Social Science in Family Medical Care

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THE CHANGES taking place in medical practice all over the world are reflected both in medical knowledge and in the roles of professional workers associated with the techniques of medicine. Efforts to reconstruct a stable system of medical care appear to stem from a number of objectives.

Most people would agree that any system of medical care should first make full use of all the modern knowledge and equipment available to produce the scientifically accurate diagnosis and treatment we call good care. It should offer a worthy and dignified role as well to the professional practitioners who are to provide that care. Also, and by no means to be taken as academic, it should be so constituted that prospective patients will choose to take full advantage of the benefits offered by such care.

There is general agreement on these objectives. But a controversy hinges on the form of organization by which they may be achieved.

This report describes an experiment in medical care that sought to fulfill these objectives, some of the findings of the study of that experiment by a social scientist, and the way in which these findings may aid in reformulating the organization necessary to achieve full use of such medical care by the public.

Family Health Maintenance Demonstration

At the Montefiore Hospital in New York City, there has been in operation since 1950 a program of comprehensive medical care on a prepayment basis for 150 families. Services are given not by individual practitioners of the various specialties, but instead by a functioning health team composed of an internist, a pediatrician for children under 13 years of age, a public health nurse, and a social worker. This is the Family Health Maintenance Demonstration (*1,2*). The families were selected at random from a large group of those insured under the Health Insurance Plan of Greater New York (*3*). The health team gave the family a baseline examination, conferred with the family on the findings, and supplied comprehensive medical care over a 4-year period. At the end of the 4-year period, the team made a second evaluation of the family's health.

Comparable data were also obtained for a matched control group, substituting the services of individual practitioners from the Montefiore Hospital medical group for the demonstration health team. The demonstration originated within this medical setting. In essence this was a controlled experiment on the effect of an organized medical care program on health. The study families were given team-organized services while the control families continued to use the individual services of the medical staff of the Montefiore Hospital medical group, and the health of both groups was assessed in the same way at the end of the program.

Part of this experiment was designed origi-

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nally to determine what health education and promotion techniques would influence the health of families favorably if added to health programs (*1*). Of course, arbitrary criteria were used to define "health education," "health," "favorable," and the like. Health, for example, was defined as capacity to function successfully in four major areas—work, sex, play, and family life. By these criteria, it was found that the program was not successful in improving the health of families. At the same time, however, team organization of medical care was successfully demonstrated and seemed highly satisfactory to the patients.

The Role of Social Science

The social scientist could take no active or manipulative role in the demonstration. By its controlled nature, changes could not be introduced. Instead, the social scientist sought to study, in a broad, exploratory way, the relation of the organization of medical practice to the behavior of patients. Attention was concentrated on the patients' conceptions of professional practitioners and the processes by which the patients use the services. Through this study, hypotheses were developed about the conditions under which professional services could be used, based on a theoretical framework which stems from communications research and anthropological conceptions of the community.

Analysis of the findings seemed most appropriate within the context of an organized process of interpersonal influence similar to that described by Katz and Lazarsfeld (*4*). The process seems of particular significance when the patient is uncertain, as on occasions when he must select a new doctor, or when he uses a doctor for the first time, or when he is undergoing mild suffering from ambiguous symptoms and cannot decide how his illness should be treated or whether he should consult a professional practitioner about it. Whether or not this uncertainty occurs is, of course, largely the result of the culture or knowledge of the patient. But when it does occur, the course taken seems to be determined by the lay culture in which he lives and the network of lay and professional consultants to whom he turns for help. We have chosen to label this the "lay referral system." The lay referral system is paralleled by the professional referral system, with its own culture and network of consultants and colleagues.

Use of Services

The primary objective of the Family Health Maintenance Demonstration was to experiment with team organization of health services (*5*). It became clear rather early that one member of the professional team, the social worker, was not being consulted to the degree considered appropriate by professional standards. This was not due to a lack of personal problems in which a social worker could assist, since members of about one-third of the families were recognized as having such problems. Neither was it due to the patients' failure to recognize that they had such problems, for they did seek help from other team members.

