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A Sociological Study of the High Use of Primary Care

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DEPENDENT PATIENTS AND THEIR PHYSICIANS: A SOCIOLOGICAL STUDY OF THE HIGH USE OF PRIMARY CARE SERVICES

By

Rita Schlesinger Gallin

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ABSTRACT

DEPENDENT PATIENTS AND THEIR PHYSICIANS: A SOCIOLOGICAL STUDY OF THE HIGH USE OF PRIMARY CARE SERVICES

By

Rita Schlesinger Gallin

This study is about female patients who use high levels of primary care services and their physicians' response to them. The purpose of the study was to explore the way in which (1) variations in the background factors of patients and the context of the medical profession influence the nature of the interaction between physician and patient; and (2) variations in the use of primary care services are generated by the dynamics of their interaction in a medical situation.

To explore these variations, a retrospective research plan was developed. A sample of young "healthy" females, stratified according to patterns of use during a six-month period, was selected and the data contained in their medical records for that period abstracted. These patients were interviewed in their homes using a structured survey instrument. In addition, a sub-set of these patients was interviewed in-depth. Finally, the physicians who cared for these patients completed a self-administered questionnaire. Pearson product-moment correlations and multiple regression analyses were used to analyze the data collected from the samples.

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The data showed that the poor, less educated, separated or divorced were likely to consider themselves financially and socially deprived and to have experienced a series of stressful events that challenged their resources and skills. Furthermore, the data showed that such women were likely to feel that their psychological assets were limited and their social assets only nominally effective in mediating between them and the consequences of life difficulties.

It was found that differences in women's life situations were predictive of variations in their medical and non-medical needs as patients. Women who considered the quality of their life poor tended to express a need to cope with failure and a need for catharsis, as well as to present many "symptoms of dependency." Perceived financial and social deprivation exerted the most consistent influence on these patient needs. Psychological and social assets available, however, also exerted an effect on the women's needs as patients.

The data also showed that physicians' decisions influenced patterns of utilization and the total volume of use of medical services. Patients who were assigned a low proportion of supported diagnoses and received a high proportion of psychotropic and symptomatic therapies had a high volume of self-initiated use. Patients who received many requests for follow-up visits and a high proportion of prescriptions for curative and symptomatic therapies had a high volume of physician-initiated use. The total volume of use was highest, however, among patients who (1) expressed a need to cope

with failure and/or a need for catharsis; (2) presented many "symptoms of dependency;" and (3) received a high proportion of psychotropic and symptomatic therapies.

It was concluded that the high use of primary care services was a consequence of the conjunction of the needs of the patients and physicians' responses to these needs. Some patients frequently sought care in the hope that the physician would legitimate their feelings of failure and provide the support that was lacking in their personal environment. When the physician responded sympathetically to these needs, the patient was encouraged to return for the purpose of additional reassurance and support. When the physician responded unsympathetically to these needs, the patient was moved to return in a continuing attempt to satisfy her frustrated needs.

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which I hope one day to emulate. Bo Anderson, Ph.D., my major professor throughout most of my graduate training, and my teachers, Harry Schwarzweller, Ph.D., and Joseph Spielberg, Ph.D., provided me with supurb training and served as whetstones on which I have tried to sharpen my thinking. Peter Manning, Ph.D. was a reader of the thesis. I am grateful to him for taking time from a very busy schedule to offer assistance.

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of this report possible. Marcia Kettler, Karolyn Lee and Jane Wisner performed the difficult task of "deciphering" physicians' handwriting and abstracting data from medical records. Richard E. Sturm, M.D., coded the data and provided me with valuable insights. William Crano, Ph.D., gave me invaluable help with the analysis of the data. I am grateful to these people for their efforts on my behalf.

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CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

Introduction

A growing concern for the inequitable distribution and rising costs of health services in the United States has led to considerable research over the last decades on the utilization of medical care. Much research has been conducted on the influence of patient social, economic and attitudinal characteristics on the utilization and underutilization of medical care services. Little research, however, has been carried out on identifying the components of high utilization of health services or on the way in which the behavior of health care providers affects patterns of use. Furthermore, the notion that utilization behavior may be consistent with and an adjustment to a general life situation virtually has been ignored in past research.

Most researchers have accepted the values, questions and problems defined by health planners and providers as the reference point of their work (Gold, 1977; Roth, 1962). They have focused on the individual and explained utilization behavior on the basis of sociocultural or psychological attributes which predispose people to behave in certain ways. For example, underutilization of services is suggested to be due to lack of knowledge, trust or responsibility by the individual and an impediment to the efficient functioning of the medical system.

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This focus on the individual patient or potential patient is but one example of the social scientists' acceptance of the viewpoint of medical personnel as the norm for research. Since physicians usually prefer to accept their own actions as a given (Roth, 1962:47), researchers rarely have considered the behavior of the practitioner and the way in which it affects patterns of utilization. This omission leaves untouched important issues that need to be considered: for example, the expectations practitioners bring to the medical encounter; the definitions they apply to patients and their conditions; and the effect these expectations and definitions have on the management process and patterns of utilization. The exclusion of the provider of care as a variable in research has led to incomplete analyses of interaction within the health care delivery setting, a setting that includes the provider as well as the patient.

Most researchers also have tended to focus on a few specific characteristics of the individual and have examined their relationship to the use of medical services. For example, variations in patterns of utilization have been explained in terms of social class. However, the particular elements of class (e.g., income, life style, values or beliefs) that relate to utilization behavior have not been isolated. Furthermore, the contribution that the life situation associated with a social position makes to the utilization of medical services rarely has been explored systematically in past research.

This study attempts to examine these neglected issues in research on utilization behavior. It takes into account both the patient and the physician and their contribution to the volume of use of medical services. Furthermore, it places these individuals within the different contexts that condition their orientations and behavior. The study is about female patients who use high levels of medical services for multiple, diffuse symptoms and their physicians' response to them. It is an exploration of the interaction between physicians and patients and the way in which the nature of this interaction influences utilization behavior. It is argued that the doctor-patient relationship cannot be examined as an isolated dyad, but that background factors of the patient and the context of the medical profession influence this relationship. Thus, variability in the life situations of individuals and in the orientations of physicians generate important variations in utilization behavior.

Literature Review

The following review is not a compendium of the available literature on utilization. Several such summaries already are available (Aday and Eichhorn, 1972; Anderson, 1963; Graham, 1957; Kasl and Cobb, 1966; McKinlay, 1972; Stoeckle, et al., 1963). Instead, it is a discussion of selected works and it is divided into two sections. The first section reviews works that focus on utilization as a dependent variable and that identify specific factors associated with the use of medical services. This section is organized within a framework of five different models that have been employed in the study of utilization behavior: (1) the sociodemographic model; (2) the social-psychological model; (3) the social structural model; (4) the delivery system model; and (5) the social system model.[1] The second section reviews works that focus on utilization as an independent variable and that discuss the outcomes of physician encounters with patients who frequently seek care for multiple, vague and diffuse symptoms. This section is organized within a framework of the two most frequent results of such physician-patient interaction: (1) a psychiatric diagnosis; and/or (2) a stigmatizing label.

Utilization: A Dependent Variable

The Sociodemographic Model

Utilization of medical services is related to a variety of sociodemographic variables. Age, for example, is an important determinant of utilization, primarily because of its association with patterns of morbidity (Aday and Eichhorn, 1972; Anderson, 1963; Sussar and Watson, 1962). The old tend to use more services because of a higher prevalence of chronic disease and the very young more services because of a higher prevalence of acute conditions (Anderson, 1968; Bice and White, 1969; White, 1968). Similarly, data indicate that sex influences the differential use of services. Women tend to use more services than men, primarily because of their need for obstetrical care (Anderson and Anderson, 1967; Feldstein, 1966). However, even when utilization of services associated with pregnancy and childbirth is excluded, the volume of use for women is greater than it is for men (Nathanson, 1975).

Marital status also is related to the use of physicians' services since (1) married and widowed persons tend to be older; and

(2) married women use more obstetrical services (Anderson and Benham, 1970; Avnet, 1967). The separated and divorced, particularly those raising children, however, show more physical morbidity and use more medical services than married women living with spouses (Abel-Smith and Titmuss, 1965; Berkman, 1969).

Available data furthermore suggest that socioeconomic status is associated with the use of physicians' services (Antonovsky, 1967; Cartwright, 1967; Koos, 1954; National Center for Health Statistics, 1975a). The poor are sicker than other segments of the population but make less use of health services than do the non-poor (Richardson, 1969; Ross, 1962). Kadushin (1964, 1967), however, argues that the inverse relationship between socioeconomic status and illness (and, by extension, use of medical services) is spurious. He suggests that lower class people tend to express anxiety in physical terms and, therefore, over-report morbidity in health surveys. Antonovsky (1967) and McBroom (1970), in critical assessments of Kadushin, find no evidence to support this position.

Several researchers have shown, nevertheless, that both the lower and higher social classes tend to see physicians at the same rate when illness occurs (Anderson, 1968; Graham, 1957; Richardson, 1970). Moreover, new methods of financing medical care for the poor are believed to have caused the gap in use between classes to narrow (Bice and Eichhorn, 1972; Kriesberg, 1963; Muller, 1965; National Center for Health Statistics, 1975a).

Finally, race and education have been shown to be related to the use of health services. Whites and the better-educated utilize

more physician services than non-whites and the less-educated, primarily because of the former's preventive care-seeking behavior (Anderson, 1968; Anderson and Anderson, 1967; Feldstein, 1966; Richardson, 1970; Ross, 1972).

