

PLANNING FOR WOMEN'S HEALTH NEEDS:
AN ALTERNATIVE APPROACH
CASE STUDIES OF WOMEN'S CLINICS

by

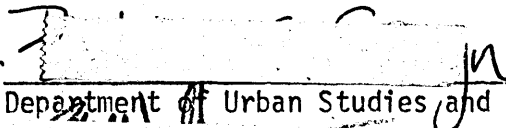
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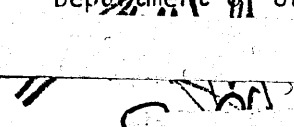
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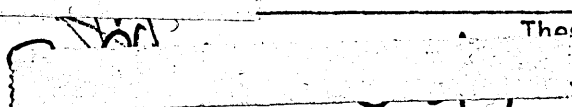
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by

Barbara El Selwyn

Submitted to the Department of Urban Studies and Planning on May 15, 1973 in partial fulfillment of the requirements for the degree of Master of City Planning.

Many segments of our population have become concerned with the shortcomings of America's system of health care. The Women's Health Movement is one such group which has recently emerged on the American Health scene. Its emergence can be viewed as an indication that growing numbers of women are becoming impatient and dissatisfied with the ways the current health system has failed to meet their health needs. Part of their discontent is exacerbated by the fact that women are in more frequent contact with the medical system than are others in our population. Moreover, their experiences with the medical system resonate with larger issues of a woman's identity and status in our society.

The dissatisfaction of these women who are committing themselves to improving their relationship to the health system is taking different forms. One has been to apply pressure as organized groups of women directly on the existing health system. Another has been to create alternative service options outside dominant health institutions. A third has been the practice of self-help whereby women are taught about their bodies so they can provide better health care for themselves as well as become more informed consumers. This thesis examines one of these approaches, the creation of alternative women's health clinics.

During the past three years, women's clinics have been growing in popularity and appeal throughout the country. To some, these alternative health settings are viewed as models for improving the delivery of health care for women; for others, they are seen as radical departures from the traditional modes for providing health care and are in the vanguard of many significant and dramatic changes in the ways health care is conceived and delivered. To this end, women's clinics are demonstrating new roles for both consumers and health workers in the medical encounter and are partially redefining health care to further their belief that women should be their own health managers.

One of the objectives for this thesis is to describe the women's clinic phenomenon which some consider to be a "movement-in-progress." Chapter 3 describes those aspects of the American health system which have, in part, contributed to the problematic experiences women have had in seeking medical care. The nature of women's relationship to the health system is explored, as well as the origins and present directions of the women's health movement. Chapter 4 provides an overview and general description of the salient features of women's clinics: their goals, functions, approaches and outcomes. Moving from the general to the specific, Chapter 5 is an examination of two women's clinics located in Somerville and Cambridge. The purpose of this chapter is to give the reader a better understanding of two variations upon the women's clinic themes. The final chapter relates to the other objectives of this thesis. One is to evaluate the efficacy of these alternative service models for meeting women's health needs and for leveraging changes in the broader health system. The other is to consider the implications of these health settings for the future planning of women's health services.

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CHAPTER 1

INTRODUCTION

American people are deeply concerned about medical care. Three-quarters of the heads of families in the U.S. sampled in a recent nationwide study, agree that "there is a crisis in health care in the U.S."¹ Among both the providers and consumers of health services, there is some consensus as to the general nature of the crisis facing our country. It is characterized by inequity in the access to and nature of health services, rising costs and inefficiency, alienating and depersonalizing consumer/provider interaction, and fragmented, uncoordinated care.

The perceived problems have indicated to many that major changes must take place in our health care system if the needs of the population are to be satisfied. The extent and nature of change being proposed and implemented has varied greatly, depending on how different interest groups view the difficulties with our present system of health care. The means by which these changes can and have been actualized are either through making adjustments in our existing health agencies and institutions concerned with providing health care, or by generating new systems. Some of these changes are being sponsored by the institutions themselves who are responsible for delivering medical services; others are being initiated by individuals and groups outside of the system.

Those who are generally interested in maintaining the present structure of health care are merely proposing "more of the same." In order to improve our health system, they advocate a move toward a more

technical, centralized, and systematized approach to delivering health care; expansion and diversity in available health facilities and resources; and new mechanisms for financing health care.²

Another style proposed to improve our health system involves a basic restructuring of various aspects of our system in order to move away from the present situation characterized by "dynamics without change."³ Its thrust is to depart from the existing system into new models and concepts of what constitutes health care. Alternative approaches in delivering health care are encouraged since they are seen as essential both to filling in gaps in our present system and to keeping up with changing needs.

Despite the differences in the changes being proposed, there is a similarity which overrides them. That has been the growth of consumerism and its subsequent involvement of the public in issues of health care. Consumers have begun to take an active role in making health institutions and services more responsive to their needs. This has occurred for several reasons, one of which has been their increasing awareness of how they are adversely affected by the shortcomings of our present system of health care. Another has been their belief that service needs are no longer privileges, but human rights.⁴

In the past few years, a number of new constituencies have evolved. Some believe that if mobilized, they can become a significant force to produce changes in our health system. The Women's Health Movement is one such group which has recently emerged on the American health scene. Women have long been concerned with issues of health care. However, in the past, they generally saw their problems with

the health system in terms of a problematic person-to-person interaction.⁵ Now, there can be identified distinct groups of women who are collectively involved with issues of health care.

The emergence of such groups can be viewed as an indication of women's growing impatience with the current health situation and their desire to change it. Part of this impatience is exacerbated by the unique relationship which women have to the health system. "Women consume the largest proportion of health services. On the average, women make 25% more visits each year to the doctor than men and 100% more if pediatric visits are included. They take 50% more prescription drugs than men, and are admitted to hospitals much more frequently than men."⁶

The Women's Health Movement has begun to take the initiative in attempting to narrow some of the gaps between health service potential and current practice. Their collective involvement with health issues has taken different forms. One has been to apply pressure as organized groups of women directly on the existing health system. Another has been to create alternative service options outside dominant health institutions. This has generally taken the form of women's clinics. The third, is self-help, whereby women are taught firsthand knowledge of their bodies so that they can ultimately provide better health care for themselves as well as become better medical consumers. All of these activities are aimed in some way in trying to bring about changes in the health system, especially as it relates to meeting women's health needs.

It is my interest in this thesis to focus on one of these

three approaches, the creation of women's health clinics. The advent of these women's clinics on the health scene can be viewed in various ways. To some, it is seen as a means of providing direct services to women; to others, it is seen as a model for improving the delivery of health care which embodies some of the more frequently proposed reforms for change; for still others, it is seen as a radical departure from the traditional modes for providing health care and is in the vanguard of many significant and dramatic changes in the ways in which health care is conceived and delivered.

Since the creation of women's health clinics is to some extent, a "movement in progress," my thesis will be an initial exploration into the nature of these clinics. I will explore why these clinics developed; what are some of their functions, both health and health related; what is their efficacy for meeting women's health needs and for leveraging change in the broader health system, and, what are the implications of these clinics for the future planning of health services for and by women.

CHAPTER 2

METHODOLOGY

In many ways, I would consider my thesis an "engaged investigation" since it is an exploration of a movement in which I am deeply interested and concerned. Women's health care speaks to my personal experiences as a woman seeking medical services from a system that has not always responded adequately to my physical and psychological needs. In other ways, the advent of women's health clinics can be considered a movement in progress. As a movement which is still in its formative stages of development, there are many limitations which preclude an in depth and definitive exploration of its goals, activities, and outcomes. For many reasons, which I will describe below, my thesis is, at best, a preliminary investigation of this movement. In the writing of this thesis, I have attempted to provide information on the philosophy and procedures of women's clinics. I do not purport to have been either totally objective or extensive in my recitation, but perhaps I have given new insights into this movement which might serve as a basis for further investigation and evaluation.

Movement in Progress--Characteristics and Limitations

Since women's clinics are a relatively recent phenomenon emerging in the area of health care, little information has as yet, been generated on the subject either in the form of descriptive articles or evaluative studies. The individuals involved in the creation and operation of these clinics are usually dedicating the bulk of their energies to making the clinic endeavor a viable one, and few have had the time

or perspective to step back to analyse their activities and the nature of their involvement. Furthermore, as with similar activities which are innovative, highly political, and organized on the grassroots level, the participants are often unable or reluctant to communicate the essence of their clinic experience to outsiders. Perhaps, the greatest obstacle for such a dialogue to occur is time - which is extremely limited. The participants have chosen to focus their energies on delivering the medical services for which their clinics were designed.

Oftentimes, the participants are cautious about giving information about their clinic to those people not directly concerned with women's health. The following quote by a health worker in one of the clinics I studied, illustrates this point: ". . . we're careful that we don't get ripped off by people who give us nothing, yet they walk away with papers and books they can publish. We don't mind talking to women who we can help with services they're trying to set up."⁷ Another example is the case of a newspaper with a large circulation which wrote an article about a woman's clinic that misrepresented their activities, and to some extent, maligned their reputation.⁸ It is a concern of the individuals working in these clinics, that generalizations based on a casual and limited visit not be made since a deeper and more lengthy involvement is necessary in order to understand the meaning and purpose of women's clinics.

All of these attitudes and realities in some way limited my exploration of women's clinics and determined the final nature of my thesis. Since I felt a great affinity with the philosophies and concerns of the women working in these clinics, and respected the tremendous com-

mitment which was devoted to their continuation, I was unable both on ethical and practical grounds to pursue the kind of in-depth exploration that I had initially envisioned for my thesis.

Areas of Investigation

As described in the introductory chapter of my thesis, I was concerned with generating information and insights on various questions related to women's relationship to the health system and the evolution of alternative health settings. My first interest was to understand the motivations and intent of the women's health movement that gave birth to women's clinics. Second, was to describe the nature of the clinical program and operation which grew out of these goals. Next, I sought to reach some tentative conclusions about the efficacy of this service model for fulfilling its goals. Another question of interest was to determine what some of the implications of these clinics were for delivering health care to women in the future.

Data Collection

A variety of methods were used in this investigation to provide information by which some tentative conclusions about women's clinics could be reached. Considering the limitations previously mentioned, which prevented me from engaging in a more rigorous study of these clinics, a variety of techniques were chosen. These included a review of literature, interviews, case studies, and participant observations.

Literature Search

The study of women's clinics involves many subject areas, the

main ones being: the organization and delivery of medical care; women's health needs; the women's health movement; health planning; and, the creation of alternative settings. Since the advent of women's clinics has taken place within the context of several overlapping fields, I have examined those areas which have had some bearing on the history, present and future of these clinics.

The literature generated by the health care field was essential for a study of women's clinics. Books, periodicals and journal articles were examined for information about the organization and delivery of medical care in the United States, nature of the medical encounter, new roles for medical personnel, current styles of delivering primary care in neighborhood facilities, and the interface between women and the health system.

Another area of literature explored was that generated by factions of the women's liberation movement and the radical health movement. Although rather limited in number and scope, the articles written by movement representatives lent an interesting and thought provoking perspective to my thesis. Particular attention was given to finding articles written by women interested in health care, since a small number are presently involved in critiquing and rewriting some of the literature about women in the health system. They are developing a new body of literature in the hope of changing the male-bias, which characterizes much of the present literature, to one which is a more truthful and representative interpretation with regard to women.

When possible, I have assembled some material on the experiences of other women's clinics as a means to supplement the limited

information base. These women's clinics were exceptionally supportive and interested in my study and directed me to additional resources so that I could complete my investigation.

Interviews

A significant amount of information was derived through interviewing individuals who were directly or indirectly involved in women's clinics. The major thrust of my interviewing was directed toward those providers and consumers who were presently involved in the two women's clinics under study.

* Providers of Health Care

As previously stated, engaging in prolonged discussions and interviews with the health workers in these clinics proved to be quite difficult due to reasons of inaccessibility, or negative feelings about "being studied." After some persistence and clarification of my interests in these clinics, I was able to arrange interviews with three key providers in each of the two clinics studied. Based on a structured interview guide (See Appendix), I spoke with these individuals for approximately one and one half to two hours each, about most facets of the clinic in which they were involved. To a great extent, responses were very similar among the respondents of each clinic, which led me to believe that many of my previously formulated assumptions about women's clinics could be substantiated, if necessary. With the exception of one respondent, all were present at the early stages of planning and implementation of the clinic with which they were affiliated. In all of the interviews with providers, I visited the individuals in their homes during the evenings. I feel that the informality of the

home environment had a significant impact on the interviewing process. By being accepted into the home, there were less distractions than usually occur in an interview, less constraints for time, and greater opportunities to establish a rapport and trust.

* Consumers

Certainly, one of the most crucial areas of investigation for this study of women's clinics was the attitudes and profiles of women patients. However, this source of information was the most difficult to obtain and one which still remains woefully, incomplete. There were many constraints preventing me from interviewing women consumers which I shall briefly explain. Perhaps the largest obstacle to interviewing patients was posed by the health workers in the clinics. They were quite adamant about the importance of respecting the privacy of the consumers and were against my questioning them. One of the reasons given was that, in their opinion, poor and working class women had been studied and exploited by too many opportunists and that they could not allow, with any good conscience, another study to be imposed upon these women. Also, if they allowed everyone who wanted to study the clinics have access to the consumers, there would be an endless stream of interviewers pouring through the clinic.

Realizing the unfeasibility of interviewing patients, I presented both clinics with a suggestion that I would be willing to conduct an evaluation that could be useful for their own planning and programming purposes. But this arrangement was not acceptable.

Despite these negative experiences in both clinics which precluded the kind of investigation I desired, I was able to get some data

on the female patients in one of the clinics studied. They allowed me to analyze the results of a client evaluation that they had conducted. Unfortunately, the questionnaire was a limited one both in the scope of the questions and the number of interviewees (twenty). It was designed to provide general, baseline information pertaining to client's age, income, employment, health needs, and reasons for seeking the services of the clinic. My interests were directed more at understanding the attitudes, motivations and degree of satisfaction of the women patients. To some extent, though, the questionnaire did confirm some of my hypotheses about the composition of the clinic's client population based on my observations and other sources of information.

In the other clinic studied, I was able to talk to three women who used the clinic several times. One of the women was a classmate of mine who referred me to two of her friends who also used the clinic. These brief phone interviews gave me some subjective evaluations of the clinic and additional insights into the attitudes and perceptions of a few consumers.

Since characteristics and views of the consumers of these services were so difficult to assess, and yet essential to a complete analysis of women's clinics, I have relied on indirect measures of consumer attitudes and experiences with the clinic. One of these were the accounts and perceptions of client behavior given by the providers and individuals associated with the clinic that I interviewed. The limitation of this technique is that such accounts run the risk of being one-sided and extremely biased. To partially alleviate this problem, I attempted to interview a number of individuals who had

varied contacts with the clinic. My intention was to provide a more objective and consumer-oriented viewpoint of the clinics under study.

* Community Representatives

Prior to and during the actual study of the two women's clinics, I contacted various individuals whose names had been mentioned by numerous sources as being active in issues pertaining to women's health care. Over a four week period, I interviewed eleven people who had some relationship with women's clinics either as a consultant, or health worker familiar with the clinic, providers of women's health service other than the cases studied, or individuals active in the communities in which these clinics were located. Generally, these interviews were quite useful in both laying the groundwork on which I could build the case studies of women's clinics, and providing me with a range of perspectives about the clinics and the women's health movement. (The names and affiliations of the people interviewed is included in the appendix.)

These interviews were conducted in the place of employment of the respondents, or in two cases, by phone, and were based on a flexible interview form I developed.

Participant Observation

Since the number and variety of interviews that I had were extremely limited, I sought other sources of information which could supplement my observations and findings. One of these, was being an observer on several different occasions at the women's clinics under study. Having spent some time in the waiting areas at the clinics, I was able to make some observations and get a sense of the atmosphere,

general activities, superficial characteristics of health workers and patients, and clinic procedure. It was important that I identified myself to the receptionist, and did not let my presence disrupt the regular routine of the clinic.

Another source of information was being a participant observer at a meeting sponsored by one of the clinics which was attended by approximately forty women. They, like myself, were interested in becoming active in some capacity in the women's health movement. The majority of the women wanted to learn how to become gynecological paramedics so they could get together with a group of women with similar skills to start a clinic of their own. The meeting was quite illuminating since the women present each discussed their backgrounds, present interests or involvement in women's health care, and what they hoped to accomplish by becoming a woman health worker.

Case Study

A major approach taken in this investigation of women's clinics was the case study. Each case was developed from the above mentioned methods of inquiry: written and oral sources, participant observation, and interviews. These were designed to indicate and describe various aspects of the women's clinics, the attitudes and behaviors of the participants in the clinic experience, and their effect on the users and providers of care as well as on the broader health system.

