

SOCIAL SUFFERING AND GAPS IN ALTERNATIVE HEALTH CARE FOR VULNERABLE WOMEN WORKERS

Leah Shumka* and Cecilia Benoit**

ABSTRACT

Taking a micro-level perspective, this paper examines the prevalence of social suffering – the pain and distress that can result from what is done to and by people through their involvement with processes of political, economic and institutional power – among a purposive sample of Canadian women working in socially and economically marginalized ‘frontline’ service occupations (food and beverage servers, hairstylists and sex industry workers). Participants identified a number of health concerns that they link to the everyday suffering they endure, including feeling inadequate, incompetent, lonely, self-conscious, disenfranchised and/or dissatisfied. The complex, and often inchoate, etiology of this kind of suffering bars many women from finding appropriate health care because: 1) medical professionals do not have the time and/or expertise to address their concerns; 2) the primary health care they require is often not within their reach. While the women working in these service-oriented industries often articulated a desire for alternative care in the form of, for example, counseling, naturopathy, therapeutic massage or acupuncture, the Canadian health care system does not currently fund these services and many are unable to afford the out-of-pocket costs. As a result, there is a gap in the healthcare that some Canadians receive and this has resulted in health disparities among our vulnerable populations.

* Department of Anthropology, University of Victoria, P.O. Box 3050, Victoria, B.C., Canada, V8W 3P5; Phone: (250) 472-5413; fax: (250) 721-6217; email: lshumka@uvic.ca.

** Corresponding author’s address: Department of Sociology, University of Victoria, P.O. Box 3050, Victoria, B.C., Canada, V8W 3P5. Phone: (250) 721-7578, fax: (250) 721-6217; email: cbenoit@uvic.ca; website: <http://web.uvic.ca/~cbenoit/>

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

INTRODUCTION

This paper documents the *social suffering* of a group of women who occupy marginalized social locations in Canada. By social suffering we mean the pain and distress that can result from what is done to and by people through their involvement with processes of political, economic and institutional power (Kleinman, Das and Lock, 1997). Social suffering manifests itself in many ways but, as noted by medical anthropologists and sociologists, it often becomes embodied as physical pain and illness by vulnerable individuals who lack the power to communicate their distress by other, more overt, means (Kleinman, Das and Lock, 1997; Kleinman and Kleinman, 1991, 1997; Lock and Wakewich-Dunk, 1990; Scheper-Hughes, 1994). This is certainly the case for the women whose voices are documented here. Their words and images of pain and illness communicate a deeper, more complex, set of meanings that are intimately linked to the circumstances of their everyday experiences (Brodwin, 1992; Herzfeld, 1986).

An individual's *social location* – i.e. the multiple roles or statuses that a person can occupy at any given time depending on their age, gender, ethnicity, socio-economic and health-status and occupation (Shumka, 2006) – can change shape as the circumstances of their lives change. What forms and coalesces the societal location of our the women in our study, is their engagement in one of three marginalized 'frontline' service occupations – two in the formal economy (food and beverage service and hairstyling) and one in the informal/shadow economy (sex work). These women's involvement in these economic activities is not necessarily the sole cause of their social suffering; however, as shown below, structural aspects of these occupations, including low pay, poor work security and lack of workplace health insurance, do bar them from accessing many non-medical alternative services¹ not covered by the public health care system and enjoyed by better-off Canadians with access to private health insurance and/or the surplus

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

income to pay out-of-pocket costs (Armstrong and Armstrong, 2003). While some of these services are available to very low-income people on Income Assistance or, in a small number of cases, to those receiving Disability Benefits, many people working in marginalized jobs such as the women in this study, tend not to be eligible for these means-tested services and thus fall through the cracks.

Below we examine in more depth how social suffering becomes embodied and results in unequal health outcomes among our purposive sample of women working in frontline service jobs. Before presenting our findings, we review the relevant literature and present the research setting and methodology. The final section of the paper discusses the relevance of our results for health care policy – upstream approaches that includes holistic care for vulnerable populations.

RELEVANT LITERATURE

The term social suffering is defined by anthropologists Arthur Kleinman, Veena Das and Margaret Lock (1997) as the pain and distress that can result from what is done to and by people through their involvement with processes of political, economic and institutional power. By this definition, pain and distress refers to all manner of “wound or injury to the [mind], body and spirit” (Kleinman and Kleinman, 1991). This definition is broad but useful because it acknowledges an assemblage of different human experiences – including health, welfare, legal, moral, ethical, political and religious issues – that can shape individual suffering. Traditionally, the term social suffering has been applied to three areas of social science interest. There are the “contingent misfortunes” which refer to serious acute diseases such as cancer. This suffering can strike suddenly and affect anybody but is considered traumatic to the afflicted person because of the threat of imminent mortality. Less obvious, but more insidious are “routinized forms of suffering” that are attached to conditions like poverty and the attendant hunger, thirst,

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

homelessness and contagious infections; this suffering tends to strike “the poor, the vulnerable and the defeated”. Finally, is the “suffering resulting from extreme conditions” such as war, famine, dispossession, rape and torture (which are often found in combination with one another) (Kleinman and Kleinman, 1991). As may seem readily apparent, this suffering has a strong political dimension to it and is often tied to the oppression and rejection of economically, politically and socially marginalized groups of individuals.

More rarely discussed in this literature are ‘everyday’ forms of suffering. Everyday is defined here as the ‘commonplace’ events that impact the lives of ‘ordinary’ individuals who do not necessarily fall within the category of oppressed or downtrodden. These events are a quotidian experience, which is to say they are virtually normative. However, everyday suffering is known to be embodied in culturally elaborated ways that have specific moral and political dimensions (Kleinman et al., 1997). Pertinent here, is the highly gendered nature of social suffering. As social scientists have pointed out, women are more commonly linked to the expression of pain and illness than are men (Annandale and Hunt, 2000). Reasons for this are complex but, as Das Gupta (1997) suggests, women may be more likely to embody their experiences of suffering because they have less power and autonomy to negotiate their circumstances. The author’s research into the phenomenon of pre-menstrual syndrome (PMS) and other related illnesses such as menopause, anorexia nervosa and bulimia, highlights that these illnesses are indicators of women’s experiences of feeling overwhelmed by a need to fulfill contradictory social roles – mother/nurturer, home caretaker, wife, employee/employer, friend and lover (Davis, 1996).

