>4 (4.5%)</td>
</tr>
<tr>
<td>Divorced</td>
<td>1 (2.8%)</td>
<td>6 (11.3%)</td>
<td>7 (7.9%)</td>
</tr>
<tr>
<td>Separated</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>I (Professional)</td>
<td>1 (2.8%)</td>
<td>0 (0%)</td>
<td>1 (1.1%)</td>
</tr>
<tr>
<td>II (Intermediate occ.)</td>
<td>9 (25%)</td>
<td>16 (30.2%)</td>
<td>25 (28.1%)</td>
</tr>
<tr>
<td>III (Skilled occ.)</td>
<td>15 (41.7%)</td>
<td>16 (30.2%)</td>
<td>31 (34.8%)</td>
</tr>
<tr>
<td>IV (Partly skilled)</td>
<td>2 (5.6%)</td>
<td>1 (1.9%)</td>
<td>3 (3.4%)</td>
</tr>
<tr>
<td>V Unskilled</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>VI Other</td>
<td>9 (25%)</td>
<td>20 (37.7%)</td>
<td>29 (32.6%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24 yrs</td>
<td>7 (19.4%)</td>
<td>7 (13.2%)</td>
<td>14 (15.7%)</td>
</tr>
<tr>
<td>25-34</td>
<td>12 (33.3%)</td>
<td>16 (30.2%)</td>
<td>28 (31.5%)</td>
</tr>
<tr>
<td>35-44</td>
<td>9 (25%)</td>
<td>13 (24.5%)</td>
<td>22 (24.7%)</td>
</tr>
<tr>
<td>45-54</td>
<td>0 (0%)</td>
<td>8 (15.1%)</td>
<td>8 (9%)</td>
</tr>
<tr>
<td>55-64</td>
<td>5 (13.9%)</td>
<td>6 (11.3%)</td>
<td>11 (12.4%)</td>
</tr>
<tr>
<td>65 &amp; over</td>
<td>3 (8.3%)</td>
<td>3 (5.7%)</td>
<td>6 (6.7%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Afro-Caribbean</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Asian</td>
<td>1 (2.8%)</td>
<td>2 (3.8%)</td>
<td>3 (3.4%)</td>
</tr>
<tr>
<td>European (inc UK)</td>
<td>34 (94.4%)</td>
<td>51 (96.2%)</td>
<td>85 (95.5%)</td>
</tr>
<tr>
<td>Oriental</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (2.8%)</td>
<td>0 (0%)</td>
<td>1 (1.1%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>
As can be seen from Table 1 53 (59.6%) of the respondents were female and 52 (58.4%), were married. 29 (32.6%) of the respondents were allocated to 'other' for social class either because they were students, unemployed, or had not provided the information needed to place them in a social class category. The one male who gave 'other' response to ethnic origin was of arabic background.

5.2 General State of health

All respondents were asked what they considered their general state of health to be like. Their responses are shown in Table 2.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>9 (25%)</td>
<td>11 (20.7%)</td>
<td>20 (22.5%)</td>
</tr>
<tr>
<td>Good</td>
<td>19 (52.8%)</td>
<td>33 (62.3%)</td>
<td>52 (58.4%)</td>
</tr>
<tr>
<td>Fair</td>
<td>7 (19.4%)</td>
<td>9 (17%)</td>
<td>16 (18%)</td>
</tr>
<tr>
<td>Poor</td>
<td>1 (2.8%)</td>
<td>0 (0%)</td>
<td>1 (1.1%)</td>
</tr>
<tr>
<td>Very Poor</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>

52 (58.4%) respondents felt their health to be good. A higher proportion of males (25%) to females (20.7%) felt their health to be very good. However, 44 (83%) females compared to 28 (77.8%) males felt their health to be good or very good.
5.3 Importance attached to one's health

All respondents were asked to tick one statement which best represented the importance they placed on their health. 48 (53.9%) of the respondents claimed that "I only think about my health from time to time". 9 (17%) females claimed that "my health is the most important consideration in my life." as compared to 5 (13.9%) males. A very similar proportion of male and female respondents claimed that "I almost never take the illnesses I get seriously." - 4 (11.1%) males and 6 (11.3%) females.

TABLE 3
Importance attached to one's health

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>My health is the most important consideration in my life</td>
<td>5 (13.9%)</td>
<td>9 (17%)</td>
<td>14 (15.7%)</td>
</tr>
<tr>
<td>Whenever I'm ill, no matter how mild the symptom, I take it seriously.</td>
<td>7 (19.4%)</td>
<td>10 (18.9%)</td>
<td>17 (19.1%)</td>
</tr>
<tr>
<td>I only think about my health from time to time</td>
<td>20 (55.6%)</td>
<td>28 (52.8%)</td>
<td>48 (53.9%)</td>
</tr>
<tr>
<td>I almost never take the illnesses I get seriously</td>
<td>4 (11.1%)</td>
<td>6 (11.3%)</td>
<td>10 (11.2%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>
5.4 Health information sources

All respondents were asked where they gained their health information. They were asked to indicate from a list of sources how many they themselves have used. Both relatives/friends and health-care provider were cited by 48 (53.9%) of the respondents. 30 (56.6%) females as opposed to 18 (50%) males cited health-care provider but 21 (58.3%) males as opposed to 27 (50.9%) female cited relatives/friends. The one respondent who ticked 'other' cited medical journals as a source of information. She was not a doctor and stated that she was unemployed. 11 (30.6%) males cited the health information centre as a source. All these men were respondents at the Health information centre in Loughborough. Additionally, 15 of the 24 (45.3%) women who cited a health information centre as a source were respondents at the Loughborough Health information centre. Obviously, people using the health information centre are likely to state that it is a source of health information for them.

Table 4 gives the results whilst Table 4.1 lists the sources in order of those most cited by male and female.

<table>
<thead>
<tr>
<th>TABLE 4</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Health information sources</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sources</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives / Friends</td>
<td>21 (58.3%)</td>
<td>27 (50.9%)</td>
<td>48 (53.9%)</td>
</tr>
<tr>
<td>Television</td>
<td>14 (38.9%)</td>
<td>17 (32.1%)</td>
<td>31 (34.8%)</td>
</tr>
<tr>
<td>Radio</td>
<td>10 (27.8%)</td>
<td>5 (9.4%)</td>
<td>15 (16.9%)</td>
</tr>
<tr>
<td>Newspapers</td>
<td>15 (41.7%)</td>
<td>12 (22.6%)</td>
<td>27 (30.3%)</td>
</tr>
<tr>
<td>Magazines</td>
<td>7 (19.4%)</td>
<td>20 (37.7%)</td>
<td>27 (30.3%)</td>
</tr>
<tr>
<td>Library</td>
<td>5 (13.9%)</td>
<td>8 (15.1%)</td>
<td>13 (14.6%)</td>
</tr>
<tr>
<td>Workplace</td>
<td>2 (5.6%)</td>
<td>8 (15.1%)</td>
<td>10 (11.2%)</td>
</tr>
<tr>
<td>Health Info Centre</td>
<td>11 (30.6%)</td>
<td>24 (45.3%)</td>
<td>35 (39.3%)</td>
</tr>
<tr>
<td>Health-care provider</td>
<td>18 (50%)</td>
<td>30 (56.6%)</td>
<td>48 (53.9%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>1 (1.9%)</td>
<td>1 (1.1%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>103 (40.4%)</strong></td>
<td><strong>152 (59.6%)</strong></td>
<td><strong>255 (100%)</strong></td>
</tr>
</tbody>
</table>
TABLE 4.1
Sources in order of those most cited

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives / Friends:</td>
<td>Health-care providers:</td>
<td>Relatives / Friends:</td>
<td></td>
</tr>
<tr>
<td>Health-care providers:</td>
<td>Health Info Centre:</td>
<td>Health Info Centre:</td>
<td></td>
</tr>
<tr>
<td>Newspapers:</td>
<td>Television:</td>
<td>Newspapers:</td>
<td></td>
</tr>
<tr>
<td>Television:</td>
<td>Health Info Centre:</td>
<td>Libraries:</td>
<td></td>
</tr>
<tr>
<td>Health Info Centre:</td>
<td>Radio:</td>
<td>Workplace:</td>
<td></td>
</tr>
<tr>
<td>Radio:</td>
<td>Libraries:</td>
<td>Radio:</td>
<td></td>
</tr>
<tr>
<td>Libraries:</td>
<td>Workplaces:</td>
<td>Libraries:</td>
<td></td>
</tr>
<tr>
<td>Workplaces:</td>
<td>Other:</td>
<td>Workplaces:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

5.5 Where the most health information is gained

All respondents were also asked to indicate from which source they gained the most health information. Their responses are shown in Table 5.

TABLE 5
Sources where most health information is obtained

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives / Friends:</td>
<td>13 (36.1%)</td>
<td>12 (22.6%)</td>
<td>25 (28.1%)</td>
</tr>
<tr>
<td>Television:</td>
<td>5 (13.9%)</td>
<td>2 (3.8%)</td>
<td>7 (7.9%)</td>
</tr>
<tr>
<td>Radio:</td>
<td>1 (2.8%)</td>
<td>1 (1.9%)</td>
<td>2 (2.2%)</td>
</tr>
<tr>
<td>Newspaper:</td>
<td>3 (8.3%)</td>
<td>0 (0%)</td>
<td>3 (3.4%)</td>
</tr>
<tr>
<td>Magazines:</td>
<td>3 (8.3%)</td>
<td>8 (15.1%)</td>
<td>11 (12.4%)</td>
</tr>
<tr>
<td>Library:</td>
<td>3 (8.3%)</td>
<td>1 (1.9%)</td>
<td>4 (4.5%)</td>
</tr>
<tr>
<td>Workplace:</td>
<td>0 (0%)</td>
<td>4 (7.5%)</td>
<td>4 (4.5%)</td>
</tr>
<tr>
<td>Health Info Centre:</td>
<td>0 (0%)</td>
<td>2 (3.8%)</td>
<td>2 (2.2%)</td>
</tr>
<tr>
<td>Health-care Provider:</td>
<td>8 (22.2%)</td>
<td>23 (43.4%)</td>
<td>31 (34.8%)</td>
</tr>
<tr>
<td>Other:</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

TOTAL: 36 (40.4%) 53 (59.6%) 89 (100%)
31 (34.8%) respondents cited health-care providers as their greatest source of health information. 23 (43.4%) females as opposed to 8 (22.2%) males cited health-care providers. 13 (36.1%) males compared to 12 (22.6%) females cited relatives/friends as their greatest source. Table 5.1 shows the sources of health information in order of importance by male and female.