Inasmuch as the purpose of this study is to obtain information about a group of people involved in creating an innovative medical setting, certain statements can be made to support this choice of

collecting information. It is my belief that there is a great deal of very specific information that can be learned from a small group of individuals. Since a major concern in this study was an awareness of the interpersonal relationships among patients and staff, more quantitative research might have overlooked some of these factors. Perhaps what needs to be done before further research and understanding of these health settings can be undertaken, is to isolate and clearly define important, but perhaps overlooked variables and issues that are in operation. "Case histories, biographies, and anecdotes are not usually employed most usefully to test hypotheses. They can, however, be especially useful in generating such hypotheses."⁹

Thus, this investigation concentrates on two women's health clinics and on the individuals actively involved in the women's health movement out of which has grown these alternative health settings. In assembling and integrating the information derived from these various sources, I have been able to arrive at some tentative hypotheses and conclusions about various aspects of women's clinics. The perspective that the various methods of investigation contributed to this thesis has yielded many common threads which confirmed my initial assumptions about these clinics.

However, despite these inquiries, I do feel that there are limitations with the information that was available to me. Thus, this thesis should be viewed as an exploratory investigation rather than as scientific research. It is my hope that this thesis will raise some issues and generate questions that are important for people interested in the health care system, and, in particular, women's relationship to

to this system. In addition, in that women's clinics are an alternative setting for delivering health care, this thesis will hopefully add to the extremely limited body of knowledge about such innovations — their assumptions, processes, and outcomes.

CHAPTER 3

WOMEN'S RELATIONSHIP TO THE HEALTH SYSTEM

"When a woman waits anxiously for her period, sits up with a sick child, or even cooks breakfast, she is feeling the weight of life and death responsibility for her own and her family's health. But when something goes wrong, she can't get decent health care, or even straight answers. Doctors make us feel stupid, ashamed of our bodies, guilty about medical problems. Those of us who are female, black, poor, old, gay, or can't speak English are treated with contempt and brutality. We are tired of feeling powerless and alone in waiting rooms, labor rooms, operating rooms. We are getting angry and we are getting together."

"Our anger is changing our faces, our bodies... our anger is changing our lives."¹⁰

The many shortcomings of America's system of health care are currently being criticised by many segments of our population. During the last several years, we have witnessed attempts by certain groups to ameliorate the problems inherent in our health system. Some have proposed changes in the way health care is presently organized and financed. Others envision a more rational and systematized approach to delivering health care as one possible remedy. A new response to some of the failures of our health system has emerged and it appears to be growing in popularity and appeal. In the past five years, the development of alternative medical structures has been achieved by various groups in our society.

One such group has been women who are realizing that in many ways, traditional medicine has been unable to serve their health needs. Women's growing discontent with our health system is taking many forms. An increasing response of women across the country has been to follow the route blazed by other groups in our population to establish health facilities of their own, apart from the existing health system. These alternative structures largely resemble free clinics which are organized for and by women, exclusively. In some cases, these clinics are meant to serve as a model of what women consider to constitute decent health care. In others, they have taken the double task of meeting women's health needs and attempting to challenge existing health institutions. Whatever the form and functions of these clinics are, they were precipitated by the growing awareness and discontent of many women with their relationship as consumers to the health system.

The experiences which women have encountered in seeking and receiving health care is determined by a number of factors. One is

the nature of our present health system which is frequently subject to influences of professional dominance. Another is the commercial orientation which underlies much of our present system and determines many of its priorities and practices. A third factor, which particularly affects women is the overwhelming patriarchal nature of our health system whereby most decisions relating to a woman's health care are made by men.

These aspects of our medical system are viewed by many women as being detrimental to their physical and mental health. The desire to change their relationship to the health system has propelled growing numbers of women into action. An understanding of the nature of the health system as it affects women is essential for an appreciation of the activities in which they have been involved.

American Medical Care

Many of the complaints waged by women against our health system pertain to the style in which medical care is delivered and the priorities which determine current practice. They characterize our health system as being dominated by professional and commercial interests which very often preclude the decent and humane treatment of patients. Much of the medical care delivered today treats women as passive recipients of health care who are dependent on the imputed wisdom of male physicians. The means by which women can become their own health managers are often inaccessible to them. Much of medical care is ensconced in an aura of mysticism whereby the power and dominance of the medical profession over its patients is perpetuated. The profit-motive inherent in much of the health field often subjects women to unnecessary medical procedures and risks.

Professional Dominance

Friedson, a foremost medical sociologist, believes that "professional dominance is the analytical key to the present inadequacy of our health services." Health care is the most professionalized of all human services, and is consequently organized around professional authority. Its basic structure is constituted by the dominance of a single profession.¹¹ In medical care, it is the physician who possesses the power to decide which patients get treated, where, how, and the cost of treatment. Implicit in the concept of professional dominance is the belief that the medical profession is the best judge and guardian of the "rights of man."

The imputed authority of the profession has manifested itself in many ways. First, in matters pertaining to health care, the opinions of the layman are very likely to be subordinated to opinions of professional experts. As Freidson says: "This subordination is based on the assumption that a professional has such special esoteric knowledge and humanitarian intent, that he and he alone should be allowed to decide what is good for the layman."¹² Further evidence of this attitude of subordination toward the laymen is witnessed in the Hippocratic oath which has become a basic ritual in the training of physicians. It states that:

"...lacking professional training, the client is too ignorant to be able to comprehend what information he gets, and that he is, in any case, too upset at being ill to be able to use the information he does get in a manner that is rational and responsible."¹³

These attitudes which are a basic part of the socialization of doctors contribute to the unhappy experience of a large number of patients in medical encounters. In this situation, where the physician

perceives that the status of the patient is subordinate to the doctor, the medical encounter between doctor and patient is likely to assume the following characteristics: First, the choice of the treatment becomes the prerogative of the doctor. It is he who possesses the power to decide how the patient is to be treated and what the nature of the medical encounter shall be. The physician thus assumes the role of universal healer. Secondly, the patient is treated like an object rather than a person. Since an object supposedly does not possess the capacity for understanding, information is withheld and communication is avoided in the doctor/patient interaction. The patient is expected to have faith in his doctor, and to do what he is told without question. In so doing, the patient is put in a position where he must relinquish his role as an independent adult and assume that of a passive and compliant child.

Another manifestation of the dominance of the medical profession has been to create a hierarchy in traditional medicine. The elitism which characterizes the medical profession permeates the health settings in which they practice. The exclusiveness of knowledge and hierarchy of responsibility and roles have come to typify the way in which medicine is practiced.

Professional dominance manifest in American medical care also perpetuates an aura of mysticism which has served to maintain the power and dominance of the profession over its patients. Mysticism, which implies a guarding of information and knowledge has been reinforced by the use of titles, dress and language within the medical establishment.¹⁴ Awe and respect of medical professionals are inspired by those who do

not possess the well-guarded knowledge about health care. It has also allowed physicians to maintain their apostolic function; widen their area of medical jurisdiction, and insure the perpetuation of their status as gatekeepers of the health system.

Commercial Orientation

Other critics of our health system attribute some of the problems faced by a large number of consumers of medical services to be a result of the commercial orientation of our medical system. To some extent, it is seen as being a major determinant of many of its priorities and current practices.¹⁵

The profit motive underlying our health system has been well documented, and is one of the most frequently voiced criticisms by both consumers and providers. In its National Health Plan, the Medical Committee for Human Rights, a group of professionals and individuals concerned with radically changing our health system, describes the present concern with profit making in health care:

"The health care system is organized as a profit-making business, not primarily as a service. The main profit makers - - drug and medical supply companies, individual doctors charging excessive fees, the health insurance industry, and nursing homes -- use over \$7 billion each year for profit and for unnecessary profit-creating advertising and administration. In addition, the profit orientation grossly distorts medical practice by stimulating more operations than are needed, excessive use of dangerous drugs, overhospitalization and overtesting of those who can pay, and neglect of health care for poor and minority people."¹⁶

The consequences of the profit motive in medicine are being felt by many in our society. Some reformers of our system want to challenge the free enterprise system which has been firmly entrenched in

the medical community and which has had serious consequences for many in our population. Among their concerns is to challenge the current medical practices which allow, in many cases, profits to be derived from sickness and which has made it financially prohibitive to be sick in America.

Women's Relationship to the Health System

These aspects of the health system — its professional dominance and commercial orientation, have had particularly adverse consequences for women, the most frequent users of medical services. Coupled with these factors is the patriarchal nature of medical care whereby men make most of the decisions pertaining to women's health care. In many ways, these factors have affected the nature of women's relationship to the health system. Unfortunately, many of the medical experiences which women have had have been problematic. Growing numbers of women are coming to realize the conflicts that they have had and continue to have in seeking medical care. They are becoming increasingly more adamant in seeking some voice in the way health services are delivered.

Women, as do others, have special health needs. It is my contention, however, that women experience the negative aspects of our health system — its depersonalizing and alienating nature, its inaccessibility and expense — more profoundly than other individuals for various reasons. Women are in more frequent contact with the medical system than are men. In the medical professions, they are overwhelmingly underrepresented, and are thus subject to a male dominated profession. In addition, their experiences with the medical system

resonate with larger issues of a woman's identity and status in our society.

As consumers, women confront the medical system 25% more often than men, for both their general health care needs and those associated with their reproductive system.¹⁷ In contrast to their greater dependence on the health system, women are poorly represented in the medical professions. The roles of women in health care have been restricted to those of the most menial and lowest paying status. Thus to a large degree, the practice of medicine has been male-dominated. Further evidence is provided by the Bureau of Labor Statistics' findings that only 7% of American physicians are women.¹⁸ Contrast this to the fact that women comprise about 70% of all health workers and 75% of hospital workers. Judging from the number of female students admitted to Harvard Medical School, the bastion of traditional medicine, it seems as though the discrepancies between the number of male and female physicians will continue. (See Table 1)¹⁹

TABLE 1

Enrollment in Harvard Medical School by Sex & Race

	<u>White Men</u>	<u>Black Men</u>	<u>White Women</u>	<u>Black Women</u>
Class of 70	111	1	13	0
Class of 71	110	2	14	0
Class of 72	112	1	15	0
Class of 73	114	15	10	1

Thus, due partly to the fact that women have been predominantly excluded from the role of physician, medicine has evolved into a patriarchal system.

Yet this situation should not be too surprising, since

medicine does not transpire in a vacuum, rather it is microcosm of society and incorporates its values and practices. It follows then, that

"...as in almost every other institution of American life, it is men — doctors, medical school deans, hospital directors and trustees, drug and insurance company executives — who make the decisions... For women health consumers, men decide on the most personal issues of health care, what form of birth control a woman should use, whether she should have an abortion, what method of childbirth she should use, and of course, how much she should be told about the risks and options." ²⁰

Women's secondary status in our society accounts for much of their greater use of the health system and the added humiliation and objectification which they encounter.

Empirical studies on the disadvantaged status of women demonstrate that sex is probably one of the most obvious criteria of social differentiation and one of the most obvious bases of economic, political, and social inequalities. ²¹

As will be seen, many issues considered the domain of health care resonate with other, larger issues of identity. One such relationship is that between the objectification and discrimination which women experience in our society and the treatment they receive in the medical encounter. To illustrate this point, Friedson, in his analysis of the system of professional dominance characteristic of medical care, found that most people who enter the medical system in search of care are likely to find themselves treated as objects, depersonalized, transformed into organs and pathologies. For women, however, they have a special handicap: they generally start out being regarded in our society as objects or secondary citizens. "Thus, the women-as-patient embodies much of the general anguish of women in this society, as well as the

particular frustrations of any patient."²²

Growing out of women's frustration with their secondary status in our society and the restricted areas of expression open to them, women have come to rely on the medical setting to work out their problems and legitimate them to themselves and society. In the medical encounter, some women are allowed the opportunity to express their problems in living and dissatisfaction with their status and themselves. These complaints are very often manifested by somatic disorders, such as headaches, nausea, fatigue and obesity. In our society, the sick role is a legitimate one for women to play, whereas dissatisfaction, anger, and frustration with a woman's status is generally not sanctioned.

A woman's sex role has had more severe consequences for some than just relying on the medical setting for a source of remediation and relief from their problems in living. In a recent study completed by Gove, he found that there was a relationship between a woman's role and the incidence of mental illness:

"...there are ample grounds for assuming that women find their position in society to be more frustrating and less rewarding than do men and that this may be a relatively recent development. Let us, then, at this point postulate that, because of the different association with the feminine role in modern western society, more women than men become mentally ill."²³

Despite women's greater dependence and use of the health system, there exist major areas of conflict between them. Numerous examples can be cited of the mistreatment that women have been subjected to in their confrontations with the medical system. The largest number fall in the area of the doctor/patient relationship where a woman is most affected by the authoritative, sexist and commercial interests which characterize much of traditional medicine. Upon examination of these problematic

interactions that women have had in their medical encounters, the groundwork can be laid by which the complaints propelling many women into action against the health system can be understood.

Doctor/Patient Relationship

An important determinant of the type of treatment given in primary care encounters is the attitude of both doctor and patient toward each other. The suggestion that subtle, unconscious attitudes of the physician may adversely affect his treatment of patients has often been voiced by individuals concerned with the delivery of medical care. It is now becoming clear that societal forces, such as racism and sexism are not irrelevant to medical care since in many cases, they influence the attitudes and behavior of doctors and other health professionals. Presumably, male physicians' attitudes are influenced not only by their professional training, but also by their experience and exposure to women.

In a recent study by Lennane and Lennane, they attempted to provide some evidence to support their hypothesis that sexual prejudices of physicians, more than normal objective scientific methods, determined the diagnosis and treatment of certain conditions which affect women. The subjects that they studied were found to readily accept psychogenic* rather than organic causes for menstrual pains, nausea of pregnancy, pain in labor, and disturbances in young babies (such as prolonged crying and infantile cholic).²⁴

The persistence of these beliefs in psychogenesis is potentially damaging to the patient in many ways, though possibly convenient for the doctor.

* psychogenic: originating in the mind; caused by mental influences.

They found that:

"There is widespread view that the patient whose symptoms are psychogenic is not entitled to any symptomatic relief. The terms commonly used to describe the psychic difficulty -- 'neurotic' or 'unfeminine' -- are, to the laity, simply derogatory, and patients reluctant to be so classified may be unduly dependent, complaisant, uncritical, and 'feminine' in their behavior and reluctant to report severe symptoms or failure to respond to treatment."²⁵

These attitudes of male doctors toward women, as revealed in the Lennane article, remind us how misconceptions and the myths that have been created about the female character and personality have distorted their views of women as patients. It is important to recall the power that male doctors hold over many aspects of women's lives, and realize how their official ideas about women have affected the medical care they get. These findings reinforce the growing belief that there is an inability among many physicians as they are presently trained and socialized to relate to a woman's experience in terms of her body as well as her life situation. This along with many other factors previously described has contributed to negative experiences which women have been reporting in growing numbers concerning their encounters with the medical system.

Another example of problems women face in their encounters with physicians can be drawn from the field of obstetrics and gynecology (ob-gyn). Since a high proportion of medical care for women centers on the reproductive system, the gynecological relationship distinguishes women from other users of the health system. Ironically, it is the source of most of the complaints which are currently propelling women into action against the system.

As mentioned earlier, a commonly held image of doctors by

both patients and the profession itself has been the doctor as "universal healer." This image is particularly fitting for gynecologists, who have become "our society's official specialists on women."²⁶ Much attention is currently being directed by feminists to examining to what extent there exist male biases and sexism in the practice of ob-gyn. A few studies have been undertaken and articles written to explore the nature of the relationship between gynecologists and their female patients. The findings have consistently exposed a certain "benign paternalism" to characterize the profession; numerous instances of how women are treated as passive objects rather than responsible adults; and how women have been denied control over their own bodies. It is on these findings which I would like to expound, since they are crucial to an appreciation of women's activities in the health field, and particularly, to the reasons why women have felt the need to create their own health clinics.

Women of all classes almost uniformly express negative attitudes toward gynecologists. Why do so many women possess these feelings? Nancy Shaw, a sociologist who has extensively studied the experiences of childbirth in the U.S. writes:

"The reasons for the negative attitude itself can be found in factors as varied as puritanism, expectations induced by 'medical' information and preparations, general absorption of 'old wives tales' (e.g. the agony of childbirth), advertising ('Midol for that time of the month'), and bad experiences (rape, badly managed childbirth, previous pain with sexual or feminine experiences)."²⁷

To these explanations, I would like to add the attitudes and behavior of the gynecologist himself as a prime factor responsible for evoking these feelings of fear and anger among women. Professional dominance and male-biases are certainly characteristics which describe physicians

in many different specialities, but they seem particularly pervasive in gynecology. "Gynecology is a specialty practiced on women by men and for men."²⁸

In a study conducted by Scully and Bart, they examined gynecology textbooks, a main agent of socialization for the profession from 1943-1972, to determine to what extent sexism pervades the field of gynecology. Their findings substantiated their hypothesis that "gynecology is just another of the forces committed to the maintenance of traditional sex role stereotypes, in the interest of men and from a male perspective."²⁹

General comments that they make pertaining to the nature of the gynecologist seem particularly relevant to further elucidating the doctor/patient relationship.