Gender inequality thus leads to health disparities. Gender also interacts with the work people do for a living, resulting in increased health disparities for those who have ‘unattractive’ jobs (Lipscomb et al., 2006). A large portion of the work that women do for pay (as well as the

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

work they do inside the home) – often dismissively referred to as ‘women’s work’ – is work of this type (England, Hermsen and Cotter, 2000). Perhaps it is not surprising then that, according to Bendelow and Williams (1998), women workers in the United States demonstrate a higher incidence of temporary, persistent and chronic pain than men and other research and scholars have found this to be the case for Canadian women (Stephens, Dulberg and Joubert, 2000). Bendelow and Williams (1998:201) contextualize their findings with a discussion of the cultural appropriateness of expressing pain and point to cross-cultural studies in other Westernized countries. Their research shows that there is an overwhelming perception among both men and women that women are more able to cope with pain than are men. This is partly credited to women’s experience of childbirth, and thus it is hypothesized that they have a higher pain threshold than men. More intriguing is the argument that women are socialized to believe it is culturally acceptable to communicate that they are in pain, whereas men are encouraged to exhibit stoicism and fortitude. Bendelow and Williams (1998:209) also report that there is a perceived hierarchy to pain whereby physical pain is considered more ‘real’ and ‘legitimate’ than emotional pain or anguish and that physical pain is more deserving of sympathy and respect.

Numerous studies have also shown that women are more likely to experience work-related stress and or psychological distress than men (Jick and Mitz, 1985; Haw, 1982; Lennon, 1987). It is not clear from these reports, however, why women are vulnerable to work-related psycho-social stress. One suggestion is that women are more likely to work in jobs that are known to be stressful, and thus it is an issue of exposure (Lennon, 1987; Sprout and Yassi, 1995). For example, service-oriented occupations where women predominate are commonly characterized as high-stress jobs with low work control (Benoit, 2000; Statistics Canada, 2005). Women are thus more exposed to repetitive and monotonous work and to stressful conditions and, as a result, have

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

a greater likelihood than men to experience back strain, skin diseases, headaches and eyestrain (Messing, 2000). What this means is that women are not necessarily more vulnerable to distress, but more likely to *embody* the effects (Lennon, 1987). DelVecchio-Good (1992:51) notes that it is well documented that women have “higher physical and psychiatric morbidity than do men and are more likely to seek health care for their symptoms.” Waldren (1991:20) indicates that while men are more likely to suffer occupational health injuries because they tend to work in ‘dangerous’ or ‘hazardous’ jobs (i.e. logging, mining and construction), women “report more symptoms, more acute conditions, more days of restricted activity due to illness, and more doctor visits than do men.”

To clearly conceptualize how social suffering becomes embodied as physical pain and illness we need to examine the recent literature on the body. At one time, the body was considered simply a biological/organic organism. More recently, however, social scientists have argued for a more sophisticated perspective of the body, one that considers it simultaneously an individual, social, cultural, historical and political entity (Frank, 1995; Messing, 1998; Moss and Dyck, 2002; Scheper-Hughes and Lock, 1987; Van Wolputte, 2004). This epistemological perspective views the body as three separate, yet overlapping units of analysis. The first ‘body,’ is the individual or phenomenological body, where the body is perceived, experienced, and sensed in the mind of the individual. The second body is the social body, and it links individual experience to more widely shared interpretations and to social relationships. The third and final body is referred to as the “body politic.” This unit of analysis is more concerned with collective bodies and how they are regulated and controlled (Scheper-Hughes and Lock, 1987).

Society at large has given scant attention to how social suffering becomes embodied by women workers in service industries across high-income countries. According to Karen Messing

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

“the types of health problems women have are not recognized or compensated, creating a vicious circle where women's occupational health problems are not taken seriously, therefore not recognized, therefore do not cost enough to matter” (Hazards Magazine, 2007). The result is that there exists little research on women's health problems at work – instead these problems get dismissed as due to women’s reproductive events (menstruation, menopause, etc.), aging, or hysteria. Physicians, the gatekeepers to compensation claims for injuries at work as well as Disabilities Benefits are often blind to the health problems experienced by women service workers. When diagnosis is given at all, their ‘complaints’ are usually categorized as a medical condition falling under the rubrics ‘stress,’ ‘anxiety’ and/or ‘depression.’ However, as shown below, the women in our study, for the most part, do not see themselves as having mental illnesses or mental health problems. Instead they speak about the everyday emotional and social problems that are affecting their overall health and well-being. These include experiences such as: a separation from a spouse, the inability to gain meaningful employment, feeling dissatisfied with one’s personal achievements, not getting along with family members and/or feeling pulled in too many directions (work, friendships, school and family).

The complex, and often inchoate, etiology of this kind of suffering thus makes it difficult for many women service workers to find help for their health problems through the Canadian public health care system. Medical professionals often do not have the comprehensive level of training necessary to diagnose or treat these health problems and the alternative services the women would like to access – ranging from counseling, naturopathy, therapeutic massage or acupuncture – are not currently funded by the public system. Instead these services are included in the 30 percent of health care services in Canada that are paid by residents through other means (i.e. private insurance and/or workplace health benefits), as well as homecare, prescription drugs,

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

dentists and long-term care (Armstrong and Armstrong, 2003). Highly problematic is that women working in low-paying service jobs do not have access to additional health insurance through their job. Some of them are covered under a partner's health insurance plan but others do not have this recourse (i.e. are single, their partner does not have private health insurance, etc.) or additional funds to pay the out-of-pocket costs. Some very poor women working in the sex industry have access to alternative services through the Income Assistance available in Canada but many of the other women workers are deemed to be making too much money to be eligible for this program and thus fall through the cracks of the health care system.

STUDY and METHODS

Parent Study

The data presented below are drawn from a qualitative study, *Working through the Body: Women, Pain and the Embodiment of Work* (henceforth referred to as the Working through the Body sub-project), that builds on an ongoing mixed-methods research project entitled, *The Impact of Stigma on Marginalized Populations' Work, Health and Access to Services*, led by the second author (Benoit et al., 2002-2005). This latter study is a longitudinal study funded by the Canadian Institutes for Health Research (CIHR) that examines the social and health costs associated with providing emotional labour in working environments that are non-unionized, sexualized and, in the case of the sex industry, highly stigmatized. To date, the study has interviewed 306 adults living in the Victoria Metropolitan Area of British Columbia, Canada, who are working in one of three service occupations that are socially and economically marginalized to greater and lesser degrees: hairstylists and barbers (henceforth referred to as hairstylists), food and beverage servers (henceforth referred to as servers) and people working in different sectors of the sex industry

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

(henceforth referred to as PWSI). A parallel study also lead by the second author is underway in Sacramento.