All of these findings appear to account for differences in utilization behavior of some groups vis-a-vis others. The sociodemographic model, however, has a major shortcoming; sociodemographic findings do not explain why differences in use occur _among_ individuals within a categorical group. For example, Berkman (1969) has suggested that spouseless mothers frequently use physician services because of the stresses involved in performing dual roles. This explanation, however, fails to take into account the large number of spouseless mothers who do not exhibit such behavior. Sociodemographic findings, then, do not tell us about the human situations that contribute to the individual's decision to visit the doctor. Thus, other models must be employed to explain _why_ variations within groups occur.

The Social-Psychological Model

Two psychological concepts seem to provide promising approaches to the study of high utilization: perception and motivation. Researchers who adopt a perception approach focus on the individual's view of specified phenomena as a basis for understanding behavior. Those who adopt a motivation approach focus on the individual's needs, assuming that people behave in such a way as to satisfy their needs.

The Perception Approach. Twaddle (1969:106) has stated that illness is in large part "a matter of social definition which varyingly reflects cultural and individual differences in orientation toward the biological organism." Put simply, illness is a subjective reaction to a physical state (Kirscht, 1971); individuals exhibit a "selective attention" to symptoms and, accordingly, behave differently. One person may be extremely concerned about a set of symptoms and seek professional help for them. Another may completely disregard the same symptoms and fail to do anything at all about them.

Mechanic (1972a) has suggested that such differences in perception and behavior are a function of culturally and socially learned responses. Several researchers have examined the health and medical beliefs of Mexican and Spanish Americans and found them different from the Anglo-Saxon model (Clark, 1959; Saunders, 1954). Similarly, Zborowski (1958) in a study of hospitalized Jewish, Italian, and Anglo-Saxon patients, and Zola (1966) in a study of Italian, Irish, and Anglo-Saxon ambulatory care patients, demonstrated the differential reaction to and concern with similar symptoms by different groups. In addition, Koos (1954) found significant differences in the way in which the lower and upper classes perceived physical symptoms. All of these findings lead to the inference that the presence of the same symptoms in these populations would result in vastly different rates of use of physician services: for example, immediate concern and consultation versus dismissal and abstention from seeing a doctor.

Social scientists also have long recognized that the ascription of sex status provides a complex of culturally defined behaviors that are relevant to action (Bierstedt, 1963; Davis, 1962). Phillips and Segal (1969:58), for example, argue that "the ethic of health is masculine" and that women report more illness than men because it is more culturally acceptable for them to be expressive about their difficulties. Men are socialized to ignore symptoms and are expected to exert more self-control, to be more stoical (Zelditch, 1960). Illness is considered a feminine characteristic to be shunned by men (Barker, 1953; Chesler, 1972; Mechanic, 1965).

Gurin, et al. (1960:209) also maintain that the male role is an active one and that "a man's masculine identity is closely linked to his success in coping with his environment." As a result, they posit that men will resist giving in to symptoms and, even if they perceive symptoms, will be less likely than women to report them. Sex differences in perception of symptoms, then, may strongly influence an individual's readiness to seek medical care.

Another factor that has been studied as a determinant of responses to symptoms is stress, that is, interpersonal crises that signify or require change in an individual's ongoing life pattern (Rabkin, et al., 1976). McKinlay and Dutton (1974:255) argue that "stress heightens symptom sensitivity, producing an increased awareness of illness symptoms that might otherwise have been ignored." Mechanic (1964) found that mothers under temporary psychological stress tended to report more symptoms for both

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themselves and their children. Similarly, Berkman (1969) found that the stresses of spouseless motherhood--i.e., inadequate income, unfulfilled financial expectations, and poverty-area residence--were significantly related to reports of physical illness. In addition, Coe, et al. (1969) and Hochstim (1968), in studies contrasting the stress experienced by those living in poverty areas to that experienced by their counterparts living in better neighborhoods, concluded that the conditions of the poverty neighborhood were a source of stress and related to perceptions of poor health.

Since it has been shown that defining oneself as "ill" usually preceeds seeking care (Antonovsky, 1972; Suchman, 1965), all of the factors discussed above have a relationship to the decision to seek medical care. Stress not only plays a role in increasing symptom sensitivity, it also increases the likelihood that an individual will seek professional medical care (McKinlay and Dutton, 1974; Mechanic, 1963; Stoeckle, et al., 1963). Indeed, a number of studies have demonstrated that psychological distress is associated with higher levels of utilization of medical services (Cooper, 1964; Cummings and Follette, 1968; Shepherd, et al., 1966; Tessler, et al., 1976).

Mechanic (1974), for example, reporting on a study of 151 women living in London, indicated that those who defined their health as fair or poor, reported more stress and used more medical services than those not experiencing stress. In addition, Mechanic and Volkart (1961) found that psychological distress played a significant role in the decision to seek medical care and was

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associated with higher levels of utilization of medical services. They suggest that persons who are distressed or who otherwise face life problems with which they have difficulty in coping, deal with such situations in part by seeking medical care. Perception, then, is interdependent with motivation. A person perceives selectively in accordance with his motives (Secord and Backman, 1964).

The Motivation Approach. Researchers who employ the motivation approach emphasize social-psychological needs as triggers for physician utilization. Roghmann and Haggerty (1975) suggest that the use of services is a coping device by persons who have a need to come to terms with the stress of their situation or the discomfort they are feeling. Similarly, Mechanic (1972a:119) has argued that utilization may be seen as "an attempt to make an unstable, challenging situation more manageable for the person who is encountering difficulty." The presentation of a complaint may be "one way of seeking assurance and support through a recognized and socially acceptable relationship when it is difficult for the patient to present the underlying problem in an undisguised form" (1972a:124).

Stoeckle, et al. (1964) report such a situation among patients seeking care at a medical center. In a study in which they assessed psychological distress in medical patients via sociological and clinical judgments they found that (1) distress seemed to influence the decision to see a doctor because the individual's usual capacity to cope with changing environmental stress was temporarily impaired; and (2) patients under stress seemed to have expectations of how the doctor could help them during this period, that is, how he could satisfy their needs. One such need they describe is the need to communicate aggrieved feelings to a sympathetic, understanding, and supportive listener.

The need for social contact that permits or encourages such free communication has been labeled "the need for catharsis" by Shuval, et al. (1970). In a study exploring utilization behavior among immigrants in a prepayment medical insurance system that serves the majority of the population of Israel, Shuval and her colleagues found that the need for a person with whom to communicate correlated positively with high utilization rates, regardless of whether the physician satisfied this need or not. Furthermore, they found that "the need to cope with failure," which they defined as the utilization of illness as a legitimizing mechanism, also correlated positively with high frequency of use of medical services. Individuals faced with increasing helplessness in coping with personal problems were more likely than others to seek solutions within the framework of the medical institution (also Stoeckle, et al., 1964).

These findings support Parsons' formulation (1951) that illness represents one way of coping with failure in Western society. Once a person's illness is legitimized by medical sanction (or significant others), the individual occupies a special role in society, i.e., the sick role. During that time he or she is relieved of the usual demands and obligations that accompany his or her occupational and/or familial roles and the sick role takes priority. Such a favored role, then, introduces important variations into the realm of utilization behavior since it may motivate the individual, consciously or unconsciously, to seek and adopt the sick role as an escape mechanism.

Behavior, then, emerges out of motivation and, by implication, is influenced by the course of action available to the individual. Health-related behavior may be determined by motives that are not health related (Rosenstock, 1960). Minor complaints may be used as an excuse for seeking medical care, when in fact the reasons for seeking care are (1) a need to air personal problems; and/or (2) a need to cope with the stress of an untenable situation. Important as these findings are, few researchers employing the social-psychological model have comprehensively examined the bases of these non-medical needs. A promising start has been made, however, by those using the social structural model.

The Social Structural Model

Two concepts frequently considered within the context of the social structural model seem applicable to the origin of non-medical needs: isolation and feelings of failure. Researchers who deal with isolation tend to focus on social supports as a basis for understanding behavior. Those who deal with feelings of failure tend to focus on roles to account for differences in behavior.

Isolation.

Several studies have suggested that isolation is an objective state that arises from an absence of an adequate social support system (French, et al., 1974; Langner and Michael, 1960; Segal, et al., 1965). Such systems consist of enduring interpersonal ties to a group of people who (1) can be relied upon to provide emotional sustenance, assistance, and resources in times of need; (2) provide feedback; and (3) share standards and values (Caplan, 1974). They serve to ameliorate or buffer the effects of stress for the individual, mediating between stresses and his or her response to them (Kaplan, et al., 1977: Rabkin and Struening, 1976). Presumably, then, the effects of exposure to stressful events will be exacerbated when the supports accessible to the individual within his or her social environment are insufficient or inadequate. Furthermore, the individual not effectively embedded in social networks or support systems might rely upon the physician as a substitute to satisfy basic social needs not gratified through social interaction with significant others.

The findings of several studies dealing with differential use of medical services support this reasoning. Hoppe and Heller (1975), working with a sample of Mexican-American women living in a barrio of Texas, found that familism (as measured by frequency of visitation with relatives) and occupational stability were negatively correlated to consulting a physician. The stable poor who were more familistic turned to relatives for advice in times of trouble. The unstable poor, in contrast, "alienated, anxious, and void of family support," responded to "day-to-day living crises" by seeking medical help (1975:312). Miller, et al. (1967) studying a sample of patients of a Scottish general practitioner, also found that people with few friends were more likely to develop symptoms and to seek

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medical care in the presence of threatening life events than those with many friends. And, in a somewhat similar vein, Fanning (1967) working with British housewives, attributed the higher consultation rates among those living in flats to their relative isolation and loneliness, and the lower consultation rates of those living in houses to the greater level of social integration among neighbors that this arrangement permitted.