"Gynecology and obstetrics is overwhelmingly a male specialty (only 6.8% are female practitioners). The male gynecologist is socialized first as a male and second as a doctor, the latter by the most powerful and elite profession, medicine. As a gynecologist, he is the official and legitimate specialist on women, their personality adjustment, needs and values, as well as their illness associated with the reproductive tract. He wields great power vis à vis women seeking to understand their bodies and themselves, particularly their sexuality. As the official expert on women, the gynecologist is in a privileged position to define what is 'normal femininity' and 'normal sexuality.'"³⁰

Yet, gynecologists, in fact, know little about women, about sex and about psychology. Serious training in sex education and psychosomatic aspects of illness is limited or non-existent in medical school.³¹

Is there any way that we can estimate what the deleterious effects of these attitudes are on female patients? What are the consequences of the mysticism, "benign paternalism," withholding of information, control of important decisions, sexist attitudes, which are

characteristic of both physicians and gynecologists, in terms of the experiences which women have had as patients? Much of the current feminist literature addresses itself to the ways in which women are "victimized" by doctors through their own bodies. The evidence is growing to document women's various experiences with the health system by its critics.

The biological needs of women related to their reproductive function make them particularly dependent on the health system. For women, abortion, birth control and child bearing, which are associated with reproduction are more than just medical concerns. These aspects of woman's reproductive functions are inextricably tied to their feelings about their sexuality, identity, and womanhood. The importance of making these experiences more than just physical acts is essential for the continued physical and emotional well-being of women. Paradoxically, these health needs have been woefully mismanaged.

To date, men have controlled the treatment of women's health needs almost entirely. Profound decisions such as those pertaining to whether or not a woman will bear children and the style in which she gives birth, are deferred to men. The following section describes the experiences which women have had in their dealings with the medical establishment regarding abortion, birth control and childbirth.

Abortion

The most blatant instance of women being denied control of their bodies has been with the abortion experience. It was not until several months ago, that abortion was granted to be the right rather than the privilege of every woman. Prior to the dramatic ruling by the Supreme Court this winter which repealed most anti-abortion laws

in the 46 out of 50 states where they now exist, women with unwanted pregnancies were frustrated and obstructed in their search for abortions. Male dominated legislatures and physicians had possessed the power to determine who would and who would not bear children. For women, their anatomies determined their destinies. (It should be noted that although the Supreme Court's ruling of January 21, 1973 repealed anti-abortion laws, the decision did not give women an absolute right to abortion on demand. The State is still permitted to intervene if the abortion is sought after the first trimester.)³² The decision as to whether or not a woman will continue a pregnancy and ultimately give birth is a highly emotional and complicated one which often has profound and traumatic implications for her. The style in which abortions have been performed in this country has definitely not been conducive to the well-being of women. Instead of considering the emotional, medical and financial needs of women, emphasis has been placed on the moral and ethical questions implicit in abortions, the economic advantages to medical institutions and practitioners, and the expediency with which they can be performed.

The attitude of the medical profession rivals that of the legislature in its patronizing and moralistic posture. Once again, men have monopolized the control of this highly personal and significant area of a woman's life. In so doing, they have empowered themselves with the right to decide how a woman shall deal with her body and her life.

Birth Control

Drug companies, doctors, and medical institutions have a lot of control over women's choice and acquisition of birth control

methods. Much of the available information about effectiveness, safety, and possibility of side effects of the different methods of contraception is researched and published by the drug companies, who are interested primarily in sales.³³ Relying on doctors for trustworthy and unbiased information about birth control has not always been successful, since much information is traditionally withheld from patients or is irresponsibly administered to women. Furthermore, counseling women on the type of birth control selected is rarely provided.

An example of this lack of information and irresponsibility of those in charge of prescribing various methods of birth control, is illustrated by the experience of women and the Pill. Women (especially poor, black, and other minority group women) have been used as subjects in experiments conducted by doctors, hospitals, and drug companies. The much cited example has been the case of poor Puerto Rican women who were among the first humans using birth control pills. Many of them did not even know they were being used in an experimental study.³⁴

On a larger scale, this experimentation exists for almost 8.5 million women in America who are taking birth control pills today. Hearings in Congress about the Pill have revealed shocking facts about the dubious safety of these drugs.³⁵ Women are clearly discriminated against and their safety is endangered by the withholding of information which could inform women of the possible dangerous side effects of the pills.

Birth control is particularly important to women — as a right and as a matter of health. However, the concern of those individuals and institutions controlling most birth control programs in the U.S. today is directed more narrowly to serving their own interests. The moral and economic overtones to the distribution and use of birth

devices deny to women the right to make their own decisions about parenthood and childbearing.

Childbearing

For many women, pregnancy and childbirth have been stressful rather than fulfilling experiences. The act of childbearing is often characterized by: a lack of information about what to expect physically and emotionally; lack of continuity and humanness of the experience; denial of control by women over the childbearing experience. In America, women have characteristically been passive in the act of giving birth. They defer responsibility for the preparation and actual delivery to the male obstetrician in charge. These problems are often attributed to the medical context in which childbirth takes place with its consequent fragmentation of medical services, objectification of women, and the mystification of the entire childbearing experience. Another is the dominance of the profession that has placed women in the passive role and assumed full charge of the experience.³⁶

A response to women's dissatisfaction with the way childbearing is treated has been the growing popularity in recent years in the use of midwives, home deliveries, and natural childbirth, done in the presence of friends and family.³⁷ Women have found that putting the control of childbirth in their own hands has been an advantage when it comes to receiving humane care.

Surgery

Because lack of information and control can produce a passive and accepting attitude toward a doctor, few women challenge the physician's authority over their lives. This is particularly true in relation to surgery. Few people question medical judgement when a surgical

procedure is advised. Not all surgery advised and performed is necessary. In gynecological and obstetrical care, unnecessary surgery seems disturbingly common.

Women have long been extremely vulnerable to needless surgical procedures. In a study done by several medical students of Boston City Hospital, it was found that unnecessary hysterectomies as well as other operations that result in sterility have been performed on non-white women without their consent. In a similar study of a community hospital, the same findings were revealed: "...it was found that only 30% or slightly less than 1/3 of the hysterectomies done were medically justified."³⁸

Another surgical procedure which women have undergone are mastectomies. Since a woman's feelings about herself and her sexuality are so closely tied with her body, changes in its appearance or functioning are experienced very deeply. In operations which are as massive as hysterectomies and breast removals, women often must make dramatic readjustments in their self-image and life style. At present, little is done to support a woman emotionally for the traumatic changes which she is likely to experience.

The case of women and drug use is yet another example of the mistreatment of women by the medical system. Very often instead of dealing with the ill-defined medical problems which women present to doctors, as legitimate social problems stemming from women's dissatisfaction with their roles, or other factors, physicians are apt to label these symptoms tension, anxiety and depression. The type of treatment most often prescribed for women with these symptoms are the prescription of minor tranquilizers.³⁹ To support this hypothesis are the following

statistics compiled by the Langley-Porter Neuropsychological Institute:

"On an overall basis, women account for about 67% of all psychoactive drug usage nationwide. Twice as many women as men are utilizing prescription psychoactive drugs. Overwhelmingly, the majority of women receive these drugs from a medical source." 40

From these findings, one might infer that one of the explanations for such excessive use of tranquilizing drugs is economic. The drug companies, physicians dispensing the drugs, and the advertisers, reap profits from such consumption. Another might be the lack of understanding and/or tolerance of the physician who prescribes these drugs. Unaware of a woman's psyche and status in society, it is possible to misjudge certain symptoms as being medically caused rather than as being precipitated by problems in living.

The Women's Health Movement

In most of the experiences of women confronting the health system as patients, there are issues which are common to all. Clearly, women in their frequent confrontations with the health system, have experienced the lack of control in their medical encounters; their being treated as passive recipients of health care which is very often injurious to their physical as well as their social beings; and, they have been alienated from their bodies and thus from themselves. Emanating from these experiences and their heightened awareness of their rights to decent treatment, women have become painfully aware of how the health system fails to meet many of their health needs. Out of their growing sense of anger and frustration, many women have become more and more active in struggles to regain control of their lives and to effect some measure of change in the ways in which medical care is presently delivered.

What are the demands and objectives of the women who are collectively involved in assuming active roles to improve their relationship to the health system? What form has their involvement with issues of health taken? Have their activities culminated in any meaningful changes in the ways in which health care is delivered?

As in most national movements, there are many variations in the women's health movement. Yet, despite these differences, there is general agreement on the basic aspects of the health system which growing numbers of women are committing themselves to changing. In essence, women are seeking a dramatically different kind of health care than they have been receiving to date. Women are challenging the commercialism, sexism, and professionalism which they feel typifies American medicine.

In the words of Dr. Mary Costanza, an advocate for the women's health movement:

"Women are seeking cooperative care, where health is a common concern to patient and professional alike, where self-knowledge replaces mystery, where orders bow to instructions; where self-help is regarded as a matter of common pride and not as stubbornness; where decisions are made by all involved and not passed down from on high."⁴¹

Thus, women are rejecting some of the most salient features of our present system. They view the traditional model of providing care which implies a carer and cared for, as an obstacle to achieving their goals for self assertion and reliance. By becoming their own health managers, it is hoped that women will be able to move away from the passive roles they have played in health encounters to ones that enable them to assert themselves and become active decision making agents.

Additional changes in the way health is presently conceived

and delivered are being proposed by the women's health movement. First, women are insisting that doctors become accountable medically, financially, and psychologically. Second, women are demanding the facts and information which they feel will enable them to make rational decisions about health care needs. This information is also seen as giving those women the opportunities to do for themselves medically what is reasonable for them to do.⁴²

The women's health movement believes that health is more than just the mere absence of disease. They feel medicine in America has been concerned for too long with providing crisis medical care rather than on promoting health education, self help, and research into causes. The hope of new responsibilities to be assumed by the patient, and the cooperative relationship between patient and doctor along with the other goals, might be a step toward attaining the basic changes in the way health care is viewed and practiced.

Directions of the Women's Health Movement

The women's health movement has taken diverse forms, depending on the particular aspects of the health system which women want to ameliorate and the strategy which they feel will best utilize their energies to accomplish their ends. Although there exists no body of literature as such to delineate the origins, goals, and variations within the women's health movement, several major trends and strategies are already visible. One has been to pressure existing health institutions and to demand changes directly from the power source. Some women believe that the most powerful thrust for change comes when they form alliances with other groups to put pressure on established health institutions and those responsible for policy making on issues pertaining

to health. Believing that by organizing themselves into groups, women have focused pressure on the institutions to respond to a number of demands which they feel are legitimate and central to their cause. The Abortion Repeal Movement is a clear-cut example of the use of this strategy. It was the kind of issue that dealt with the right of women to control their bodies in whatever way they choose. As organized health consumers, women and other sympathetic groups, focused their energies on the legislative bodies to abolish existing abortion laws. Through the success of the abortion repeal experience, women have come to recognize their considerable leverage with a system as powerful as the medical one.

A second type of involvement, which will be the prime focus of this thesis, is the creation of alternative medical settings to provide health care for women. The women setting up these clinics see their energies best realized by giving substance to the right of women to control their own lives and bodies by providing free medical care run for and by women. Although there is some variation in the goals and functions of these clinics, most are designed to provide routine medical services, emphasizing the teaching/learning relationships between patients and staff, health education and preventive care. Women's clinics provide a concrete situation in which women can learn and share medical as well as organizational skills, offer some badly needed services, and serve as a model of decent health care.

The third, is the self help contingent which is becoming a growing and controversial outgrowth of the women's health movement. Its main thrust is to assist women to learn about their bodies, to be better able to care for themselves when possible, and to challenge the

mystique and performance of health providers. "Do-it-yourself gynecology", a popular conception of the self-help concept, is, on the simplest level, examining a woman's own reproductive organs. Self-help is a form of preventive care, not an end in itself.⁴³ By learning about their bodies, women feel they will be better able to provide health care for themselves.

To a large extent, there is a significant overlap in the activities of these groups of women. For example, some women's clinics also involve themselves in working with community groups to pressure health institutions and in emphasizing the self-help concept in their clinic's operation. Implicit in each of the above mentioned activities which women have joined in increasing numbers, is the belief that women have to work together in order to challenge the practices in the health system which they feel have persisted for too long. Requisite to achieving this, they see their passivity which they have assumed for so long to be one of the first changes that must be made before they can bring about changes and regain control over their own bodies. Women must rely on themselves, rather than solely on doctors, which they had in the past. In its entirety, "the womens' health movement is seen as a significant force which asserts that only by becoming active participant in health care, will there be any chance of improving the American health care system."⁴⁴

The implications of this movement are several. First, it is being asserted that professionals have no intrinsic expertise about the wisdom of health care. Second, it is being demonstrated that the public can participate in deciding what the health system should be like. Third, and perhaps most central to this thesis, is the belief that individuals have the power to decide their own fate.

Origins of the Women's Health Movement

Why did a women's health movement emerge? Did it incorporate some of its goals and strategies from the experiences of other, already existent movements? Acquiring empirical evidence as to the origins and goals of a national movement is a difficult task in and of itself. This is further complicated by the fact that the women's health movement is a movement-in-progress, and little has been written about its recent history. Drawing from the limited literature on the women's health movement, there is some agreement that its development, and particularly that of women's health clinics, represents to some extent, the overlapping of three existent movements: the women's liberation movement, the evolution of the counter-culture; and the Free Clinic movement. It has also been postulated that it has historical antecedents.⁴⁵

My purpose in attempting to relate the women's health movement to ongoing movements is threefold: (1) to place the objectives and experiences of this movement into a broader framework in order to better evaluate its goals and efficacy for actualizing them, (2) to demonstrate the broad-based support which this movement potentially has in striving to achieve its goals, (3) to illustrate that the activities of the movement tie into larger movements dedicated to bringing about some degree of social change in our country.

Today's women's health movement is not without historical antecedents. In the 1830's and 40's, feminist and working class groups formed the backbone of what was then called the Popular Health Movement. The Movement was a radical assault on medical elitism, and on affirmation of the tradition of people's medicine. Licensed doctors were criticized

as members of the "parasitic, non-producing classes": universities were denounced as places where students "learn to look upon labor as servile and demeaning." ⁴⁶

An outgrowth of the movement was "Ladies Physiological Societies" which were the equivalent of today's know-your-body courses. They flourished throughout the country and involved large audiences in learning about anatomy and personal hygiene. The emphasis was on preventive care and numerous other issues women could relate to.

The peak of the Popular Health Movement coincided with the beginnings of an organized feminist movement. Accounts state that: "The health movement was concerned with women's rights in general, and the women's movement was particularly concerned with health and with women's access to medical training." ⁴⁷

This health movement was not just a movement for more and better medical care. Like its successor, the women's health movement, it sought a radically different kind of health care, and was a challenge to the prevailing medical dogma, practice and theory.

Women's Liberation

Perhaps the strongest influence on the women's health movement has come from within the ranks of the national women's liberation movement. Essentially, the thrust of the women's health movement is an extension of the ethos of the larger women's movement which believes that women should have the right to control their own lives and bodies. The goal of most factions within the women's liberation movement (of which there are several) can be summed up as follows:

"Women today, like Blacks, Mexican-Americans, Vietnamese, etc., want to be people in our own right; in order to be respected for ourselves we must fight those forces in our basically oppressive society which oppress us as

women. We need to assert ourselves against those forces that have controlled our bodies and ignored our minds. Since the alienation of women from their own bodies has been one of the main aims of male domination, we must take control of our own bodies before we can liberate our minds and be our own people." ⁴⁸

The methods for actualizing these goals have varied widely, depending on the branch of the movement being described. Some advocate a national organizational structure which utilized the tools the system provides to effect reform for women's rights. Others, which have been more influential in the development of women's clinics, perceive their activities as being more radical and directed toward liberating women rather than reforming their status. This branch has been the major source of new feminist ideas and its accomplishments have ranged from the development of many alternative institutions, to the creation of a broad-based constituency, involving ever-increasing numbers of women into the movement. Their emphasis has been on personal change, as a means to understand the kind of political and social change desired. ⁴⁹

Rise of Counter-Culture

The growth of the women's health movement which has spawned the development of alternative models for delivering health care, can be seen as an outgrowth of a larger movement in this country, popularly referred to as the counter-culture. This movement which was hoped to be the beginnings of a social revolution in America, developed out of a realization that:

"We are powerless and have lost the ability to control our lives and our society. We have become alienated from ourselves and from other people and life around us." ⁵⁰

The proponents of this counter-culture believe that changing the structure

of our institutions and society without changing the consciousness of its consumers and providers is a futile attempt at bringing about social change. This "new consciousness" which characterizes the counter culture believes in the celebration of the uniqueness of individuals; the need for education that will enable people to use technology, control it, and give it direction to serve the values and needs chosen by the people; and the search for satisfying and non-alienating jobs and life styles which facilitate the fostering of mutual aid and self actualization.