These jobs differ in terms of social prestige but they share important structural characteristics that marginalize them to greater and lesser degrees. Firstly, the *financial remuneration* (i.e. tips and commission which these occupations depend) these women receive is contingent on successfully hiding or disguising their own emotions while managing their customers' feelings (Hochschild, 1983; Hall, 1993). Thus, women working in these occupations are expected to follow particular 'serving scripts.' These scripts involve 'doing gender' by giving 'good service' so that customers will leave satisfied and return (Hall, 1993). Secondly, all three of these occupations are *disproportionately female*. According to Statistics Canada, 81 percent of hairstylists and 77 percent of food and beverage servers in the study area were female (Statistics Canada, 2005). It is estimated that between 70-80 percent of sex workers in most metropolitan areas of Canada, including Victoria, are female (Benoit and Millar, 2001). Thirdly, these occupations are marked by *limited educational requirements*. According to Provincial statistics, the food and beverage and hair and beauty industries require a minimum grade 10 high school education or equivalent (Industry, Training and Apprenticeship Commission, 2001). There is no minimum education requirement for PWSI. Fourthly, there is a *distinct hierarchy of work settings* within and between each of these occupations. Individuals can work across a variety of venues that includes high prestige venues (i.e. elite hair salons, expensive fine-dining restaurants and exclusive escort agencies) to low-end locations (i.e. budget hair salons, family style restaurants with simple food and low prices and, in terms of PWSI, street-level work). The result of this hierarchy of work setting is differing levels of prestige/stigma and significant difference in economic stability vis-à-vis commissions and tips. Fifthly, all the jobs are marked by *unstable*

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

employment which translates as frequent moves from one venue to another, high turnover of personnel over short periods of time and lack of access to employment-based health benefits. Sixthly, on average, all three occupations are rewarded with *low-pay*. The average income for hairstylists and barbers in Victoria in 2001 was approximately \$18,000; for food and beverage workers it was even lower, at \$12,700 per annum (Statistics Canada, 2005). Tips, however, are not included in these reported earnings, which can be between 10-15 percent of the hairstylist or server's sales per shift (Industry Training and Apprenticeship Commissions, 2001; Industry Training and Apprenticeship Commissions, 2002). The median earnings of PWSI reported in a former study in the same the research site was \$18 000 (Benoit and Millar, 2001).

The parent study comprises four separate interviews or waves that are administered approximately every four months. Each interview is made up of a series of closed and open-ended questions that cover a range of topics including: demographic variables (age, gender, ethnicity); family history; education (early education and on-going training or education); work history; description of current occupation (hours, schedule, satisfaction and description of working environment); income (monthly, yearly and household income); tipping (reliance on tipping, percentage of take-home wage); enacted and internalized stigma; occupational injuries (including perceived occupational risks); current physical and mental health; utilization of health care services and children's access to and use of health care services. Data collection for the Victoria and Sacramento projects are scheduled to be completed in 2007.

From September, 2005 through January, 2006 the first author conducted a fifth wave of interviews with a select group of women who had completed all four interview waves of the parent study and reported significant levels of physical pain, stress and fatigue during earlier interviews. This fifth interview focused specifically on the personal experiences of women

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

workers only for two reasons. First, women make up the majority of workers involved in these occupations; of the 306 individuals involved in the parent project, 77 percent of these are women. Second, as mentioned in the literature review above, research suggests that women are more likely than men to embody their suffering as physical pain and illness (Lennon, 1987; DeIVecchio-Good, 1992).

The purpose of these follow-up qualitative interviews was to better understand how women workers use their bodies and the language of pain and illness to communicate distress. In other words, how and where do women embody their distress and how do they manage the physical and emotional consequences? A second purpose was to discover what these women do to negotiate their social suffering, including what health services – conventional or alternative – they accessed, the main purpose of this paper.

Sub-Study Methods

The methods employed to get at the deep descriptions of women workers' everyday lives included life history/"illness narratives" (Kleinman, 1988). Our participants were asked to speak about their personal histories (i.e. the life circumstances that led them to certain occupations and their health). We focused in considerable depth on their current experiences with pain, stress and fatigue and what they believed was the etiology of these experiences. As a result, the life histories did not entail an exhaustive summary of each woman's life; instead the purpose was to have each woman trace her individual pathway (not necessarily linear) to pain and illness. We were able to link this fifth wave of data with information from earlier interviews about work, family life, and everyday experiences to gain a more complete picture. In the end, this approach did not necessarily produce neatly packaged illness narratives (Bury, 2001; Kleinman, 1988).

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

Instead, the women spoke about what was important to them. Sometimes their responses revealed a clear pathway to physical, emotional and mental pain and illness; other times, answers were ambiguous and contradictory and the pathway was less clear.

An additional methodological tool employed to get at women's embodied experiences was *body mapping* (Cornwall, n.d.; Guillemin, 2004; Mitchell, 2004-2006). This is a visual technique based on asking participants to map out locations of pain, stress and fatigue on an outline of their body. This process began with each woman lying on the floor on a large piece of white paper. The first author drew an outline of the woman's entire body in a black felt marker. From there, each woman was given eight different coloured felt tipped markers and asked to personalize her body map by drawing her favourite and least favourite aspects of herself; the women were also asked to draw what she felt was the strongest and weakest areas of her body. The purpose of this was to encourage women to see the drawing as their own or as a space to visually depict their lived experiences and sensations (Mitchell, 2006). Once a woman had personalized her drawing, she was asked to mark all the places where she experienced 'general' and 'work-related' pain, stress and fatigue. The goal throughout was to move beyond a strictly physical understanding of pain to a wider holistic understanding that might include mental, emotional and even spiritual elements.

While the body mapping exercise yielded evocative and insightful qualitative data, we will not be presenting those findings here. This is due to space considerations and because body mapping as a methodological approach and the body maps themselves warrants a separate and more in-depth discussion than possible here.

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

Sub-Study Population

Fourteen women were involved in this purposive sub-project: four servers, five hairstylists and five PWSI. Our participants occupy social locations shaped by a number of social factors. While many of the women were born in Canada, three others were born outside Canada – Eastern Europe, England and New Zealand – and immigrated to Canada in their late adolescence or early twenties. Two women self-identify as belonging to an ethnic minority – Aboriginal and African Canadian. The women's ages range from 22 to 57 with the average age being 41. In terms of education, the typical level of school completion is grade eleven. Forty-three percent of the women are married or involved in a common-law relationship and while many have children, only 21 percent have dependant children (i.e. 18 years old or younger). The average yearly income of the women is approximately \$22,175; however, because many of these women were not working at the time of their interview (43 percent of the women are unemployed, and 21 percent reported that they work only part-time) the income they report may include the money received from social-service programs such as Income Assistance and/or Disability Benefits. While owning a home in Victoria is not necessarily an index of social security due to the notoriously high cost of housing in the study area, it is, nonetheless, significant to mention that only 29 percent of the women indicate that they own their own home, 57 percent rent a house or apartment and 14 percent indicate that they lack secure housing all together.