These findings, then, suggest that kin, friends, and neighbors are particularly useful to the individual as a field for expressing and coping with feelings and unmanageable difficulties. People who are socially well-integrated and have favorable relationships with others that are marked by emotional and material support, will be less likely to seek outside help for their problems. Those without such viable relationships, will be more likely to seek to cope with the problems that confront them within the framework of the medical system and will be characterized by high frequency of utilization.

Feelings of Failure. Feelings of failure represent a subjective state that can arise from different situations: role strains and conflicts; inadequate role performance; or powerlessness to control events. Numerous studies have employed these variables to account for differentials in health behavior both between men and women and among women in the United States.

Gove and Tudor (1973) provide a good illustration of the general orientation of those who adopt the role strain and conflict

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approach. They argue that the higher prevalence of emotional problems among women in the United States (as measured by first admission rates to psychiatric hospitals and out-patient clinics) is due to five factors: (1) housewives have no alternative sources of gratification outside the family; (2) housework is unskilled and of low prestige; (3) the housewife role is relatively unstructured and invisible, giving women leisure to brood over their troubles; (4) working wives have less satisfactory jobs and working places them under more strain than men; and (5) role expectations confronting women are generally unclear and diffuse.

There seems to be some indirect support for Gove and Tudor's thesis that women with more "leisure" tend to show higher levels of use than women with a large number of role obligations. Cartwright and Jefferys (1958), found that among workers and non-workers alike those with fewer children had a higher volume of use than those with more children. Similarly, Geertsen and Gray (1970) showed that women who had heavy responsibilities at work or with their children were less inclined to adopt the sick role than others. Petroni (1969), in addition, demonstrated that family size was related to use inversely.

The fact that women have more absences from work than men (Blumberg and Coffin, 1956; Enterline, 1961) also seems to support Gove and Tudor's argument that working places women under more strain than men. Yet, data indicate that working may serve as a source of gratification for women. Feld (1963), for example, found that employed married women were less likely to report major illnesses and "minor neurotic symptoms" than unemployed married women. Similarly, Rivkin (1972) showed that working women reported less morbidity, less anxiety and fewer disability days than women who did not work. Among non-working women, then, illness may be used as a reaction to "exclusion from the life open to a man" (Parsons and Fox, 1958). Between men and women, however, working may contribute to differential rates of use by placing greater strains on women who perform both integrative and functional roles as well.

This notion that strains induced by the performance of dual roles may contribute to differentials in health behavior is supported by two studies about "spouseless" women. Berkman (1969) found that physical illness was more prevalent among spouseless mothers than among their married counterparts. Similarly, Renne (1971) showed that divorced women were more likely than married women to report physical disability, neurosis, and depression. Role strain and conflict, then, can lead to feelings of frustration and failure, and the adoption of the sick role may be used as a mechanism to cope with such feelings.

Feelings of failure also can arise in situations in which an individual perceives his or her role performance as inadequate. Beresford, et al. (1977) found that among women in charge of "running the household" (i.e., the widowed, separated, and divorced), those who found it difficult to manage the task visited the doctor significantly more often than those who did not. Similarly, Cole and Lejeune (1972) found that black women who felt inadequate in their performance of roles as wives and mothers were more likely to

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define their health as poor than were women who considered themselves relatively successful in these roles.

Furthermore, feelings of failure can arise in situations in which the individual feels powerless to control events. Phillips' (1965) research on the concept of self-reliance (defined as the ability to cope with life's problems) is an example of this orientation. Working with a sample of married white females in a suburb, he found that those who placed the highest value on self-reliance were least likely to indicate a willingness to adopt the sick role. In a somewhat similar vein, Gurin, et al. (1960) and Koos (1954) found that a frequently cited reason for not seeking help for illness was the respondent's attempt to cope with it himself. Finally, Berle (1958), writing about Puerto Rican immigrants in New York noted (1958:206):

> . . . illness may be an aspect of lack of success and may therefore become a justification for failure. Failure is almost inevitable when there is a discrepancy between an individual's aspirations and the limited opportunities open to him.

All of these studies, then, suggest that the sick role can provide a refuge when an individual feels (1) the well role is unsatisfactory; or (2) inadequate in performing that role; or (3) unable to cope with problems of life. To be sick implies an inability to fulfill tasks and an acceptable avoidance of responsibility. Sensing failure, the individual may resort to becoming ill to escape from the pressures of life. Illness provides a rationale for failure and the use of medical services a mechanism to legitimize this failure.

Of the three models already discussed, the social structural model appears the most promising avenue via which to understand the bases of high utilization of medical services. This model, however, as the other dealt with earlier, only considers the contribution of the individual to utilization behavior. And, as Coe and Wessen (1965:1027) point out: "Our understanding of the medical behavior of patients is incomplete if the influence of the physician is omitted from consideration."

The Delivery System Model

McKinlay (1972) provides a seminal review of the literature published in the fifties and sixties on works that employ the delivery system model. Most of these earlier works focused on those characteristics of the medical institution that tend to inhibit utilization. More recently, a body of literature has appeared which, though not necessarily concerned with the use of health services, deals with factors that impinge on physicians and induce high utilization. This literature is scattered and nonaccumulative. Yet, it suggests that the decisions that physicians make strongly influence the direction of utilization. As Shortell (1972:2) has noted:

> . . . once the patient has made initial contact with the medical care system, the physician becomes the principal decision maker and allocator of medical resources. He, in effect, decides how much and what types of additional medical services the patient should receive.

Most analysts would agree that these decisions are influenced by a host of factors other than the physical signs of illness alone.

One important factor among these is the basic assumption that underlies diagnosis and treatment. That is, "it is better to impute disease than to deny it and risk overlooking or missing it" (Freidson, 1970:225; also Scheff, 1972). Backwin's study (1945) of medical decisions regarding the need for tonsillectomy in children and Garland's studies (1959) of diagnostic error in roentgenology all suggest that the pervasive attitude among physicians is that it is better to suspect illness than not. This implicit norm, then, creates a bias, for the physician feels impelled to do something and tends to overtreat and schedule multiple tests and follow-up appointments. As Freidson (1970:257) notes:

> The aim of the practitioner is not knowledge but action. Successful action is preferred but action with very little chance for success is to be preferred over no action at all.

Medical decisions of the probability type, however, may be determined by factors other than this implicit norm. Haney (1975) notes a variety of factors that affect the physician in his decision making, factors that derive from the social background of the patient, the value system of the physician, and the interaction of the two. In addition, Hershey (1972), in a study of 17 physicians practicing in an urban area, found that most of those interviewed thought that liability considerations had a relatively strong influence on their practice; the majority took into account their assessment of a patient's likelihood to sue when making medical decisions.

Medical decision making, and resultant use, also may be affected by the way in which the system of care is organized (Simon, 1966). Freidson (1973:475), for example, found that a ". . . prepaid service contract, which freed the subscriber from having to pay for each service he wished . . . encouraged many physicians to manage patient demands by increasing referrals and reappointments." His finding is supported by data collected at a prepaid group practice affiliated with John Hopkin's which indicate that 47.2 percent of visits there were initiated by providers of care (Gertman, 1974: 364). Moreover, the amount of time available to practicing physicians to treat patients also may affect decisions. Muller (1972:489) suggests that the ". . . doctor's contribution to overmedication must be seen in the context of need to balance time available for practice against time demanded for medical care." Thus, the longer the doctor's day, the more drugs prescribed (Hemminki, 1974:355).[2]

In summary, then, the implicit norm underlying medical practice, the perception of patients, and the organization of practice all may influence physicians to order unnecessary tests, superfluous appointments, and unneeded medications. Such actions may bring about use of medical services by encouraging individuals to enter the sick role (Warren and Wolter, 1954). As Kuch, et al. (1977:647) have noted, when a ". . . physician 'organifies' a psychosomatic complaint . . . and labels it a disease for which treatment is prescribed, then the physician reinforces the patient's feelings and beliefs that his or her body is sick and supports the patient in the sick role." In addition, such actions also may cause use of medical services by exposing patients to the hazards involved with some diagnostic procedures or therapeutic regimens, thereby causing iatrogenic disease (Cartwright, 1974; Illich, 1976; Mapes, 1977; Mulroy, 1973; Waldron, 1977; Warren and Wolter, 1954).

These hazards and their consequences have been examined in depth in a recent book by Illich (1976) in which he discusses the "crises" in our western system of medicine, i.e., the growth of iatrogenesis. Illich argues that the roots of iatrogenesis are found in modern technology which determines the underlying assumptions of physicians and patients as well as the organization of medicine. Moreover, he posits that the consequences of this technology not only are clinical, but social (1976:39-124) and cultural (1976:127-208) as well. For Illich, medicine is a monopoly that fosters a "patient population" for the "medicalization of health," turning self reliance, mutual care, and personal responsibility into "misdemeanors or felonies."[3]

Thus, although analysts may not agree on the bases of physicians' decision, all do concur that their actions affect the use of health services. This consequence is not always intended or recognized by physicians. But, in fulfilling their manifest function (i.e., the prevention and cure of disease), doctors do induce utilization. Moreover, as Shuval, et al. (1970) have demonstrated, physicians also fulfill latent functions and these too bring about the use of services.