Research by intensive interview and questionnaire suggested that the role of the social worker in the team was both culturally and structurally isolated from the lay referral system (*6*). The patients seemed to avoid using the social worker because her professional role was segregated not only from medical problems but also from such everyday affairs as nutrition, housing, and the children's schooling. In consequence, the social worker came to be defined by the patients as a specialist rather than an everyday consultant. Functionally, a specialist is consulted only after exhausting more commonplace resources. In avoiding the social worker and seeking the aid of the public health nurse and the physician for their personal problems, the patients were in essence seeking less specialized aid.

Thus it was hypothesized that because of the cultural background of these patients, early use of the social worker as a preventive measure could be expected only if her role were changed to more closely resemble, for example, that of the public health nurse, which was more informal and more concerned, on the surface at least, with the manifest medical, economic, and interpersonal affairs of everyday life. This role was subordinate to and chronologically was used prior to that of the physician in the process of defining illness and seeking

aid, standing as it did between that of the physician and that of some such lay consultant as a relative or friend. However, if the social worker's role was not changed and if the patients' culture remained unchanged by an educational campaign, it was concluded that the social worker would be used primarily by those few who believed themselves to have exhausted "ordinary" sources of help, and thus conceded the "special" nature of their problem.

Use of the social worker reflected the organized process of seeking help stemming from the concept of the lay referral system. This was also seen to be the case in the use of medical services.

Eleven percent of the families (13 of the 117 responding) reported that some member of the family at his own expense had a surgical operation performed or a child delivered by an independently practicing physician while the family was enrolled in the demonstration and was entitled to this medical care under the terms of its subscription. For more everyday, nonsurgical services, 6 percent of 119 families indicated that some member had used the services of an independent practitioner "quite a bit," and an additional 31 percent reported that an independent practitioner was used "occasionally" at out-of-pocket expense.

But an overwhelming proportion of patients were far more satisfied with the health team organization of care than with care received from individual practitioners, either in group or independent practice. Ninety-two percent of the families responding believed that the health team demonstration was more beneficial to them than care received from the Montefiore Hospital medical group, and 85 percent concurred in approving the health team when comparing its care with that received from their prior "private doctor." Also 94 percent stated that it was more pleasant to be a Family Health Maintenance Demonstration patient than to be a Montefiore Hospital medical group patient, and 74 percent stated that it was more pleasant to be a demonstration patient than to be the patient of a "private" doctor outside either scheme.

There seems to be a contradiction in these data. If so many patients believe that the demonstration is beneficial to their health and pleasant to use, why did one-third of them use outside services? On the whole, and we must compress a good deal of data here, two things seemed to be involved in the use of outside services—the patient's assessment of the quality of medical care available to him and his assessment of the importance of his medical complaints. In what seems to be the bulk of the instances of use of outside services, the patients assessed their complaints as minor, and assumed that for minor complaints any physician is competent. Under such circumstances, simple convenience seemed to dictate the occasional use of a neighborhood, independent physician rather than the demonstration physician at the centralized medical group. This was particularly the case for home calls at night when the demonstration physician was unavailable, and other physicians of the medical group were on call in rotation. In this situation, of course, the ability to pay the fee of the independent practitioner is an important element. It was found, in fact, that the use of outside services increases in general as social class, and its contingent ability to pay, rises.

Where just convenience is involved and the illness does not seem to be critical, typically the patient acts as an individual, without interaction with lay consultants. This is not the case in more analytically interesting instances when the patient feels some anxiety about the illness and becomes uncertain about the qualifications of the physicians involved. On these occasions, the relationship of the lay referral system to the professional referral system becomes quite important.

Analysis of instances of the use of outside service, probed during intensive interviewing, has not been completed. But at present it seems that the necessity to use a specialist rather than the everyday family health maintenance physician, whether for surgery, child delivery, or special therapy, seems to be common to all instances that do not rest on sheer convenience. These were cases where referral from the demonstration to a Montefiore medical group specialist was not sustained. And, by definition, these were cases where referral implied the illness was serious. In these cases,

the diagnosis or the referral or both were questioned by the patients, and, in the course of seeking alternative diagnoses or of validating the competence of the specialist to whom they were referred, they were led outside the medical group.