### TABLE 5.1
Sources of health information in order of those where most information is obtained

<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relatives / Friends</td>
<td>Health-care Provider</td>
<td>Health-care Provider</td>
</tr>
<tr>
<td>Health-care Provider</td>
<td>Relatives / Friends</td>
<td>Health-care Provider</td>
</tr>
<tr>
<td>Television</td>
<td>Magazines</td>
<td>Relatives / Friends</td>
</tr>
<tr>
<td>Newspapers</td>
<td>Workplace</td>
<td>Magazines</td>
</tr>
<tr>
<td>Magazines</td>
<td>Television</td>
<td>Television</td>
</tr>
<tr>
<td>Library</td>
<td>Health Info Centre</td>
<td>Library</td>
</tr>
<tr>
<td>Radio</td>
<td>Radio</td>
<td>Workplace</td>
</tr>
<tr>
<td>Workplace</td>
<td>Library</td>
<td>Newspapers</td>
</tr>
<tr>
<td>Health Info Centre</td>
<td>Newspaper</td>
<td>Radio</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Health Info Centre</td>
</tr>
</tbody>
</table>

5.6 The type of health information looked for.

All respondents were presented with a list of health matters and asked if they had ever looked for information on any of them. 57 (64%) respondents had looked for information on exercise while 52 (58.4%) respondents had looked for information on diet. 38 (71.7%) females compared to 14 (38.9%) males had looked for information on diet while a slightly higher proportion of males had looked for information on exercise. Consistently more females looked for information on family planning, women's health matters, and children's health matters than males.
Table 6.1 presents the type of health information looked for in order of those cited most frequently by male and female.

### TABLE 6.1

Health information looked for in order of those cited most frequently

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exercise</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diet</strong></td>
<td>14 (38.9%)</td>
<td>38 (71.7%)</td>
<td>52 (58.4%)</td>
</tr>
<tr>
<td><strong>Physical/sport Injury</strong></td>
<td>24 (66.7%)</td>
<td>33 (62.3%)</td>
<td>57 (64%)</td>
</tr>
<tr>
<td><strong>Women's health</strong></td>
<td>6 (16.7%)</td>
<td>25 (47.2%)</td>
<td>31 (34.8%)</td>
</tr>
<tr>
<td><strong>Chronic disease</strong></td>
<td>5 (13.9%)</td>
<td>12 (22.6%)</td>
<td>17 (19.1%)</td>
</tr>
<tr>
<td><strong>Psychological problems</strong></td>
<td>7 (19.4%)</td>
<td>12 (22.6%)</td>
<td>19 (21.3%)</td>
</tr>
<tr>
<td><strong>Acute disease</strong></td>
<td>12 (33.3%)</td>
<td>10 (18.9%)</td>
<td>20 (22.5%)</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>3 (8.3%)</td>
<td>0 (0%)</td>
<td>3 (3.4%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>93 (32.9%)</td>
<td>190 (67.1%)</td>
<td>283 (100%)</td>
</tr>
</tbody>
</table>
5.7 Reasons for visiting the Health Centre

The Health Centre respondents were asked for their reasons for visiting the doctor's surgery. 14 (40%) respondents gave their reason as children's health matters. 3 (33.3%) males gave 'other' reasons which were 'accompanying wife', 'vaccination', and 'partner's pregnancy'. 3 (11.5%) females gave 'other' reasons which were 'tennis elbow', 'eye test needs investigating', and one female did not specify the reason. 10 (38.5%) females compared to 0 males were attending the surgery for women's health matters.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children's health matters</td>
<td>3 (33.3%)</td>
<td>11 (42.3%)</td>
<td>14 (40%)</td>
</tr>
<tr>
<td>Women's health matters</td>
<td>0 (0%)</td>
<td>10 (38.5%)</td>
<td>10 (28.6%)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (33.3%)</td>
<td>3 (11.8%)</td>
<td>6 (17.1%)</td>
</tr>
<tr>
<td>Common virus infection</td>
<td>2 (22.2%)</td>
<td>1 (3.8%)</td>
<td>3 (8.6%)</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>1 (11.1%)</td>
<td>1 (3.8%)</td>
<td>2 (5.7%)</td>
</tr>
<tr>
<td>Acute disease</td>
<td>0 (0%)</td>
<td>1 (3.8%)</td>
<td>1 (2.9%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>9 (25%)</strong></td>
<td><strong>27 (75%)</strong></td>
<td><strong>36 (100%)</strong></td>
</tr>
</tbody>
</table>

5.7.1 Reasons for visiting the Health Information Centre

The respondents at the centre were asked to state their reason for visiting the centre. These ranged from requiring information on fibrosis tissues, angina, cover for health whilst overseas, stress reduction/relaxation techniques, where to obtain a full medical, facilities for head injury victims and where to locate the local red cross.
5.8 Do you ever visit your doctor?

The Portsmouth respondents were asked if they ever visit their doctor. 26 (96.3%) respondents had visited their doctor while only one (3.7%) respondent claimed to have never visited his doctor.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14 (93.3%)</td>
<td>12 (100%)</td>
<td>26 (96.3%)</td>
</tr>
<tr>
<td>No</td>
<td>1 (6.7%)</td>
<td>0 (0%)</td>
<td>1 (3.7%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>15 (55.6%)</td>
<td>12 (44.4%)</td>
<td>27 (100%)</td>
</tr>
</tbody>
</table>

5.9 Satisfaction with doctor's explanation of a problem.

The Portsmouth and the Health Centre respondents were asked if they were satisfied with the way in which their doctor explained their problems to them. 25 (41%) respondents were always satisfied with their doctor's explanations. However, 12 (52.2%) males were always satisfied compared to 13 (34.2%) females. 1 (2.6%) female claimed to never be satisfied with her doctor's explanations.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0 (0%)</td>
<td>1 (2.6%)</td>
<td>1 (1.6%)</td>
</tr>
<tr>
<td>Occasionally</td>
<td>3 (13%)</td>
<td>4 (10.5%)</td>
<td>7 (11.5%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>4 (17.4%)</td>
<td>8 (21.1%)</td>
<td>12 (19.7%)</td>
</tr>
<tr>
<td>Frequently</td>
<td>4 (17.4%)</td>
<td>12 (31.6%)</td>
<td>16 (26.2%)</td>
</tr>
<tr>
<td>Always</td>
<td>12 (52.2%)</td>
<td>13 (34.2%)</td>
<td>25 (41%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>23 (37.7%)</td>
<td>38 (62.3%)</td>
<td>61 (100%)</td>
</tr>
</tbody>
</table>
The Health Information Centre respondents were asked a series of questions to establish if having consulted a doctor previously with their problem they were satisfied or not with the explanation given by the doctor. Firstly, respondents were asked if they had previously consulted a doctor about the problem with which they were currently concerned. The responses are shown in Table 9.1.

### TABLE 9.1
Whether a doctor has been previously consulted or not

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4 (33.3%)</td>
<td>9 (60%)</td>
<td>13 (48.1%)</td>
</tr>
<tr>
<td>No</td>
<td>8 (66.7%)</td>
<td>6 (40%)</td>
<td>14 (51.9%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12 (44.4%)</td>
<td>15 (55.6%)</td>
<td>27 (100%)</td>
</tr>
</tbody>
</table>

The responses for male and female are to some degree inversely related.

The respondents were asked if having consulted a doctor they were satisfied with the explanation given by their doctor. Again the results for male and female were to some degree inversely related with 7 (77.8%) females compared to 1 (25%) male answering yes and 3 (75%) males compared to 2 (22.2%) females answering no.

### TABLE 9.2
Whether respondents were satisfied with doctors explanation or not

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1 (25%)</td>
<td>7 (77.8%)</td>
<td>8 (61.5%)</td>
</tr>
<tr>
<td>No</td>
<td>3 (75%)</td>
<td>2 (22.2%)</td>
<td>5 (38.5%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4 (30.8%)</td>
<td>9 (69.2%)</td>
<td>13 (100%)</td>
</tr>
</tbody>
</table>
The respondents who were not satisfied with the doctor's explanation were asked why. They were given a choice of reasons and were allowed to tick more than one reason, if appropriate. 2 (66.7%) males compared to no females said that the doctor did not explain the condition fully. One (33.3%) female who ticked 'other' said the doctor had not been able to provide a solution to her problem.

**TABLE 9.3**

Reasons for dissatisfaction with doctor's explanation of problem

<table>
<thead>
<tr>
<th>Reason</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor did not explain the condition fully</td>
<td>2 (66.7%)</td>
<td>0 (0%)</td>
<td>2 (33.3%)</td>
</tr>
<tr>
<td>Doctor appeared to not listen to your own views on the problem</td>
<td>1 (33.3%)</td>
<td>1 (33.3%)</td>
<td>2 (33.3%)</td>
</tr>
<tr>
<td>Doctor did not allow enough time for you to ask questions</td>
<td>0 (0%)</td>
<td>1 (33.3%)</td>
<td>1 (16.7%)</td>
</tr>
<tr>
<td>Doctor used too technical terms</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>1 (33.3%)</td>
<td>1 (16.7%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>3 (50%)</td>
<td>3 (50%)</td>
<td>6 (100%)</td>
</tr>
</tbody>
</table>

5.10 **Seeking health information on someone else's behalf**

The 3 samples were all asked relevant questions as to whether they were acting on someone else's behalf.