These latent functions stem "from the professional role of the physician and from the nature of the sick role" (1970:4) and open up the possibility for the individual to turn to the physician to satisfy "non-medical" needs. On the one hand, the physician's role is ideally suited to the individual's needs for catharsis since it involves communication in an uncritical, supportive atmosphere. On the other hand, it is suited to the individual's need to cope with failure since the legitimization of illness enables the individual to use the sick role as an escape mechanism.

In their study, Shuval and her colleagues demonstrated that the latent functions of the physician motivated individuals to use medical facilities and increased utilization rates. When the individual's needs were not satisfied, high utilization occurred as the patient's desire to obtain such satisfaction was intensified. When the individual's needs were satisfied, high utilization occurred as the patient was motivated to "enjoy" the latent function (1970).

The notion that the latent functions of the physician encourage individuals to use his services or that non-medical needs activate these functions suggests that consumers and providers conjointly have an influence on utilization behavior, that they constitute a social system.

The Social System Model

This approach first was proposed by Henderson (1935) in a challenge to the medical profession to study the physician and patient as a social system. His challenge was accepted, not by physicians, but by sociologists and other social scientists who have examined the interaction between the physician and patient. Probably the most widely recognized of these investigations is that of Parsons who developed a theoretical model of the social roles of the two parties and the norms governing them in his book *The Social System* (1951:429-479).

According to Parsons, the social system is disrupted (or in a state of disequilibrium) when individuals cannot fulfill normal social roles. Society, therefore, uses illness as a mechanism to isolate such deviants and channel their behavior into another role (the sick role) that has less dangerous consequences for it. Moreover, society designates the physician as its agent to serve the system's need to keep deviance within bounds and to maintain viability.

The physician's role is conceptualized by Parsons as a social role that is universalistic, functionally specific, and affectively neutral. Universalism implies that the physician views patients as equal members of a universe of health and that categorical criteria (e.g., sex, race, or religion) are irrelevant to the process of care. Specificity of function implies that the physician limits his attentions and activities to areas that are strictly medical and within the purview of his technical competence. Affective neutrality implies that the physician adopts an impersonal attitude toward patients and avoids emotional involvement with them or their plight.

The sick role is defined by Parsons by reference to physician expectations of patients: that is, the ill person has the obligation to seek technically competent help and to try to get well as quickly as possible.[4] Moreover, although the patient initiates the relationship, the values and norms of the physician take precedence in and pattern the interaction. As Wilson (1963:279-280), in a discussion of Parson's formulation, notes:

> . . . the practitioner has a nearly exclusive monopoly of psychological and social leverage . . . [H]e is active doing something for and to the patient, while the patient is passive, asking that something be done for him.

Parson's active-passive construct is similar to a model of the physician-patient interaction formulated by Szasz and Hollender (1975) to describe the relationship between a physician and a patient with an acute infection.[5] In this model, which they call "guidance-cooperation," both participants are active in the sense that they contribute to the relationship and what ensues from it. However:

> The main difference between the two participants pertains to power and its actual or potential use. The more powerful of the two (. . . physician) will speak of guidance or leadership and will expect cooperation of the other member of the pair (. . . patient) (1975:434).

Empirical data are available to support interactional constructs based on a theory of power (Ford, et al., 1967, Ort, et al., 1964). Ort and his colleagues (1964:31), for example, found that medical students, their faculty, and practicing physicians described the physician-patient relationship as ". . . interaction that takes place within a specifically medical setting and is characterized by the doctor's active involvement and by cooperation

on the part of the patient." On the basis of their data, they derived a model of the physician-patient relationship in which the doctor is the locus of control.

The physician and patient, then, theoretically and empirically, are seen as constituting a dyadic system in which interaction is patterned by the congruence of the norms for the patient with the expectations of the professional. Bloom (1965) argues, however, that much more of reality could be traced intelligibly if the physician-patient relationship was defined, not solely in terms of the physician's orientation, but in terms of the patient's orientation as well. Because the physician's orientation results from participation in a medical culture and the patient's orientation from participation in a socio-environmental culture, ". . . the patient's culture leads him to expect what the doctor's culture does not suggest" (Freidson, 1962:215). As a result, the two are always in potential conflict with each other (1962:209; also Bloom, 1965; Bloor and Horobin, 1975; Sussar and Watson, 1962).[6]

The patient, holding distinct beliefs about the nature of his problems, feels obliged to try to judge and control what is happening to him. The physician, unaware of the patient's background, feels convinced that he is "right" and most able to decide what is "best" for the patient. At best, the clash results in the castigation of the patient for his illogicality and the assignment of pejorative labels (Duff and Hollingshead, 1968; Freidson, 1975; Lorber, 1975). At worst, it results in missed or ignored cues and

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inappropriate or misdirected responses (Zborowski, 1975; Zola, 1975). In either case, utilization may be increased (1) as the patient embarks on a career of "doctor-shopping" to find the help he or she needs; or (2) as the patient returns for care in response to iatrogenic disease.

Utilization: An Independent Variable

The "high use" patient has long been recognized as a unique medical phenomenon. Indeed, reports on this type patient appear annually in the medical literature. Most of these reports are the products of studies about patients who frequently present for care with vague and multiple complaints (Fabrega, et al., 1969; Kuch, et al., 1977; Matarazzo, et al., 1961; Stewart, et al., 1975) that are located in diffuse body systems (Farmer and Harvey, 1975; Lipsitt, 1968, 1970; von Mering, et al., 1976). Such patients usually undergo extensive and expensive diagnostic procedures with few objective findings (Kaywin, 1973; Kuch, et al., 1977; Malcom, et al., 1977). Moreover, although they receive more therapies, these patients usually are found to be refractory to treatment (Kaywin, 1973; Lipsitt, 1968, 1970; Schuller, 1977; von Mering and Early, 1969). As a result, their problems are considered difficult to define and diagnoses arrived at usually are not reproduceable (Farmer and Harvey, 1975; Kuch, et al., 1977; Lipsitt, 1978; Schuller, 1977).

Unfortunately, the reports on "high use" patients rarely extend beyond descriptions of their clinical and, less frequently, behavioral traits. Little, if any, information is provided about the management strategies adopted to care for them or the outcome

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of their repeated visits to the physician. It is not difficult to infer what this outcome is, however. The titles given to the reports leave little doubt that it is a psychiatric diagnosis and/or a stigmatizing label.

The Psychiatric Diagnosis

A patient is at high risk to be assigned a psychiatric diagnosis if he or she frequently seeks care (Banks, et al., 1975; Bellin, et al., 1976; Locke and Gardner, 1969) for a large number (Matarrazzo, et al., 1961; Stewart, et al., 1975) of vague and diffuse symptoms (Farmer and Harvey, 1975; McCranie, et al., 1978; Stimson, 1976) that are presented in a helpless and complaining manner (Fabrega, et al., 1969; McCranie, et al., 1978; Mechanic, 1976; Zola, 1963). Most frequently, because the volume of use of these patients is considered disproportionate to their actual physical findings, their complaints are assumed to be of emotional origin (DeVaul, et al., 1977; Farmer and Harvey, 1975; Hesbacher, et al., 1975; Kellner, 1966). The assignment of a psychiatric diagnosis " . . . often serves as a disguise for the fact that no proper diagnosis can be affixed" (Balint, 1970:7). The psychiatric classification is used as a residual category by the somatically-oriented physician after he has ruled out organic bases for symptoms (Bellin, et al., 1976; Kessel, 1965; Mechanic, 1972b).

Estimates of this type of patient range from a low of ten percent (Locke and Gardner, 1969) to a high of eighty percent (Kaufmann and Bernstein, 1957; Stoeckle, et al., 1964). Most

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estimates, however, are in the neighborhood of thirty percent (von Mering and Early, 1966). The proportion of such patients is reported to be larger among those of the lower classes (Dohrenwend and Dohrenwend, 1967; Petras and Curtis, 1968). Furthermore, females have been found to predominate among such patients (Bellin, et al., 1976; Hesbacher, et al., 1975; Kellner, 1976; Locke and Gardner, 1969; Matarrazzo, et al., 1961).

The preponderence of women diagnosed as psychiatrically ill may be due to the kinds of symptoms they report, the ways in which they express distress, or to sex-role stereotypes physicians may hold about women and their characteristics (Mechanic, 1976). A number of researchers (Campbell, 1973; Corea, 1978; Ehrenreich and English, 1973) have asserted that male physicians have a general tendency to stereotype and devalue women relative to men. Frequently, they diagnose women's presenting physical symptoms as psychogenic rather than organic in origin, thereby implying that the symptoms are not reflective of "bona-fide" or serious illness.[7]

Furthermore, the preponderence of high users of services among all patients diagnosed as having psychological illness may be due to the physician labeling of patients itself. Shepherd, et al. (1966:20) raise this possibility:

> If two of the factors influencing doctors in labeling patients as 'neurotic' are the frequency of attendance and the multiplicity of complaints, it would hardly be surprising to find that psychiatric patients were frequent attenders with many bodily complaints.

Whatever the reason for the assignment of a psychiatric diagnosis, if the physician does little else than label and dismiss the patient,

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then his or her subsequent behavior is likely to remain substantially similar to the original pattern.

The Stigmatizing Label

Patients at high risk to be assigned a stigmatizing label share many of the same clinical characteristics as patients diagnosed as psychiatrically ill. They frequently seek medical care for multiple and diffuse symptoms and are considered to have less or no "bona-fide" illness (Fabrega, et al., 1969; Fox, 1957; von Mering, 1972). Often, in fact, once all plausible medical conditions are ruled out, a psychiatric diagnosis is assigned to these patients as well as a label such as "problem," "crock," "turkey," or "fat file" (Bellin, et al., 1976; Kaufman and Bernstein, 1957; Lipsitt, 1968, 1970; Schuller, 1977). They do not fit the medical model which is inappropriately applied to them (Malcom, et al., 1977) and are patients "from whom the diagnostic sheen has been worn" (Martin, 1957:192).