This difficulty in professional referral seemed to stem in part from the very mode in which medical care was organized. The patients rightly viewed the Montefiore Hospital medical group in which the demonstration operates as a cooperative organization. In this sense, when their demonstration physician referred them to a medical group specialist, they believed that the referral was necessarily to the man who happened to be working in the medical group, and not necessarily (but of course possibly) to the so-called best man in the field. The patients who went outside wanted what they believed to be more disinterested validation of the quality of the physician to whom they were r e f e r r e d. Disinterested sources of validation, however, are also outside the professional organization of the group—"private" physicians and the lay community. In those few cases recorded where temptation to use outside services existed but was resisted, the patients happened to obtain recommendations of the group specialist to whom they had been referred from lay consultants who knew the work of the specialist or, in one case, from an independent "private" physician. The major source of such validation of professional quality appears, in fact, to lie in the lay referral system, so that we may expect those patients whose lay consultants do not know the reputation of the medical group physicians to be subjected to interpersonal forces that encourage the use of outside physicians. Some statistical evidence to support this conclusion has been gathered.

On the basis of these exploratory findings, it was hypothesized that a medical care organization has a better chance of holding its patients through all contingencies if the patients interact with each other in inclusive natural networks of interpersonal influence. Where patients are unknown to each other and yet they participate in a number of lay referral systems the bulk of whose members have no experience with the medical organization in question, it is to be expected that use of the service will be diminished to some extent.

Application of the Findings

As Katz and Lazarsfeld have shown (*4*), the concept of personal influence has relevance to sociometric and small group studies. We may add that it also underscores the relevance of comparing anthropological studies of "little communities" (*7,8*) with studies of urban aggregates (*9*). The concept of the lay referral system allows us to consider simultaneously the culture, or "health education," of the patient, his participation in a highly influential network of lay consultants, and, finally, the structured relations which exist between the lay and professional worlds. This relevance is most extensive in instances where patients have a considerable latitude of choice between practitioners, a situation characteristic of some parts of the United States but not of some other countries (*10,11*). It is also relevant to any medical system where the patient may at least choose not to use available medical services at all (*12*).

In the program described here, however, and in future plans for similar programs of research in modes of family health care, a number of implications have emerged. First of all, it may be observed that the picture of society that it gives us is one obviously incompatible with viewing the patient as an isolated individual or even as a member of an isolated nuclear family. In future experiments with the organization of medical care, it seems that we must deal with the patient as a member of a network of interpersonal influences. This means that a fruitful source of study populations may lie more in such networks than in individuals selected at random. A selection of such networks should also include the members of the network to whom others would naturally turn for medical and personal advice and guidance. After influencing these "influentials," health education may not continue to be unsuccessful in modifying behavior, and, as hypothesized, patients might be more thoroughly "held."

In a future program, it seems also that the social worker need not be used as a primary teamworker. The public health nurse's role could be exploited to greater effect and her ef-

fectiveness increased by adding the benefits accruing from more extensive training in casework and psychiatry. The day-to-day team would thus be smaller, composed of two physicians (one for adults and the other for children) and the public health nurse. The social worker, however, might continue in close liaison with the team, but not on a full-time basis: she could represent the first echelon of referral for emotional difficulties in those families which recognize and accept the fact that psychiatric care is required.

Finally, it might be said that both the demonstration and the findings of the social scientist in his study of it have had important and encouraging implications for social policy. The popular fear of governmental or private large-scale medical service in the United States seems to be based on the fear of loss of personal attention in a bureaucratic setting. Team practice, as it was observed in the Family Health Maintenance Demonstration, seems to provide the attention desired, even though the setting is bureaucratic, since the patients expressed a high degree of personal satisfaction with the care they received.

A notable aspect of this satisfying team action was the family conference, an annual, hour-long discussion between parents and professional team members which seemed to allay suspicion, deflect hostility, and offer a unique opportunity for the exchange of information. If such team practice could be integrated into the informal conferences that take place between patients and their lay advisers, it might be possible to allay even those instances of suspicion occurring when patients are referred to specialists in a bureaucratic setting.