5.10.1 The Portsmouth respondents were asked if they ever visit the doctor on someone else's behalf. 21 (77.8%) respondents claimed never to visit on someone else's behalf. 13 (66.7%) males compared to 8 (66.7%) females never visited on behalf of someone else. 4 (33.3%) females compared to 2 (13.3%) males visited on someone else's behalf either sometimes or frequently.
5.10.2 The Health Centre respondents were asked if they were visiting the surgery on someone else's behalf. 15 (42.9%) respondents said yes whilst 19 (54.3%) respondents said no. One female respondent was enquiring both on her own behalf and on her child's behalf. More males claimed to be visiting the surgery on someone else's behalf than females.

### TABLE 10.2

<table>
<thead>
<tr>
<th>Visiting the surgery on someone else's behalf.</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5 (55.6%)</td>
<td>10 (38.5%)</td>
<td>15 (42.9%)</td>
</tr>
<tr>
<td>No</td>
<td>4 (44.4%)</td>
<td>15 (57.7%)</td>
<td>19 (54.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>1 (3.8%)</td>
<td>1 (2.8%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9 (25.7%)</td>
<td>26 (74.3%)</td>
<td>35 (100%)</td>
</tr>
</tbody>
</table>

5.10.3 The Health Information Centre respondents were asked if they were making enquiries on someone else's behalf. 14 (51.9%) respondents said yes while 13 (48.1%) respondents said no. 8 (53.3%) females compared to 6 (50%) males were making enquiries for someone else.
### TABLE 10.3
Making enquiries on someone else’s behalf

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6 (50%)</td>
<td>8 (53.3%)</td>
<td>14 (51.9%)</td>
</tr>
<tr>
<td>No</td>
<td>6 (50%)</td>
<td>7 (46.7%)</td>
<td>13 (48.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>12 (44.4%)</td>
<td>15 (55.6%)</td>
<td>27 (100%)</td>
</tr>
</tbody>
</table>

Table 10.4 represents an accumulation of the results from all three samples on making health enquiries on someone else’s behalf. 22 (41.5%) females compared to 13 (36.1%) males make health enquiries on someone else’s behalf. 30 (56.6%) females compared to 23 (63.9%) males do not make health enquiries for someone else.

### TABLE 10.4
An accumulation of results in Tables 10.1, 10.2 and 10.3

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13 (36.1%)</td>
<td>22 (41.5%)</td>
<td>35 (39.3%)</td>
</tr>
<tr>
<td>No</td>
<td>23 (63.9%)</td>
<td>30 (56.6%)</td>
<td>53 (59.6%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>1 (1.9%)</td>
<td>1 (1.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>

5.11 Those who were making enquiries for themselves

The Health Centre and the Health Information Centre respondents were asked either if they were visiting the surgery on their own behalf or if they were making enquiries for themselves.

5.11.1 The Health Centre respondents were asked if they were visiting the surgery on their own behalf. 19 (54.3%) respondents said yes whilst 15 (42.9%) respondents said no. One female respondent was enquiring both on her own behalf and on her child’s behalf.
TABLE 11.1
Are you visiting the surgery on your own behalf?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4 (44.4%)</td>
<td>15 (57.7%)</td>
<td>19 (54.3%)</td>
</tr>
<tr>
<td>No</td>
<td>5 (55.6%)</td>
<td>10 (38.5%)</td>
<td>15 (42.9%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>1 (3.8%)</td>
<td>1 (2.8%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>0 (0%)</td>
<td>26 (74.3%)</td>
<td>35 (100%)</td>
</tr>
</tbody>
</table>

5.11.2 The Health Information Centre respondents were asked if they were making enquiries for themselves. Their responses are shown in Table 11.2.

TABLE 11.2
Are you making enquiries on your own behalf?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9 (75%)</td>
<td>9 (60%)</td>
<td>18 (66.7%)</td>
</tr>
<tr>
<td>No</td>
<td>3 (25%)</td>
<td>6 (40%)</td>
<td>9 (33.3%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12 (44.4%)</td>
<td>15 (55.6%)</td>
<td>27 (100%)</td>
</tr>
</tbody>
</table>

Table 11.3 represents an accumulation of the results shown in Tables 11.1 and 11.2. 37 (59.7%) respondents were making enquiries on their own behalf as opposed to 24 (38.7%) respondents who were not. Very similar figures exist between male and female respondents.

TABLE 11.3
An accumulation of results shown in tables 11.1 & 11.2

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13 (61.9%)</td>
<td>24 (58.6%)</td>
<td>37 (59.7%)</td>
</tr>
<tr>
<td>No</td>
<td>8 (38.1%)</td>
<td>16 (39%)</td>
<td>24 (38.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>1 (2.4%)</td>
<td>1 (1.6%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>21 (33.9%)</td>
<td>41 (66.1%)</td>
<td>62 (100%)</td>
</tr>
</tbody>
</table>
5.12 Those for whom health enquiries are most often made

The three samples were all asked relevant questions about who they were making enquiries for, if not themselves.

5.12.1 The Portsmouth respondents were asked who they visit the doctor for, if not themselves. 4 (50%) respondents visited the doctor for their children. 3 (60%) females compared to 1 (33.3%) males visited for their children, while 1 (33.3%) male compared to no females visited the doctor for his spouse. The one female who ticked 'other' visited the doctor for her clients as she was a nurse for the mentally handicapped.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your children</td>
<td>1 (33.3%)</td>
<td>3 (60%)</td>
<td>4 (50%)</td>
</tr>
<tr>
<td>Elderly relative</td>
<td>1 (33.3%)</td>
<td>1 (20%)</td>
<td>2 (25%)</td>
</tr>
<tr>
<td>Husband/wife/partner</td>
<td>1 (33.3%)</td>
<td>0 (0%)</td>
<td>1 (12.5%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>1 (20%)</td>
<td>1 (12.5%)</td>
</tr>
<tr>
<td>Friend</td>
<td>0 (0%)</td>
<td>1 (20%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>3 (37.5%)</strong></td>
<td><strong>5 (62.5%)</strong></td>
<td><strong>8 (100%)</strong></td>
</tr>
</tbody>
</table>

5.12.2 The Health Centre respondents were asked who they were visiting the surgery for, if not themselves. 13 (81.3%) respondents were visiting for their children. 10 (90.9%) females compared to 3 (60%) males were visiting for their children. One (9.1%) female who ticked other was visiting for her grandson.
### TABLE 12.2
Who are you visiting the surgery for?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your children</td>
<td>3 (60%)</td>
<td>10 (90.9%)</td>
<td>13 (81.3%)</td>
</tr>
<tr>
<td>Husband/wife/partner</td>
<td>2 (40%)</td>
<td>0 (0%)</td>
<td>2 (12.5%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>1 (9.1%)</td>
<td>1 (6.3%)</td>
</tr>
<tr>
<td>Elderly relative</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Friend</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>5 (31.3%)</td>
<td>11 (68.8%)</td>
<td>16 (100%)</td>
</tr>
</tbody>
</table>

5.12.3 The Health Information Centre respondents were asked who they were making enquiries for, if not themselves. 4 (28.6%) respondents said they were making enquiries for a partner whilst the same amount of respondents said they were making enquiries for an elderly relative. One (16.7%) male who ticked other was making enquiries for students he was taking on a trip whilst one (12.5%) female was making enquiries for a client.

### TABLE 12.3
Who are you making enquiries for?

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband/wife/partner</td>
<td>2 (33.3%)</td>
<td>2 (25%)</td>
<td>4 (28.6%)</td>
</tr>
<tr>
<td>Elderly relative</td>
<td>2 (33.3%)</td>
<td>2 (25%)</td>
<td>4 (28.6%)</td>
</tr>
<tr>
<td>Your children</td>
<td>1 (16.7%)</td>
<td>1 (12.5%)</td>
<td>2 (14.3%)</td>
</tr>
<tr>
<td>Friend</td>
<td>0 (0%)</td>
<td>2 (25%)</td>
<td>2 (14.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (16.7%)</td>
<td>1 (12.5%)</td>
<td>2 (14.3%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>6 (42.9%)</td>
<td>8 (57.1%)</td>
<td>14 (100%)</td>
</tr>
</tbody>
</table>

Table 12.4 represents an accumulation of the results from all three samples which are shown in tables 12.1, 12.2 and 12.3. Although, strictly speaking, these cannot be accumulated, the results are interesting to see. 19 (50%) respondents make enquiries on behalf of their children. 14 (58.3%) females compared to 5 (35.7%) males
enquire on health matters for their children. 5 (35.7%) males compared to 2 (8.3%) females were making enquiries for their husband/wife/partner.

### TABLE 12.4
An accumulation of results shown in tables 12.1, 12.2, and 12.3

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your children</td>
<td>5 (35.7%)</td>
<td>14 (58.3%)</td>
<td>19 (50%)</td>
</tr>
<tr>
<td>Husband/wife/partner</td>
<td>5 (35.7%)</td>
<td>2 (8.3%)</td>
<td>7 (18.4%)</td>
</tr>
<tr>
<td>Elderly relative</td>
<td>3 (21.4%)</td>
<td>3 (12.5%)</td>
<td>6 (15.9%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (7.1%)</td>
<td>3 (12.5%)</td>
<td>4 (10.5%)</td>
</tr>
<tr>
<td>Friend</td>
<td>0 (0%)</td>
<td>2 (8.3%)</td>
<td>2 (5.3%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>14 (36.8%)</td>
<td>24 (63.2%)</td>
<td>38 (100%)</td>
</tr>
</tbody>
</table>

### 5.13 Convenience in visiting a doctor

All 89 respondents were asked how convenient (in terms of time, money, physical effort etc.) it was for them to visit their doctor. 19 (52.2%) males and 28 (52.8%) females stated that it was either convenient or very convenient to visit their doctor. However, 10 (27.8%) males and 10 (18.9%) females stated that it was inconvenient or very inconvenient to visit their doctor.