The label of "problem" however, does not denote primarily the presence of a diagnostic problem. Rather, it is a declaration of the difficulties associated with the care of these patients. "Problem" patients ". . . make extensive and intensive demands on the physician's time and role, pose administrative and managerial difficulties to the medical profession, and not infrequently frustrate those who attempt to help them" (Fabrega, et al., 1969:334; also von Mering and Early, 1966).

In large part this frustration lies in the fact that the conduct and values of "problem" patients are not congruent with normative medical expectations (Ima, et al., 1970; Lipsitt, 1970; von Mering and Early, 1969). They are patients with "deviant" attitudes in the areas of trust, cooperation, complaints, and demands (Glogow, 1973; Kaywin, 1973; Lorber, 1975; Schuller, 1977) who do not respond to the efforts of the professional in the way that he would like. Labeling a patient, however, does little to ameliorate the physician's frustration. Moreover, it does little to mitigate the patient's "demands" on the physician. As researchers in the sociology of deviance have suggested (Becker, 1963; Erickson, 1964), the process of labeling an "offender" and making him conscious of himself as a deviant may evoke the very behavior that was thought to be "inappropriate."

Summary

The review of the literature suggested the following points which seem to be especially important with respect to this research.

1. Differences in use of medical services cannot always be explained by differences in clinical morbidity. Individuals exhibit a "selective attention" to symptoms and the person whose capacity to cope with environmental stress is impaired is likely to be more sensitive to symptoms and to seek medical care for minor complaints.

2. Such individuals are likely to seek solutions to their problems within the framework of the medical institution as a result of a need for the kind of social contact that permits or encourages

free communication (i.e., a need for catharsis); and/or a need to legitimize feelings of lack of success (i.e., a need to cope with failure).

3. The need for catharsis is likely to arise in situations in which the individual is not effectively embedded in a social network or the members of the network are unable to serve as a satisfactory field for expression and coping with feelings and unmanageable difficulties.

4. The need to cope with failure is likely to arise in situations in which the individual suffers role strain or conflict; feels inadequate in the performance of roles; and/or feels powerless to control events.

5. Physicians may strongly influence the direction of utilization since once initial contact is made with the medical care system, the doctor decides how much and what types of additional services the patient should receive.

6. These physician decisions are affected not only by the physical signs of illness but also by the implicit norm underlying medical practice, the perception of patients, the physician's own values, and the interaction of the two.

7. The interaction of physician and patient takes place within a specifically medical setting. However, each interactant brings to it an orientation resulting from a different social sphere which serves to define his or her expectations of the others' behavior. When these expectations are not congruent, high use of medical services is likely to occur.

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The studies and analyses reviewed above and summarized here, demonstrate that many factors have been identified as contributing to frequent utilization. In addition, this review suggests that a conceptual framework which focuses on (1) the sources of the expectations that influence the medical behavior of patients and physicians; and (2) the conjoint influence of physicians and patients on use of medical services is likely to provide insights of value in understanding this phenomenon.

Plan of Report

This report is divided into two main parts. Part I presents the research problems and methods of investigation; Part II, the findings and conclusions. In Part I, Chapter 2 outlines the conceptual framework adopted in this study and defines the main concepts used. Chapter 3 discusses the data sources and research design. Chapter 4 describes the setting in which the study was conducted.

In Part II, Chapter 5 presents findings relative to the individual and to the patient and discusses the way in which individual characteristics are related to patient attributes. Chapter 6 discusses the physician and his orientation and presents data on the interaction of physician and patient. Emphasis is placed in this chapter on the management process and the outcome of it. In Chapter 7, the findings are summarized and implications for further research are discussed.

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CHAPTER I: NOTES

[1] The models were selected because they appear to represent promising approaches to the study of high utilization. Not all the models are mutually exclusive and the assignment of a work to one model rather than to another may appear arbitrary. In the writer's opinion, assignments best reflect the model under which works are included. (See McKinlay, 1972 for a discussion of additional models that have been employed in the study of utilization behavior.)

[2] The use of drugs, particularly prescription drugs, increased substantially in the United States during recent decades. According to Silverman and Lee (1974:18): "In 1950, an average of 2.4 prescriptions per person were filled in community pharmacies, in 1960 an average of 3.5, and in 1972 an average of 5.5"

[3] See Navarro (1976) for a critique, developed within a Marxist framework, of Illich's argument.

[4] To the best of my knowledge, Parson's formulation of the patient (or sick) role has been systematically investigated only twice: by Gordon (1966) and by Twaddle (1968).

[5] Szasz and Hollender also posit an active-passive model, but consider it applicable only to the relationship between a physician and a patient in coma or under anesthesia. In addition, they posit a mutual participation model that they consider applicable to the relationship between a physician and a patient with a chronic disease. In this latter relationship, the physician helps the patient to help himself. According to Szasz and Hollender, however, this model is "essentially foreign to medicine" (1975:435).

[6] This conflict has been documented in studies of patients' satisfaction with and acceptance of medical personnel (Freidson, 1961; Koos, 1954, 1955; Reader, et al., 1957) as well as in more general studies of physician-patient interaction (Clark, 1959; Lazare, et al., 1975; Paul and Miller, 1955; Saunders, 1954).

[7] Two sources of such sex-role stereotypes among physicians have been suggested: (1) the socialization which they receive during their medical school training (Howell, 1974; Safilious-Rothschild, 1974); and (2) the images of women communicated in medical drug advertisements (Prather and Fidell, 1975; Seidenberg, 1971).

CHAPTER II

THE RESEARCH PROBLEM

As suggested in Chapter I, this study is concerned with (1) the contribution of the patient and the physician to the frequent use of medical services; and (2) the circumstances that affect their orientations and behavior. These are research problems which have been studied separately, but, they seldom have been examined together. The central questions posed by this study, therefore, can be defined as:

> Is the high use of medical services related to non-medical needs arising from the individual's environment?
>
> Is the response of the physician to these needs associated with attitudes arising from membership in a medical profession?
>
> Is frequent utilization of medical services related to patients' needs as well as to physicians' patterns of response to them?

To further specify the research problem, this chapter undertakes three related tasks. First, the theoretical framework within which the problem is analyzed is described and the rationale for its adoption set forth. Then, the basic concepts used in the study and the range of questions to be explored are discussed. Finally, a model of the use of medical services, including the hypotheses to be tested, are presented.

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Theoretical Framework

In order to examine the influence of physicians and patients on the use of medical services, a basic theoretical framework is needed. Specifically, a framework is needed that will relate seemingly disparate realms of social action to each other: social relationships; the medical profession; role behavior; and cultural values concerning appropriate health behavior in the United States. Parsons' theory of the social system would seem useful in providing such a framework.

Parsons' Theory of the Social System

Parsons offers a definition of the social system at several points in his work:

> . . . a social system consists in a plurality of individual actors interacting with each other in a situation which has at least a physical or environmental aspect, actors who are motivated in terms of a tendency to the 'optimization of gratification' and whose relations to their situations, including each other, is mediated in terms of a system of culturally structured and shared symbols (Parsons, 1951: 5-6).
>
> A social system is a system of the actions of individuals, the principal units of which are roles and constellations of roles. It is a system of differentiated . . . roles (Parsons and Shils, 1959:197).
>
> A social system . . . is a system of interaction of a plurality of actors in which action is oriented by rules which are complexes of complementary expectations concerning roles and sanctions (1959:195).

These quotes suggest key elements in Parsons' theoretical framework--e.g., action, orientation, motivation, rules, roles--elements on which the following discussion focuses.

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The System of Social Action

Action is the starting point for the social system and is defined as behavior that is oriented to the attainment of ends in situations by means of the normatively regulated expenditures of energy (Parsons and Shils, 1959:53). It involves a choice among alternatives and the use of criteria derived from past experience to make that choice. The choice is oriented to the attainment of goals and is made from among alternatives that may be particular to a given situation or specific to all situations.

In choosing and pursuing alternatives, the actor employs two distinctive systems of orientation: a motivational orientation and a value orientation. There are three "modes" or forms of motivational orientation: the cognitive, the cathetic, and the evaluative. The "cognitive mode" consists of behaviors by which an actor perceives an "object" and defines its characteristics and consequences for the gratification or deprivation of his needs. The "cathetic mode" consists of behaviors by which an actor invests an "object" with affective significance in accordance with its consequences for his needs. The "evaluative mode" consists of those behaviors by which an actor " . . . allocates his energy among the various actions with respect to various cathected objects in an attempt to optimize gratification" (Parsons and Shils, 1951:59). The motivational orientation, then, essentially provides a framework for analyzing "problems of interest" to the actor (Parsons, 1951:14).

In the course of this analysis, the actor employs what are variously called norms, standards, and criteria that define a

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appropriate methods of choosing among alternatives, i.e., the value orientation. There are three modes of value orientation, each corresponding to a mode of motivational orientation:

> The *cognitive* mode of value-orientation involves the various commitments to standards by which the validity of cognitive judgments is established . . . . The *appreciative* mode . . . involves the various commitments to *standards by* which the appropriateness or consistency of the cathexis of an object or class of objects is assessed . . . . The *moral* mode of value-orientation involves the various commitments to standards by which certain consequences of particular actions and types of action may be assessed with respect to their effects upon systems of action (Parsons and Shils, 1959:60, emphases in original).

