

UCSF

UC San Francisco Electronic Theses and Dissertations

Title

Gender bias in cancer treatment setting

Permalink

<https://escholarship.org/uc/item/54z5f9cm>

Author

Hawkins, Christopher A.

Publication Date

1995

Peer reviewed|Thesis/dissertation

GENDER BIAS IN CANCER TREATMENT SETTING:
MYTH OR REALITY?

by

CHRISTOPHER A. HAWKINS

THESIS

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

NURSING

in the

GRADUATE DIVISION

of the

UNIVERSITY OF CALIFORNIA

San Francisco

er)

Abstract

While gender discrimination has been reported in the delivery of health care (especially in the treatment of cardiovascular disease) it has not been reported in the treatment of cancer. Secondary analysis of data collected in two separate cancer studies shows that women in these studies were significantly more likely than men to be treated at community hospitals rather than teaching hospitals. In one of the studies, this likelihood was even more pronounced in the case of women with breast cancer. The findings are provocative, especially since a literature review indicates that women with breast cancer receive superior treatment at teaching hospitals. A number of hypotheses are offered to explain the findings from these studies. Further studies are needed to clarify some of the issues raised in the discussion.

A total of 1,252,000 new cases of cancer are expected in the United States in 1995, with 547,000 deaths, placing cancer second only to cardiovascular disease as the leading cause of death among Americans (Holleb, Fink, & Murphy, 1991; Wingo, Tong, & Bolden, 1995). A total of 677,000 new cases of cancer are expected to occur in men, with the remaining 575,000 occurring in women (Wingo, Tong, & Bolden, 1995). Differences in the incidence of cancer in men compared to women may be attributed to the gender-specific nature of some of the diseases and gender differences in behavior (e.g., increased incidence of tobacco and alcohol consumption in men). While gender discrimination in the treatment of heart disease has been reported (see below) a comparable situation has not been reported with cancer.

Where a gender issue controversy has occurred in the treatment of cancer is in the funding of research on breast cancer and breast cancer treatment. Breast cancer activists have taken this controversy to the popular press (*Women with breast cancer speak out*, 1991; Ames & Buckley, 1990). Comparisons have been made between the breast cancer movement and the political and financial gains made by AIDS activists. In 1991, 160 million dollars were spent on AIDS research compared with only 90.2 million dollars for breast cancer, despite the fact that since 1980 breast cancer had taken four times as many lives (Byman, 1992). This funding debate has taken place in the context of a health care system where there is inequality in the treatment of women simply by virtue of their gender (Byman, 1992; Clark, 1994a, 1994b; Leuning, 1994).

In view of an apparent gender controversy in the delivery of health care, a secondary analysis was performed on data from two studies undertaken by investigators at the University of California, San Francisco, to determine if there was a dif-

ference in the type of treatment setting where women received cancer treatment compared to men. A secondary aim was to determine if there was a difference in the type of treatment setting by diagnosis within each gender group. The first study (hereafter referred to as Study I) was a longitudinal study designed to test a model of self-care to determine predictors of self-care behavior (Dodd *et al.*, c1992), funded by the NIH National Cancer Institute. The second study (hereafter referred to as Study II) was a cross-sectional study that measured the incidence and morbidity of pain in oncology outpatients (Miaskowski & Dibble, c1993) funded by the Oncology Nursing Foundation and University of California Cancer Research Coordinating Committee.

Both studies involved the collection of data from multiple community and teaching hospitals. For both studies, the defining characteristics for a teaching hospital were the presence of a residency training program for physicians encompassing several specialties and affiliation with at least one major medical school. Typically these hospitals were large urban institutions (> 500 beds) offering a full array of services. The defining characteristic for a community hospital was the absence of such a residency training program. Typically, these hospitals were smaller, offered a narrower range of services, and some were suburban or rural.