### TABLE 13
Convenience in visiting doctor

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very inconvenient</td>
<td>3 (8.4%)</td>
<td>6 (11.4%)</td>
<td>9 (10.1%)</td>
</tr>
<tr>
<td>Inconvenient</td>
<td>7 (19.4%)</td>
<td>4 (7.5%)</td>
<td>11 (12.4%)</td>
</tr>
<tr>
<td>Neutral</td>
<td>7 (19.4%)</td>
<td>15 (28.3%)</td>
<td>22 (24.7%)</td>
</tr>
<tr>
<td>Convenient</td>
<td>12 (33.3%)</td>
<td>23 (43.4%)</td>
<td>35 (39.3%)</td>
</tr>
<tr>
<td>Very convenient</td>
<td>7 (19.5%)</td>
<td>5 (9.4%)</td>
<td>12 (13.5%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>
5.14 Preference for doctor of the same sex

All respondents were asked whether they prefer to see a doctor of the same sex as themselves. 26 (72.2%) males compared to 28 (52.8%) females either stated they were indifferent or that occasionally they preferred a doctor of the same sex. 10 (27.8%) males and 25 (47.2%) females stated that either sometimes, frequently, or always they preferred to see a doctor of the same sex as themselves.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indifferent</td>
<td>22 (61.1%)</td>
<td>23 (43.4%)</td>
<td>45 (50.6%)</td>
</tr>
<tr>
<td>Occasionally</td>
<td>4 (11.1%)</td>
<td>5 (9.4%)</td>
<td>9 (10.1%)</td>
</tr>
<tr>
<td>Sometimes</td>
<td>4 (11.1%)</td>
<td>15 (28.3%)</td>
<td>19 (21.3%)</td>
</tr>
<tr>
<td>Frequently</td>
<td>1 (2.8%)</td>
<td>6 (11.4%)</td>
<td>7 (7.9%)</td>
</tr>
<tr>
<td>Always</td>
<td>5 (13.9%)</td>
<td>4 (7.5%)</td>
<td>9 (10.1%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>

5.15 Initial confidant for health matters

All respondents were asked who they would turn to first if they were concerned about their health. 22 (61.1%) males compared to 24 (45.3%) females said they would turn to a husband/wife/partner. 21 (39.6%) females compared to 9 (25%) males said they would turn to a doctor first.
TABLE 15
Initial confidant for health matters

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husband/wife/partner</td>
<td>22 (61.1%)</td>
<td>24 (45.3%)</td>
<td>46 (51.7%)</td>
</tr>
<tr>
<td>Doctor</td>
<td>9 (25%)</td>
<td>21 (39.6%)</td>
<td>30 (33.7%)</td>
</tr>
<tr>
<td>Relative</td>
<td>3 (8.3%)</td>
<td>4 (7.5%)</td>
<td>7 (7.9%)</td>
</tr>
<tr>
<td>Friend</td>
<td>2 (5.6%)</td>
<td>4 (7.5%)</td>
<td>6 (6.7%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>

5.16 Life threatening or disabling illness

All respondents were asked if they, or anybody close to them, had ever suffered from a life threatening or disabling illness. Their responses are shown in Table 16.

TABLE 16
Life threatening or disabling illness

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22 (61.1%)</td>
<td>29 (54.7%)</td>
<td>51 (57.3%)</td>
</tr>
<tr>
<td>No</td>
<td>14 (38.9%)</td>
<td>24 (45.3%)</td>
<td>38 (42.7%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>36 (40.4%)</td>
<td>53 (59.6%)</td>
<td>89 (100%)</td>
</tr>
</tbody>
</table>

5.17 Social role stresses e.g. running the household

Firstly, all respondents were asked who was in charge of running the household at home. Respondents were then asked to state how difficult or easy they found running the household, if they took part. Table 17 shows 29 (54.7%) females and 8 (22.2%) males stated that they alone were responsible for running the household. Alternatively 4 (11.1%) males and 2 (3.8%) females stated that someone else was in charge.
Table 17.1 shows that 20 (39.2%) females compared to 9 (28.1%) males found running the household either easy or very easy. 8 (15.7%) females compared to 10 (31.3%) males found running the household difficult or very difficult. However, 23 (45.1%) females and 13 (40.6%) males remained neutral on the matter.

### TABLE 17.1

How easy or difficult respondents perceived running the household

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very difficult</td>
<td>3 (9.4%)</td>
<td>0 (0%)</td>
<td>3 (3.6%)</td>
</tr>
<tr>
<td>Difficult</td>
<td>7 (21.9%)</td>
<td>8 (15.7%)</td>
<td>15 (18.1%)</td>
</tr>
<tr>
<td>Neutral</td>
<td>13 (40.6%)</td>
<td>23 (45.1%)</td>
<td>36 (43.4%)</td>
</tr>
<tr>
<td>Easy</td>
<td>7 (21.9%)</td>
<td>13 (25.5%)</td>
<td>20 (24.1%)</td>
</tr>
<tr>
<td>Very Easy</td>
<td>2 (6.2%)</td>
<td>7 (13.7%)</td>
<td>9 (10.8%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>32 (38.6%)</td>
<td>51 (61.4%)</td>
<td>83 (100%)</td>
</tr>
</tbody>
</table>

5.18 Concern with appearance

All respondents were asked a series of four questions in order to measure their concern with their appearance (see section 4.4.2). The lowest possible score was '1' and the highest was '5'. However, no respondent scored lower than 1.5 nor higher than 4.75. The score obtained by most respondents i.e. 15 (18%) was 3.5. The score obtained by most females i.e. 10 (18.9%) was 3.75 whilst 7 (19.4%) males scored 3.25. 12 (33.3%) males compared to 5 (9.5%) females scored 2.5 or less.
TABLE 18
Concern with appearance

<table>
<thead>
<tr>
<th>Concern with appearance</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.50</td>
<td>2.00</td>
<td>2.25</td>
</tr>
<tr>
<td></td>
<td>0 (0%)</td>
<td>1 (0.9%)</td>
<td>1 (0.9%)</td>
</tr>
<tr>
<td></td>
<td>1 (1%)</td>
<td>4 (4.5%)</td>
<td>3 (5.7%)</td>
</tr>
<tr>
<td></td>
<td>36 (40.4%)</td>
<td>1 (0.9%)</td>
<td>16 (18%)</td>
</tr>
</tbody>
</table>

5.19 Patients' rights to information

The Portsmouth and The Health Centre respondents were asked to what extent they agreed with the statement: 'Doctors should provide detailed information to a patient on their medical condition.' 35 (92.1%) females and 22 (91.6%) males either agreed or strongly agreed with the statement. No females disagreed but 3 (7.9%) were neutral.

TABLE 19
Level of agreement to doctors supplying information to patients

<table>
<thead>
<tr>
<th>Level of agreement</th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (4.2%)</td>
<td>0 (0%)</td>
<td>1 (1.6%)</td>
</tr>
<tr>
<td>Neutral</td>
<td>1 (4.2%)</td>
<td>3 (7.9%)</td>
<td>4 (6.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>12 (50%)</td>
<td>22 (57.9%)</td>
<td>34 (54.8%)</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>10 (41.6%)</td>
<td>13 (34.2%)</td>
<td>23 (37.1%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>24 (38.7%)</td>
<td>38 (61.3%)</td>
<td>62 (100%)</td>
</tr>
</tbody>
</table>
5.20 Agreement/disagreement to patients' freedom to make decisions about their treatment

The Portsmouth and The Health Centre respondents were asked to what extent they agreed with the statement: 'Doctors should give patients full freedom to make decisions about their treatment after a full explanation of the problem.' 35 (92.1%) females compared to 16 (66.6%) males either agreed or strongly agreed with the statement. 2 (4.2%) males and no females disagreed or strongly disagreed with the statement.

**TABLE 20**

Level of agreement to patients' freedom to make decisions about their treatment

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly disagree</td>
<td>1 (4.2%)</td>
<td>0 (0%)</td>
<td>1 (1.6%)</td>
</tr>
<tr>
<td>Disagree</td>
<td>1 (4.2%)</td>
<td>0 (0%)</td>
<td>1 (1.6%)</td>
</tr>
<tr>
<td>Neutral</td>
<td>6 (25%)</td>
<td>3 (7.9%)</td>
<td>9 (14.5%)</td>
</tr>
<tr>
<td>Agree</td>
<td>11 (45.8%)</td>
<td>25 (65.8%)</td>
<td>36 (58.1%)</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>5 (20.8%)</td>
<td>10 (26.3%)</td>
<td>15 (24.2%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>24 (38.7%)</td>
<td>38 (61.3%)</td>
<td>62 (100%)</td>
</tr>
</tbody>
</table>

5.21 Social role of women

All respondents were asked two questions on the social roles of women. Firstly, they were asked to what extent they agreed with the statement: 'Women have less areas in life than men in which they can fully exercise choice.' Table 21 shows the responses. 24 (45.3%) females compared to 20 (55.5%) males agreed or strongly agreed with the statement. 17 (32.1%) females and 10 (27.8%) males disagreed or strongly disagreed with the statement. No females, however, strongly disagreed with the statement.
Table 21.1 shows to what extent respondents agreed with the statement: 'It is more socially acceptable for women than men to admit weakness and to seek help when they have a problem.' 34 (64.1%) females compared to 22 (61.1%) males agreed or strongly agreed with the statement. 11 (20.8%) females and 8 (22.2%) males disagreed or strongly disagreed with the statement.

### TABLE 21.1

It is more socially acceptable for women than men to admit weakness and to seek help when they have a problem
CHAPTER SIX - DISCUSSION

Introduction

The samples used in this study were too small for any decisive conclusions to be drawn from the results. However, it is hoped that the results may indicate some important trends.

6.1 Gender and perceptions of health

One of the aims of the survey was to determine whether or not gender affects how a person perceives their health generally. A slightly greater proportion of females to males felt their health to be good or very good. In addition, slightly more females than males claimed to attach a high importance to their health. Conversely, a few more males than females were relatively unconcerned with their health (see sections 5.2 and 5.3). These results are possibly an indication of the more active role which women take in their health care.