Free Clinic Movement

The rapid growth in the past six years of free clinics, a new kind of center for the delivery of health care services, has certainly been a prime force in the emergence of the women's health movement.

"Free clinics in many respects, distill the experiences and beliefs of the New Left, underground culture, Black Power advocates, and OEO. The vision of the free clinic movement is founded on the twin convictions that: the American medical system does not meet the people's needs; and the American medical system must be radically restructured!"⁵¹

There are many distinctions among various free clinics depending on the purposes for which they were established and the resources available to them, yet overall, there are more similarities than differences. In capsulized form, free clinics share the following principles: (1) health care is a right and should be free at the point of delivery; (2) health services should be comprehensive, unfragmented and decentralized; and (3) medicine should be demystified and deprofessionalized.

There is a large degree of overlap and similarity between this form of free clinics and those created by women's groups. However, in a number of cases, women's clinics are in part a reaction to the overt sexist treatment women were receiving at regular free clinics. Many of

the moralistic and insensitive overtones which characterized traditional medicine vis à vis women were carried over to these "alternative" health settings.

Common Themes

In these seemingly different social developments several common themes emerge. To some measure, these similarities involve the growing dissatisfaction with many segments of our population that are adversely affected by some aspect of American society. Another, is the increasing role of the public in participating in the struggle to make services and institutions more responsive to their needs, and in so doing, striving for a greater degree of self determination. Consequently, there has been an emergence of a new class consciousness which seeks to rectify their alienated and unrepresented status vis à vis our service institutions.⁵²

Perhaps, the most compelling and unique aspect which these movements share and which bears most strongly on the development of women's health clinics, has been the growing involvement and preference of many individuals to work collectively in creating alternative settings and services.

Hopefully by recapitulating the general objectives of the women's health movement, its emergence on the American health scene will no longer be viewed as an isolated event which was responding primarily to women's awareness of how they have been mistreated by the health system. Rather, it can be seen as the culmination of several on-going movements which have provided some direction, structure and support to the women's health movement.

As mentioned earlier, the principal goals of the women's

health movement are to reject the professional dominance and patriarchal nature of our health system; to enable women to regain control over their own lives and be their own health managers; to press for a reorientation in the underlying assumptions in our health system which affect the ways in which medical care is controlled, organized, and delivered; and, when necessary, to create alternative means by which the health needs of women can be served.

Thus, like free clinics, the women's health movement seeks to deprofessionalize and deinstitutionalize medical services to meet the needs of its constituents. Consonant with the counter-culture, women, collectively involved in issues of health, are contributing to the creation of a new consciousness whose aim is to move away from their objectified, alienated status in society by revitalizing and reasserting the uniqueness which women possess. By focusing on the rights of women to control their own bodies, the women's health movement has given substance to the main rallying cry for the women's liberation group.

The advent of women's clinics is a culmination of several forces which have been developing over time. Primarily, the impetus for their creation has come from the women's health movement in which women have collectively realized the problems inherent in their relationship to the health system and the need to change it.

In the chapters that follow, I will describe the nature of these clinics, which have been a new phenomenon on the health care scene. Issues to be explored will be concerned with the various functions, goals, and services which these centers fulfill; what some of their unique characteristics are which make them worth studying; how their activities relate to the larger women's health movement and its efforts to change women's status vis à vis the health system.

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CHAPTER 4

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WOMEN'S CLINICS - OVERVIEW AND GENERAL CHARACTERISTICS

The idea of women's clinics is an exciting and forceful one that is spreading in popularity and appeal throughout the country. In Berkeley, Seattle, Baltimore, New York and Boston, women have gotten together to plan and operate these alternative medical settings. As described in the previous chapter, women's clinics are not without precedence. For example, in 1916, Margaret Sanger established the first birth control clinic for women. Maternal and child health programs were developed by Public Health departments. The 1950's saw the advent of comprehensive female health clinics operated by non-physicians in rural, low-income areas of the South.

Unlike these historical antecedents which were primarily concerned with providing services to give specific needs that weren't being met by the existing system, today's women's clinics are seeking to redirect the focus and practice of medicine to better serve women. To this end, women are experimenting with new concepts and forms of providing medical care for women. They are focusing their energies on seeking ways to improve the present modes of delivering health care. To recapitulate, these women are seeking to become their own health managers; to become active participants rather than passive recipients of medical care; to revive the personalized, educational, and preventive aspects of health care; and, to return to women ultimate control over their lives and bodies.

Out of these concerns, shared by most women's clinics, have grown a set of goals which determine to a large extent the functions,

characteristics, and outcomes of these clinics. In this chapter, the features of women's clinics that make them a significant model for delivering medical care will be discussed. Though I feel that there are many similarities among clinics, I cannot offer comprehensive data to support this assumption. This account is based on my own analysis of the very limited number of readings available about women's clinics, and my varied contacts with individuals directly or indirectly involved with these clinics. My thesis, therefore, should be viewed as a preliminary investigation of a recently emerging trend, rather than as a definitive study of women's clinics. Thus the reader may extrapolate from my findings, but they do so at their own discretion, since my main concern is to describe, as best I can, the salient features of these clinics which are growing in number and vitality.

Goals

Women's clinics have formulated a number of goals which developed as a response to the numerous difficulties which women have had with the existing health system. These goals, which largely define the focus of the activities and functions of women's clinics, are upheld to a greater or lesser extent in most clinics. Depending on the philosophical and/or political orientation of the clinic, some goals are given greater priority than others.

Perhaps, the goal which is most commonly upheld by women's clinics and which is their "raison d'être," is to provide a model of what they consider to constitute decent and humane health care for women. Other goals designated by women's clinics are: to provide direct services for women; to enable women to be their own health managers;

and to provide opportunities for the staff to learn and grow from their clinic involvement.

Many women's clinics see themselves as providing an example of what they consider to constitute good health care and to provide a model for the future. Implicit in this model which partially redefines health care is the belief that health care should be demystified, de-professionalized, non-patriarchal, free at the point of delivery, and comprehensive. Because these are not the realities of the present medical system, the ideal must be created to prove that it can exist before it can be demanded of the health system. To this end, women's clinics are demonstrating new roles for both consumers and health workers in the medical encounter and overall clinic operation. In addition, changes in organization and decision-making are being tried to move away from the hierarchy and professional dominance which pervades traditional medicine. Emphasis is being redirected from purely curative and crisis care to preventive care and health education.

A second goal held by these clinics is to provide direct, personalized services to women, which were either not being provided by the existing system, or, if they were, not being delivered in the way women would prefer. In addition, these clinics were designed to provide a place for women who were turned off or turned away from the system could get treated.

Another goal of the women's clinics is to provide women the opportunity to be their own health managers. By increasing the individual initiative and participation on matters pertaining to health care, it is hoped that women patients will begin to feel as if they have more

control over their bodies and lives, rather than allowing decision-making and control to be the responsibility of the omnipotent physician. For the staff, a goal is to provide opportunities by which they can learn and grow from their involvement in the clinic. It is recognized by many clinics that in order to deliver health services to women sensitively and effectively, it is essential for the staff to grow and adapt to the changes that naturally occur in all facets of the clinical setting.

Implicit in these goals which are expressed by women's clinics, is the hope that the various aspects and experiences of the clinics will have an impact on the way services are delivered in the larger system. By creating a model of decent health care for women, providing active learning opportunities for women to be their own health managers, or by organizing and directly confronting medical institutions, women seek to change and restructure the health system.

Many of these practices have been tried in traditional health settings or have been proposed by others in health fields. However, women's clinics are attempting to incorporate the entire package of goals and techniques into their operation.

Approaches

Women's clinics have employed several different approaches to actualize their goals. Many of these approaches reinforce and complement each other, which serves to strengthen the clinic operation. Those approaches which are characteristic of most women's clinics are: transfer of skills, client advocates, job rotation and paramedics.

These different approaches relate, in some ways, to the stated goals of the women's health movement.

Transfer of Skills

A basic tenet of operations in women's clinics is the transfer of skills from staff to patient. There is a sharing of information and knowledge about the medical procedure which has traditionally been withheld from patients. At most points during a woman's contact with the clinic, she is told what is being done to her, for what reasons, and how it will feel. When possible, the patient is encouraged to look at herself while she is being examined; or is shown how a certain treatment or test is administered. For simple procedures (such as self-examination with a vaginal speculum), women are instructed on how to perform them.

By putting a major emphasis on the teaching/learning relationships between patients, staff and doctors, several goals of the women's health movement are put into practice. When women learn about their bodies and how they work, they are beginning to reclaim that part of their lives which they have an intimate right to understand and control. Through the self awareness which is gained by this transfer of skills and information from providers to patient, women are put in a better position to determine for themselves the quality of health care they will receive. When a woman is knowledgeable and informed about the medical procedure and can participate in the medical experience, she is moving toward a decreasing dependence upon the "wisdom" of her physician which has characterized traditional medical practice for so long.

The skill transfer system thus serves to demystify medicine by explaining the medical procedure and showing women that they can assume active roles in their health care. With this arrangement, women are no longer confined to the role of passive consumers. They are helped to become more informed and intelligent users of the health system, and can place demands for decent care in later contacts.

Furthermore, this practice moves women closer to their goal of making medical care more of a cooperative venture rather than one based on competitive and power relationships. By respecting the woman as patient and giving her a role as learner, these clinics are moving away from the objectification of women which has hampered their development of self-respect and confidence.

Client Advocates

In many women's clinics, the use of client advocates has been initiated as a basic part of their clinic operation. The role of the client advocate is to (1) help the patient understand the procedures, assure follow-up, and referral if necessary, and protect the patient from medical abuse, and (2) raise the political consciousness of patients by informing them of the philosophy and intent of women's clinics.⁵³

Many have likened these advocates to community aides for other social services. Client advocates are either paid or non-paid individuals both from the community and elsewhere and are considered to be an integral part of the clinic's staff.

In order to become a client advocate, a woman is usually trained for a period of time ranging from several weeks to months, depending on the responsibilities which she will assume in the clinic. Some advocates

are trained to counsel women patients or lead "rap" groups on birth control and general health issues. Others have been trained to do simple medical tests or assist in examining the patient. Training programs are initiated and assembled by the advocates themselves, or by the staff of the clinic. Oftentimes, health and social service professionals from the community volunteer their time to the preparation and/or training of client advocates.

The actual job of the client advocate begins with the patient's first contact with the receptionist. At that point, the patient is given an advocate who takes her medical history or collects the file if the patient has come before. In discussing the patient's complaint, a rapport is built up between patient and advocate which personalizes the medical encounter for both. In creating this bond, the patient is apt to feel more comfortable about discussing her personal attitudes toward her health problem and the forthcoming encounter with a physician. In addition, it allows the advocate to communicate some of the goals of the clinic to the patient, such as, why women run the clinic, why its important for women to control their own bodies, and what distinguishes a women's clinic from other medical settings.

Another function which the advocate often serves, is to acquaint the women patients with other aspects of the clinic's services. Since many of the problems which motivate women to seek health services require more than purely medical attention, some clinics have created supportive services and activities to meet these other needs. For example, a young woman who has complained of headaches and backaches may seek treatment for these problems. However, in the discussion with

the client advocate, the patient talks about her problems with her young children and her concerns about meeting their needs. The advocate may decide to tell the woman about the young mother's group that meets at the clinic during the mornings and will suggest that she attend. Thus, efforts are made to view the patient in more than just purely medical terms. Where appropriate, the multiple facets to a health problem are dealt with.

The advocate introduces the patient to the doctor and is frequently present during the examination to make sure that the patient's needs are met, since in some cases, the woman might be reluctant to explain her health problems to the physician, as she did to the advocate. Other roles of the advocate are ensuring that the patient understands the medical treatment, and that a follow-up appointment is made if needed. If a referral is made to other facilities, in some cases an advocate might accompany the patient or keep in contact with her to discuss the outcome of the visit.

Many of the advocates were once clients themselves, which serves to involve more women in the actual running of the clinic. This consumer-as-provider process is one which often characterizes many women's clinics. Thus their participation in the clinic helps to personalize the patient/provider encounter, and contributes to attaining continuity of care which is a fundamental goal of most women's clinics. Some feel that the client advocate system is the most promising aspect of these women's clinics.⁵⁴

Job Rotation

Some clinics have instituted a formal job rotation where

members of the staff rotate responsibilities. They believe that all areas of work in the delivery of health care in the clinic are of equal importance, and deserve mutual respect and cooperation. In addition, by rotating and sharing responsibilities, the hierarchy which has pervaded traditional medicine is being challenged. One way this has been tried, is by having the health worker perform all of the clinical functions which a particular patient will need, such as taking her medical history, to the actual examination, lab work, treatment and follow-up.

Another method is to assign each provider a different responsibility every time that she is working in the clinic. For example, one night the staff person is providing direct service to a patient, and the next week she might be meeting with local groups to plan a community based health activity.

In practice, however, neither one of these methods of job rotation has been entirely utilized. Physicians are usually exempt from such rotation, since they are in such short supply and their time is carefully spent to deliver needed services, teach staff and patients, and guide the work of paramedics. Thus, those clinics who have most of their staff trained to do similar jobs (such as client advocates and paramedics), this approach has been followed.

Paramedics

The use of paramedics is one of the strongest elements of women's clinics and seems to be growing in popularity. Generally, the paramedics have had no previous medical training. They are usually trained at the clinics by doctors and by each other, in classes, and/or

while on the job. "A typical training course includes a series of lectures or discussions on the menstrual cycle and birth control, on pregnancy and its effects on prenatal care, on abortion, urinary tract infection, vaginal infections, sexuality and counseling on all these subjects."⁵⁵

The paramedic begins her work by assisting a previously trained paramedic and a doctor during examinations. To avoid the perpetuation of using patients as teaching material, which is antithetical to the philosophy of the women's health movement, the paramedics ask their patients' permission to observe the exam.

After a period of about 12 training sessions when the new paramedics have developed their skills and gained confidence in their newly acquired knowledge, they assume the responsibilities of the paramedical functions. Although paramedics are required by law to work with a supervisory physician, they perceive their roles as being more than merely doctor's assistants. While the doctors must check their examinations and diagnoses and write prescriptions, the paramedics may do a routine pelvic exam, fit diaphragms, take tests for cancer and vaginal infections, do breast exams, test for pregnancy. In addition, paramedics adhere to the principles of job rotation and transfer of skills. In so doing, they are involved in most aspects of patient care from taking the history, examining the patient, to counseling and teaching the patient about the procedure and matters pertaining to her health care.

To further the goal of cooperative rather than hierarchical care, the paramedics participate in the discussion and diagnosis of the patient's case along with the doctor and patient herself. Also,

they play an equal role in determining the policies of the clinic. The women who become paramedics were usually themselves treated in a women's clinic and felt an affinity with the ideology of women becoming providers of care. Some paramedics are women who were dissatisfied with their treatment in other medical settings and wanted to participate in furthering the goals of the women's health movement.

By engaging women in these provider positions, much is being done to change traditional sex roles to which women have been accustomed. Women patients can see that non-professional people are able to learn about medicine and are willing to share their skills with others. At a meeting I attended for women interested in paramedic training, those women who had been working as "paras" in clinics, felt that the confidence that they developed on the job could not be underestimated.

The concept and practice of women as paramedics, along with transfer of skills, job rotation, and client advocates are reinforcing the goals shared by most women's clinics that health care should be a cooperative venture, and that women should regain control over health matters.

Functions

A number of functions are served through the activities of women's clinics. As with most aspects of these clinics, the functions served depend on a number of interrelated variables: the goals and objectives of the particular clinic; the nature of the client population and their health needs; the orientation and skills of the clinic staff; and the resources available to perform its functions.

The provision of direct services, as well as learning opportunities for both patients and health workers are examples of functions

that are clearly observable in the clinic activities. Less tangible are those functions involving activities which seek to challenge and change the delivery of health care. Another set of functions that are difficult to describe and delineate are those that affect the mental health of both workers and patients.

Perhaps the most basic function of women's health clinics is to provide needed medical services to women of a particular community. Depending on the nature of the clinic's staff, facilities, and client needs, the service mix usually resembles basic primary medical care. Services can include diagnostic and preventive procedures, treatment for routine medical and gynecological problems, well-baby care, and mental health and counseling. If a clinic has enlisted the services of doctors with specialties, its range of services can be increased.

Along with providing direct services for women as patients, some women's clinics are providing learning opportunities for the women who work there. Women can be trained to perform various functions while they are assisting in the clinic, i.e., lab work, counseling for clients, leading rap groups on birth control and general health issues, and administrative skills. Thus, women's clinics provide a concrete situation in which women can learn and share medical as well as organizational skills.