Review of the Literature

Two literature reviews were undertaken. The first examined differences in the characteristics of large teaching hospitals compared to community hospitals, because these differences might have implications for interpreting the findings from this study. In particular, differences in breast cancer treatment between these two types of institutions were examined. Second, the literature was reviewed with regard to gender discrimination within health care in general and cancer treatment in

particular.

Teaching Hospitals and Community Hospitals

A typical teaching hospital which belongs to the Council of Teaching Hospitals [COTH] is large (often > 500 beds), has many more times the number of out-patient visits and has, on average, 5.6 times the number of employees compared to non-teaching hospitals. To be eligible for COTH membership, a hospital must sponsor, or participate in, four approved residency programs including at least two programs from the following six: family practice, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, or surgery, and have a signed affiliation agreement with a school of medicine accredited by the Liaison Committee on Medical Education. Hospital members of COTH offer a wider range of services than non-member hospitals and care for a disproportionate number of the poor. The average COTH member writes off 9.4% of their revenues for charity and bad debts compared to 5.1% for community hospitals (Association of American Medical Colleges, 1982). The 440 members of the Council of Teaching Hospitals (representing only 5.6% of all hospitals) provide 20% of all inpatient care and 40% of all indigent care. They also maintain most of the highly specialized care units, such as trauma centers, burn units, intensive care units, coronary care units, transplant programs, and cancer treatment centers. (Anlyan & Elchlepp, 1982; Baumgardner & Kabat, 1992; Choi, Allison, & Munson, 1986).

With regard to the treatment of breast cancer at large teaching hospitals compared to smaller, non-teaching hospitals, the literature clearly favors treatment at large teaching hospitals. A particular focus of investigation has been the use of breast conserving surgery compared with radical (or modified radical) mastectomy. Satariano, Swanson, & Moll (1992) found that the larger the hospital the more likely

it was that a woman would receive breast conserving partial mastectomy with radiation. In another study (Hand *et al.*, 1991) women treated in a group of urban hospitals that were generally small and marginally reimbursed did not receive comprehensive diagnosis and treatment of breast cancer. In addition, Howe, Katterhagen, Yates, & Lehnerr (1992) found that, compared with women diagnosed in urban areas, women in rural areas were less likely to have their breast cancer staged, and were less likely to have access to state-of-the-art treatment for breast cancer.

Recent data (Lee-Feldstein, Anton-Culver, & Feldstein, 1994) suggest that the use of recommended breast conserving surgery was greatest in teaching hospitals (i.e., over 50%) compared to nonteaching hospitals (30% or less). The authors noted that teaching hospitals are usually affiliated with medical schools, and therefore their physicians are presumably better informed about current treatment trends and are more likely to participate in clinical trials. Several additional studies that have compared the size of the hospital and teaching versus nonteaching hospitals have noted that breast cancer patients: receive poorer quality care in smaller hospitals (Hand *et al.*, 1991), have a higher quality of care in teaching and larger hospitals than in nonteaching and smaller hospitals (Keeler *et al.*, 1992), and have lower mortality rates in teaching hospitals (Hartz *et al.*, 1989).

There is also the issue of the public *perception* of large urban hospitals. Bronstein and Morrisey (1990) concluded that women in rural areas in need of obstetrical care viewed their local rural hospitals as "inferior". As incomes rose, more rural women "migrated" to urban hospitals for care.

Gender Discrimination in Health Care

Differences in the medical treatment of women compared to men have been documented, especially in the field of heart disease. Kennedy *et al.* (1982) found a

rate of coronary arteriography 3.4 times greater in men than in women. Gillum (1987) found an age-adjusted sex ratio (male/female) of 2.5:1 for the rate of cardiac arteriography, and 4.1:1 for coronary artery bypass surgery. Tobin *et al.* (1987) found that only 4% of women with abnormal cardiac nuclear scans were subsequently referred for cardiac catheterization, compared to 40% of men. A detailed examination of the exact abnormalities identified in the nuclear studies could not justify these differing rates of referral. Heston & Lewis (1992) found that in patients with acute, nonpleuritic, nontraumatic chest pain, women were evaluated later and managed less aggressively than men. In spite of evidence to the contrary, heart attacks may still be considered a disease of men, or more serious in men than in women (Genest, McNamara, Salem, & Schaefer, 1991; Heston & Lewis, 1992; Manson *et al.*, 1991; Steingart *et al.*, 1991).