Also influencing the social location of these women is the set of factors contributing to the occurrence and degree of their suffering. Data from the parent study at the time of the current analysis revealed that a substantial number of the women participants have endured various forms of suffering throughout their lives. For instance, 17 percent of the women interviewed for the parent project indicated that they had lived in a foster home or some other form of government

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

care at some time in their childhood or adolescence. Forty-eight percent of women indicated that they or their family has experienced “serious financial difficulty” in their lifetime. When asked if they had ever been a victim of abuse, 45 percent of women indicated that they had been physically abused, 44 percent said they had been sexually abused and 60 percent reported that they had been emotionally abused. Just under one-third of the women involved in the parent project specified that they had experienced all three forms of abuse. In terms of the fourteen women interviewed in the sub-project, 85 percent included tales of abuse in their narratives. While the women only rarely used the term “abuse” to describe some of the traumatic events in their lives, they spoke about being physically hit or detained, inappropriately touched or sexually molested, feeling emotionally “put down” or “damaged” by close family members including romantic partners. While these high numbers may be attributable to the fact that 40 percent of the women involved in the parent study and 36 percent in the sub-project have been involved in the sex industry, the numbers are, nonetheless, disturbingly high for participants across the three lines of work. On the other hand, while these life experiences are integral to the women’s overall health and well-being, these experiences of abuse and trauma were not necessarily the focus of their illness narratives and body maps. As mentioned in the introduction, it was the everyday experiences of suffering that shaped our conversations; these experiences were the ones our participants linked to their health. It is significant that when women from the parent project were asked to rate their health, one-quarter said that their physical health was “fair” or “poor”² and 23 percent considered their mental health to be “fair” or “poor.” When asked “How often do you experience body pain?” approximately one third of the women indicated that they “very often” or “always/chronically” experience body pain. These numbers are obviously much higher among

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

the sub-population as their recruitment into the fifth interview was based on their reporting significant levels of pain, stress and fatigue.

It should also be noted here that there was a time delay between the participant's fourth interview with the parent project and their fifth interview with the *Working through the Body* study. For instance, although the average time span between the fourth and fifth interviews was four months, in some instances women were interviewed nine months after their fourth interview. This meant that, in a few cases, the women were no longer experiencing significant pain or illness at the time of their fifth interview. While initially this finding was met with concern, it was soon realized that this actually strengthens one of the central tenets of the project: that individuals embody their economic and social locations. Thus, when a woman has made significant, positive changes in her life, her experience with pain and illness is also likely to change. In addition, body mapping the experiences of these relatively 'healthy/pain-free' women highlighted the potential for this method. Mapping women's bodies through periods of sickness and health is a rich area for analytical investigation.

FINDINGS

Finding Help in the Public Health Care System

When we asked women to speak about their health and the circumstances that led to their current experiences with pain and illness, they were apt to tell us about their experiences interacting with healthcare professionals. Through these discussions, we were able to identify many positive points about Canada's primary health care system, which are confirmed in the literature (Verhoef et al., 2006). We were also able to identify a number of problems in the women's stories in regards to their encounters with physicians. These problems overlap considerably in that they share an underlying concern with issues of communication and power –

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

the ability to take an active role in the diagnosis and treatment of a health concern(s). In many ways, these two themes were inseparable; when women indicated that their physicians “did not listen” to them they were referring to verbal communication problems and a lack of power in the exchange. The problems women articulated are as follows: a) time constraints (visits with their physicians are too short to speak in-depth); b) rejection of patient’s etiology (physicians not validating or ‘hearing’ women’s perspectives on the root cause of their health problem); c) not addressing patient’s concerns (physicians disregarding/ignoring specific health concerns or the request for specialized treatments); one dimensional care (physicians focusing solely on physical health and bodily ‘symptoms’); inappropriate care (physicians prescribing medications that women consider inappropriate for their problem(s)). Below we present the women’s own words and the main concerns articulated by them in regards to seeking the services of physicians.

At the time of our fifth interview Coral³ was unemployed. Up until recently she had been working as a hairdresser in a chain of “budget” hair salons. Coral disliked her job and frequently commented on the embarrassment she felt at working in a “dead end” job⁴. Coral’s dissatisfaction was not limited to her job; she also describes feeling unfulfilled in her personal life. Coral spoke about wanting a “real career,” rewarding friendships, enough money to buy a home and a “healthier” relationship with her husband and in-laws. She also describes her adolescents as a particularly difficult time.

When speaking about her health, Coral identified a range of health problems including intense pain in her neck, shoulders, wrist, lower back and head, acid reflux, stomach ulcers and discomfort associated with being overweight. Coral’s health concerns were such that, “I didn’t want to go to the doctor with four hundred things ‘cause I thought they’d put me in a straight-

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

jacket [light laughter].” When Coral did, eventually, decide to go see her physician, she described the interaction this way:

I wrote down a list for my doctor and I wrote down the problems I was having and he kind of chucked [threw] it. I started crying, and he kind of chucked it down and he was like, ‘I don’t need this.’ I felt like a 5 year old kid going, “Sorry,” you know? And he’s like, “I think you’ve been suffering from depression cause you have this chronic [pain]”...like it’s written down that I have chronic pain now. And um, I kept going in cause my shoulder . . . like I kept going in for these [health concerns] but he’d be just like “oohhhh.” Um, it wasn’t ever dealt with; it was never, so that day I said, I said, can I get my wrist checked? He said “oh, you don’t need to get your wrist checked, you . . . ” and he prescribed me some anti-depressants.

According to Coral, her doctor had already decided that the pain she was experiencing was “all in her head” and consequently he was unwilling to listen to what she felt might be the root cause of some of her body pain:

I always thought there was something wrong but my doctor wouldn’t help me. So it’s kind of, really strange for me, to like the doctor not helping me, and wanting to feed me antidepressants. I never took them. I’m glad I didn’t ‘cause I did not feel depressed at all, I feel frustrated sometimes, but I do not feel depressed. I want to put somewhere [on body map] like not feeling believed when I went to the doctor. Not feeling umm...yeah...like the doctor didn’t really believe me. I didn’t feel validated by the doctor.

While Coral’s health had improved between the time of these incidents mentioned above and her fifth interview, these changes were brought about through Coral’s commitment to self-improvement and her ability to access some alternative therapies through her husband’s health insurance (she was able to receive both personal and marital counseling and limited therapeutic massage).