In broader terms, some women's clinics describe as one of their functions, to be an "instrument of change" to restructure the health system. In some instances, women's clinics provide a focal point around which political and community organizing activities can take place which are aimed at bringing about some degree of change in the way health is delivered in the community. In purely logistical

terms, the women's clinics can serve as a base where community and health workers can meet to discuss issues of common concern. One example of an activity that grew out of such meetings is the initiation by one women's clinic of a community wide campaign to pressure city officials to establish a comprehensive health facility.

Furthermore, most of the women working in these clinics are volunteers and they are afforded the opportunity to view and criticize health care from the inside looking out, which is not often possible by other means to nonemployed persons.⁵⁶ Despite what would seem to some as a periferal role in health care delivery, these women are in a position to express militancy and criticism of the health system. Since they are directly involved in delivering health services and not outside observers of the system, they are supported by the many other women who are devoted to bringing about changes.

Another function that women's clinics serve, is providing an opportunity for women who would normally not portray themselves as health activists, to become informed and involved in the politics of health care. While availing themselves of badly needed services, women who would otherwise have little opportunity, are exposed to the women's health movement. This exposure takes place through the conversations with client advocates, the literature available in the clinics, and "rap" groups in the waiting area, which all contribute in some measure, to heightening the women patients' consciousness of health issues. To what extent this awareness has led to action and involvement has not been documented. I would postulate that the women exposed to such conversations and literature would at the least be sympathetic and supportive to the efforts of the clinic to organize and press for changes in

health care delivery.

Mental Health Functions

For the women involved both in the creation and operation of women's clinics and those who are consumers of the services, the clinic serves many sociotherapeutic functions for them. For women patients, in coming to a medical setting which was specially created for treating women's health problems, they experience feelings of being accepted, understood, special. By treating a woman in a sociomedical rather than solely medical frame of reference, many women find their health needs legitimated and understood. Symptoms which are often overlooked, denied or mistreated in traditional health settings, such as menstrual cramps, headaches, nervous tension, are dealt with by women who have probably also experienced similar symptoms.

For many women who had no previous outlet for expressing problems in living which often manifest themselves in physiological symptoms, women's clinics are providing such an outlet. Individual or group counseling, "rap" groups, and discussions with client advocates provide such opportunities for women to air their concerns. Another aspect of women's clinics which has sociotherapeutic effects on the women who are both consumers and providers is the emphasis on health education and body knowledge. The understanding of one's body and how it functions gives many women feelings of power, greater confidence and self pride.

Some observers have said that the women's clinics have a more profound effect on the attitudes and life experiences of the health workers themselves than on the female patients. This may be true due to a number of factors. The clinics are largely cooperative ventures which creates a milieu characterized by mutual aid and group involvement.

To a large extent, women's clinics are innovative alternatives which provide an atmosphere of human relatedness. In an article on "Women and Volunteerism" which speaks to the experiences of women's clinics, the author states that:

"The sense of achievement that results from working together with others to effect action is a feeling not easy to duplicate among co-workers in the context of a job. The experiences of brotherliness among union members in the heyday of trade union formation was probably akin to this excitement."⁵⁷

Women in positions of responsibility gain a certain amount of confidence and self respect from running their own institutions. Psychiatrist Thomas Szasz recently remarked that women as a group are insecure because they lack power.^b By volunteering in a women's health clinic, women are allying themselves with an activity which rivals the dominant health institutions and a male dominated profession. It is not unreasonable to assume that women must certainly feel strength and power by being involved in such a venture. In addition, by mastering their roles in these clinics, women who have felt inferior and frustrated because of their unproductive, domestic chores and their missed opportunities for training and education, are working toward gaining a sense of self respect and motivation to actualize their abilities.

Working as a volunteer in a women's clinic also provides women opportunities to try out a new environment and various roles. The new and challenging roles and responsibilities offered by women's clinics give some women an opportunity to try a new role. For others, it acts as a first step to prepare women for paid work by bolstering their confidence and helping them master needed qualifications.

By partaking in challenging and innovative health settings

like women's clinics, women are not only extending the clinic's program, acting as catalysts for societal change, but are at the same time, finding self satisfaction and new found confidence in their roles.

General Characteristics

Even though the number of women's clinics in this country is limited, there are minor variations among them. Some may be founded by a group of women interested in pooling together their skills as paramedics to treat the gynecological needs of women. Others were created to provide direct services for a community where the health resources for women are severely limited. In some cases, they are founded by politically active women who are seeking to develop a constituency by which they can pressure health institutions for change. When examined closely, one can identify many characteristics which women's clinics have in common. Those that I will briefly describe are: scope of services, organization, decision-making, financing, staff and patient characteristics, and physical facilities.

Scope of Services

The services provided by a particular women's clinic depend on a number of factors. The prime determinants of services are the goals and objectives of the women in the clinic; types and amount of funding; the expertise and/or orientation of the clinic staff; the facilities and equipment to which the providers have access; the health needs of the population to be served; and the number and type of alternative and supportive health resources available to the community. In terms of direct medical services, women's clinics offer either one or all of the following: gynecological and birth control services, routine medical care, well baby care, and mental health counseling.

Those specializing in providing gynecological services, which include the majority of clinics, concentrate on diagnosing and treating vaginal and urinary infections, prescribing and fitting various birth control devices, and testing and counseling for pregnancy. The providers of these services are either gynecological paramedics working under the supervision of a physician, or, by a licensed physician herself.

Some clinics do not restrict their services to just gynecology. They aim to treat the general and minor health needs of women and consequently have a wider variety of services and health workers. In narrow medical terms, the clinics are not equipped to treat very complex medical problems usually dealt with in a traditional primary care setting, due to limitations in facilities, time and staff. This presents a conflict between a goal of the women's health movement for comprehensive medical care and the capabilities of the clinics to meet this end. To attain the goal of comprehensiveness, some clinics have recruited specialists such as gynecologists, pediatricians, and internists. Others, have tried to emphasize the preventive and follow-up aspects of medical care which contribute to a comprehensive approach. To this end, periodic check-ups and tests are encouraged, and where possible, self examination techniques are taught. Despite these efforts, some critics have said that "...the medical attention provided in these clinics is that of a neighborhood first aid station, if such a thing existed. Most clinic services don't extend beyond routine intervention and screening..."⁵⁸

Another category of services that women's clinics offer is related to health education for the public. Women working in clinics have often been invited by community groups, agencies and schools to hold seminars, give lectures and classes in issues concerned with

women's health. For some, this has taken the form of speaking to a local high school class about birth control and sexuality. Others, have interpreted this service function by holding various classes in the clinic about public concerns, such as alcoholism, dieting, and drug use.

Counseling is a large part of a women's clinic operation since they believe that a woman's medical needs are psychological as well as physical. Women can avail themselves of many types of counseling. They have the option to discuss certain questions and conflicts which trouble them with the help of their client advocates. This takes place on either an individual basis, or, if they prefer, they can meet in a group to discuss these concerns with other women. These groups can be very informal and spontaneous, or highly structured around a particular topic. A heavy emphasis in some of these groups is on consciousness raising and on body knowledge. Some clinics have mental health services which include individual and group therapy for women led by trained therapists. If long term therapy or psychiatric treatment is recommended, efforts are made to refer those women to appropriate settings.

As previously mentioned, women's clinics provide varied opportunities for training women interested in the health care fields. For women seeking to become paramedics, much of their training takes place within the context of the clinic operation. Client advocates, lab workers and counselors learn many of their skills while on the job. Of great concern to these women, is to avoid exploiting and humiliating the women patients while they are being trained. To avoid taking advantage of patients, permission is asked of the women to have a trainee

present during the examination, etc.

Since most women's clinics are not equipped or staffed to provide the complete range of services of traditional primary care settings, or because of an excessive demand for their services as compared to the supply, they must rely on referrals to other facilities and services to fill in the gaps in treating their patients. Some clinics turn away and refer elsewhere a significant number of would-be patients. To avoid repeating the mistakes of traditional medicine, the women's clinics devote much energy to making appropriate referrals to services that a woman can afford and which have been assessed by the clinic to provide quality care.

Perhaps, the most frequent instance of patient referrals is for abortion. Women health workers have carefully evaluated many abortion clinics and services⁵⁹ and maintain strict standards for quality of care, cost, and concern for the individual. If the abortion experience is likely to be traumatic for a woman, it is not unusual for a client advocate or other health worker to accompany her through the ordeal. Follow-up examinations and counseling are suggested and arranged to insure that the woman has fared well both physically and emotionally. If one or more women have unpleasant and troublesome encounters at an abortion clinic, contact is made by a health worker to investigate the matter, and if warranted, the clinic will not only cease referring its patients there, but will also inform other women's groups to exercise caution with respect to that service. This commitment on the part of the woman health worker to follow a patient through a medical procedure like an abortion, and that of the patient to report back her experience at a particular facility, has in many cases contributed to making the

delivery of medical care accountable to its users. By disseminating information about certain services and facilities and by maintaining contact with other providers of care, a network is being established which is committed to monitoring certain facets of the medical system. A resource recently developed by the National Women's Health Coalition is an "abortion clinic monitoring kit." This kit includes regulations, standards, and cost analyses and is designed to assist individuals and groups of women in evaluating abortion clinics.⁶⁰

When a clinic is both interested and equipped to broaden its concept of health care from focusing on the individual to including care of the community, it is possible for the clinic to provide certain outreach services. For example, in one local woman's clinic, they have implemented a program of screening for lead paint poisoning in neighborhood children. As a recognized health resource, the city entrusted them with the responsibility to test for this serious childhood health problem by giving them equipment and referring children to their clinic. This clinic is one of three that are providing the service in the city. Unfortunately, it is a rare clinic that is not so bogged down in keeping pace with excessive service demands that can branch out to provide services to the total community.

Organization

To further the avowed goals of the women's health movement of deprofessionalizing medical care, giving women control over health, and making medicine a cooperative venture, women's clinics have adopted a special type of organizational structure. These clinics are effectuating an alternative to the pyramidal and hierarchical organization which

characterizes traditional health and "helping" settings. Conceptually, the organizational structure is horizontal rather than vertical which encourages staff relationships without status differentials. The peer organization of the clinic, along with the self-selection of volunteers, has helped to bring the clinics closer to their goals of deprofessionalization and democratization in the clinic operation. The non-hierarchical milieu of the clinic helps to produce an egalitarian, mixed staff which minimizes special expertise, rank and status. In addition, it facilitates the sharing of responsibilities and the participation by the entire staff in the clinic's decision making process.

Cooperative rather than top-down organization along with the ethic of sisterliness which characterizes many women's clinics has also had an effect on the nature of the client-provider interaction. By bridging the gap between staff and patients, and by diffusing authority within the clinic, there is likely to be more communication among all health workers and between patients and staff.

Decision-Making and Control

In the inception of women's clinics, it appears as though efforts were made to achieve new forms of decision-making which were alternatives to authoritative and top-down control characteristic of most medical institutions. A basic belief of women's clinics is to strive for consumer, staff and community participation in decision-making, since it was apparent that these groups were usually denied opportunities to partake in the design of policy and actual control of medical care.

In reality, decision-making occurs on many levels in the operation of women's clinics. Daily administrative decisions that arise

are usually made by the staff volunteering on that particular day or evening. Medical decisions occurring during clinic hours are generally made by the doctor, with the cooperation of paramedics and/or client advocates, and, with the agreement of the patient, herself. Decisions relating to overall clinic policy are handled in different ways. Some clinics have a board made up of community people, staff workers and consumers who help to formulate policy. Others have frequent and more informal meetings with staff, interested community individuals and consumers to discuss clinic policy. In those, which are operating out of an already established free clinic or other medical facility, there are policy guidelines that must be adhered to which were already formulated by a group other than the women at the clinic.

Since the ethic of egalitarianism is upheld in most women's clinics, efforts are made to avoid deferring decision-making to the physicians. However, this is not always possible. Due to the fact that physicians are not nearly as available as other health workers (especially female doctors), that their time is volunteered, and that they are a vital part of the clinical operation — there has developed to some degree, a situation in which the staff must cater to the needs of the physicians on duty. For example, when the physician in charge of supervising the work of paramedics is unable to attend the clinic night, medical services must be cancelled or rescheduled for another evening. This is a point of contention among some women's clinics since it betrays the practice of deprofessionalism which is so highly valued.

Due to the enormous time and energy commitment which is volunteered to run women's clinics, the goal of involving patients and community in decision-making and control is often more rhetorical than

real. So far, though, there have been no instances to my knowledge, of consumers and community people seeking increased participation in this area of the clinic's operation. Perhaps, this is partly attributable to the fact that the women volunteering at the clinic are representative of the community, and, that the services and operation of the clinic are consonant with the needs and expectations of the consumers and staff involved. Despite rationalizations, several critics of women's centers and some providers interviewed have voiced a concern that more participation be encouraged in the near future.

Financing

Since women's clinics depend almost exclusively on volunteer help, and on donations of supplies and equipment, they therefore operate on extremely modest budgets. In most cases, income is derived from small grants and contributions made by private and public funding agencies and foundations, which contribute to one or more aspects of the clinic's activities. For example, the National Institute of Mental Health has funded one clinic to provide drug counseling for their women patients. Another has received a modest grant from the National Free Clinic Council to help finance their operation. Most of the medical care in the women's clinics is free, with the exception of certain prescription drugs, birth control devices, and tests which are at cost. Some clinics accept donations from consumers and others are contemplating charging a modest fee of \$2 or \$3 for each visit — to keep themselves solvent. In some cases, clinics have arrangements with local hospitals and medical institutions for lab tests, drugs, supplies, and back-up facilities. Women's clinics are quite careful about the sources of their funding,

since autonomy is the preferred status for the clinic and efforts are made to avoid being coopted through financial arrangements. A great proportion of the staff's time is spent fund raising and writing proposals for future grants. Despite their dissatisfaction with their financial instability, the women's clinics have not yet devised a solution to this problem.

With the exception of a few community workers who are paid on a part-time basis, the overwhelming majority of the staff volunteers their time and services. As I have discussed in a previous section, the volunteerism which typifies women's clinics has been a prime contributor to keeping medical care free at the clinics, and to creating an atmosphere of mutual aid and cooperation. Unfortunately, volunteerism is difficult to sustain over a prolonged period of time. As some predict, perhaps more than any other factor, the lack of funding which necessitates that labor must be volunteered and not remunerated, will contribute to the demise of women's health clinics.

Third party payments and Medicaid reimbursements are not realistic sources of income for women's clinics since in order to be eligible for qualifying as a legitimate provider of medical care, women's clinics must be licensed and accredited. Once licensed, it is reasonable to expect that a women's clinic will be eligible for more public funding as well as health insurance, and Medicaid reimbursements. As yet, there are some clinics that have not yet become licensed. They cannot call themselves "clinics", but instead are women's health centers, projects, etc. There are basic ideological conflicts to becoming licensed which women's clinics are facing, since many of the requisites for licensure conflict with the goals and practices of their clinics. One such

conflict arises from the requirement that there be a medical director who acts as supervisor of the clinic. The idea of having a physician wielding such exclusive power over the policies and practices of the clinic is antithetical to their philosophy of egalitarian and non-hierarchical organization.

Clinic Procedure

Most clinics are open one to three evenings or afternoons a week. Appointments are necessary in some clinics, and in others, there is a sign up system resembling the first-come, first-served practice. On the average, between twenty and thirty women are seen each evening, with a clinic visit lasting about one hour. In the case of emergencies or when patients need medical help during non-clinic hours, they have several options. One is to be referred elsewhere by a staff member on duty or "on call". Another is to contact their client advocates who are trained to handle referrals. The last option is to seek services elsewhere and resume contact with the clinic for follow-up treatment.

Women's clinics, like their coed counterparts, free clinics, are confronted by more patients than they can handle. Consequently, they must turn those patients away who have access to other health resources or whose health needs are less pressing than most. Despite the use of appointments for patient visits, women's clinics are still confounded by the problem of waiting time. Like the much criticized out patient departments in hospitals, the long wait which is common practice in these clinics, is a negative aspect of their operation that must be dealt with. The wait may be broken up with extensive medical histories, rap groups, and discussions with client advocates:

The long wait is usually attributable to the limited number of physicians on duty during clinic hours, and the lengthy visit which each patient has when she is finally seen. The solutions to alleviate the long waiting time that are proposed in most health settings are either "shortening the patient's time with the doctor or instituting staff routines that use the doctor's time more efficiently."⁶¹ These solutions violate some of the fundamental principles held by women's clinics to humanize the patient/doctor encounter, explain clinic procedure to the patient, and avoid the perpetuation of the staff-serving-doctor syndrome.

Therefore, most clinics have made the conscious choice to maintain the high quality of care afforded to each patient at the expense of turning many patients away. They fully realize that they cannot, with their limited resources and staff, treat everybody and that they are careful to preserve and uphold the principles for and by which they were established.