Bernard, Hayward, Rosevear, & McMahon (1993), in a study at a large teaching hospital, found that men were 1.13 times more likely than women to be placed in the intensive care unit. It has been claimed that women with end-stage renal disease are less likely to receive dialysis and a kidney transplant than men (Byman, 1992; Council on Ethical and Judicial Affairs, 1991).

Health care issues that are specific to women are consistently underfunded. The Government Accounting Office disclosed in 1990 that only \$778 million (or 13.5%) of the National Institutes of Health (NIH) budget was spent on women's health issues, compared to 80% on issues that affect women and men equally (Culliton, 1993; Woods, 1994). Criticism of NIH budgeting priorities led to the development in 1991 of the Women's Health Initiative (WHI), a 14-year study of women's health. Among the aspects of women's health that the WHI is investigating are dietary links with cancer, hormone replacement therapy, heart disease, and

osteoporosis. Recently the WHI has become an object of criticism as being a poorly designed response to political pressure rather than a scientifically sound investigation (Culliton, 1993; Cummings, 1994).

Women have been historically underrepresented in research trials. Researchers often exclude women from study protocols because of concern over medical and legal risks about pregnancy and fears that hormonal factors may confound results. Such thinking has even influenced experimental trials involving animals, where, for decades, researchers have preferred to use castrated males in place of females. The end result of such systematic bias against the feminine within the health care system results in clinical practice which does not take into account women's particular needs (Byman, 1992; Perry, 1994).

Gender discrimination in the treatment of cancer has not been reported. However, Lazovich, White, Thomas, & Moe (1991) noted that after breast surgery, and after adjustment for age, married women were more likely to receive radiation therapy than widows. Satariano, Swanson, & Moll (1992) observed that younger women and women undergoing treatment at large hospitals were more likely to receive the recommended breast conserving surgery than those receiving treatment at smaller hospitals. They speculated that older women might be more sensitive to their physician's opinions and recommendations, and more likely to defer to their doctor. In contrast, younger women might be more likely to read materials presented to them, to question the physician, and to take a more active role in the decision-making process. Further, physicians may be more likely to recommend a breast-sparing technique to a younger woman, bringing in their own attitudes about "femininity" and the age-relatedness of the importance of breast conservation.

To summarize, therefore, while specific gender discrimination in cancer

treatment has not been reported, a number of observations provide cause for concern. These include: 1) the historical bias against women in research funding and research trials; 2) the finding that there is gender discrimination in the treatment of cardiovascular disease; 3) the finding that women with breast cancer receive better treatment at large teaching hospitals compared to smaller, nonteaching hospitals; and 4) the influence of attitudes regarding femininity, age and marital status on treatment plans. The secondary analysis being pursued here directly addresses the third factor, and is the first attempt to discover where women with cancer are most likely to be treated. Such information will help to move forward the debate on the delivery of health care to women and may help to improve the quality of their cancer treatment.

Method

Both studies that provided data for this secondary analysis had comprehensive, specifically designed methodologies. Only those aspects of the methodologies that are pertinent to the present research study are described.

Settings: Sixteen sites that are part of the Oncology Nursing Research Network in California and Montana were used in the two studies. The aim was to provide a cross-section of sites that would provide a typical picture of oncology treatment throughout rural and urban areas. Of these sixteen sites, four were teaching centers and twelve were community centers. The same four teaching hospitals were used for both studies; four of the community hospitals were the same for both studies.