Coral was not alone in feeling disillusioned by the care she received through primary health care. Sam is a 46 year old woman working in the sex industry. She took up this line of work in her thirties because it paid more and was less physically demanding than the minimum

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

wage, manual labour jobs she had in the past. Furthermore, Sam felt that she got “more respect” from her clients in the sex industry than she ever did from the romantic partners in her life. At the same time, Sam disliked the inconsistent wages and bad weather associated with street work. At the time of our interview Sam was single and sharing a low-income apartment with a friend.

Similar to Coral, Sam had health concerns that ranged from arthritis and gastro-intestinal problems (acid reflux, stomach pain and irritable bowel syndrome [IBS]) to what she describes as “chronic pain” (neck, back and shoulders). When Sam was asked to talk about what she felt might be causing the chronic pain and illness, she responded, “[F]rom what I’ve been ‘eating.’ By eat I mean the crap I take and the feelings I put down. I’ve been pushing down for years and, and, and the result is the IBS, the arthritis and definitely the stress headaches.” When asked about her interactions with physicians, Sam became frustrated:

I wish he would listen to me a little bit more. I wouldn't mind giving root therapy a chance. On my exit from that counselor I was seeing, [root therapy] was suggested [as] an alternative to help me with ah, dealing with stress and stuff. . . [M]y doctor just went over that one and he's more into “let's get you on pills” and I've always ah, been one who didn't like to do a lot of pills, I want to try and find a different approach. I'd like to find out what the problem is. You know, what's the problem?!

While Sam was eventually able to access free acupuncture for her chronic neck and shoulder pain and counseling programs through a local community outreach program for people working in the sex industry, Sam's describes her access to these services as precarious:

I've been going to PEERS⁵ the last four months and we've been doing a lot of step work. I don't have an alcohol problem but you get all the childhood crap brought up. I'm getting the acupuncture through PEERS. PEERS [program] ends in two and half months, that scares me. The program I'm in will be done in two and half months. And I'm going to . . . acupuncture's out the window and that bar [referring to a “bar” of pain across shoulders] could be right back.

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

Other women, such as Tobi, feel as though their healthcare requests are ignored and disregarded by their physicians. Tobi is a self-employed hairstylist in her mid-thirties. She has a common-law spouse who is unemployed and together they have three dependant children. While Tobi loves her occupation, she has to be available to work at least 6 days a week to make ends meet. As she puts it, “. . . if I don't work, I don't get paid.” The stress of having to support herself and her family on a single income takes a toll on Tobi. Not only does she not have time for exercise (which has led to significant weight gain) but Tobi is concerned that she is not living up to her idea of a “good” parent:

I'm not a very good mom. I'm not saying that in a negative way. I'm just not your stay-at-home typical, really 'Good Housekeeping,' mom. So it's an effort for me and um, I don't always look forward to it. And I like being at the shop but I don't always like being at home. I feel good about what happened in the day but I don't always feel good about having to go home and deal with dinner and that time, things like that.

These everyday concerns, in turn, have had a negative impact on Tobi's health. Through body mapping Tobi identified stomach “issues,” chronic headaches and physical discomfort/low self-esteem related to her weight gain. When asked how she ‘deals’ with these problems Tobi responded:

I get constant headaches, always have. Um, no one's ever delved into it enough to... give me any insight into that. If there is a problem, a lot of the time [my doctor] just brushes it off. Like I've been getting headaches for years.

Tobi goes on to describe another incident when her doctor was seemingly unresponsive to her request for a referral:

I have behavior problems with one of my daughters. And I've told [doctor] over and over that I want to see a child psychologist or a ... professional to deal with her behavior issues and [doctor] just won't do that. I don't think he thinks it's serious. He says “well what's the problem.” You know. So and I know it's a huge problem. I know it's something we can't deal with at home.

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

While Tobi identifies the need to find a more responsive physician and communicates the desire to receive alternative health therapies, her circumstances make it difficult:

[T]here's a lot of things that I feel that I could be doing for myself. I could be doing ... um, chiropractic and massage um... alternatives but... [brief interruption, while someone comes into her salon]...taking the time off work to go do it and the money situation, um, paying it out [of pocket]. [If] I make an appointment, I don't know that I'm gonna have money that day. 'Cause I don't always.

Seeking Alternative Health Services

When women communicated their concerns with the current delivery of health care, they invariably described what kind of health care they want to receive. They did this in two ways: a) by describing something that they have, as of yet, not received; b) by describing the alternative services they have actively sought to fill the gaps in the public health care system. The overwhelming description of what women want is non-medical/non-conventional health care – in other words, holistic health care that considers the interconnection of mind, body and the social environment while being both preventative and therapeutic (Saks, 1992, 2001). Alternative or “complementary” care (Sharma, 1992; Verhoef et al., 2006) exists in the shadow of the Canadian public health care system and receives almost no support from the medical establishment and the government (Kelner et al., 2000).

Athena is in her late twenties. She was originally recruited into our parent project through her involvement in the food and beverage industry. At the time of our fifth interview Athena was still working part-time as a restaurant manager but she had also started up her own small business. Athena was also one of the few women who had made significant improvements in her health between her fourth and fifth interview and consequently described herself as “in the best health of my life” when we last spoke to her. Athena’s illness narrative included a sustained period of

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

“poor” health, including recurring fatigue and body pain. She linked her poor health to “not listening” to her body and “not being very happy.” As Athena puts it, “I look back and think ‘jeez I haven’t really been that happy’ because I have never really gone with what I feel like doing. [Instead] a lot of the time I do what I think I should do or what other people feel I should do.” During the past several years, Athena has gradually been learning about what it takes for her to be healthy. This has involved getting into “natural medicine and alternative medicine over the last four years, [and] that’s been the greatest catalyst to me feeling better.” When asked about why she no longer seeks conventional medical care Athena states:

Unless I’ve lost a limb I don’t go and see a regular doctor anymore . . . we [herself and naturopath] discuss the work that I do and the hours and sleeping patterns and basically my entire day, which work is always a part of, and um, and so he tries to understand what I do I think more than anyone else has. He pays a lot of attention to that because to me it’s smaller changes that are going to make a difference in my life, or my energy level or how I feel, not major ones.

Athena then goes on to comment on the added expense of going to see a naturopath:

I think the money that I spend there [at the naturopath] is... well, well, well worth it. And sometimes I see [naturopaths and acupuncturists] for preventative things and sometimes I see them to actually treat something that I have. But, they do a better job for me than any general practitioner has ever done. So I don’t really use our medical system that we pay for. I wish that part of it [alternative therapies] was paid for.