The perennial problem of excessive demand on limited supply which plagues most decent health services is one to which women's clinics are not immune. In the final chapter, I will explore this issue in greater detail since it is one which has important implications for the continuation of alternative health settings like women's clinics whose resources are so limited and whose services are so sought after.

Patient and Staff Characteristics

Since no comprehensive study of patient profiles has been made available yet, it is difficult to give a precise description of the women patients who utilize these clinics. As stated before, clinic

utilization depends on the type of services provided, the existing health resources in the community, and the particular posture of the clinic with regards to women's health care. Generally speaking, the women who use the clinic range in age between 17 and 30 years. The women are predominantly white and are women on limited incomes. Many of these women are heads of households whose incomes are just above the welfare level; others are employed in part-time or low paying jobs, yet do not qualify for Medicaid and other reimbursement schemes. There does not seem to be a clear pattern with respect to marital status of the women patients.

An impressive percentage (sometimes well over 50%) of the patients are returnees who have had several contacts with the clinic. This high rate of return has several implications which can be a reflection of satisfaction, need for the service, or numerous other factors.

Staff

Most clinics are dependent almost entirely on volunteer staff, which can include several physicians, client advocates, paramedics, and therapists. The staff is usually recruited from a variety of sources (including referrals from other free clinics, physicians, and health workers). Depending on the availability of clinic staff and the demand for services, physicians and other health workers will work anywhere from one evening per week to one per month. When not working in the clinic, almost all of the health workers have full or part-time jobs elsewhere.

In attempting to decrease the male domination of medicine, the clinics have tried to attract a majority of, if not all, female

workers. However, some clinics with a strong feminist orientation will not accept male volunteers. This search is complicated by the problem of finding individuals who are willing to work outside the traditional framework of medical care delivery, and who are sympathetic with the ideals of the women's health movement.

Where possible, a handful of community women are paid very modest salaries for their participation so they can continue their work with the clinic. The bulk of the labor contributed to women's clinics comes from women who have had a limited and in many cases, no formal health science education.

Physical Facilities

Women's clinics are free and operate on shoestring budgets. Consequently, the buildings in which these clinics are housed are often in refurbished storefronts, donated space in an existing community facility, or in a facility leased from the city for a modest rent. In many clinics, the women devote their energy to renovating the facility themselves, with minimal financial and technical assistance.

Drugs and supplies which are dispensed free or at cost, are either donated, bought cheaply in bulk, or are samples given by drug company detail men, hospitals, city departments of public health, or sympathetic private practitioners. Simple tests (urine cultures, blood counts, smears) are done by the clinic staff. A hospital or commercial laboratory will usually do the more complicated ones.

The physical layout is generally quite simple, with about three examining rooms, a front waiting area, and space to do some lab work. The reading matter can range from posters and announcements tacked on a wall to political papers and pamphlets on health related issues.

Having drawn a general picture of the form and function of women's clinics in which various aspects of their operation — including the scope and context of services, staff and client mix, methods of organization, control and financing, were described, a more detailed account of two Boston-based women's clinics will follow. My main interest in describing these clinics is to give the reader a greater understanding of how two different groups of women, espousing different objectives, got together and have created distinct, yet, in many ways, similar women's clinics. There are many difficulties in generalizing as to the features of women's clinics. All too often, these generalizations belie the individuality of a particular clinic and do not allow us to appreciate the unique adaptation which groups of women have made to a set of goals, needs, and resources. Therefore, what follows is an attempt to describe two different interpretations of the women's clinic theme with a preliminary analysis of their outcomes.

CASE STUDIES OF TWO WOMEN'S CLINICS

Women's clinics share many commonalities. Very often, they articulate the same goals and philosophies. Frequently, there are striking similarities in the kinds of services offered, patterns of staffing, and client use. As might be expected, despite this large degree of homogeneity, there do exist variations among women's clinics. Through an examination of different women's clinics, insights can be gained on questions pertaining to why some clinics seem more successful in actualizing their goals than others; what combinations of service elements seem to work most effectively for different client populations etc.

As yet, no study has been undertaken to evaluate women's clinics. The two case studies which follow, are an initial attempt to describe the origins and present operation of two women's clinics located in the Boston area. The first is an account of a women's health center in Somerville which has been in operation for almost three years. The second, describes the women's night at the Cambridgeport Free Clinic, which was instituted less than one year ago.

SOMERVILLE WOMEN'S HEALTH PROJECT

Origins and Background

During the fall of 1970, a group of about twenty-five women, some of whom were involved in Bread & Roses, a women's liberation group, others in health professions and community activities in Somerville, came together and began meeting to discuss their common interest and concern with health care in Somerville. This group was primarily

organized by the women in Bread & Roses, who knew one another through the organization or through their jobs and activities in Somerville. Most of the women were white, middle-class and well-educated. Several had been active in New Left politics, feminist organizations, and/or OEO community action programs. Many women were health or mental health professionals or graduate students. All were dedicated in some way to improving women's relationship to the health system.

During a ten month period, these women met approximately twice per week to discuss issues of common concern and to decide on a course of action that would best utilize their energies to meet the pressing health needs of Somerville women. Some of the alternatives proposed were to maintain a political orientation and engage in activities directed toward making health institutions more responsive to women's health needs. Another was to develop a women's clinic in the community which would serve several ends: provide health care to women; be an exemplar of what they considered to constitute decent and personalized health care; and to be a base from which they could engage in political activities to press for change.

The group seemed to lean toward the idea of creating a women's clinic in Somerville. Those few women who were opposed to the direction that these meetings were taking and who wanted to focus their energies on political activities almost exclusively, broke away from the group. Among the women that remained, there was a tacit understanding that in any course of action, there would be limitations. But, they were willing to accept these limitations and accomplish as much as was possible. For example, if they decided to establish a health

clinic, they realized that there would be limits to the amount of time they could devote to activities such as organizing the community around issues of health politics.

Goals

In the spring of 1971, it was decided that the group would work together to start a health center expressly for women in the community. From the outset, there were several goals which were shared by the women. First, they wanted to provide a model of humanistic, non-sexist health care that emphasized prevention and education as vital components in their health program. Implicit in this model was the belief that women should be their own health managers; and that the professional hierarchy which characterizes traditional medical practice would not be perpetuated. Next, they wanted the clinic to be entirely operated and controlled by women. Less central was the goal to provide free medical services for women.

Functions

The center was viewed as serving several interrelated functions in addition to providing direct medical services to women of the community. One was to raise the consciousness of the consumers about their health needs and rights to decent and humane treatment through the medical encounter. Another was to provide a place where people could organize around health concerns and pressure for change in the larger system.

While a storefront was being refurbished for the center's use, the facilities of a neighboring community organization were utilized by the women's group. In the spring of 1971, arrangements were made with several female doctors who shared the feminist orientations

of the other women to work in the center. The original group of women developed their own training program to better equip themselves to work in a health setting. By tapping on resources in the community and larger health institutions, and by sharing the collective skills and knowledge of the women participants, they developed a series of training sessions which were focused on birth control and abortion counseling, physiology, anatomy, and lab work. These women were not being trained to become physician's assistants per se, but rather as health workers who had specific roles to play in the clinic operation, both in conjunction with and separate from that of the doctor.

Scope of Services

Since the women realized that medically, they could offer only limited services, it was decided that the center would be open two evenings per week for medical nights and some afternoons for group meetings, classes, and other activities. The services provided by the clinic have remained fairly constant over time: they are; primary health care (such as that range of services usually provided by a general practitioner), gynecology, well-baby care, birth control and abortion counseling, drug and mental health counseling, and alcoholism and diet workshops. Most of the services rendered are related to gynecological/ pregnancy and routine medical problems. A salient feature of all of these services is the emphasis on education during the medical encounter. Each woman is seen for approximately one hour in which the procedure, treatment, and personal feelings of the patient are discussed with the client advocate and physician.

Staff

The all-female staff of the clinic is composed of physicians,

client advocates, birth control counselors, therapists, and nurses. With the exception of a handful of community workers who are paid part-time salaries, the forty woman staff is all volunteer. Most of the workers have jobs outside of the center in social service and health institutions, and volunteer their time during evenings. Over the two year period that the center has been in operation, there has been very little turnover of staff. In fact, most of the original group of women are still active participants in the center.

However, there have been changes in the participation and level of involvement of physicians. Initially, they were deeply involved in the various aspects of the center and had a role in the formulation of policy. They spent much of their time talking with patients and being challenged by the general ambience of the center. Now, they are not as integral and active as they had been previously. One health worker interviewed felt that this situation has evolved because the physicians' tasks have become more like traditional "doctoring" and less novel and challenging due to the excessive demands placed on their time and routine nature of their jobs. She added that this decrease in energy and enthusiasm of the physicians might be reversed if new opportunities were created for them once again, to help make their hours spent in the center less repetitive of their daily jobs outside the center where the main function is just "doctoring". To the dismay of some health workers, the center is becoming somewhat more dependent on the physicians, and must cater to their routines and needs. Without them, the women realize that it is not possible to provide the range of services they would like to offer.

The client advocates have consistently played a major role in the center's operation. Like the physician, their role is an important one. It is they who first relate to the patients and take their medical history, accompany patients through the medical encounter, and maintain contact with them to insure continuity of care and follow up.

Patients

Since its inception, the center has seen over 1,000 women and children on medical nights. If the total number of visits were calculated, rather than the number of different individuals seen, this figure would be much higher, since in any one night, as many as 60% of the patients can be returnees. To demonstrate that preventive care is actualized in the center, many of the patient visits are for check-ups and treatment of minor problems. The center serves Somerville women from a variety of backgrounds, ages and income groups. Most of the women are in their early thirties, and are seen for gynecological and routine medical problems. About one-fifth of the women are new to Somerville, unmarried, and in their twenties. Those women who do not reside in Somerville, or who have access to other health services are urged to seek medical help elsewhere. Many of the women seen are medically indigent: either employed but uninsured, or on welfare. For them, the Somerville Health Center offers them a source of free health care where they do not have to endure the impersonal and often humiliating treatment provided in their local hospital's OPD's.

Since the center does not advertise its services, most women hear about the clinic through word-of-mouth, referrals, and occasional articles about them in a local newspaper. Appointments are necessary and are made with an appropriate doctor. At present, the waiting time

before being seen is about two weeks. In case of emergencies, the women, depending on their problem, are sent to local hospitals where they are equipped to deal with such cases. Also, for problems requiring more medical attention than the center is able to provide, referrals are made elsewhere.

Not only does the center refer people to outside facilities, but, they accept referrals originating with several community agencies, such as the Welfare department, Visiting Nurses, Women's Civic Association, and health clinics that cannot treat women outside of certain district lines. Many patients are referred to the Center since it is the only free health service for women of its kind in Somerville.

Organization and Decision-Making

Organizationally, the center is structured to allow for decentralized decision-making whereby workers and consumers are allowed to partake in policy formation at the general meetings. At these meetings, problems and issues related to various aspects of the clinic's operation are raised for discussion by the group. Most minor decisions are made at those meetings with more important ones decided at the meeting with the board and staff. Despite the fact that the process is an open one, the staff that are most actively involved and committed to the center's operation are the ones that play the most central role. One worker interviewed said that..." if you don't get involved in the day-to-day activities and decisions, you begin to feel alienated from the center."

In terms of staff organization, it seems that issues of status have less salience than in conventional health care institutions. Health workers, regardless of the nature of their jobs, are encouraged to view

their roles as being significant and as contributing to the health care of patients. As was the opinion of two health workers interviewed, a reason that women were interested in participating in their clinic was that they wanted to experience working in a health setting that provided an alternative to hierarchical organization. The literature on women's clinics substantiates this preference among health workers to strive for a de-professionalized working environment. Job rotation as exists in other women's clinics is virtually non-existent here since the pressing demands for services precludes spending time retraining the pool of health workers by teaching them new skills. Furthermore, some of the women health workers have become disillusioned with generalists, since they realize that "everyone can't do everything". Part of their response has been to utilize specialists to meet particular needs. Despite time constraints, and doubts about the virtues of being a generalist, about 1/5 of the workers have learned other skills, and are able to increase the scope of their activities.

Financing

The center operates on a \$15,000 per year budget which involves costs for rent, phones, lab work and some supplies and limited salaries. Their money comes from private foundation grants and some public funding, (i.e., NIMH & National Free Clinics Council grants). Since financial instability is a problem for the center, they are considering becoming a licensed clinic. This would enable them to become eligible for third party payments and Medicaid reimbursements. However, in order to be licensed, they must meet certain physical requirements, which would necessitate large sums of money for renovations.

In addition to providing direct medical services, a significant

proportion of the health workers are also involved in community wide activities pertaining to health. The center is presently involved in a petition campaign to get a comprehensive health clinic for Somerville. Also, some of the workers are members of a lead paint board in the community. This level of involvement and commitment to the community is not that unusual since Somerville was recently presented the All-American City award for outstanding community participation.

Physical Facilities

The center is housed in a refurbished storefront and is centrally located along one of the main arteries of Somerville. Several people not directly connected with the center commented on the physical appearance of the center. Some felt that potential patients were reluctant to use the clinic because of its "shabby and gypsy-like" appearance. Unlike most other women's clinics, the Somerville women's center does not cater to a young "hip" client population. Therefore, for women unfamiliar with counter-institutions, the center's appearance might be an important factor in determining the client group. Presumably, women who have been treated exclusively in hospital clinics and the like, will be reluctant and wary to use the center. It was the feeling of one community worker who was familiar with the center that many of these attitudes and preconceptions about the center are dispelled when friends of a prospective user speak affirmatively about the care they received at the center.

Community Acceptance

An important source of information was derived from interviews with several community representatives of Somerville. Understanding the way the center is perceived and related to by other agencies and workers

in the community was especially important in this case, since my access to a wide-range of consumers and health workers was so limited. In those interviews that I conducted, the presence of the women's center seemed to be well received. The consensus of the respondents was that the center was providing a much needed service in a city faced with such a dearth of adequate health facilities.

Most of the individuals I interviewed were contacted in the initial stages of planning by the women's group. This request for the input of community workers early in the history of the center was felt to be a clear demonstration of the women's genuine desire to strive toward responding to community needs rather than to promote their own interests. Some of the respondents admitted that initially they were concerned that the women's center would have a radical-feminist orientation. In their opinion, the concerns of women's liberation were not central issues of the community. Thus, if the women's center were to become an "outpost of women's liberation", they believed it would not have been used by the city's women. In those initial contacts with the center, their fears were dispelled.

In describing their perception of the center based on their own contacts and the feedback received from women patients, there were several features that were most applauded by the community workers. The first was the excellent quality of care provided by the center which was viewed as being essential for its continuation. Very few, if any, negative comments had been heard by these individuals in reference to the quality of medical services offered. Another aspect of the center which was perceived as being unique in the experiences of Somerville women, was the educational component of the services. Many women praised

the importance and benefits for the patients of discussing health problems openly and sensitively. It was their feeling that this feature was the most favored of all among the consumers.

The volunteer nature of the staff was felt to elicit much pride and respect for the women health workers. Knowing that women are volunteering their time and services to help the patient has had an effect on the way the center is viewed. The community workers interviewed felt that it has enhanced both the self-respect of the women patients, and also the reputation and credibility of the center. In essence, through the active involvement of the health workers in the women's center in providing direct medical services and in participating in broader community activities, they have, in the words of one respondent, "proven themselves".

With respect to their impact on the community, most respondents felt that only a moderate number of Somerville residents actually know about the center and use its services. Pertaining to the attitudes of private practitioners, some have felt threatened by the center and fearful that its existence would draw away some of their business. Yet, they soon realized that the part time nature of the center with its limited services are not really making a dent in their patient population. For the individual users, the center is providing a solution to their health problems. As one community person states: "People don't get upset about things until there's an alternative." It was the consensus of the respondents that the Somerville Women's Health Center was in many respects, an alternative, and in so being, could have an effect on the future attitudes and demands of women as health consumers.

Despite the appreciation and respect which the center commanded

among respondents, all expressed some concern about the uncertainty of its existence. They are fearful that the lack of financial stability, the volunteer nature of the staff, and the excessive demands for services, might eventually lead to its demise. To prevent this, they are urging the center to consider ways to build in some continuity into their operation. The words of one community worker seems to sum up the essence of the center's existence . . . "they have many more friends and supporters than they think they have!"

CAMBRIDGEPORT FREE CLINIC - WOMEN'S NIGHT

Origins and Background

A group of women previously active in the Seattle Free Clinic Movement and new to Cambridge, reunited rather unexpectedly while participating in a local women's center. Together, they decided to form a health collective where they could work with other women around issues of health care. A few of the women had been previously trained as client advocates or paramedics during their experiences in Seattle. With some additional women who shared their interest in women's health care, they began developing a paramedic training program. The ultimate aim of this group of twelve was to create a women's free clinic in Cambridge where they could work toward providing good gynecological care for women.

In the spring of 1972, the women were teaching themselves paramedical skills with the assistance of a physician committed to the ideal of a women's free clinic. A local clinic which was interested in training women to become paramedics was contacted by these women in the hope that they could augment their training experiences by practicing

their newly acquired skills in the clinic.