6.2 Health information sources

The survey indicated that different sources of health information are used to different degrees by men and women. In particular, women make more use of their health-care providers than men, whilst men appear to rely more heavily on their close social network of friends and/or relatives. Perhaps this reflects that admitting illness is more threatening to a man than to a woman, or that men take illness less seriously than women. Men also claim to gain more of their health information from the media, i.e. television, radio and newspapers than women, though women obtain more information from magazines than men. It is possible that men gain their health information much more within the home/private sphere whereas women obtain most of their health information in the public sphere.
6.3 Initial confidant for health matters

In keeping with where men and women obtain most of their health information, a greater proportion of males (61.1%) than females (45.3%) said they would turn first to their husband/wife/partner if they were concerned about their health. In addition 21 (39.6%) females compared to 9 (25%) males said they would turn first to their doctor. This is another possible indication that men prefer to keep their health matters within the private sphere while women go into the public sphere much more.

6.4 The type of health information looked for

The majority of females (71.7%) compared to 38.9% males had looked for information on diet. This figure could include looking for information on nutrition as well as losing weight and unfortunately this is not distinguished between in the results. However, the results could be seen as an indication of the obsession that our society has with the female slenderness ideal - and that women obtain this ideal by dieting to a greater extent, than by exercising.

Family planning, women's health matters and children's health matters accounted for 38.9% of the information sought by women compared to 19.4% for men. Reproduction, birth control, etc and women's social role as carers must account to some degree for their predominance as enquirers into health matters. Interestingly, more men (33.3%) had looked for information on chronic disease than females (20.8%). Although more females suffer from non life-threatening chronic diseases, more males suffer from life threatening or disabling chronic diseases. In addition more females suffer acute diseases than males and a greater proportion of females (22.6%) to males (13.9%) had looked for information on acute diseases.
Only a very small margin existed between males (19.4%) and females (22.6%) who had looked for information on psychological problems so few conclusions can be drawn. However, 10 (27.8%) males compared to 10 (18.9%) females had looked for information on physical/sport injuries, an indication perhaps of the more 'macho' image attached to illnesses which have a definite physical rather than emotional or social origin.

6.5 Reasons for visiting the Health Centre

As could be expected, 10 (38.5%) females and no males were attending the surgery for women's health matters, again demonstrating how this plays a part in women's health care behaviour. A greater proportion of women (42.3%) to men (33.3%) were attending for children's health matters. 2 (22.2%) males were at the surgery simply because they were accompanying their wife or partner. Although the very small numbers make conclusions difficult it is interesting to note that a higher proportion of men (11.1%) to women (3.8%) were attending for a chronic disease and 1 (3.8%) woman but no men were attending for an acute disease. These results match those found elsewhere in the literature for the type of health information sought by men and women.

6.5.1 Reasons for visiting the Health Information Centre

These were so varied that no discernible trend is noticeable. The question, therefore, proved to be obsolete as it was not possible to fit the enquiries into similar categories to those used for the Health Centre.
6.6 Attitudes towards health-care providers

6.6.1 Satisfaction with doctor's explanations

There was some difficulty with the questionnaire design here as the Portsmouth and Health Centre respondents were all asked the same question (when you visit your doctor are you satisfied with the way in which he/she explains your problem to you?) but the Health Information Centre respondents were asked the question in a slightly different way.

Firstly, from the Portsmouth and Health Centre respondents it appeared that men were more satisfied with their doctors than women. 12 (52.2%) males compared to 13 (34.2%) females were always satisfied with their doctor. However, a greater proportion of females (31.6%) than males (17.4%) were frequently satisfied so the evidence is a little unclear. One could state though that the females seemed a little more reserved in claiming complete satisfaction with their doctors.

The Health Information respondents were asked a series of questions to establish if, having consulted a doctor previously with their problem, they were satisfied or not with the explanation given by the doctor. A greater proportion (60%) of females than males (33.3%) had previously consulted a doctor indicating their greater use of health-care providers. Interestingly, though, a far greater proportion of females (77.8%) than males (25%) said they had been satisfied with the explanation they received. It would have been interesting to know why these women had brought their problem to the Health Information Centre if they were satisfied with their doctors explanation, but, unfortunately, no allowance was made for this in the questionnaire. It is likely that these women are supplementing information that they received at the doctors. In addition, not all the information asked for at the Health Information Centre was strictly concerned with illnesses/diseases but more to do with health
welfare, and may have been, therefore, something mentioned very briefly to their doctor and in return a very brief answer was received.

The Health Information respondents who were not satisfied with their doctor proved to be such a small sample that no definite conclusions are available.

6.6.2 Preference for a doctor of the same sex

One of the aims of this study has been to determine whether the gender of the doctor and the patient plays a part in the doctor-patient relationship. The results of the survey indicated that 26 (72.2%) males compared to 26 (52.8%) females were either indifferent or only occasionally prefer to see a doctor of the same sex as themselves. Conversely, 25 (47.2%) females compared to 10 (27.8%) males preferred to either sometimes, frequently or always see a doctor of the same sex as themselves. As most women patients have to see a doctor of the opposite sex it is possible that this could cause some dissatisfaction for a female patient who may prefer a female doctor.

6.6.3 Convenience in visiting a doctor

It was found that both 52.8% males and 52.8% females found visiting the doctor either convenient or very convenient. However, 7 (19.5%) males and only 5 (9.4%) females found it very convenient, disputing perhaps, the claim that women have more time on their hands to visit the doctor which is why they consult more. In addition, 6 (11.4%) females and only 3 (8.4%) males found it very inconvenient to visit their doctor. It should be noted though that 10 (27.8%) males and 10 (18.9%) females found it either inconvenient or very inconvenient. The figures do not appear to show any great difference in how convenient it is for men or women to attend their doctor.
6.7 Seeking information on someone else's behalf

The three samples used meant that slightly different questions were directed at each sample. The results from the Portsmouth respondents shows clearly that women attend a doctor on someone else's behalf more frequently than men. 13 (86.7%) males compared to 8 (66.7%) females never visited a doctor on someone else's behalf.

At the Health Centre more males (55.6%) than females (42.3%) claimed to be visiting the surgery on someone else's behalf. However, 2 (22.2%) of those males were at the surgery simply waiting for their wife/partner to see the doctor. All the women, on the other hand, were accompanying either their children (38.5%) or their grandson (3.8%). If this is taken into account then only 3 (33.3%) males are strictly at the surgery on someone else's behalf compared to 11 (42.3%) females.

At the Health Information Centre there was a slightly greater proportion of women (53.3%) to men (50%) who were enquiring for someone else.

An accumulation of these results show that a greater proportion of women (43.4%) to men (36.1%) enquire on behalf of someone else. However, if the 2 men waiting for their wife/partner at the Health Centre are taken into account the percentage of men enquiring on someone else's behalf is reduced to 30.6%. These results would seem to demonstrate that women's social role as carers does affect their health-care behaviour and explains, in part, the high proportion of female health enquirers.
6.7.1 Those for whom health enquiries are most often made

All respondents were asked who they were enquiring for, if not themselves. Overall, more women than men were enquiring for their children, i.e. 14 (58.3%) females compared to 5 (35.7%) males. Although 5 (35.7%) males and only 2 (8.3%) females were enquiring for their husband/wife/partner this figure has to be treated with caution. Of those 5 men 2 were accompanying their partners at the surgery and 1 was also accompanying his wife at the Health Information Centre for an enquiry which did not involve him. This figure becomes very precarious, therefore, and maybe a truer reflection of the truth would be 2 (14.3%) men were enquiring on their partner's behalf. Overall, the most prominent feature to emerge is that women are primarily responsible for their children's health care.

6.8 Those who are making enquiries for themselves

Obviously it was only possible to address a question of this nature to the Health Centre and Health Information Centre respondents as they were actively engaged in pursuing information at the time. At the Health Centre a greater proportion of women (61.5%) were attending the surgery on their own behalf than men (44.4%). However, those men that were waiting for wives/partners were not strictly either attending on their own behalf or on someone else's behalf. In addition, one woman was attending for herself and her child.

At the Health Information Centre, 9 (75%) males compared to 9 (60%) females were enquiring for themselves reflecting the amount of women who enquire on someone else's behalf.

However, an accumulation of the results show that similar proportions of males and females were enquiring on their own behalf, i.e. 13 (61.9%) males and 25 (61%) females. These figures cannot be compared to the figures for enquiring on someone else’s behalf as the sample used does not include the Portsmouth respondents.
6.9 Life threatening or disabling illness

It was felt that had a respondent personally suffered, or was close to somebody who had suffered, a life threatening or disabling illness that this may affect their preventive health care behaviour. In particular, it was believed that those respondents who answered yes to this question were more likely to take an active role in their health care and actively seek health information. However, it was found that 22 (61.1%) men compared to 29 (54.7%) women answered yes whilst 14 (38.9%) men and 24 (45.3%) women answered no. Life threatening or disabling illnesses may affect the individual's behaviour but as the figures confirm the fact that more men suffer life threatening illnesses than women it would appear these illnesses do not alter the overall gender divide that exists between health information enquirers.

6.10 Social role stresses

The survey attempted to establish whatever the social role of housewife is stressful and unfulfilling and so consequently plays a part in women's predominant use of health care services. Respondents were asked who was in charge of running the household. As could probably be expected 29 (54.7%) females and only 8 (22.2%) males started they alone were in charge of the household. In addition 4 (11.1%) males and only 2 (3.8%) females stated that someone else was in charge. When those that took part in the running of the household were asked how easy or difficult they found it 20 (39.2%) females and 9 (28.1%) males found it either easy or very easy. In addition, 8 (15.7%) females and 10 (31.3%) males found it difficult or very difficult. Although those figures would appear to show that women do find housework easy it does not necessarily follow that women do not find housework stressful. The fact that 23 (45.1%) females compared to 13 (40.6%) males remained neutral is perhaps an indicator of the boredom and the possible stress attached to housework. The results overall are probably more of an indicator of women's greater familiarity with housework compared to men's. It is difficult to draw conclusions, therefore, as to how this particular social role affects women's use of health care services and health information sources.
6.11 Concern with appearance

One of the aims of the survey was to determine whether gender plays a part in an individual's concern with appearance. The close association between 'health and beauty' which exists in our culture could affect women's predominance as enquirers into health information. From a series of questions asked each respondent gained an overall score (see section 4.4.2). The modal average for females was 3.75 which was scored by 10 (18.9%) women whilst for men, the modal average was lower at 3.25 scored by 7 (19.4%) men. A greater proportion of males (47.2%) than females (35.8%) scored the median average of 3 or less. These figures would suggest, therefore, that women have a greater concern with their appearance than men. When one considers that far more women than men looked for information on diet, either because they wish to lose weight or to find out more about nutrition, a very tenuous link between concern with appearance and health care behaviour can be made.