Athena was not alone in her endorsement of alternative care. For instance, Brandy is a woman in her middle to late twenties. She too has worked in the food and beverage industry but at the time of our fifth interview she had gotten a “great” job with the Provincial government. While Brady, like Athena, had recently been through a difficult and unhappy period of her life, she described herself during the fifth interview as also being in “the best health” of her life. She described the unhappy times in her recent past as being brought on by relationship problems, poor self-esteem and a general lack of direction in her life. In turn, these everyday sources of suffering

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

had caused her to experience significant physical pain and illness including chronic pain in her back and shoulders, severe anxiety and stomach pain. When she looks back on the conventional medical care she received at that time, she communicates her frustration and dissatisfaction:

I remember I went to a drop-in clinic and um I had broke up with my boyfriend and I was going through a horrible break-up, this was like two years ago. I went to a drop-in clinic, and he [doctor] prescribed me sleeping pills. Like 'hey, that's just wrong! Looking back on it, you don't know anything about me, and you just go prescribing drugs to fix something! Which I think, that's just horrible.

Shortly after this incident, Brandy started to see a naturopath. When asked why she decided to make this switch she says:

. . . medical doctors I think should only really be used if you know you broke your leg or you broke, you know, something like that. For the most part, if you take care of your body and you look at the whole picture and you're not just treating one little symptom or something, you know like, you're looking at everything, then um, a naturopath is the way to go to overall health.

Brandy was lucky because she had personal resources vis-à-vis her new job to purchase natural remedies and seek the ongoing advice of a professional counselor. This ability to purchase alternative health services to fill the gaps in the primary health care system was not, however, the case for all the women we spoke to.

Evelyn is a single mother in her late twenties. She does not currently have a “square” (i.e. regular, mainstream employment) job but hopes to one day upgrade her skills to get a job she finds fulfilling. At the present time, Evelyn is on Income Assistance and, to supplement her meager income, works sporadically in the sex industry. When asked about the health care she receives, Evelyn is very articulate about what she wants and needs:

Well, I think rather than looking on what I'm experiencing more as a symptom, right, like, coming in with a sore back, right, certainly helping me with my sore back would be one way of doing it and that would be cool, but I think you know, helping me learn new ways [to] prevent getting a sore back [and] giving me a handful of condoms

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

right before I leave is preventative measures. Or, you know, help me become aware of the long term effects of different ways of coping, even if it's just emotional coping. Asking me if, asking me questions like if I'm eating properly or becoming anorexic or bulimic. Those sorts of things. But of course that takes longer than 15 minutes, so.

What is concerning about Evelyn's situation is that while she is able to access some of the alternative services she needs, her situation is precariousness and it forces her to make some difficult life decisions:

I have been thinking about going back full-time into the [sex] trade. I don't know if that's gonna be good for me or not, right? And the problem is that if I get out of the system [social welfare] then all of my supports leave as well. Like it's very difficult to find a good therapist. I finally found a good therapist and ah I need to stay in the system in order to get the therapy that I need. So even if I were to get a job – which is part of, you know, one of the programs that I'm doing which is about looking forward and train[ing] you to get a job or at least, get you moving – If I get a job I lose my therapy.

Evelyn was not the only woman we spoke to who had to rely on Income Assistance and community outreach programs to provide the alternative health care they need to get well.

Sage is a single woman in her late forties. She collects Income Assistance and has only recently been able to get a phone (first time in four years) and a television. Like Evelyn, Sage has worked in the sex industry but left very recently. Her exiting was precipitated by a long stay in the hospital due to a “horribly painful” infection that was brought on by the use of “dirty coke.” While Sage describes herself as “on the mend,” she requires on-going medical help to help her deal with her addictions, arthritis, irritable bowel syndrome and “unhealthy thoughts.” Sage is very pleased with the healthcare she receives through a community outreach program:

They're really helping me pull through. They've given me a rent incentive that's a little bit extra money a month towards my rent. They provide all kinds of self-healing and group therapy, you name it, everything. And you know they're really helping me get back on my feet.

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

Sage is fortunate because, at the moment, she is getting exactly the kind of non-conventional alternative health care she wants. She has access to numerous alternative therapies and she received care from a volunteer doctor at the community outreach centre who is attentive and responsive to all of her concerns:

A doctor there who um volunteers on Monday morning [sent me to] go get some X-rays. My X-ray looked like I had bone spurs on it. “Oh no!” So she sent me for a cat scan and then it was, it was discovered it was [an] infection.

While this situation is a vast improvement from the life Sage had recently been living she, like Evelyn and Sam introduced above, are reliant on continued funding through this community outreach program. When she leaves Income Assistance, Sage will not have access to these alternative health benefits she currently relies on.

DISCUSSION and CONCLUSION

We have presented findings from a qualitative study of Canadian women working in three frontline service occupations (food and beverage servers, hairstylists and sex industry workers). Our participants identified a number of health concerns that they link to the everyday suffering they endure – feeling inadequate, incompetent, lonely, self-conscious, disenfranchised and/or dissatisfied – indicating that socioeconomic status, gender and work interact to create health disparities as well as barriers to accessing the health services certain women desire to ease their social suffering.

First of all, many of these women do not have the economic resources to purchase the services they feel would have positive preventative and therapeutic benefits. This is not to say that none of the women documented here are accessing alternative health resources. Rather, access is precarious and largely dependant on: a) Income Assistance (for those who are very low income) or b) spouses/partners who cover the participant under an employment insurance plan.

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

Secondly, many of the women described health problems that are complex and rooted deep within their social, cultural and economic environment. As a result, they deemed physicians not to have the time or expertise to explore and adequately address these particular concerns. As a result, women complained that their physicians were focused on diagnosing only acute illness and taking a one-dimensional view of their health which, in the long run, does little to improve their overall health and well-being. Not all the women we spoke to were dissatisfied with their physicians. Some women indicated that they “like” their physicians and that their physical health concerns are addressed adequately. In some instances, women narrate stories of doctors who have gone to extraordinary lengths to ensure that they received the best possible care. However, in almost every instance, it was volunteer doctors and nurses at street-based outreach centers who earned this kind of praise.

Although the publicly funded, universal health care system in Canada takes us a long way in the equitable access to medical and hospital services (Benoit, 2003; Armstrong and Armstrong, 2003), our findings suggest that it falls short in regards to the health care needs of vulnerable women and as such, other strategies are required to sensitize health services to meet their individual needs. It comes as no surprise that research on the kinds of people who access alternative health care in Canada and other high-income countries tend to be mainly older women who are well-educated, employed in more prestigious professional occupations and earning good incomes (Kelner and Wellman, 1997; Kelner et al., 2000). Unfortunately, women working the frontline are not so lucky.

These findings are preliminary due to our small sub-sample size and need for further confirmation via analyses of the larger sample of participants involved in the parent study. Additional thought is also needed to address the healthcare gaps identified. While the women we

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

spoke to were clear that our publicly-funded health care system should expand to include an array of alternative services, how best to integrate these into the current health care system remains a major challenge, as does finding the resources to do so.