Facilities

Having developed the skills and know-how to become paramedics, the next task was to find a place where they could practice. One of the alternatives available to them was to set up a women's night in an already established free clinic in Cambridge. The director of the clinic, a pioneer in the free clinic movement, was receptive to the goals and requests of the women's health collective, and agreed to take a chance and allow them to use the facilities and supplies of the clinic on Sunday evenings, when it was not being used by the regular free clinic.

Goals

The goals of the CP Women's Night are to simultaneously be a model for training paramedics and for providing personal, humane medical care for women. The use of paramedics is believed to have several advantages for both the women patients and the paramedics themselves. Some feel that the health care provided by a paramedic working with a physician is superior in the quality of care and degree of patient satisfaction to that provided by a physician alone. Also, the paramedics feel a sense of pride and accomplishment that they are capable of providing and teaching fundamental medical care. Finally, the existence of paramedics proves that it is possible for women to help themselves, a basic tenet of the women's health movement. Another goal of the women's night is somewhat political in that it is hoped that by teaching women about their bodies and how to care for them, changes are being made in the way women feel about themselves and the system that treats their health needs.

Services

Based on the realization that the paramedics were not trained in all areas of health care, it was decided that the women's night would focus their activities on providing gynecological and birth control services. Trained to do pelvic examinations, counsel on birth control and abortion, test and diagnose vaginal infections, take medical histories and do basic lab work, the paramedics provide a range of medical services. They also lead rap groups in which information is shared among patients and a pelvic exam is demonstrated. Each paramedic follows one patient through the whole clinic procedure, from taking her medical history, to assisting in the examination and insuring follow up. Thus each provider gets an opportunity to partake in all experiences of clinic care. A conversation is maintained throughout the encounter which puts the patients at their ease and makes both provider and patient feel as if they are playing an active role in the delivery of health care. There is an emphasis on prevention and education in all aspects of the clinic procedure which is directed toward transferring skills. Although these activities add a considerable amount of time to the patient visit, it is felt that it is vital prerequisite to providing quality of care as defined by the women in the clinic.

Staff

The all volunteer clinic is composed of a team of approximately twelve female paramedics and one male physician. Most of the women are in their twenties, single and from the original group in the collective. The doctor works full time at a Boston-based hospital, and volunteers his time for the Sunday evening clinic. His role is primarily one of teaching the women how to perform various medical procedures and

assisting them to assure greater competence in care. There is mutual concern that they do not overestimate what they can do in the clinic, and that no woman is mistreated. Therefore, if for some reason, it is felt that they are unable to treat a woman, they will refer her elsewhere.

Organization and Decision-Making

The clinic is organized horizontally to foster an atmosphere of equality among the staff. No distinctions are made in status among the paramedics and there is a job rotation whereby everyone shares tasks. Although there is no formal mechanism to involve patients in decision making, there is a suggestion box where patients' comments and criticisms are seriously considered. The active joining of women to the clinic is yet another way of increased involvement of patients in the clinic operation.

Patients

Based on a survey conducted by the CP free clinic (See Appendix), it was found that of the approximately twenty women seen each Sunday evening, most are between the ages of 18 and 23. Only 16% are enrolled in college, with the majority, 63%, being employed in fairly low-paying jobs (under \$5,000/year). Their reasons for seeking care on women's night in the clinic are primarily for the free services available combined with the positive attitudes of the staff. Many of the women have had bad experiences with prior gynecological care and are seeking an alternative type of treatment. Slightly more than one-half of the patients are returnees and are seeking help with a new medical problem. They generally hear about the clinic through friends, the newspaper, and referrals from other facilities. Women are seen in relation to the severity of their problem. Those women who have access to student health

and other medical services are asked to seek care elsewhere. Referrals are frequently made if the clinic does not have the time or resources to treat a particular woman's problem. As with other free clinics, there is a long waiting time before being seen by the medical team. This is viewed by the staff to be one of the most alienating outcomes of the clinic and might be rectified by rescheduling the patient visits.

Financing

The facilities and many of the supplies are shared with the regular Free Clinic which operates on Monday through Friday evenings. Much of the support for the women's night has come from a grant by NIMH with the stipulation that they deliver drug education and counseling for women patients. There are no fees for services at present, but the idea of charging a minimal fee (\$3 to \$5 per visit) is being considered by the staff.

Additional Activities

Out of the original activities has grown a number of new directions for the clinic. One involves efforts to acquire a storefront in another neighborhood which would enable the clinic to become completely autonomous rather than being under the aegis of the CP Free Clinic. It would also give the women an opportunity to branch out and offer services to a community of women in greater need of medical care than the present patient population. Another outgrowth of the present clinic operation, has been the vast interest of over fifty women seeking to learn paramedical skills so they can work with other women to establish women's clinics. In addition, the clinic experience has inspired one-fourth of the original group of women paramedics to seek admission to medical schools to further their practical training.

Possibly through the affiliation of the clinic's physician with the Family Health Center at a Boston hospital, an opportunity is being cultivated whereby the female paramedics would work with community people in a new careers program. The thrust of the program would be to develop a paramedic training program utilizing the facilities and resources of the hospital.

Finally, women's groups in Boston have asked the CP paramedics to testify on behalf of women's medical needs at state legislative hearings. They felt that their opinions have been sought for these hearings due to their reputation as being a legitimate and concerned provider of services.

By raising the consciousness of both staff and patients to health needs and potential changes that can be made in the health system, combined with providing an example of good medical care, a powerful base is being created from which changes can be made. Despite the fact that some of the participants feel that the clinic and the use of paramedics is in the vanguard of radical change in the way health care is delivered, there are some who would like to see the clinic develop a more conscious political ideology which would help them to know how to approach many of the situations which arise in the clinic. Also, it would bind the women closer together and help them to have a greater impact on the way care is being delivered. Right now, some of their potential impact is being diverted by conflicting ideologies and philosophies guiding the clinic operation.

CONCLUSION

At the outset, the objectives for this thesis were threefold. The first was to describe the women's clinic phenomenon which has very recently emerged on the American health care scene. These clinics, which are growing in popularity and numbers, propose changes that are departures from our existing system of health care for women. To the extent that women's clinics are in their formative stages of development, this thesis was intended to add to the limited body of literature that exists regarding the origins, present and future, of these alternative medical structures. A second objective was to evaluate the efficacy of these alternative service models, both for meeting women's health needs, as they were defined by the women's health movement, and for leveraging changes in the broader health system. Still another intention of this thesis was to consider some implications of these health settings for the future planning of women's health services.

In order to make some preliminary judgements concerning the efficacy of these clinics for meeting women's health needs, it is necessary to review the goals articulated by the women's health movement which largely determines the nature and outcomes of women's clinics.

The creation of women's clinics was partially born out of the shared frustration of women regarding their relationship to the health system; their rejection of many traditional assumptions about health care for women; and their collective hope to create an alternative model of health care.

Several goals were formulated with the hope of improving women's relationship to this system. In essence, these women have been

seeking a radically different kind of health care than they are presently receiving from existing medical facilities. A principal goal of the women's health movement is to enable women to regain control over their bodies and to become their own health managers. Rather than being passive recipients of health care where most decisions pertaining to their physical and emotional well-being are deferred to physicians, women want to become active participants in the delivery of health care. To this end, women must be informed about their health needs and the types of treatment that they can expect. Wherever possible, women should be able to make decisions about their health care, and rely on themselves rather than solely on physicians.

These proposed alterations in delivering medical services are attempting to redefine health care. Thus, another goal of the women instrumental in establishing these clinics, maintains that health is more than the mere absence of disease. This implies that the emphasis from crisis medical care should be shifted to that which promotes preventive and continuous care. Emphasis should be placed on self-help, health education, and transfer of skills and information in order to further this end. In pressing for a reorientation in the underlying assumptions of our health system, these women are also challenging the professional dominance, male-bias, and commercial orientation characteristic of today's medical institutions.

A third and possibly more ambitious goal shared by many women's clinics is to ultimately bring about changes in the way health care is delivered to women by our medical system and to restructure the present system of care.

Assessing the outcomes and implications of such settings with

respect to the individual participants, and to the broader issues of institutional change is essential for a thorough understanding of the women's clinic experience. However, to the extent that this is a movement-in-progress, some of the outcomes of the women's clinics are just now being noticed. Others, are being postulated by individuals interested in the ability and long-term impact of these clinics.

Positive Aspects of Women's Clinics

There exist several aspects of women's clinics that have helped to bring these settings closer to their avowed goals and thus, to contribute to meeting women's health needs. In that women's clinics are run almost exclusively for and by women, they are in control of most aspects of female health care delivery. The fact that women, rather than men, are the prime decision-makers in the clinic operation has provided an alternative to the prevailing patriarchal system of health care. In addition, the horizontal organization of these clinics along with the practice of job rotation, has fostered an environment de-emphasizing status differentials among staff and patients.

Health Education

The heavy emphasis on health education in women's clinics through the use of client advocates and paramedics, individual and group discussions, learning-through-teaching relationships in the medical encounter, and the transfer of skills have had varied, and positive effects on women and the larger health system. Women's understanding of their bodily processes and the health system which serves them has been enhanced by the educational component of the clinic operation.

"Learning to understand, accept, and be responsible for our physical selves, has had a life changing effect on women. It has been a liberating force which has strengthened

our self image, and made us feel more autonomous, strong and more whole. . . Women who are informed about their bodies are in a better position to evaluate their doctors and those institutions that are supposed to meet their health needs. By understanding what their health care needs are, doctors can be held accountable for their work; and unnecessary procedures can be avoided." ⁶²

The educational aspect of women's health care practiced by these clinics may eventually enable women to assume responsibility for their own health and thus be their own health managers. This outcome, if actualized, is consonant with one of the recommendations frequently advanced by various health reformers. In a report published by the National Commission on Community Health Services, the importance of health education was consistently stressed.

"Education for health is a fundamental aspect of community health services and is basic to every health program. Every person to the extent of his knowledge, must assume responsibility for his continuing good health. . . Health education should: interest each individual in his own health and the means to improve it; to teach him where health services are available; to motivate him to use them; and to enable him to discriminate between scientific health care and quackery." ⁶³

Through the health education which women can avail themselves of at these clinics, they are moving toward becoming more informed and active consumers. Unlike other health services which very often fail to assist consumers in providing the information they need to maintain their health and make better use of existing medical resources, women's clinics have taken a major step toward providing this information. In so doing, they are furthering their belief that health is not something that can be given to or bestowed on one individual by another. Moreover, by giving women access to information about health care, they are moving closer to their goal of demystifying medical care.

Being an informed consumer also has implications for the ways women utilize other health resources. For example, there is reason to believe that the medical profession might be enriched rather than hampered by enlightened consumers that are able to scrutinize, evaluate and challenge the health care they are receiving. For example, we have already witnessed women's groups challenge the right of doctors to dispense birth control pills promiscuously. Prior to this challenge, many doctors had prescribed the pill without having taken its potentially serious side effects into account.^{6A}

Since the substantive aspects of the health education provided in these clinics focus on preventive health measures, women are also furthering a goal of re-orienting the emphasis of medical care from crisis and curative treatment to one which recognizes the importance of maintaining and perpetuating a state of positive health. Thus, a preliminary step toward approaching the ideal of continuous and comprehensive care for women is being taken.

New Health Personnel

Another aspect of women's clinics that has been viewed as possibly having positive outcomes for both consumers and providers is the use of new health personnel. These clinics are creating new roles and responsibilities for health workers, such as paramedics and client advocates. Through their involvement in teaching roles in the clinic as well as in providing direct medical services, the ideal of women becoming deliverers of care is being reinforced. In addition, their participation in the clinic which is meant to perpetuate the system of transfer of skills and personalization in treatment helps to make women feel more like active participants in the cooperative venture of health

care. The experiences that many women health workers have had in women's clinics has inspired them to pursue health science educations. Medical school, the major source of training for such professions may be affected by the increased fraction of women who are applying and being accepted to their programs. It is possible that the curriculum could be changed to include courses on women's health needs taught from the women's perspective. The women students who have been exposed to the problems faced by women consumers, might press for new areas of medical research, such as those dealing with women's health and pathologies. One forecast for women in academic medicine is as follows:

"The women's health movement, receiving an assist from society's commitment to improve opportunities for members of disadvantaged minorities, is now zeroing in on academic medicine. There's been much more talk than action thus far, but the current discrepancy between the fraction of women in the population and negligible fraction that occupy key positions in academic medicine is unlikely to persist." ⁶⁵

Provision of Direct Services

Women's clinics have provided a means for women to respond to some of the failures of our health care system. The most obvious outcome to these clinics has been the provision of direct health services to women. This has enabled them to actualize their goal of providing personalized health services to some women by respecting both their medical and social needs. In addition, their existence in communities with limited services for women has created an additional health resource.

The mere presence of women's clinics can have an impact on the communities they serve, and on the larger health system. The concerns and activities of women's clinics serve to draw attention to the strains and pressure points in our health system. By providing certain services expressly for women, women's clinics are implying to some that these

services are not being provided as certain women feel they should be in the community and larger health system. For example, in one community, the superintendant of a hospital had heard about the services provided by a women's clinic. He went to see their operation and sensed that their services were well received by the women consumers. When approached by certain health workers within the hospital to open up a women's clinic there, he was both supportive and helpful in lending his assistance when needed.⁶⁶ Furthermore, by providing specialized services to women in a new organization, it is not long before the needs of the client group served become visible to the community. When women's clinics have been recognized and sanctioned by reputable health workers and community representatives, they have helped to make women's health needs legitimate public concerns. Previously, many women's health needs had been unrecognized, and even if recognized, not really understood. Now, because of their presence in the community, and their local reputation, women's clinics have become organizational advocates both for patients they refer and for many like them.

Limitations and Problems of Women's Clinics

The positive outcomes of women's clinics can disguise the limitations manifest in current clinic practice. Some of these shortcomings are now being recognized as the "halo effect" of the clinic movement has begun to wear off. Some of the supporters of the women's clinic concept are apprehensive that these new institutions will begin to resemble the old institutions from which they are trying to move away.

Supply/Demand

Women's clinics are faced with one of the same problems con-

fronting established ambulatory care settings, such as hospital outpatient departments, and neighborhood health centers. The demands for their services have far outweighed the supply, and they are grappling with the dilemma of turning away potential clients in order to maintain services of high quality. Despite this trade off, the clinics have been unable to eliminate the long waiting time before a patient is seen by a health worker. This situation raises serious questions as to the effectiveness of the present clinic operation in meeting women's health needs. Each patient visit lasts on the average one hour, in which the patient is taught about health care, a personal rapport is established, and questions are discussed at length. Obviously, given the limited resources and staff available, the number of women that can move through this system and benefit from the positive aspects of these clinics is limited. One could infer from this experience that the personalized care and extensive medical encounters which are characteristic of women's clinics can preclude seeing larger numbers of women.

Dependence of Physicians

Another problem of women's clinics has been their inability to decrease their dependence on a limited number of physicians. Due to the volunteer nature of the staff, the excessive patient loads of each health worker, the current licensing laws which require the presence of a physician for all medical care, and the often times routine nature of the medical problems for which women seek treatment, it is difficult to maintain an adequate supply of physicians in the clinic. This situation has made women's clinics more dependent on physicians than they would prefer to be. To some extent, this dependence threatens

the actualization of the women's goal to de-professionalize medical practice. The scarcity of female doctors has placed them in a privileged position whereby without them, many of the clinic's services cannot be provided. In order to keep them on the staff, many concessions have to be made, which may run counter to the philosophy of the women's clinic movement. This dependence on a limited pool of physicians decreases the capacity of these clinics to treat a larger number of patients.

Licensure

Licensing laws, as they presently exist, have been a fundamental barrier to expanding the services, manpower and facilities of women's clinics. These laws, initially designed as a means to protect the patient's health, have resulted in restricting the variety and number of individuals and settings that can be providing health care. If licensing laws were modified to include the accreditation of all women's clinics, and the new provider roles they have developed, it is feasible the clinics could expand certain aspects of their operation, qualify for additional sources of funding, and allocate care-giving responsibilities to new personnel. All of these, while contributing to increasing the resources of these clinics, would thus help to relieve some of the enormous pressures now being placed on their operation. On the other hand, without licensing laws, there is virtually no practical way to maintain standards that would insure some uniform quality of care among women's clinics. Should not a woman seeking health services at such a clinic be afforded some assurance that the care she receives will be of high quality? This poses a dilemma for groups like women's clinics that want to experiment in new forms of delivering health care and in new roles for health personnel that go beyond present legal guidelines. The

potential to be innovative in the delivery of health care is impeded by existing licensing laws, yet without them, or some equivalent system of quality assurance, there is no way to monitor and guarantee that decent health care is provided. In a recent court case in Los Angeles, this conflict was addressed. Two women of a self-help clinic were arrested for "practicing medicine without a license."⁶⁷ Ultimately, they were found not guilty on the grounds that a woman has the right to privacy. The fact that they were arrested for engaging in self-help practices would indicate a conservative response of public agencies and medical societies to innovation and experimentation. However, since the outcome was favorable, there seems to be hope that some compromise situation will take place in issues of this sort in the future.