6.12 Patients' right to information

An attempt was made to establish if gender affects an individual's belief in the patient's right to detailed information on their medical condition. A belief of this sort could possibly explain active seeking of health information, which is affected by gender. However, both 35 (92.1%) females and 22 (91.6%) males either agreed or strongly agreed with this belief. In actual fact, a greater proportion of males (41.6%) than females (34.2%) strongly agreed with supplying detailed information. One (4.2%) male disagreed with the belief whilst no women disagreed. These figures do support other research evidence that many patients feel it important to receive enough information from their doctors. They do not explain, however, women's more active role than men in seeking health information from alternative sources other than the medical profession.
6.13 Patients' freedom to make decisions about their treatment

When the same respondents as those in section 6.12 were asked to what extent they agreed that 'doctors should give patients full freedom to make decisions about their treatment after a full explanation of the problem' somewhat different results to those in section 6.12 were obtained. 35 (92.1%) females compared to 16 (66.6%) males either agreed or strongly agreed with this statement. A large percentage, therefore, of the women felt this statement to be true but the percentage of males had fallen from the 91.6% of men who agreed that full information should be provided to 66.6%. In addition, 2 (8.4%) men as opposed to no women disagreed or strongly disagreed with the statement.

It is tenuously suggested that women may be more concerned with having choices in their health care than men are. This consequently could urge women to actively seek health information so that they have the knowledge necessary to make these choices.

6.14 Social roles of women

One aim of the survey was to yield information on how some social roles of women affect their seeking of health information. The main problem encountered, of course, was that this in itself could have been the sole theme of a questionnaire. However, the researcher did attempt to obtain a very few subjective opinions in order to gain some insight.

All respondents were asked to what extent they agreed with the statement 'women have less areas in life than men in which they can fully exercise choice.' Obviously, a question of this sort does provide problems of interpretation. The results obtained showed that fewer women (45.3%) than men (55.5%) agreed or strongly agreed with the statement, whilst fewer men (27.8%) than women (32.1%) disagreed or strongly disagreed. A minority of both men and women disagreed with the statement so it would appear that there is generally a
belief that women have fewer choices in life than men. As has previously been shown (section 6.13) a large majority of female respondents felt it important to be able to make choices about their medical treatment. More women (22.6%) than men (16.7%) remained neutral on whether women have fewer choices than men. If these respondents had been questioned further on this issue then more in depth, and possibly quite different results, could have been obtained.

6.15 Social acceptability for women to admit weakness

When respondents were asked to what extent they agreed with the statement: 'It is more socially acceptable for women than men to admit weakness and to seek help when they have a problem', slightly different results from those in section 6.14 were obtain. 34 (64.1%) females compared to a slightly lower figure of 22 (61.1%) males agreed or strongly agreed with this statement. In addition, 11 (20.8%) females and 8 (22.2%) males disagreed or strongly disagreed with the statement.

Overall, a fairly substantial majority of respondents (both male and female) agreed that it is more socially acceptable for women to admit weakness and seek help when they have a problem. It could be argued that the belief is a self-fulfilling prophecy in that if women are expected to admit weakness and seek help then they are more likely to do so, therefore, reinforcing the belief that it is more socially acceptable for women to admit weakness and seek help.
CHAPTER SEVEN - CONCLUSIONS AND RECOMMENDATIONS

7.1 General Conclusion

If one is to answer the question 'why do women predominate as enquirers into health information' then the most obvious starting point has to be gender identities. Throughout history, woman has been perceived as more emotional, irrational, and unpredictable than man. Women, therefore, have had to be regulated in the interest of social order. The medical profession, particularly during the eighteenth and nineteenth centuries, through its medicalisation of the female body contributed to this regulation of women.†

Today that medicalisation continues with women being treated as patients during natural physiological processes such as childbirth. Consequently, women often come into contact with health care services when they are healthy. Additionally, their social roles as carers in the family brings women into the medical orbit. Women's interest in health information may also be a consequence of many women needing to be knowledgeable about health in order to act as the health educator within the family and serve as gatekeepers between the family and the outside world.

It is extremely difficult to measure to what extent other social roles affect women's concern with health matters. The multiple role of mother, housewife, and employee can bring frustration and tension which requires some form of outlet. To argue that many women suffer greater mental stress than men is in part playing into the hands of the medical viewpoint that women are more emotionally unstable than men. However, this does not justify the rate at which mood-altering drugs are so often prescribed to women. This form of treatment often only numbs the symptoms and does nothing to eradicate the cause.

Historically, women have been seen as 'biologically' more excitable and prone to mental illness. In addition, much greater emphasis is placed on women verbalising their health problems and
seeking help for a problem. In contrast, illness is purported to be a much more threatening experience to a man's gender identity than to a woman's. To be ill is to take on more feminine, and less masculine, characteristics, such as dependency and submissiveness.

Many research studies have focused on how doctor-patient communication is often ineffective and how patients report dissatisfaction with the information they receive from their doctors. Little attention, however, has been paid to how gender affects the doctor-patient relationship. Some research studies, though, have tentatively suggested that opposite gender identities between doctor and patient may exasperate the dissatisfactions experienced in the doctor-patient relationship (see Chapter 3). The results of this study have shown that more women than men prefer to see a doctor of the same sex as themselves and that overall, the female respondents at Portsmouth and at the Health Centre were less satisfied with their doctor than the male respondents. It is suggested that because of the more active role which women take in their health care and the fact that they express greater dissatisfaction with their doctors than men, women may supplement the sometimes inadequate information received from their doctors with information obtained from other sources.

As argued in the literature review of this study, concern with health is constructed, in our culture, as a feminine rather than a masculine characteristic. For example, the survey showed how women's role as carers, i.e. being primarily responsible for other family member's mental and physical wellbeing, stresses that illness and health are 'women's business'. Gender identities, therefore, are an integral part of why women predominate as enquirers into health information.
7.2 Specific conclusions arising from the survey

1. Women tend to gain their health information from the public sphere, i.e. medical profession, health information centres, whilst men tend to gain their health information from the private sphere, i.e. social network of relatives and friends, television, newspapers, etc. The survey appeared to show that it is more socially acceptable for women to admit weakness and to seek help for a problem.

2. Women's health matters and children's health matters accounted for a large majority of the health information sought by women and was also a significant proportion of the reasons for utilising health care services. The medicalisation of women and their role as carers was shown, therefore, to contribute to their predominance as health information enquirers.

3. A greater proportion of females to males preferred to see a doctor of the same sex as themselves. It was not asked whether there was a preference when specifically dealing with women's health matters or when dealing with health matters generally. Gender roles may effect the doctor-patient relationship.

4. It is not the case that women in the survey found it more convenient to visit their doctor than the men. Although it has been argued that women's time is more flexible than men's it is suggested that many women have multiple roles and often, therefore, have little time on their hands.

5. Enquiries into health could lead to behaviour which reduces life threatening illnesses. Alternatively, suffering from life threatening illnesses may affect the individual's health care behaviour. However, more men than women suffer from key life threatening illnesses and yet more women enquire into health matters. Arguably, therefore, gender identities affect health care behaviour more than the affect of having a life threatening illness.
6. Some health information sought by women may have as much to do with concern over their appearance as to do with health. Media portrayals and the slenderness ideal which exists in our culture may affect this.

7. A very large majority of the female respondents were concerned with freedom to make choices about their medical care. Choices cannot not be made without information and knowledge. Within the sphere of health having choices was more important to the female respondents than the male respondents.

7.3 Recommendations

1. One of the problems of this study was that much of the data it yielded was of a subjective nature. This is to some extent unavoidable when dealing with an issue which is primarily a consequence of the culture and society within which we live. Few research studies have directly addressed the issue of why women predominate as health enquirers. Much more research is required, therefore, in order to gain further insight into this subject.

2. More research is required on how gender affects the doctor-patient relationship and whether this has a 'knock-on' effect on women seeking health information elsewhere.

3. Investigations should be conducted to establish how the medical profession could provide women with greater freedom of choice, particularly in the area of reproduction and childbirth.
4. More health information addressed to men should be produced. Men should be encouraged to believe that concern with health matters is not simply a 'woman's business'. They should also be encouraged to take more responsibility not only for other's health but also for their own health. If the role of carer is shared more equally between men and women, women may then be 'freer' to exert some of their talents and energies towards living more of their own life rather than simply existing for the good of others.

5. In order for change to take place we need first to fully understand the images of sickness and health and the gender identities which exist within those images. Moreover, that understanding should then be used to provide more effective and wide reaching health information services.
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Appendix One - Pilot Study Questionnaire
I would be most grateful if you could assist me by filling out the following questionnaire. The questionnaire is anonymous and will be completely confidential. Please tick only one answer to each question unless stated otherwise.

1. Do you consider your general state of health to be:
   - Very good
   - Good
   - Fair
   - Poor
   - Very poor

2. Please tick one of the following statements with which you agree:
   (i) My health is the most important consideration in my life.
   (ii) Whenever I'm ill, no matter how mild the symptom, I take it seriously.
   (iii) I only think about my health from time to time.
   (iv) I almost never take the illnesses I get seriously.