The value orientations, then, provide the standards of what constitutes "satisfactory solutions" to the actor's "problems" (Parsons, 1951:14).

When a choice is made in a situation involving other actors, the actor-subject also employs schemes for classifying social objects on the basis of their significance to him. He must decide how to act toward them in terms of what they are (their quality) or in terms of what they do (their performance). And, he must decide how to act toward them in terms of their "scope of significance" to him. If the objects have:

> . . . a broad and undefined significance for the actor-subject . . . [then] he feels obliged to grant them any demand they make of him, so long as the granting of the demand does not force him to fail in other obligations higher on a priority scale of values. In this case we may say the object has for the actor-subject a broad scope of significance. Its significance is *diffuse* . . . . [If the objects have a] narrow and clearly *defined* significance for the actor-subject . . . [then he] does not feel obliged to grant them anything that is not clearly called for in the definition of the relationship which obtains between them. In this case we say the scope of significance of the object . . . is *specific* (Parsons and Shils, 1959:57-58, emphases in *original*).

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Parsons contends that an actor must select from these types of motivational and value orientations and evaluative schemes when he makes a choice in a situation:

> Specifically . . . the actor must make five specific dichotomous choices before any situation will have a determinate meaning. The five dichotomies which formulate these choice alternatives are called the pattern variables because any specific orientation (and consequently any action) is characterized by a pattern of the five choices (Parsons and Shils, 1959:76, emphasis in original).

These five pairs of choices are: affectivity versus affective neutrality; self-orientation versus collective-orientation; universalism versus particularism; ascription versus achievement; and specificity versus diffuseness.

The "system of action" described above is organized into three sub-systems: the social system; the personality system; and the cultural system. The three systems are not reducible in terms of one another. However, they interpenetrate one another and each is indispensible to the others in the concrete manifestation of action.

The Social System

The basic unit in a social system is the role, the dynamic aspect of status. Status is a collection of rights and duties and to put these into effect is to perform a role (Parsons, 1951:25). Expectations are the primary components of roles and have two aspects:

> On the one hand . . . expectations . . . concern and in part set standards for the behavior of the actor, ego, who is taken as the point of reference; these are his 'role-expectations.' On the other hand, from his point of view there is a set of expectations relative to the contingently

> possible reactions of others (alters)--these will be called 'sanctions,' which in turn may be divided into positive and negative according to whether they are felt by ego to be gratification-provoking or depriving (Parsons, 1951:38, emphasis in original).

A crucial component of expectations, then, is the probable reaction of others to an actor's possible action, a reaction which is antifipated in advance and affects choices.

Roles within a social system must be complementary if goals, both private and collective, are to be pursued effectively. "Although conflict can exist within a social system and, in fact always does, there are limits beyond which it cannot go and still permit a social system to exist" (Parsons and Shils, 1959:198). An important characteristic of a social system, then, is that it must possess a minimum degree of integration based on a system of generalized and institutionalized patterns of value-orientation.

No social system is ever completely integrated, however. There always are some discrepancies between role expectations and performances of roles, i.e., tendencies to deviance. On the one hand, new members coming into the system have not "learned" their given role orientations and thus tend to act in ways that are unsatisfactory (Parsons, 1951:205). On the other hand, established system members may:

> . . . depart from conformity with the normative standards which have come to be set up as the common culture. A tendency to deviance in this sense is a process of motivated action, on the part of an actor who has unquestionably had a full opportunity to learn the requisite orientations (1951:206).

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Both forms of "deviance" are a threat to the "equilibrium" of the system. And, since the "first law of social process" is to maintain the interaction process (1951:205), the system contains these problems through two mechanisms: mechanisms of socialization and mechanisms of social control.

Socialization refers to the process by which an actor learns the requisite orientations for satisfactory functioning in a role (1951:205). It is a life-long process that requires actors to adjust to changing roles and shifts in role expectations. Social control refers to the process by which the social system motivates actors to abandon tendencies to deviance and resume conformity. The most common mechanism employed to check disruptive tendencies is "defense;" sufficient rewards are accorded for conformity and punishment for deviance to tip the balance in favor of conformity. The mechanisms of socialization and social control function to motivate actors to conformity with a given set of expectations, to counteract deviance and other strains in the system and to bring it back to a stable state, thereby maintaining equilibrium. If the system's mechanisms of control do not work adequately, the system changes its state or disintegrates.

The Cultural and Personality Systems and Their Relationship to the Social System

The cultural system constitutes the standards for conducting action and gives the action system its primary "sense of direction." It is not a system of interaction as a social system is, but, rather, is a system of values, norms, and symbols that guide the choices of in

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individual actors and limit the types of interaction. The personality system constitutes a constellation of "need-dispositions" that ". . . control a system of concrete orientations and actions aimed at securing for the personality certain relations with objects" (Parsons and Shils, 1959:159). It is not a system of action organized about the relation of actors to each other as a social system is, but, rather is a system organized about the "living organism," the individual.

The relationship between personality and social systems lies in the fact that the need-dispositions of the former and the role expectations of the latter are both derived from the same patterns of value orientation. The relationship between the cultural system and these two systems lies in the fact that, on the one hand, the values, norms, and symbols of the former are internalized and become a main part of the personality and, on the other hand, they are institutionalized and become part of the social system. In a system of action, then, the personality system provides the motivational energy and orientation, the cultural system provides the value orientation and the social system provides the structure of the situation. Action, Parsons contends, is understandable only when all three systems are considered.

Theoretical Rationale

The social system is a concept that was developed in order to analyze macrosocial phenomena. It is a concept that refers to a complex of interdependencies between parts as well as to an interdependency between such a complex and its surrounding environment. This environment is not just physical, however. It includes the cultural and personality sub-systems as well. The social system, generated by the process of interaction, is the primary link between culture and the individual. The concept is adapted in this study in order to analyze microsocial phenomena. Specifically, it is used to analyze the relationship between physician and patient in order to understand (1) the whole complex of interdependencies of which the relationship forms part; and (2) the consequences of the relationship.

Three elements of Parsons' theory guide this report's discussion: the cultural system; the personality system; and the social system. The cultural system, represented by the traditional belief system in America, is considered since dominant values theoretically guide the choices of individual actors. The personality system, represented by the individual located within a social or a professional context, is considered since motivations and orientations are organized and develop at this level. And, the social system, represented by the doctor-patient relationship, is considered since interaction takes place at this level.

The cultural tradition of American society is that "medical practice is organized about the application of scientific knowledge to the problems of illness and health, to the control of 'disease'" (Parsons, 1951:432). In order to effect this idea, the physician role is culturally defined as oriented toward universalism, functional specificity, and affective neutrality. That is, the physician: (1) views patients as equal members of a universe of health without regard to categorical criteria that are irrelevant to the process of care; (2) limits his attentions and activities to areas that are strictly medical and within the purview of his technical competence; and (3) adopts an impersonal attitude toward patients and avoids emotional involvement with them or their plight. Similarly, the patient role is culturally defined as functionally specific and affectively neutral in orientation. That is, the patient role is confined to the sphere of health and "is focused on an objective problem not on . . . orientations to an emotionally disturbing problem, although this may be instrumentally and otherwise involved" (1951:438).

The interaction of physician and patient, then, is culturally formulated in terms of role complementarity, of parallel expectations. This prototype of the physician-patient interaction, however, may be modified by varying orientations that derive from the different contexts in which the physician and patient are located. The physician's definition of his role may be shaped by the type of medical school he attended and/or the structure of the medical setting within which he provides care. He may believe his functions are limited solely to biophysiological problems. Or, he may believe his authority extends to psychosocial pathology. The patient's definition of her role may be affected by the resources she has available to cope with her general life situation. She may focus on her medical problem only. Or, she may consider personal problems apposite to the situation. The expectations brought by the i

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interactants to the medical encounter may complement or may contradict each other. They are a product of a host of factors experienced at the individual level.

Furthermore, the interaction of the physician and the patient may be expected to be influenced by the extent to which the expectations are or are not congruent. If their expectations do not parallel each other, the physician may demand conformity to the ideal patient role by adopting certain management strategies to contain deviance and "reequilibrate" the system. If their expectations do parallel each other, he may disallow the ideal patient construct by adopting different management strategies that are congruent with the orientations guiding the interaction. In either case, as the literature reviewed in Chapter I indicated, differential use of medical services might be expected to occur.

The theoretical scheme proposed by Parsons appears to provide a good framework within which to analyze the outcomes of different types of physician-patient interaction. First, at the level of the social system, the theory deals with action that is oriented toward gratification of the attainment of goals within a situation. The opposites of gratification and deprivation and, therefore, of the two basic tendencies of action--seeking and avoidance--are inherent in this conception. The formulation thus seems to hold promise as a guide to the analysis of the outcomes of physician-patient interaction that might or might not be mutually goal-oriented.

Second, at the level of the personality system, the theory deals with the organization of goals and means to the accomplishment of goals. Furthermore, although understanding of the influence of experiential factors on the organization of goals is not necessary at the societal level (Parsons, 1951:9), the formulation does not preclude an exploration of these factors at the sub-population level. It thus seems to hold promise as a guide to the analysis of the way in which contextual factors, relevant to the interaction, affect variations in orientations and outcomes.

Third, at the level of the cultural system, the theory deals with appropriate behavior of physician and patient in a situation "organized about the application of scientific knowledge" to the control of somatic problems (Parson, 1951:432). The formulation thus seems to hold promise as a guide to the analysis of interaction in which deviance from this traditional American belief is likely to occur, the "mechanisms of social control" (1951:432) employed to contain it, and the subsequent effect of these mechanisms on outcomes.