Samples: For Study I, the participants ($n=127$) were a convenience sample of patients referred by physicians and nurses throughout California. All participants were adults with a diagnosis of cancer who were beginning a chemotherapy treat-

ment protocol and all were able to read and write English. The typical patient was female (69%), married (61%), Caucasian (80%) and diagnosed with breast cancer (42.5%). The mean age of the participants was 52.0 years ($SD=13.3$, range 22-82) and their mean educational level was 14.15 years ($SD=2.95$, range 7-20).

Study II participants ($n=435$) were selected in the same manner. All participants were adults attending an ambulatory oncology clinic and all were able to read and write English. The typical patient was female (55%), married/partnered (64%), Caucasian (86%) and diagnosed with breast cancer (22%). The mean age of the participants was 57.3 years ($SD=14.28$, range 19-83) and their mean educational level was 13.96 years ($SD=3.01$, range 3-24).

In both studies, the Karnofsky Performance Scale (KPS) was used to measure functional or performance status. This scale uses a self-report rating of the physical abilities of the participant based on definitions provided in a 30 to 100 scale. For example, a score of 100 indicates that the individual is able to carry on normal activities and that there is no reduction in performance status. In Study I, the mean KPS was 82.36 ($SD=14.10$, range 50-100). In Study II, the mean KPS was 82.35 ($SD=13.88$, range 30-100). A score of 80 indicates that an individual has the ability to conduct normal activity with effort (Karnofsky, 1977).

Measures: Data were collected by self-report questionnaires and from medical records reviewed by trained personnel. These data included patient demographics, type and stage of cancer, place of treatment and KPS score.

Descriptive statistics were generated, using the CRUNCH® statistical software package. To answer the research questions, chi-squared analyses were performed.

Results

Was there a difference in the type of treatment setting where women received cancer treatment compared to men?

In Study I ($n=127$), a significant difference between gender and treatment site (community hospital vs teaching hospital) was found ($\chi^2=30.35$, $p < 0.0001$). Of the 87 women in the study, 56 (64.4%) were treated in community hospitals, while of the 40 men only 4 (10%) were treated in community hospitals. In Study II ($n=433$), there was a significant difference between gender and treatment site ($\chi^2=39.12$, $p < 0.0001$). Of the 237 women in the study, 218 (92%) were treated in community hospitals, while of the 196 men only 133 (67.9%) were treated in community hospitals.

Was there a difference in the type of treatment setting by diagnosis within each gender group?

In Study I, women with breast cancer were more likely than women with other types of cancer to be treated at community hospitals ($\chi^2=18.18$, $p < 0.0001$). Of the 54 women being treated for breast cancer, 44 (81.5%) were treated in community hospitals, while only 12 (36%) of 33 women with other types of cancer were treated at community hospitals. This finding suggests that women with other types of cancers were more likely to be referred to teaching hospitals. This finding was not replicated in Study II. That is to say, there were no significant differences in the treatment setting depending on whether or not the woman had breast cancer or another type of cancer.

In an attempt to discover whether there were any differences in treatment setting for male cancers, the data for patients diagnosed with prostate cancer were analyzed. In Study II, there were no significant differences in treatment site for

patients diagnosed with prostate cancer ($\chi^2=3.66$, $p=0.056$). Because of insufficient numbers of prostate cancer patients in Study I, this statistic could not be generated for that study.

Discussion

The results indicate a significant difference between gender and treatment site. The women in the two studies were more likely to be treated in community hospitals than were the men. These findings may be explained in several ways. First, two of the four teaching hospitals that were used in the studies were military hospitals (i.e., Veterans Administration Hospitals), where one would expect to see a higher proportion of male patients. It seems appropriate, however, to include data from these hospitals in the analysis, since these settings represent legitimate sites of treatment for men, especially those in the late middle age or older age group, a higher proportion of whom are military veterans. Furthermore, the dependents of these veterans are eligible to receive treatment at these institutions and they could be female.