Financial Instability

Methods of funding is a major aspect of women's clinics which has placed them in a very precarious financial position and has threatened their continued existence. The fact that women's clinics do not charge patients for services has forced them to develop other means of financing their operations. Many clinics depend upon federal, state, and city governments for funding, and on hospitals, drug companies and city health departments for supplies. Depending on the political orientation and goals of a clinic, the receiving of public monies has different implications. For those clinics whose main activities are focused on organizing communities to pressure health institutions, it is conceivable that by accepting public monies, the clinics risk having some of their activities constricted, or worse, being coopted. As long as those women's clinics depend on public institutions in order to provide their free services, there is a chance they may be deterred from conflict with

the existing health system.

Conversely, receiving public grants and assistance can also connote the acceptance and recognition of the legitimacy of a women's clinic by governmental institutions. The tacit or formal authorization from the power structure is very often necessary for the clinic to exist. In addition, the allocation of public funding is a means by which standards and accountability of a clinic's medical services can be insured.

To achieve financial and organizational autonomy, a much valued goal, some women's clinics have been considering alternative financing schemes. There is some thought being given to the possibility of getting Medicaid and private health insurance reimbursements for certain patient services. However, this source of potential income has not been fully explored by these clinics.

A less complicated means of stabilizing the financial situation of women's clinics that is being considered, is simply to request minimal fees for service from patients. In one clinic surveyed, the women interviewed, stated that they would be willing and able to pay between \$3 and \$5 per visit, if necessary.⁶⁸ The implications of a steady source of income for women's clinics may contribute to the overall stability of these services. To a larger extent than they are now able, women's clinics can be autonomous and not wedded to the guidelines established by their funding sources. This frees a clinic to engage in the range of activities that they choose rather than to comply with the regulations of the funding agent. If additional income can be generated in the clinics, more of the staff could be salaried. This would free many of the health workers who are volunteering their time at the clinic and working on the outside for salaries. Such changes might enable clinics

to be open more than just 2 or 3 nights or afternoons per week, since there would be an adequate staff to provide services.

Returning to the reality situation, these clinics which are based on volunteer help and donated supplies are faced with increasing demands for services with limited supply. Volunteerism is very difficult to sustain over time. Thus, without continued funding, they, like other experimental ventures, may be consumed by the constant concern for funding to maintain their clinic operation. Consequently, they run the risk of diverting their energies from engaging in the activities for which they were created to ones promising survival.

Direct Service Vs. Institutional Confrontation

The conflict of goals between providing direct service and pressuring institutions is a frequently raised issue with regards to those settings which profess to be alternatives to the established structures. Is the focus of their operation, service benefits for a select few or system change for the benefits of all? Whether there can be an alliance between these activities is debatable. Allegations have been made that women's clinics are complementing rather than attacking the system. Furthermore, that by providing stopgap medical care, they are actually taking pressure off that larger health system. Another criticism of women's clinics is that they have become so immersed in the day-to-day routine that there is limited energy to focus on broader issues of change, such as institutional confrontation. These critics adhere to the belief that the power and resources of the American health system lie in institutions. Therefore, they add, these clinics should play a role in helping to shape the policies and practices of those institutions whose power and potential for generating progressive change

extends far beyond the local level.⁶⁹

Future of Women's Clinics

These problems stemming from the lack of funding, volunteer nature of the staff, limited resources in the face of excessive demands for services, and dependence on physicians, have contributed in some way to threatening the operation of women's clinics. Yet, the fact that these clinics have not yet resolved the complexities of their existence should not blind us to the positive outcomes which have grown out of these alternative medical settings. To a large extent, women's clinics have fared well in their attempts to transform their goals into practice. The emphasis on health education, prevention, self-help, transfer of skills, and sharing of information in the medical encounter have given many more women the opportunities to become active participants in their health care than was previously possible in traditional health settings. By informing women about medical procedures and the health system and by having the staff share responsibilities in the care of the patients, women's clinics are moving toward their goal of demystifying and deprofessionalizing medical care.

Their efforts to personalize the medical encounter has credited women's clinics with treating women as responsible and adult individuals rather than as passive objects that must be controlled by others. The concern with female health problems among the predominantly female staffs has demonstrated that the mistreatment which women have had in their frequent confrontations with the health system can be ameliorated.

For the patients and providers, the impact of the clinic experience has most probably affected their attitudes toward, and future

use of medical services. It has also enlisted the participation of more women in the concerns of the women's health movement and has thus broadened its base of support. As has occurred in other alternate settings, a growth of an external constituency can be anticipated. This constituency is of those people not getting the services themselves, but who know enough about women's clinics to want similar services to be offered elsewhere. This is likely to lead to placing pressure on the system to provide services similar to those offered by women's clinics, for increasing numbers of women. The opportunities for women to become providers of health care within the context of women's clinics has led to the increase in the number of women seeking advanced training in medical careers. This influx of women is predicted to have an impact on the nature of academic medicine in the future.

Women's clinics are also providing direct services to a limited number of women. Until the stigma is removed from many female health concerns, such as abortion, birth control, feminine sexuality, vaginal infections, many women continue to be reluctant to seek medical help from traditional settings. Women's health concerns are very personal issues that resonate with a woman's identity and self image. The accepting and supportive environment of a women's clinic is less threatening to many women who would be reluctant to seek such services in other health settings.

In their entirety, women's clinics involve new ways to recruit, train, and utilize women in the service of other women. They challenge the assumptions and the accepted procedures of traditional health settings. They represent efforts to humanize health services; to revitalize the doctor/patient relationship and show its relevance in modern medicine;

to widen access to the ranks of those who are deemed qualified to render service. Many of these reforms imply new forms of delivering services to women; they reduce status differences between those who already possess knowledge and those who seek to acquire it and put it to use. They have pioneered the use of paramedical volunteers and staff workers in a country faced with a shortage and maldistribution of health professionals. In some cases, women's clinics have succeeded in meeting their stated goals; in others, they have fallen short of their expectations. The complexities of their existence as alternative and innovative medical structures raise several serious points that should be considered in appraising their viability and future roles. If we accept the positive aspects of the clinics and recognize their limitations, several alternatives can be formulated for their future direction.

Institutionalizing Goals and Practices

One alternative is to seek varied ways of inculcating the goals and practices of the women's clinics into the broader health system. Some of the concepts and practices advanced by women's clinics have been absorbed on a limited scale by the health system. For example, some gynecologists have begun to allow their patients to watch their own examinations. Various public health departments are investigating self-help concepts with the intention of teaching women how to perform self-examinations. Menstrual extractions are being performed in several abortion clinics.⁷⁰ The importance of counseling, a fundamental component of the health programs of women's clinics, has been recognized and instituted by some established medical settings in their abortion activities. In a variety of locales, such as hospitals, free standing abortion clinics,

and Planned Parenthood clinics, abortion counseling has been practiced by a wide range of individuals possessing a variety of skills and experiences. Possibly through the success of the counseling component in women's clinics, the need for help, advice, and follow-up in resolving the problems of unwanted pregnancies has been recognized.⁷¹ Another example has been the increased use of paramedics and client advocates in community health programs. Finally, women have now joined the ranks of other new health workers to press for changes in licensing laws that would broaden the responsibilities they are able to assume. There should be a note of caution, however, since absorbing a practice into larger health institutions does not necessarily imply that it will be delivered in the same manner as it was in the women's clinics. Without changes in values, attitudes of staff, and what constitutes health care, it is questionable that patients will be treated differently than they were before the new practice was instituted.

Multiplier Effect

A second alternative for women's clinics is to maintain their present range of activities for as long as possible to allow for increased numbers of women to flow through their service system over time. To this end, efforts should be made to enhance and stabilize their present operation and capitalize on their strengths, rather than overextend themselves and dilute their potential impact on clients and providers alike. As has been previously described, the positive aspects of women's clinics have somewhat of a multiplier effect.

Another option for women's clinics is to align themselves to established health settings and work toward building-in the principal components of their clinical practice. One possibility for achieving

this arrangement is to work out a reciprocal plan with the existing facility whereby its women patients would be referred to the clinic, in exchange for the use of supplies and other resources. If there is an agreement as to the aims and practices of the women's clinic, it is not unfeasible to expect that a mutually beneficial arrangement can be created.

Still another alternative direction for some women's clinics is to shift their focus from providing direct service to working with health institutions in order that the latter begin to recognize their responsibility to serve women as they deserve to be treated. This tact is probably best described as institutional confrontation to make the responsible health institutions provide those services which they are mandated to provide. These confrontations can also be directed at funding sources. Especially with regards to public agencies and different levels of government, efforts can be made by women's clinics to provide appropriate funding for these legitimate and alternative health settings, since they are providing much needed services.

The direction which a woman's center will follow in the near future depends largely on the success it has had to date in actualizing its goals and objectives, the efficacy with which it is meeting women's health needs, its financial situation, client needs, and philosophical orientation. In that women's clinics are not isolated phenomena, their relationship to the larger health system is important in discussing its future direction. Since, as Alford has stated, "traditional planning methods and attempts at health reform have resulted in a situation characterized by 'dynamics without change,'" our health system should be encouraged to court the kinds of change that will enrich and strengthen

it. Individual health reformers who maintain that innovation may increase the chances of improving our health system which is faced with numerous and complex problems have stated that:

"... communities must not bind themselves to adherence to traditional methods of providing care...the delivery of health services requires flexibility and experimentation in method. No system of organization or administration should be considered permanent; new ones must be devised, tried, discarded, or developed, to keep pace with changing needs. Communities will reach their goal of comprehensive health services by many different paths and no alternative route should be blocked."⁷²

Appendix A

Results of Cambridgeport Patient Survey

	<u>Number of Respondents</u>	<u>%</u>
1. Age		
15-17	3	16%
18-20	11	58%
21-24	3	16%
25-29	2	11%
2. Marital Status		
Single	17	94%
Divorced or Separated	1	6%
Married		
3. Are you presently in High School?		
Yes	2	11%
No	17	89%
4. Are you presently in college?		
Yes	3	16%
No	16	84%
5. Are you employed?		
Yes	12	63%
No	7	37%
6. Do you live in Cambridge?		
Yes	10	53%
No	9	47%
7. How far did you travel from your residence to Cambridgeport?		
less than 1 mile	9	47%
1-2 miles	5	26%
3-5 miles	2	11%
more than 5 miles	3	16%
8. Approximate income level		
0-1000	7	39%
1-2000	5	28%
2-5000	6	33%
5-10,000		
9. How did you learn about Cambridgeport?		
newspaper	4	21%
friends	6	32%
referred from other agency	4	21%
other	5	26%

	<u>#</u>	<u>%</u>
10. Is this your first visit to Cambridgeport Women's Night?		
Yes	8	42%
No	11	58%
11. What is the reason for this visit?		
cold	1	5%
G.I.	-	-
GYN	9	47%
birth control	8	42%
urinary symptoms	-	-
VD	-	-
Other	1	5%
12. If not a first visit		
return for an old problem	4	36%
visit for a new problem	5	45%
both	2	18%
13. If you have been here before, approximately how many times before?		
1	-	-
2	5	45%
3	2	18%
4-5	2	18%
6-7	2	18%
14. When was the first time?		
0-1 month	1	9%
2-3 months	3	27%
4-6 months	4	36%
8-12 months	1	9%
1 plus years	2	18%
15. Why did you choose CP for your problem?		
free	15	
convenient hours	3	
physical environment	7	
attitude of staff	9	
afraid of hassles	2	
don't know other facilities	3	
closest	6	
16. Where would you seek care if CP did not exist?		
Cambridge City Hospital	-	-
other hospital	5	26%
Student Health Services	2	11%
private M.D.	2	11%
other free clinics	8	42%
would not seek care	1	5%
other	1	5%

	<u>#</u>	<u>%</u>
17. If charged, what would be a reasonable fee?		
zero	-	
\$3	9	47%
\$5	9	47%
\$7	-	-
\$10	1	5%
18. How much would you be able to pay?		
zero	3	16%
\$3	3	37%
\$5	7	37%
\$7	-	-
\$10	1	5%

Appendix B Interview Guide for Women's Clinics

Background

1. How did the center get started?
2. Who was involved at this stage?
3. Were you responding to some felt needs, or were you furthering your own ideals about medical care for women?
4. How long has the center been operating?
5. Did you seek the advice of other women's groups that had created a health center?
6. What kinds of contacts did you make to get started?
7. What were your goals and objectives?
8. Do you think that women have special health needs, and if so what are they

Context of Health Services

1. What is the staff make up? Kinds of positions; Background and past experiences of those filling these positions.
2. How did you select this staff? Did you have a preconceived notion of what kind of staff you wanted or range of services you wanted to provide?
3. Did most of the staff volunteer or did you recruit them?
4. Are they paid or volunteer?
5. Do most of them hold jobs elsewhere?
6. What is the average length of participation of staff?
7. Have any participants moved into or applied for admission to medical school or health science schools?
8. Do former patients frequently become providers of care?
9. Do you have a training program for your staff?
10. Do you have consultative arrangements with outside health professionals?
11. What do you think motivated most of the staff to join the center?
12. How do you feel working at the clinic?

Functions and Scope of Services Provided

1. What kinds of services do you provide at the clinic?
2. What is the nature of the medical encounter?
3. Do you have a system of referrals to and from other human service agencies or facilities in the community?
4. Do you have any outreach program into the community?
5. What kinds of contacts do you have with other health resources in the community?
6. How would you characterize your relationships with these agencies? Is there a feeling of cooperation or are there conflicts?
7. Do you feel as though any aspects of your program are unique? If so, which ones and how?
8. Do you think you are providing services that are not available in existing medical institutions?
9. Is there a waiting list for services?
10. How many women can you treat each evening?
11. Do you have appointments?
12. Are there priorities given for certain problems and women?

13. Are there any activities while women wait for services?
14. Are there any fees for services?
15. Is there an educational component to your services?
16. Which health workers see which patients and what is the nature of the care given?
17. How do you involve patients in the medical encounter?

Consumers

1. How do the women patients hear about your clinic?
2. Can you characterize the type of women that use the center?
3. What are the kinds of health needs that bring the women to the center?
4. Are there any eligibility requirements?
5. Do you give preference to these women without recourse to other health services?
6. Do you think that these services, because they are free and run by and for women, are treating women who would otherwise not use medical services?
7. What is the average number of visits of most women patients?
8. What impact do you think the clinic experience has on the users?

Financing

1. Where do you get your funding from to operate the center?
2. How are your expenses, salaries, supplies obtained?
3. Is financing a problem for your clinic?
4. Are there any payments for third party and Medicaid arrangements?
5. Have you any reciprocal arrangements with other health agencies or departments for services, supplies, back up facilities?
6. Do any patients contribute for the services you render?

Decision Making

1. How are decisions made in the center?
2. How do you elicit the participation of the women patients and community in the decision making process?
3. Would you characterize the center's organizational structure as being horizontal or vertical?

Outcomes

1. Approximately how many women have you seen so far?
2. Is there any process by which the patients can evaluate or give you feedback on their degree of satisfaction with the care they received?
3. Do you have any formal evaluation?
4. Are there any aspects of the service which you think can be improved?
5. What problems, if any, have you encountered in any aspect of the center's operation?
6. How have you sought to rectify them?

Future

1. What are your feelings about the viability of your clinic?
2. What is your opinion about the quality of care of the medical services which you provide?
3. In light of the repeal of abortion laws, do you envision the center as playing any role vis a vis abortion services?

FOOTNOTES

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INTERVIEWS

Pat Bjorcek, Nurse, Somerville Hospital's Women's Clinic

Dr. Joseph Brenner, Psychiatrist, M.I.T., founder of Cambridgeport Free Clinic

Ms. Pat Buckley, Assistant to the Mayor on Health Affairs, Somerville City Hall

Ms. Kathy Cantelupa, Chairman of East Somerville Health Center

Ms. Alana Cohen, Health Advocate of Somerville

Dr. Clyde Crumpacker, Physician at Cambridgeport Clin: Women's night

Mrs. Laurie Crumpacker, health worker at Cambridgeport Clinic Women's night

Ms. Chris Geary, Pediatric nurse in Somerville

Ms. Mary Geiger, director of Family Health Services of Boston; consultant to
Cambridgeport Free Clinic.

Ms. Judy Leiben, Health worker at Somerville Women's Health Center

Ms. Ronnie Littenberg, health worker at Somerville Women's Health Center

Ms. Judy Rosenkrantz, health worker at Cambridgeport Clinic Women's night

Ms. Eliza Sullivan, Abortion Counselor in Springfield, Massachusetts

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