End Notes:

¹ Referred to by some as Complementary Alternative Medicine or CAM (Verhoef et al., 2006).

² The response categories for this question were: “Excellent,” “Very Good,” “Good,” “Fair” and “Poor.”

³ We use pseudonyms throughout in order to help protect our participants’ anonymity and confidentiality.

⁴ It should be noted that many of the individuals in both the parent and sub-projects who worked as hairstylists derived personal pleasure and pride from working in what is viewed by many as a skilled trade.

⁵ Prostitutes Empowerment Education and Resource Society (PEERS) is a local social welfare service organization staffed in large part by former sex industry workers. It offers temporary access to education and alternative health services to adults working in the sex industry in the city. Most of these services are funded by the Ministry of Employment and Income Assistance. Their availability varies from year to year depending on monies forthcoming to PEERS from the Ministry.

References:

- Annandale E. & Hunt, K. (2000). (Eds.) *Gender Inequalities in Health*. Philadelphia, PA: Open University Press.
- Armstrong, P., & Armstrong, H. (2003). *Wasting Away. The Undermining of Canadian Health Care*. Toronto: Oxford University Press.
- Bendelow, G. A., & Williams, S.J. (1998). Natural for women, abnormal for men: Beliefs about pain and gender. In *The Body in Everyday Life*, edited by Sarah Nettleton and Jonathan Watson, Pp.199-217. New York: Routledge.
- Benoit, C. (2000). *Women, Work and Social Rights: Canada in Historical and Comparative Perspective*. Scarborough, Ontario: Prentice Hall Canada.
- Benoit, C. (2003). The Politics of Health-Care Policy: The United States in Comparative Perspective. *Perspectives in Biology and Medicine*, 46 (4), 592-99.
- Benoit, C., & Millar, A. (2001). *Dispelling Myths and Understanding Realities: Working Conditions, Health Status, and Exiting Experiences of Sex Workers*. Sponsored by Prostitutes

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

Empowerment, Education and Resource Society (PEERS). Funded by BC Health Research Foundation, Capital Health District and BC Centre of Excellence on Women's Health.

Benoit, C., Jansson, M., McCarthy, B., & Leadbeater, B. (2002-2005). *The Impact of Stigma on Marginalized Populations' Work, Health and Access to Services*. Canadian Institutes of Health Research.

Brodwin, P.E. (1992). Symptoms and Social Performance: The Case of Diane Reden. In *Pain as Human Experience: An Anthropological Perspective*, edited by Mary-Jo DelVecchio Good, Paul E. Brodwin, Byron J. Good and Arthur Kleinman, Pp. 77-99. Berkeley: University of California Press.

Bury, M. (2001). Illness narratives: Fact or fiction? *Sociology of Health and Illness*, 23(3), 263-285.

Commission on the Future of Health Care in Canada. *Shape the Future of Health Care: Interim Report*. Ottawa: Health Canada. Available at: <http://www.healthcarecommission.ca.gov>. Accessed December 2, 2006.

Cornwall, A. (n.d.). Body Mapping: Bridging the Gap between Medical Messages, Popular Knowledge and Lived Experience. In *Body Mapping in RRA/ PRA*, RRA Notes, 16:69-76.

Das Gupta, M. (1997). Life Course Perspectives on Women's Autonomy and Health Outcomes. *American Anthropologist*, 97(3), 481-491.

Davis, D. (1996). The Cultural Constructions of the Premenstrual and Menopause Syndrome. In *Gender and Health: An International Perspective*, edited by C.F. Sargent, and C.B. Brettell, Pp. 57-86. New Jersey: Prentice-Hall, Inc.

DelVecchio Good, M.J. (1992). Work as Haven from Pain. In *Pain as Human Experience*, edited by Mary-Jo DelVecchio Good, Paul E. Brodwin, Byron J. Good and Arthur Kleinman, Pp. 49-76. Berkeley: University of California Press.

DelVecchio-Good, M.J., Brodwin, P. E., Good, B. J., & Kleinman, A. (Eds.) (1992). *Pain as Human Experience: An Anthropological Perspective*. Berkeley: University of California Press.

England, P., Hermsen, J., & Cotter, D. (2000). The Devaluation of Women's Work: A Comment on Tam. *The American Journal of Sociology*, 105 (6), 1741-1751.

Erickson, R.J., & Ritter, C. (2001). Labor, Burnout, and Inauthenticity: Does Gender Matter? *Social Psychology Quarterly*, 64(2), 146-163.

Journal Article: Research in the Sociology of Health Care – Volume 25
Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

- Frank, A. (1995). *The Wounded Storyteller: Body, Illness and Ethics*. Chicago: The University of Chicago Press.
- Guillemin, M. (2004). Understanding Illness: Using Drawings as a Research Method. *Qualitative Health Research*, 14(2), 272-289.
- Hall, S. (1993). Smiling, deferring and flirting: Doing gender by giving 'good service.' *Work and Occupations*, 20(4), 452-471.
- Haw, M.A. (1982). Women, Work and Stress: A Review and Agenda for the Future. *Journal of Health and Social Behavior*, 23(2), 132-144.
- Hazards Magazine. (2007). *Women Hurt at Work: Hazards fact sheet 67*. Retrieved February 10 2007. <http://www.hazards.org/womenatwork.htm>.
- Herzfeld, M. (1986). Closure as Cure: Tropes in the Exploration of Bodily and Social Disorder. *Current Anthropology*, 27(2), 107-119.
- Hochschild, A.R. (1983). *The Managed Heart: Commercialization of Human Feelings*. Berkeley and Los Angeles: The University of California Press.
- Industry, Training and Apprenticeship Commission. (2001). Cosmetology, *Work from Work Futures BC: Occupational Profiles* [electronic version]. Accessed April 2006, from, <http://www.workfutures.bc.ca/profiles/profile.cfm?noc=6271&lang=en&site=grap>
- Industry, Training and Apprenticeship Commission. (2002). Hospitality, *Work from Work Futures BC: Occupational Profiles* [electronic version]. Accessed April 2006, from, <http://www.workfutures.bc.ca/profiles/profile.cfm?noc=645&lang=en&site=graph>
- Jick, T. B., & Mitz, L. F. (1985). Sex Differences in Work Stress, *The Academy of Management Review*, 10(3), 408-420.
- Kelner, M., & Wellman, B. (1997). Health Care and Consumer Choice: Medical and Alternative Therapies. *Social Science and Medicine*, 45(2), 203-212.
- Kelner, M., Wellman, B., Pescosolido, B. & Saks, M. (2000). *Complementary and Alternative Medicine: Challenge and Change*. Amsterdam: Gordon and Breach/hap.
- Kleinman, A. (1988). *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.
- Kleinman, A., Brodwin, P., Good, B., & DelVecchio Good, M.J. (1992). Pain as Human Experience: An Introduction. In *Pain as Human Experience*, edited by Mary-Jo DelVecchio