Second, there could have been a bias in terms of the gender of participants recruited. It could have been that the recruiters (themselves female) felt more comfortable inviting other females to participate in the study. Further, gender-stereotypical behavior portrays females as being more helpful and cooperative than men, and it may be that a higher percentage of the females invited agreed to participate than was the case with males. In both studies, however, the number of refusals was less than 5%.

A number of hypotheses can be advanced to explain the findings. First, there may have been something distinctive about the females treated at community hospitals that invited their being treated in that setting. For example, since the

largest single diagnosis for the women in both studies was breast cancer, it may be that there is something about this disease that favors treatment in a community hospital. However, the literature cited previously contradicts this idea and suggests that it is preferable for a woman with breast cancer to receive treatment in a teaching hospital.

Second, it may be that there is some gender-specific behavior which tends to make men with cancer seek treatment at teaching hospitals. Given the greater esteem with which some members of the public hold these institutions (Bronstein and Morrisey, 1990) it may be that a higher percentage of men are in a position to respond to this perception than is the case with women. For example, it may be that men are more likely to have insurance which makes a greater variety of options possible. They may have fewer obligations (including domestic obligations) that may enable them to travel to a teaching institution some distance away. Furthermore, men may be more likely to have a spouse who encourages treatment at the perceived "superior" institution, which may not be the case when the genders are reversed.

Third, there may be financial factors which favor the treatment of some diagnoses and individuals at community hospitals, while encouraging the referral of other diagnoses and individuals to teaching hospitals. In the case of insurance status the literature review suggests that a higher percentage of patients treated at teaching hospitals have no insurance (Association of American Medical Colleges, 1982). With regard to women, given that the largest single diagnosis for women was breast cancer, it may be the case that the financial reimbursement for breast cancer is sufficiently attractive to provide an economic incentive for community hospitals to treat women there. Regrettably, it seems that the information necessary to answer these and related questions is not available in the public domain.

Finally, some other factors may be involved which, alone or in combination with the above factors, result in more women than men with cancer receiving treatment at community hospitals.

In order to address the research findings with greater confidence, further studies are needed. A randomized prospective study could be designed to follow participants with specific genders and diseases along their treatment trajectories. The tumor registry could perhaps be utilized for this purpose. Such a study could be designed to provide information on why participants receive treatment in a particular setting. A retrospective study involving community and teaching hospitals is another possibility. With regard to breast cancer, it would be tempting to compare the treatment setting of women with breast cancer to that of men with breast cancer, but in fact the two groups are not comparable. Among other factors, men typically present at a much later stage of the disease (Ciatto, Iossa, Bonardi & Pacini, 1990).

It seems appropriate to apply a feminist analysis to the research findings. It might be claimed that to do such a thing is to adopt a bias, but it is fundamental to feminist thought that the inherited patriarchal systems of analysis are themselves biased. In a subject so intimately connected to women as women's cancers, it seems appropriate to apply a feminist methodology to the examination of the results - to view women's affairs "through a female prism" (Cook & Fonow, 1986; King, 1994).

Feminists see society as shaped by a male-dominated culture (Sampelle, 1990). Within health care, the traditional doctor/nurse relationship has been presented as a model of a patriarchal society (Roberts, 1983). The health care system therefore, in all its diverse aspects, is an appropriate object of feminist investigation, in an attempt to discover to what extent it still oppresses women. The inherited

status quo is unlikely to be neutral - it was cast in a patriarchal mold. Research findings such as those presented here should, therefore, immediately arouse a healthy suspicion on the part of a scholar applying feminist methodology. If these findings were confirmed by specifically designed studies, the burden of proof would be on those who claim that it is to the advantage of women with cancer to be treated at community hospitals. Until such proof were provided, the finger of suspicion would remain. It could turn out that the treatment setting for women with cancer will join the long list of systemic social biases against women that need to be challenged and changed.