Finally, the theory deals with the interaction of the three sub-systems. The formulation thus seems to hold promise as a guide to the analysis of seemingly disparate, yet intertwined phenomena. The interdependency of these sub-systems is reflected in the following definition: the doctor-patient relationship is conceived of as a system of social roles, derived from culture, and influenced by the actors' personalities.

Basic Concepts

The foci of this study are patients who frequently seek medical care for multiple diffuse symptoms and their physicians' response to them. The review of the literature in Chapter I suggested that an individual who perceives her life style as inadequate and whose social and economic environment is unstable may use high levels of medical services. Furthermore, the review suggested that this pattern of utilization may be an adjustment to the person's particular life situation. When alternative sources of gratification are blocked or less available elsewhere, the individual may seek to satisfy non-medical needs through the medical institution. Thus, she may rely on the physician to provide the support that is lacking in her personal environment. This study refers to such an individual as a dependent patient. Specifically, she is defined as an individual who frequently uses medical services to satisfy needs over and above the need for specific diagnosis or treatment of illness.

The study provides an investigation into the factors that contribute to the dependent patient's high use of services, as well as an exploration of the influence of her behavior and that of the physician on differential patterns of utilization. Specifically, the study examines the influence of (1) the life situation of the individual on non-medical needs that may affect the use of medical services; and (2) the professional experience of the physician on orientations that may evoke responses to these needs. The basic concepts employed to explore these issues and the variations in

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health and professional behavior that might be found are presented in this section.

Overview of Concepts

Three major sets of concepts are employed in this study: (1) a set relevant to the individual; (2) a set relevant to the patient; and (3) a set relevant to the physician. The set of concepts relevant to the individual is used to provide a description of the life situation of study subjects. The set of concepts relevant to the patient is used to provide a description of the need-dispositions that arise from this situation and that influence orientations toward the doctor-patient relationship. Finally, the set of concepts relevant to the physician is used to provide a description of the way in which the doctor performs his functions and the way in which his professional experiences influence his definition of the physician-patient relationship.

Concepts Relevant to the Individual and to the Patient

It has long been recognized that difficult life circumstances or stress situations lead to varied responses and that these variations are due to individuals' differing definitions of and capacities to cope with or adapt to these stimuli (Caplan, 1974; Cobb, 1976; Dohrenwend and Dohrenwend, 1974; Mechanic, 1972a). Three separate, but interdependent, phenomenon are inherent in this statement: (1) the life circumstances of the individual; (2) the crises she may experience; and (3) the resources she has available t

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to cope with or adapt to the demands of life difficulties. All three phenomenon are considered in this study.

Descriptions of life circumstances may be subjective or objective. The individual's perception of her life, i.e., its quality, reflects a subjective description of conditions that might be assumed to influence her life experiences. The individual's marital status, income or level of education reflect an objective description of characteristics that might be expected to affect her life chances. Both types of descriptions are investigated in this study. In addition, the presence of stressor events that might impose hardships on the individual and affect her sense of well being also are investigated. All three phenomena represent potential demands with which the individual may be called upon to cope or to which she must adapt.

Cobb (1976:311) defines coping as "manipulation of the environment in the service of self" and adaptation as "change in the self in an attempt to improve person-environment fit." This study is concerned with the psychosocial assets that contribute to an individual's ability to cope with deleterious life circumstances (Nuckolls, et al., 1972). Specifically, it is concerned with the individual's social support systems (i.e., social assets) and with her feelings concerning herself (i.e., psychological assets).

A large body of literature exists on the way in which social supports mediate the individual's response to difficult life situations by "buffering" or "cushioning" her from their consequences (Cobb, 1976; Crogg, 1972; Henry and Stevens, 1977; Kaplan, et al., 1977; Rahe and Arthur, 1978). Caplan (1974:6) suggests three ways in which such support systems help the individual to manage long-term burdens and privations or acute stress situations. First, the members of such systems help the individual mobilize her psychological resources and master her emotional burdens. Second, they share tasks with her. And third, they provide her "with extra supplies of money, materials, tools, skills and cognitive guidance to improve . . . [her] handling of . . . [her] situation" (1974:6).

The nature and strength of the social supports available to the individual, then, may (1) help her come to terms with the pressures of her particular situation and/or (2) provide tangible assistance in managing demanding or frustrating aspects of her environment. Three categories of people that constitute potential sources of such support are considered in this study: (1) members of the kin network; (2) members of the friend network; and (3) neighbors. Links with all three categories of significant others add up to a potential system of psychological and functional support that can facilitate the individual's ability to cope with life difficulties or stressor events.

In addition to these social assets the individual's psychological assets also can contribute to her ability to cope with the demands of environmental pressures. Henry and Stevens (1977) and Nuckolls, et al. (1972) emphasize the importance of the way in which feelings about oneself are related to the definition of a situation and subsequent behavior. "The assurance of personal worth in being able to do socially valued work or to completely maintain a home

. . . [or to solve problems independently] ranks as an important asset" that is a "defense" between distressful life changes or deprivations and an individual's ability to cope with them (Henry and Stevens, 1977:221. In this study, the individual's feelings of self-worth are defined by the presence or absence of feelings of failure. Such negative or positive feelings about herself can contribute to the way in which the individual manages difficult life circumstances with which she may be confronted.

It is argued in the study that in the absence of viable psychosocial assets certain needs arise, i.e., the need for catharsis and the need to cope with failure. The frequent use of medical services for multiple diffuse symptoms is an adjustment to this privation, a mechanism by which the individual attempts to gratify needs not satisfied within her personal environment. The dependent patient's emphasis on the socioemotional aspects of the doctor-patient relationship is consistent with her deleterious life circumstances as an individual.

Concepts Relevant to the Physician

Merton (1957a:51) distinguishes between the manifest and latent functions of an institution, defining the former as consequences that are intended and recognized by participants in a system and the latter as "consequences which are neither intended nor recognized by participants." Both functions are considered in this study. The manifest function of the physician is defined as the prevention and cure of disease, the latent functions as the satisfaction of the need for catharsis and the satisfaction of the need to cope with failure.

It is argued in the study that the physician's performance of these functions does not always conform with the primary cultural tradition, that his personal orientation determines, at least in part, his approach to medicine, his definition of disease, and even his determination of treatment. These orientations may be derived from the background in which he was raised, may emerge during his years in medical school or may be influenced by his experiences in practice. Regardless of their source, they will have an effect on his response to the dependent patient and, consequently, the outcomes of physician-patient interaction.

Concepts Relevant to the Women as Individuals

It has been argued that non-medical needs arise from the individual's social and economic environment, that needs are a product of experiential factors and perceptions of them. The differential use of medical services, then, may be a function of broad aspects of the patient's life situation. This study focuses on six such aspects: (1) quality of life; (2) social position; (3) social stressors; (4) social networks of kin and friends (i.e., social assets); (5) relations with neighbors (i.e., social assets); and (6) feelings of failure (i.e., psychological assets).

Quality of Life

Quality of life refers to the individual's perception of the objective circumstances of her life. The term quality inevitably is a comparative measure and, hence, is used to define the individual's sense of well-being about her situation (i.e., the "goodness" of it). It is assumed that people living in different circumstances will express different patterns of well-being and that these will reflect the peculiar quality of the situation in which they live.

In the study, the individual's sense of well-being is described in terms of her life as a whole as well as in terms of specific domains of life into which her experiences are segmented. The phrase general state of life is used to refer to the overall life situation of the individual. The term family life is used to refer to the way in which the family functions as a social unit, i.e., the interpersonal relations among and between its members. And, the term family money situation is used to refer to the family's financial position.

The family is considered to consist of two or more people who share living facilities and a common coffer and who perceive themselves to have a meaningful interpersonal relationship. Although this definition is not necessarily congruent with traditional sociological definitions applied to the prototype of the family,[1] it was adopted in order to account for pseudo-families such as those consisting of friends, as well as non-intact families such as those in which the marriage has been disrupted.

The family is the unit of "living" and it might be expected that the degree to which it is socially or financially disadvantaged will affect the individual's health as well as her perception of it; the health of the family as a functioning unit and the health of the individual are assumed to be interdependent (Haggerty, 1965; Mechanic, 1962). Part of the research problem, then, focuses on the following questions:

> Does the individual's perception of the general state of her life relate to the presence or absence of non-medical needs and/or her use of medical services?
>
> Does the individual's perception of her family's life and money situation relate to the presence or absence of non-medical needs and/or her use of medical services?

Social Position

One of the most glaring inequalities in the United States is the differential distribution of income. At the extreme lower end are the poor, those with little command of economic resources and little power to shape their own destiny. Such people usually are black and divorced or separated females heading households. The median income of families with children headed by women 25 to 44 years of age was $4,000 a year in 1969, compared to a median of $11,600 for all families with two parents (Stein, 1970). This discrepancy was greater for non-whites than for whites; fifty-eight percent of all non-white female headed families were poor as compared to thirty-two percent of their white counterparts (Ferris, 1971).

Furthermore, although labor force participation for women with preschool children is increasing for all females, those whose marriages have been disrupted are more likely to be working; in 1971, 20 percent of married mothers, 41 percent of separated mothers, and 62 percent of divorced mothers worked (Waldman and Gover, 1972). The jobs held by these women tended to be low-paying and insecure since they frequently enter the job market with less educational credentials essential for most well-paying occupations and are given less job training (Bluestone, et al., 1971).