3. Illness can be avoided if I take care of myself.
   - Strongly disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly agree

4. Becoming ill is usually a result of something which I have or have not done.
   - Strongly disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly agree

5. When I get ill it is because of eating incorrectly and lack of exercise.

6. Peoples ill health results from their own careless actions
   - Strongly disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly agree
7. I am directly responsible for my own health.
   - Strongly disagree
   - Disagree
   - Neutral
   - Agree
   - Strongly agree

8. How important is it to you to be considered attractive?
   - Not at all important
   - Not very important
   - Neutral
   - Important
   - Very important

9. If you are female, how important is it to you to be considered slim?
   - Not at all important
   - Not very important
   - Neutral
   - Important
   - Very important

10. If you are male, how important is it to you to be considered muscular?
    - Not at all important
    - Not very important
    - Neutral
    - Important
    - Very important

11. How important is it to you to be well dressed?
    - Not at all important
    - Not very important
    - Neutral
    - Important
    - Very important

12. How important is it to you to have a good complexion?
    - Not at all important
    - Not very important
    - Neutral
    - Important
    - Very important
13. From which of the following do you obtain your health information? (you may tick more than one)

- Relatives/friends
- Television
- Radio
- Newspapers
- Magazines
- Library
- Workplace
- Health information centre
- Health-care provider
- Other (please specify)

14. From which of the following do you gain the most health information? (please tick only one)

- Relatives/friends
- Television
- Radio
- Newspapers
- Magazines
- Library
- Workplace
- Health information centre
- Health-care provider
- Other (please specify)

15. Have you ever looked for information on any of the following? (you may tick more than one)

- Diet
- Exercise
- Family planning
- Women's health matters
- Children's health matters
- Chronic disease (i.e. a disease which progresses slowly and persists over a long period of time)
- Acute disease (i.e. a disease which has a short and relatively severe course)
- Psychological problems (e.g. anxiety/depression)
- Physical/sport injuries
- Other (please specify)
16. Do you ever visit your doctor?

Yes [ ]
No [ ]

If yes:

When you visit your doctor are you satisfied with the way in which he/she explains your problem to you?

Never [ ]
Occasionally [ ]
Sometimes [ ]
Frequently [ ]
Always [ ]

17. Do you ever visit the doctor on someone else's behalf?

Never [ ]
Occasionally [ ]
Sometimes [ ]
Frequently [ ]
Always [ ]

If you do, is it for:

Your children [ ]
Husband/wife/partner [ ]
Elderly relative [ ]
Friend [ ]
Other (please specify) [ ]

18. How convenient (in terms of time, money and physical effort etc.) is it for you to visit your doctor?

Very inconvenient [ ]
Inconvenient [ ]
Neutral [ ]
Convenient [ ]
Very convenient [ ]

19. Have you a male doctor?

Yes [ ]
No [ ]

20. Do you prefer to see a doctor of the same sex as yourself?

Never [ ]
Occasionally [ ]
Sometimes [ ]
Frequently [ ]
Always [ ]
21. If you were concerned about your health, who would you turn to first?

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<td>Husband/wife/partner</td>
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22. Have you, or anybody close to you, ever suffered from a serious illness?

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<td>Yes</td>
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If yes, did the illness prove curable?

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<td>Yes</td>
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23. At home, who is in charge of running the household?

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<td>Yourself</td>
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<td>Someone else</td>
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If you are involved in running the household, how easy or difficult do you find it?

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<td>Very difficult</td>
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<tr>
<td>Easy</td>
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<tr>
<td>Very easy</td>
<td></td>
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</table>

24. Doctors should provide detailed information to a patient on their medical condition.

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<tr>
<td>Strongly disagree</td>
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<tr>
<td>Disagree</td>
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<td>Neutral</td>
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<tr>
<td>Agree</td>
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<tr>
<td>Strongly agree</td>
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</table>

25. Doctors should give patients full freedom to make decisions about their treatment after a full explanation of the problem.

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<tbody>
<tr>
<td>Strongly disagree</td>
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<td>Neutral</td>
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<tr>
<td>Agree</td>
<td></td>
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<tr>
<td>Strongly agree</td>
<td></td>
</tr>
</tbody>
</table>
26. Women have few areas in which they can exercise choice.

   Strongly disagree [ ]
   Disagree [ ]
   Neutral [ ]
   Agree [ ]
   Strongly agree [ ]

27. It is more socially acceptable for women than men to admit weakness and to seek help when they have a problem.

   Strongly disagree [ ]
   Disagree [ ]
   Neutral [ ]
   Agree [ ]
   Strongly agree [ ]

28. Are you:

   Male [ ]
   Female [ ]

29. Age last birthday:

   16-24 years [ ]
   25-34 years [ ]
   35-44 years [ ]
   45-54 years [ ]
   55-64 years [ ]
   65 and over [ ]

30. Marital status:

   Single [ ]
   Married [ ]
   Widowed [ ]
   Divorced [ ]
   Separated [ ]

31. Occupation: ____________________________

   Husband/wife/partner's occupation: ____________
   (if applicable)

Thankyou for your cooperation.
Appendix Two - Portsmouth City Band Questionnaire
I would be most grateful if you could assist me by filling out the following questionnaire. The questionnaire is anonymous and will be completely confidential. Please tick only one answer to each question unless stated otherwise.

1. Do you consider your general state of health to be:
   - Very good
   - Good
   - Fair
   - Poor
   - Very poor

2. Please tick one of the following statements with which you agree:
   (i) My health is the most important consideration in my life.
   (ii) Whenever I'm ill, no matter how mild the symptom, I take it seriously.
   (iii) I only think about my health from time to time.
   (iv) I almost never take the illnesses I get seriously.

3. From which of the following do you obtain your health information? (you may tick more than one)
   - Relatives/friends
   - Television
   - Radio
   - Newspapers
   - Magazines
   - Library
   - Workplace
   - Health information centre
   - Health-care provider
   - Other (please specify)

4. Where do you obtain the most health information? (please tick only one)
   - Relatives/friends
   - Television
   - Radio
   - Newspapers
   - Magazines
   - Library
   - Workplace
   - Health information centre
   - Health-care provider
   - Other (please specify)
5. Have you ever looked for information on any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Exercise</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Family planning</td>
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</tr>
<tr>
<td>Women's health matters</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Children's health matters</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Chronic disease</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Acute disease</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Psychological problems</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Physical/sport injuries</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

6. Do you ever visit your doctor?

- Yes [ ]
- No [ ]

If yes:

When you visit your doctor are you satisfied with the way in which he/she explains your problem to you?

- Never [ ]
- Occasionally [ ]
- Sometimes [ ]
- Frequently [ ]
- Always [ ]

7. Do you ever visit the doctor on someone else's behalf?

- Never [ ]
- Occasionally [ ]
- Sometimes [ ]
- Frequently [ ]
- Always [ ]

If you do, is it for:

- Your children [ ]
- Husband/wife/partner [ ]
- Elderly relative [ ]
- Friend [ ]
- Other (please specify) [ ]
8. How convenient (in terms of time, money and physical effort etc.) is it for you to visit your doctor?

Very inconvenient [ ]
Inconvenient [ ]
Neutral [ ]
Convenient [ ]
Very convenient [ ]

9. Do you prefer to see a doctor of the same sex as yourself?

Indifferent [ ]
Occasionally [ ]
Sometimes [ ]
Frequently [ ]
Always [ ]

10. If you were concerned about your health, who would you turn to first?

Husband/wife/partner [ ]
Relative [ ]
Friend [ ]
Doctor [ ]
Other (please specify) [ ]

11. Have you, or anybody close to you, ever suffered from a life - threatening or disabling illness?

Yes [ ]
No [ ]

12. At home, who is in charge of running the household?

Yourself [ ]
You and someone else [ ]
Someone else [ ]

If you are involved in running the household, how easy or difficult do you find it?

Very difficult [ ]
Difficult [ ]
Neutral [ ]
Easy [ ]
Very easy [ ]
Please tick the appropriate box for each of the following questions and statements on attitudes.

13. How important is it to you to be considered attractive by others?
   Not at all important [ ]
   Not very important [ ]
   Neutral [ ]
   Important [ ]
   Very important [ ]

14. How important is it to you to be considered slim?
   Not at all important [ ]
   Not very important [ ]
   Neutral [ ]
   Important [ ]
   Very important [ ]

15. Generally, how important is it to you to be well dressed?
   Not at all important [ ]
   Not very important [ ]
   Neutral [ ]
   Important [ ]
   Very important [ ]

16. How important is it to you to have a good complexion?
   Not at all important [ ]
   Not very important [ ]
   Neutral [ ]
   Important [ ]
   Very important [ ]

17. Doctors should provide detailed information to a patient on their medical condition.
   Strongly disagree [ ]
   Disagree [ ]
   Neutral [ ]
   Agree [ ]
   Strongly agree [ ]

18. Doctors should give patients full freedom to make decisions about their treatment after a full explanation of the problem.
   Strongly disagree [ ]
   Disagree [ ]
   Neutral [ ]
   Agree [ ]
   Strongly agree [ ]
19. Women have less areas in life than men, in which they can fully exercise choice.

Strongly disagree [ ]
Disagree [ ]
Neutral [ ]
Agree [ ]
Strongly agree [ ]

20. It is more socially acceptable for women than men to admit weakness and to seek help when they have a problem.

Strongly disagree [ ]
Disagree [ ]
Neutral [ ]
Agree [ ]
Strongly agree [ ]

21. Are you:

Male [ ]
Female [ ]

22. Age last birthday:

16-24 years [ ]
25-34 years [ ]
35-44 years [ ]
45-54 years [ ]
55-64 years [ ]
65 and over [ ]

23. Marital status:

Single [ ]
Married [ ]
Widowed [ ]
Divorced [ ]
Separated [ ]

24. Occupation: ____________________________

Husband/wife/partner's occupation: ____________________________
(if applicable)

Thank you for your cooperation.
Appendix Three - Health Centre Questionnaire
I would be most grateful if you could assist me by filling out the following questionnaire. The questionnaire is anonymous and will be completely confidential. Please tick only one answer to each question unless stated otherwise.

1. Do you consider your general state of health to be:
   - Very good
   - Good
   - Fair
   - Poor
   - Very poor

2. Please tick one of the following statements with which you agree:
   (i) My health is the most important consideration in my life.
   (ii) Whenever I'm ill, no matter how mild the symptom, I take it seriously.
   (iii) I only think about my health from time to time.
   (iv) I almost never take the illnesses I get seriously.

3. From which of the following do you obtain your health information? (you may tick more than one)
   - Relatives/friends
   - Television
   - Radio
   - Newspapers
   - Magazines
   - Library
   - Workplace
   - Health information centre
   - Health-care provider
   - Other (please specify)

4. Where do you obtain the most health information? (please tick only one)
   - Relatives/friends
   - Television
   - Radio
   - Newspapers
   - Magazines
   - Library
   - Workplace
   - Health information centre
   - Health-care provider
   - Other (please specify)
5. Have you ever looked for information on any of the following?