References

- Holleb, A. I., Fink, D. J., & Murphy, G. P. (1991). American Cancer Society Textbook of Clinical Oncology. Atlanta, GSA: American Cancer Society.
- Wingo, P. A., Tong, T., & Bolden, S. (1995). Cancer Statistics, 1995. Ca - A Cancer Journal for Clinicians, 45(1), 8-30.
- Women with breast cancer speak out. (1991, August). Vogue, 181(8), 178.
- Ames, K., & Buckley, L. (1990, December 17). Our bodies, their selves: A bias against women in health research. Newsweek, 116(25), 60.
- Byman, B. (1992). Less than equal treatment. Minnesota Medicine, 75, 16-21.
- Clark, E. M. (1994a). Women in the health care system part I: As patients. Journal of the Medical Association of Georgia, 83, 189-193.
- Clark, E. M. (1994b). Women in the health care system part II: As physicians. Journal of the Medical Association of Georgia, 83, 195-198.
- Leuning, C. (1994). Women and health: Power through perseverance. Holistic Nursing Practice, 8(4), 1-11.
- Dodd, M. J., Lovejoy, N., Larson, P., Stetz, K., Lewis, B., Holzemer, W., Hauck, A. M., Lindsey, E., & Musci, E. (c1992). Self-care interventions to decrease chemotherapy morbidity. San Francisco, CA: School of Nursing.
- Miaskowski, C., & Dibble, S. L. (c1993). Oncology outpatient pain: Incidence and morbidity parameters. San Francisco, CA: School of Nursing.
- Association of American Medical Colleges. (1982). A Description of Teaching Hospital Characteristics. Washington, DC: Association of American Medical Colleges.
- Anlyan, W. G., & Elchlepp, J. C. (1982). The challenge and problems of developing a new tertiary care hospital for the 1980s: Duke University Hospital North.

In E. F. Purcell (Ed.), The Role of the University Teaching Hospital: An International Perspective New York: Macy Foundation.

- Baumgardner, K. P., & Kabat, H. F. (1992). Pharmaceutical service differences between teaching and community hospitals. Hospital Pharmacy, *27*, 1073, 1077-1080, 1085-1088.
- Choi, T., Allison, R. F., & Munson, F. (1986). Governing University Hospitals in a Changing Environment. Ann Arbor, MI: Health Information Press.
- Satariano, E. R., Swanson, G. M., & Moll, P. P. (1992). Nonclinical factors associated with surgery received for treatment of early-stage breast cancer. American Journal of Public Health, *82*(2), 195-198.
- Hand, R., Sener, S., Imperato, J., Chmiel, J. S., Sylvester, J., & Fremgen, A. (1991). Hospital variables associated with quality of care for breast cancer patients. Journal of the American Medical Association, *266*(24), 3429-3432.
- Howe, H. L., Katterhagen, G., Yates, J., & Lehnerr, M. (1992). Urban-rural differences in the management of breast cancer. Cancer Causes and Control, *3*, 533-539.
- Lee-Feldstein, A., Anton-Culver, H., & Feldstein, P. J. (1994). Treatment differences and other prognostic factors related to breast cancer survival. Journal of the American Medical Association, *271*(15), 1163-1168.
- Keeler, E. B., Rubenstein, L. V., Kahn, K. L., Draper, D., Harrison, E. R., McGinty, M. J., Rogers, W. H., & Brook, R. H. (1992). Hospital characteristics and quality of care. Journal of the American Medical Association, *268*, 1709-1714.
- Hartz, A. J., Krakauer, H., Kuhn, E. M., Young, M., Jacobsen, S. J., Gay, G., Muenz, L., Katzoff, M., Bailey, R. C., & Rimm, A. A. (1989). Hospital char-