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

- Good, Paul E. Brodwin, Byron J. Good and Arthur Kleinman, Pp. 1-28. Berkeley: University of California Press.
- Kleinman, A., & Kleinman, J. (1991). Suffering and its Professional Transformation: Toward an Ethnography of Interpersonal Experience. *Culture, Medicine and Psychiatry*, 15(3), 275-301.
- Kleinman, A., & Kleinman, J. (1997). The Appeal of Experience; The Dismay of Images: Cultural Appropriation of Suffering in Our Times. In *Social Suffering*, edited by Arthur Kleinman, Veena Das and Margaret Lock, Pp.1-24. Berkeley: University of California Press.
- Kleinman, A., Das, V., & Lock, M. (1997) Introduction. In *Social Suffering*, edited by Arthur Kleinman, Veena Das and Margaret Lock, Pp. ix-xxvii. Berkeley: University of California Press.
- Lennon, M.C. (1987). Sex Differences in Distress; The Impact of Gender and Work Roles. *Journal of Health and Social Behaviour*, 28(3), 290-305.
- Lipscomb, H., Loomis, D., McDonald, M., Argue, R., & Wing, S. (2006). A Conceptual Model of Work and Health Disparities in the United States. *International Journal of Health Services*, 36(1), 25-50.
- Lock, M., & Wakewich-Dunk, P. (1990). Nerves and Nostalgia: Expression of Loss Among Greek Immigrants in Montreal. *Canadian Family Physician*, 36, 253-258.
- Messing, K. (1998). *One-Eyed Science: Occupational Health and Women Workers*. Philadelphia, PA: Temple University Press.
- Messing, K. (2000). Ergonomic Studies Provide Information About Occupational Exposure Differences Between Men and Women.” *Journal of the American Medical Women’s Association*, 55, 72-75.
- Messing, K. (2002). Analyse du travail des travailleuses du sexe oeuvrant dans la rue: Investigations préliminaires. In *Work, Restructuring, Health and Policy Implications: The Sex Trade Environment*. Sponsored by the National Network of Environments and Women’s Health. Toronto: York University (no page numbers).
- Mitchell, L. (2006). Child-centered? Thinking critically about children’s drawings as a visual research method. *Visual Anthropology Review*, 22(1), 60-73.
- Moss, P., & Dyck, I. (2002). Working through Theories of the Body. In *Women, Body, Illness: Space and Identity in the Everyday Lives of Women with Chronic Illness*, edited by Pamela Moss and Isabel Dyck, Pp.19-34. Lanham, MD: Rowman & Littlefield.

Journal Article: Research in the Sociology of Health Care – Volume 25

Inequalities and Disparities in Health Care and Health: Concerns of Patients, Providers and Insurers

Saks, M. (1992). The Paradox of Incorporation: Acupuncture and the Medical Profession in Modern Britain. In *Alternative Medicine in Britain*, edited by Mike Saks, Pp. 183-200. Oxford: Clarendon Press.

Saks, M. (2001). Alternative Medicine and the Health Care Division of Labour.” *Current Sociology*, 49, 119-134.

Scheper-Hughes, N. (1994). Embodied Knowledge: Thinking with the Body in Critical Medical Anthropology. In *Assessing Cultural Anthropology*, edited by Robert Borofsky, Pp. 229-239. New York: McGraw Hill.

Scheper-Hughes, N., & Lock, M.M. (1987). The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology. In *Understanding and Applying Medical anthropology*, edited by Peter J. Brown, Pp. 208-225. California: Mayfield Publishing.

Sharma, U., & Black, P. (2001). Look Good, Feel Better: Beauty Therapy as Emotional Labour. *Sociology*, 35(4), 913-931.

Sharma, U. (1992). *Complementary Medicine Today: Practitioners and Patients*. London: Routledge.

Shumka, L. (2006). *Working through the Body: Women, Pain and the Embodiment of Work*, MA Thesis, University of Victoria.

Sprout, J., & Yassi, A. (1995). Occupational Health Concerns of Women who work with the Public. In *Issues in Women's Occupational Health: Invisible*, edited by Karen Messing, Barbara Neis, and Lucie Dumas Pp. XX. Charlottetown: Gynergy books.

Statistics Canada. (1998). *Dimensions: 1996 Census of Canada* [Electronic Data file]. Retrieved July 2004, from <http://www.statcan.ca/start.html>.

Statistics Canada. (2001). *Victoria Census* [Electronic Data file.]. Retrieved December 5, 2004, from <http://www.statcan.ca/english/about/first.htm>.

Statistics Canada. (2003). EStat [Electronic Data File.] Statistics Canada, Retrieved April 2006, from <http://estat.statcan.ca.ezproxy.library.uvic.ca/cgi-win/CNSMC61.exe>.

Statistics Canada. (2005). *The 2001 Census* [Electronic Data file.], Retrieved April 2006, from <http://www.statcan.ca/start.html>.

Statistics Canada. (2005). *Women in Canada: A Gender-based Statistical Analysis*. Fifth edition. Ottawa: Statistics Canada. Catalogue no.89-503-XIE.

Journal Article: Research in the Sociology of Health Care – Volume 25
**Inequalities and Disparities in Health Care and Health: Concerns of Patients,
Providers and Insurers**

Stephens T., Dulberg, C., & Joubert, N. (1999). Mental health of the Canadian population: A comprehensive analysis. *Chronic Diseases in Canada 1999*, 20 (3), 118-126.

Van Wolputte, S. (2004). Hang on to Your Self: Of Bodies, Embodiment, and Selves. *Annual Review of Anthropology*, 33, 251-69.

Van Doorslaer, E., C. Masseria, & Koolman, X. (2006). Inequalities in access to medical care by income in developed countries. *Canadian Medical Association Journal*, 174(2), 177-183.

Verhoef, M.J., Boon, H.S., & Mutasingwa, D.R. (2006). The Scope of Naturopathic Medicine in Canada: An Emerging Profession. *Social Science and Medicine*, 63, 409-417.

Waldren, I. (1991). Effects of Labor Force Participation on Sex Differences in Mortality and Morbidity. In *Women, Work and Health: Stress and Opportunities*, edited by M. Frankenhaeuser, U. Lundberg and M. Chesney, Pp17-38. New York: Plenum Press.