<table>
<thead>
<tr>
<th>Diet</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women's health matters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children's health matters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic disease (ie. a disease which progresses slowly and persists over a long period of time)</td>
<td></td>
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<tr>
<td>Acute disease (ie. a disease which has a short and relatively severe course)</td>
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<tr>
<td>Psychological problems (eg. anxiety/depression)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/sport injuries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. May I please know the reason for your visit to the surgery?

| Common virus infection        |     |    |
| Women's health matters        |     |    |
| Children's health matters     |     |    |
| Chronic disease (ie. a disease which progresses slowly and persists over a long period of time) |     |    |
| Acute disease (ie. a disease which has a short and relatively severe course) |     |    |
| Other (please specify)        |     |    |

7. Are you visiting the surgery on your own behalf?

| Yes                          |     |    |
| No                           |     |    |

8. Are you visiting the surgery on someone else's behalf?

| Yes                          |     |    |
| No                           |     |    |

If yes, is it for:

| Your children                |     |    |
| Husband/wife/partner         |     |    |
| Elderly relative             |     |    |
| Friend                       |     |    |
| Other (please specify)       |     |    |
9. When you visit your doctor are you satisfied with the way in which he/she explains your problem to you?

Never [ ]
Occasionally [ ]
Sometimes [ ]
Frequently [ ]
Always [ ]

10. How convenient (in terms of time, money and physical effort etc.) is it for you to visit your doctor?

Very inconvenient [ ]
Inconvenient [ ]
Neutral [ ]
Convenient [ ]
Very convenient [ ]

11. Do you prefer to see a doctor of the same sex as yourself?

Indifferent [ ]
Occasionally [ ]
Sometimes [ ]
Frequently [ ]
Always [ ]

12. If you were concerned about your health, who would you turn to first?

Husband/wife/partner [ ]
Relative [ ]
Friend [ ]
Doctor [ ]
Other (please specify) [ ]

13. Have you, or anybody close to you, ever suffered from a life-threatening or disabling illness?

Yes [ ]
No [ ]
14. At home, who is in charge of running the household?

Yourself
You and someone else
Someone else

If you are involved in running the household, how easy or difficult do you find it?

Very difficult
Difficult
Neutral
Easy
Very easy

Please tick the appropriate box for each of the following questions and statements on attitudes.

15. How important is it to you to be considered attractive by others?

Not at all important
Not very important
Neutral
Important
Very important

16. How important is it to you to be considered slim?

Not at all important
Not very important
Neutral
Important
Very important

17. Generally, how important is it to you to be well dressed?

Not at all important
Not very important
Neutral
Important
Very important

18. How important is it to you to have a good complexion?

Not at all important
Not very important
Neutral
Important
Very important
19. Doctors should provide detailed information to a patient on their medical condition.

Strongly disagree
Disagree
Neutral
Agree
Strongly agree

20. Doctors should give patients full freedom to make decisions about their treatment after a full explanation of the problem.

Strongly disagree
Disagree
Neutral
Agree
Strongly agree

21. Women have less areas in life than men, in which they can fully exercise choice.

Strongly disagree
Disagree
Neutral
Agree
Strongly agree

22. It is more socially acceptable for women than men to admit weakness and to seek help when they have a problem.

Strongly disagree
Disagree
Neutral
Agree
Strongly agree

23. Are you:

Male
Female

24. Age last birthday:

16-24 years
25-34 years
35-44 years
45-54 years
55-64 years
65 and over
25. Marital status:

- Single [ ]
- Married [ ]
- Widowed [ ]
- Divorced [ ]
- Separated [ ]

26. Occupation: _______________________

Husband/wife/partner's occupation: _______________________
(if applicable)

27. Ethnic origin:

- African origin [ ]
- Afro-Caribbean origin [ ]
- Asian origin [ ]
- European origin (including U.K.) [ ]
- Oriental origin [ ]
- Other (please specify) [ ]

Thankyou for your cooperation.
Appendix Four - Health Information Centre Questionnaire
I would be most grateful if you could assist me by filling out the following questionnaire. The questionnaire is anonymous and will be completely confidential. Please tick only one answer to each question unless stated otherwise.

1. Do you consider your general state of health to be:
   - Very good [ ]
   - Good [ ]
   - Fair [ ]
   - Poor [ ]
   - Very poor [ ]

2. Please tick one of the following statements with which you agree:
   (i) My health is the most important consideration in my life. [ ]
   (ii) Whenever I'm ill, no matter how mild the symptom, I take it seriously. [ ]
   (iii) I only think about my health from time to time. [ ]
   (iv) I almost never take the illnesses I get seriously. [ ]

3. From which of the following do you obtain your health information? (you may tick more than one)
   - Relatives/friends [ ]
   - Television [ ]
   - Radio [ ]
   - Newspapers [ ]
   - Magazines [ ]
   - Library [ ]
   - Workplace [ ]
   - Health information centre [ ]
   - Health-care provider [ ]
   - Other (please specify) [ ]

4. Where do you obtain the most health information? (please tick only one)
   - Relatives/friends [ ]
   - Television [ ]
   - Radio [ ]
   - Newspapers [ ]
   - Magazines [ ]
   - Library [ ]
   - Workplace [ ]
   - Health information centre [ ]
   - Health-care provider [ ]
   - Other (please specify) [ ]
5. Have you ever looked for information on any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>Diet</td>
<td></td>
<td></td>
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<tr>
<td>Exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family planning</td>
<td></td>
<td></td>
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<tr>
<td>Women's health matters</td>
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<td></td>
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<tr>
<td>Children's health matters</td>
<td></td>
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<td>[ ]</td>
</tr>
<tr>
<td>Physical/sport injuries</td>
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<tr>
<td>Other (please specify)</td>
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</table>

6. Please state the reason for your visit to the health information centre.

7. Are you making enquiries for yourself?

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<tbody>
<tr>
<td>Yes</td>
<td>[ ]</td>
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<tr>
<td>No</td>
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</table>

8. Are you making enquiries on someone else's behalf?

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<tr>
<td>Yes</td>
<td>[ ]</td>
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<tr>
<td>No</td>
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If yes, is it for:

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<tbody>
<tr>
<td>Your children</td>
<td>[ ]</td>
</tr>
<tr>
<td>Husband/wife/partner</td>
<td>[ ]</td>
</tr>
<tr>
<td>Elderly relative</td>
<td>[ ]</td>
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<tr>
<td>Friend</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>[ ]</td>
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</tbody>
</table>
9. Have you previously consulted a doctor about the problem with which you are currently concerned?

Yes [ ]
No [ ]

If yes, were you satisfied with the way in which the doctor explained your problem to you?

Yes [ ]
No [ ]

If no, please tick any of the following which apply:

- Doctor did not explain the condition fully [ ]
- Doctor appeared to not listen to your own views on the problem [ ]
- Doctor did not allow enough time for you to ask questions [ ]
- Doctor used too technical terms [ ]
- Other (please specify) [ ]

10. How convenient (in terms of time, money and physical effort etc.) is it for you to visit your doctor?

Very inconvenient [ ]
Inconvenient [ ]
Neutral [ ]
Convenient [ ]
Very convenient [ ]

11. Do you prefer to see a doctor of the same sex as yourself?

Indifferent [ ]
Occasionally [ ]
Sometimes [ ]
Frequently [ ]
Always [ ]

12. If you were concerned about your health, who would you turn to first?

Husband/wife/partner [ ]
Relative [ ]
Friend [ ]
Doctor [ ]
Other (please specify) [ ]
13. Have you, or anybody close to you, ever suffered from a life-threatening or disabling illness?

Yes [ ]
No [ ]

14. At home, who is in charge of running the household?

Yourself [ ]
You and someone else [ ]
Someone else [ ]

If you are involved in running the household, how easy or difficult do you find it?

Very difficult [ ]
Difficult [ ]
Neutral [ ]
Easy [ ]
Very easy [ ]

Please tick the appropriate box for each of the following questions and statements on attitudes.

15. How important is it to you to be considered attractive by others?

Not at all important [ ]
Not very important [ ]
Neutral [ ]
Important [ ]
Very important [ ]

16. How important is it to you to be considered slim?

Not at all important [ ]
Not very important [ ]
Neutral [ ]
Important [ ]
Very important [ ]

17. Generally, how important is it to you to be well dressed?

Not at all important [ ]
Not very important [ ]
Neutral [ ]
Important [ ]
Very important [ ]
18. How important is it to you to have a good complexion?

Not at all important [ ]
Not very important [ ]
Neutral [ ]
Important [ ]
Very important [ ]

19. Women have less areas in life than men, in which they can fully exercise choice.

Strongly disagree [ ]
Disagree [ ]
Neutral [ ]
Agree [ ]
Strongly agree [ ]

20. It is more socially acceptable for women than men to admit weakness and to seek help when they have a problem.

Strongly disagree [ ]
Disagree [ ]
Neutral [ ]
Agree [ ]
Strongly agree [ ]

21. Are you:

Male [ ]
Female [ ]

22. Age last birthday:

16-24 years [ ]
25-34 years [ ]
35-44 years [ ]
45-54 years [ ]
55-64 years [ ]
65 and over [ ]

23. Marital status:

Single [ ]
Married [ ]
Widowed [ ]
Divorced [ ]
Separated [ ]

24. Occupation: ____________________________

Husband/wife/partner's occupation: ____________________________
(if applicable)
25. Ethnic origin:

<table>
<thead>
<tr>
<th>Ethnic Origin</th>
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<tbody>
<tr>
<td>African origin</td>
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<tr>
<td>Afro-Caribbean origin</td>
<td>[ ]</td>
</tr>
<tr>
<td>Asian origin</td>
<td>[ ]</td>
</tr>
<tr>
<td>European origin (including U.K.)</td>
<td>[ ]</td>
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<tr>
<td>Oriental origin</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Thankyou for your cooperation.