- acteristics and mortality rates. New England Journal of Medicine, 321, 1720-1725.
- Bronstein, J. M., & Morrisey, M. A. (1990). Determinants of rural travel distance for obstetrics care. Medical Care, 28(8), 853-865.
- Kennedy, R. H., Kennedy, M. A., Frye, R. L., Giuliani, E. R., McGoon, D. C., Pluth, J. R., & Smith, H. C. (1982). Cardiac catheterization and cardiac surgical facilities: Use, trends and future requirements. New England Journal of Medicine, 307, 986-993.
- Gillum, R. F. (1987). Coronary artery bypass surgery and coronary angiography in the United States, 1979-1983. American Heart Journal, 113, 1255-1260.
- Tobin, J. N., Wassertheil-Smoller, S., Wexler, J. P., Steingart, R. M., Budner, N., & Lense, L. (1987). Sex bias in considering coronary bypass surgery. Annals of Internal Medicine, 107, 19-25.
- Heston, T. F., & Lewis, L. M. (1992). Gender bias in the evaluation and management of acute nontraumatic chest pain. Family Practice Research Journal, 12(4), 383-389.
- Genest, J. J., McNamara, J. R., Salem, D. N., & Schaefer, E. J. (1991). Prevalence of risk factors in men with premature coronary artery disease. American Journal of Cardiology, 67, 1185-1189.
- Manson, J. E., Stampfer, M. J., Colditz, G. A., Willett, W. C., Rosner, B., Speizer, F. E., & Hennekens, C. H. (1991). A prospective study of aspirin use and primary prevention of cardiovascular disease in women. Journal of the American Medical Association, 266(4), 521-527.
- Steingart, R. M., Packer, M., Hamm, P., Coglianese, M. E., Gersh, B., Geltman, E. M., Sollano, J., Katz, S., Moye, L., & Basta, L. L. (1991). Sex differences