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Research in Health Departments

A regional conference on the opportunities for research in local and State health departments, sponsored by the Public Health Service, drew representatives from six States to Atlanta, March 14–16, 1960.

The conference included a demonstration of the operation of a study section, reviewing grants applications, with reference to specific projects or research proposals. The study section members benefited no less than the audience from the discussion. The need for communication guiding information from the National Institutes of Health to the principal investigators and applicants was emphasized repeatedly.

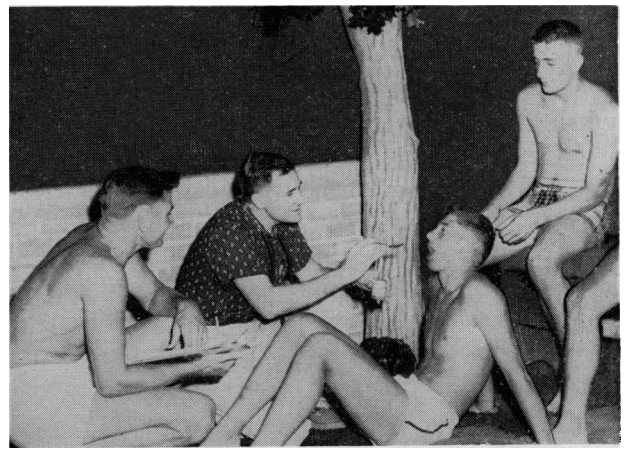
It was the consensus that such conferences in other regions would be helpful to health officials.

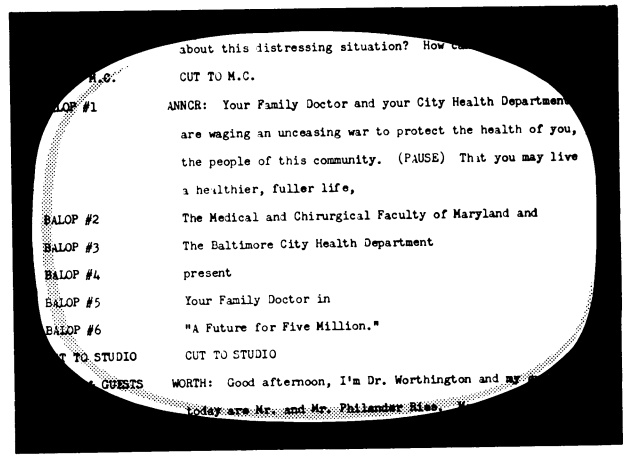
Health Television Series in Twelfth Year

IN DECEMBER 1959, Baltimore's health information television series, "Your Family Doctor," began its 12th consecutive year. The series, commencing December 15, 1948, is not only the oldest continuously produced medical television series, but now has one of the longest consecutive runs for a television series of any type. From this, one may infer a sustained viewer interest and demand for health information through television.

On a surprisingly small budget, the Medical and Chirurgical Faculty of Maryland and the Baltimore City Health Department have presented more than 550 programs in this series. Cooperation by many interested groups has kept production costs low. Broadcast time and facilities are contributed by station WMAR–TV. Civic organizations regularly provide speakers, panel members, and actors. A Boy Scout group, *upper right*, participated in a pre-Christmas "Home Safety" show, and an American Red Cross swimming class, *center*, in an early summer "Swim Safely" program.

Health directors who contemplate producing a television series or a single program may obtain information regarding the availability of source materials from the World Health Organization, Division of Public Information, Palais des Nations, Geneva, Switzerland; from the Pan American Sanitary Bureau, 1501 New Hampshire Avenue NW., Washington 6, D.C.; from the Public Inquiries Branch, Public Health Service, Washington 25, D.C.; or from the Bureau of Health Education, American Medical Association, 535 North Dearborn Street, Chicago, Ill. Sample scripts used in the Baltimore series may be obtained by writing to Dr. Huntington Williams, Commissioner of Health, Baltimore City Health Department, Baltimore 3, Md.





Portion of a script used in Baltimore series.