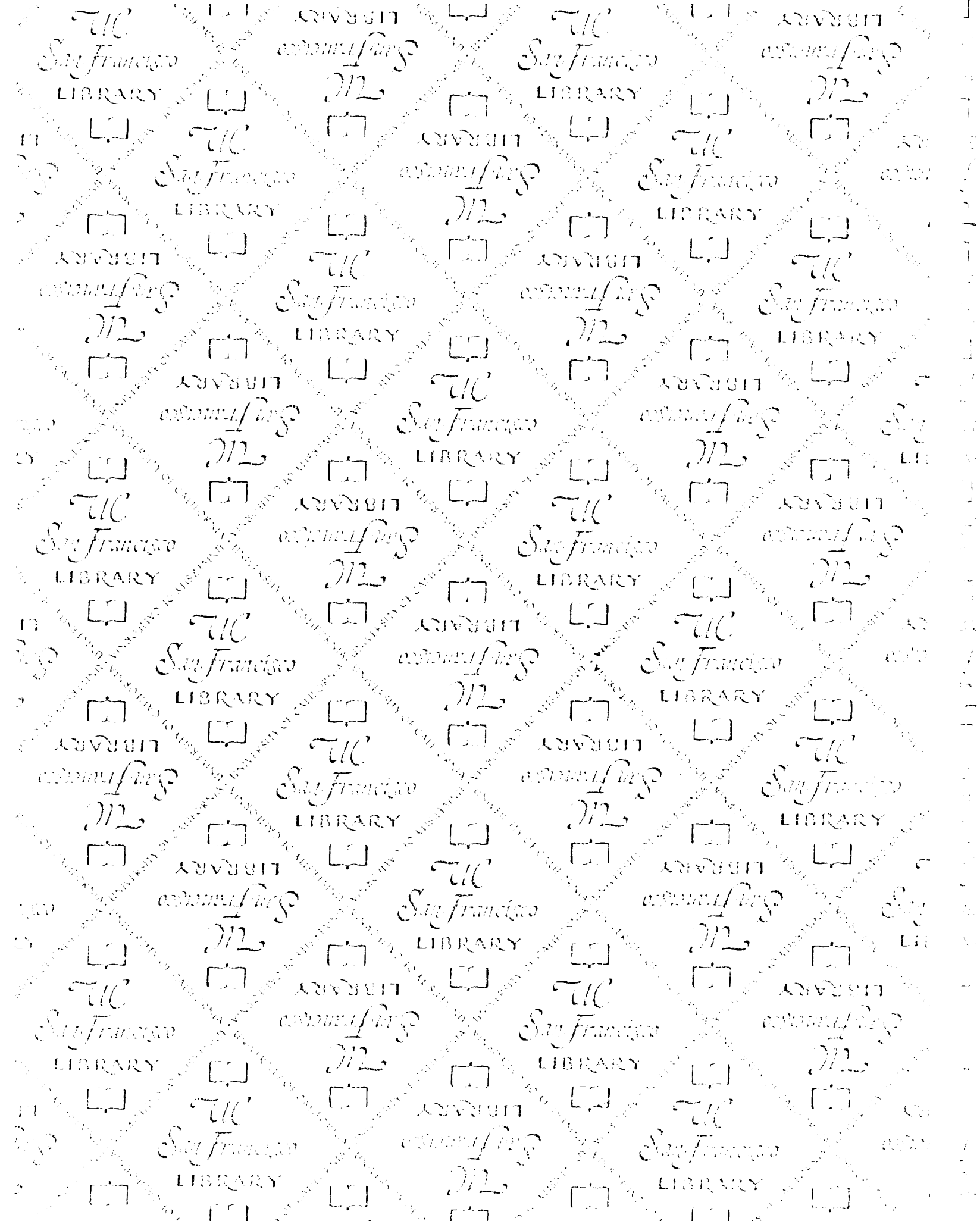
- in the management of coronary artery disease. New England Journal of Medicine, 325, 226-230.
- Bernard, A. M., Hayward, R. A., Rosevear, J. S., & McMahon, L. F., Jr. (1993). Gender and hospital resource use: Unexpected differences. Evaluation and the Health Professions, 16(2), 177-189.
- Council on Ethical and Judicial Affairs. (1991). Gender disparities in clinical decision making. Journal of the American Medical Association, 266(4), 559-563.
- Culliton, B. J. (1993, November 4). Critics condemn NIH women's study. Nature, 366, 11.
- Woods, N. F. (1994). The United States women's health research agenda analysis and critique. Western Journal of Nursing Research, 16(5), 467-479.
- Cummings, N. B. (1994). Ethical issues and the breast cancer patient. Archives of Pathology and Laboratory Medicine, 118(11), 1077-1080.
- Perry, P. A. (1994). Feminist empiricism as a method for inquiry in nursing. Western Journal of Nursing Research, 16(5), 480-494.
- Lazovich, D., White, E., Thomas, D. B., & Moe, R. E. (1991). Underutilization of breast-conserving surgery and radiation therapy among women with stage I or II breast cancer. Journal of the American Medical Association, 266(24), 3433-3438.
- Karnofsky, D. (1977). Performance scale. In G. T. Kennealey & M. S. Mitchell (Eds.) Factors that Influence the Therapeutic Response in Cancer: A Comprehensive Treatise. NY: Plenum Press.
- Ciatto, S., Iossa, A., Bonardi, R., & Pacini, P. (1990). Male breast carcinoma: Review of a multicenter series of 150 cases. Tumori, 76(6), 555-558.
- Cook, J. A., & Fonow, M. M. (1986). Knowledge and women's interests: Issues of

epistemology and methodology in feminist sociological research. Sociological Inquiry, 56(1), 2-19.

King, K. K. (1994). Method and methodology in feminist research: What is the difference? Journal of Advanced Nursing, 20, 19-22.

Sampselle, C. M. (1990). The influence of feminist philosophy on nursing practice. Image: Journal of Nursing Scholarship, 22(4), 243-246.

Roberts, S. J. (1983). Oppressed group behavior: Implications for nursing. Advances in Nursing Science, 5, 21-38.



For reference

Not to be taken
from the room.

6429305



3 1378 00642 9305