The distinctions of income, race, marital status, family structure, educational and social role, then, produce crucial differences in the life situations of individuals. Low-status people have less money, power, knowledge and other resources with which to cope with life problems. In addition, working places greater strains on spouseless mothers who must perform both integrative and functional roles. Individuals near the bottom of the social hierarchy, therefore, might be expected to attempt to manage the stress of their lives by seeking solutions within the medical institution. Part of the research problems, then, focuses on the following questions:

> Do sociodemographic characteristics relate to the presence or absence of non-medical needs and/or the use of medical services?

Social Stressors

Social stressors refer to any set of events that involve new demands, changes in life routines, and breaks in established life patterns (Mechanic, 1974; Rabkin and Struening, 1976). Such events may be socially or personally desirable such as marriage or the birth of a planned child, or they may be events that are experienced as threatening or demoralizing such as divorce or an unwanted pregnancy. In this study the focus is on the latter type events since they imply the greatest challenge to the individual's coping resources and skills.

No change in circumstance is the same for any given individual, however. Its impact ranges according to the hardships that may accompany it. A disrupted marriage may force the woman to work and to be both mother and father to her children. But the disruption also may produce a more relaxed family life. Clearly, stressor events are modified by the meanings that people attach to them, as well as by their ability to handle these events effectively.

Furthermore, the impact of such events may be presumed to be additive; more events are likely to have a greater effect on the individual (Rabkin and Struening, 1976:1014). An individual might be able to adapt to one event that required or signified change, but be unable to cope with the demands of a series of events that challenged her resources and skills.

Finally, not all stressor events precede the occurrence of illness and not all people who are exposed to them become ill. The response to bacterium as well as to symptoms that have a very high prevalence in the population are highly variable. It might be expected, therefore, that the individual who is least able to adjust to stressor events will be most likely to focus on symptoms as a way of managing them. Part of the research problem, then, focuses on the following questions:

> Does the presence of stressor events relate to the presence or absence of non-medical needs and/or the use of medical services?

Social Assets: Social Networks

The phrase a "network of social relations" frequently has been used to describe a set of interrelationships or "links" between persons.

> This use of 'network,' however, is purely metaphorical and is very different from the notion of a social network as a specific set of linkages among a defined set of persons, with the additional property that the characteristics of these linkages as a whole may be used to interpret the social behavior of the persons involved (Mitchell, 1969:1).

The concept of social networks, then, is different from that of social relationships because in network analysis the nature or characteristics of the interconnections between people are used to interpret social actions.

The analytical, rather than just metaphorical, use of the concept social networks seems to have been adopted in the 1950s by anthropologists dissatisfied with the ability of structural-functional analysis to explain social change and phenomena in complex societies. The idea was introduced by Barnes (1954) in a study of social action in a Norwegian community and developed by Bott (1957) in a study of the allocation of conjugal roles within London families.

Unfortunately, Bott's study had the initial effect of associating the notion of social networks almost exclusively with conjugal roles (Aldous and Straus, 1966; Nelson, 1966; Turner, 1967; Udry and Hall, 1965). More recently, the concept has been used by British social anthropologists to study interaction in a variety of situations.[2] It has not been so readily adopted by sociologists in the United States, however. Researchers have conducted many studies of kinship (Aldous, 1967; Cohen and Hodges, 1963; Gans, 1962, 1967; Litwak, 1965; Rainwater, 1964; Sussman and Burchinal, 1962), a few of friendship (Adams, 1967; Cohen, 1961; Lazersfeld and Merton, 1954), and a few studies in which relations with neighbors and friends as well as those with kin were examiend (Axelrod, 1956; Bell and Boat, 1957; Litwak and Szelenyi, 1969). But, few explicit studies about social networks have been carried out.[3]

Furthermore, although nearly everyone who has written on utilization behavior "seems to have paid lip service" to the influence of kinship and friendship networks on the use of medical services, there have been "remarkably few attempts to study . . . [their] nature" (McKinlay, 1972:129).[4] In part, the dearth of research employing the concept may be due to the fact that general theoretical insights about social networks gained in other disciplines have not diffused to any great extent into areas of sociological research. In part, it may be due to the fact that the influence of kin and friends on the way in which individuals "define and act (or fail to act) upon symptoms or life crises" is considered "truistic" (1972). The relationship of significant others to the use of medical services cannot be assumed a priori, however. This study, therefore, examines the "nature" of kin and friend networks in order to see if existent variations relate to differences in utilization behavior.

The personal network is the focus of the study with the individual as the reference point in the network. Only the kin and friend regions of the network are examined. Neighbors, of course, provide a pool of potential friends and may overlap with the kinship and friendship categories. Nevertheless, since it cannot be taken for granted that relationships with them imply the services and support connoted by the primary relationships of kinship and friendship, neighbors are viewed as a unique conceptual unit.[5]

Several characteristics of networks are viewed as germane to the understanding of utilization behavior: density; content; and frequency of contact. Density is a structural characteristic of networks and contributes to the shape of the network, the pattern of the links in the network in respect to one another (Mitchell, 1969:12). Content and frequency of contact are interactional characteristics and define the nature of the links themselves (1969:12).[6]

Density. The density or "connectedness" (Bott, 1957) of a network refers to the extent to which the people known by an individual know and meet with one another independently of the individual (1957:59).[7] A close-knit (i.e., dense) network is one in which there are many relationships among people; a loose-knit (i.e., sparse) network, one in which there are few such relationships (1957:59). The consequence of the density of the network, so defined, is the extent to which the norms of the network members are or are not reinforced through intercommunication:

> When many of the people a person knows interact with one another, that is when the person's network is close-knit, the members of his network tend to reach concensus on norms and they exert consistent informal pressure on one another to conform to the norms, to keep in touch with one another, and if need be, to help one another . . . . [Conversely], when most of the people a person knows do not interact with one another, that is when his network is loose-knit, more variation on norms is likely to develop in the network, and social control and mutual assistance will be more fragmented and less consistent (Bott, 1957:60).

Mitchell argues, however, that:

> The degree to which a person's behavior is influenced by his relationships with others often turns on the extent to which he can use these relationships to contact people who are important to him or alternatively, the extent to which people who are important to him can contact him through these relationships. This is the general idea of reachability in a segment of a network . . . [and] should be differentiated . . . from density . . . which refers rather to the extent to which everyone is a set of ego's contacts knows everyone else (1969:15).

For Mitchell, then, the degree to which norms are reinforced or pressure brought to bear on some individual, is likely to depend on the number of people who must be contacted to reach the person concerned. "A dense network may imply that this enforcement is more likely to take place than a sparse one, but this cannot be taken for granted" (1969:18-19).

Given Mitchell's reservation about the correctness of the definition of density developed by Bott and used in this study, the following clarification of the meaning attached to the concept is provided. The network functions as a channel for the transmission of information. The degree to which the information communicated includes judgments and opinions that are likely to serve to reinforce norms and bring pressure to bear on some specified person remains an underlying assumption in this study rather than a datum to be examined empirically. Thus, it is assumed that a close-knit network is more likely to function as an effective channel of information than is a loose-knit one.

Content. The content of the network refers to its purpose, "the meanings which the persons in the network attribute to their relationship" (Mitchell, 1969:20). This content may be, as suggested above, the flow of information. The primary purpose of networks specified in this study, however, is the provision of social support, psychological as well as functional.

The term psychological support is used to refer to any behavior that makes an individual feel better or improves her spirits. Serving as an emotional outlet so that difficulties can be acknowledged and feelings expressed, listening and helping to identify and objectify a problem, or sustaining and validating another's self-image are a few, among several possibilities, such support may take. The term functional support is used to refer to any tangible assistance that is provided for the individual such as financial assistance, or help with child care, with problems when there is illness in the family, with transportation or with home repairs.

Frequency of Contact. Frequency of contact is used to refer to the number of times individuals contact each other or have interaction. Since frequency of contact may be affected by the degree to which significant others are available for interaction, location of network members also is considered in this study. The neighborhood--the area within walking distance of the individual's front door--is the territorial unit likely to provide a pool of non-household persons actually available for interaction.[8] Thus, this area is contrasted with that outside it. Furthermore, since access to travel facilities, as well as the use of the telephone, may minimize the importance of geographic distance for frequency of interaction, type of contact also is considered in this study: that is, telephone vis-á-vis personal, face-to-face contact.

The density and content of the network and the frequency of contact between kin and friends might be expected to be related to the individual's need for catharsis and/or need to cope with failure. The psychological and functional support of kin and friends may serve as a mechanism to ameliorate the strain of problem situations and/or to mitigate the impact of problems on an individual's sense of well-being. Furthermore, the density of the network and the frequency of contact between network members may affect the degree to which such support is forthcoming. Part of the research problem, then, focuses on the following questions:

> Does the nature of the individual's social networks relate to the presence or absence of non-medical needs and/or the use of medical services?

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Social Assets: Relations with Neighbors

The term neighborhood refers to a bounded geographic unit that usually is homogenous in terms of socioeconomic criteria; in the study this territorial unit is defined as the area within walking distance of the individual's front door. The term neighborhood also may refer to a social unit in which communicative and/or functional ties exist between and among people; spatial proximity provides individuals with the opportunity to meet together, to form friendships, and to establish relationships of mutual obligation. The term neighborliness is used to refer to the extent to which such intimate and cooperative relationships exist between people living within a defined geographical area.

Neighborliness is a consequence not only of contact, but of common interest and continuity as well. The homogeneity and population stability of the neighborhood, therefore, might be expected to be related to the degree of interaction between neighbors. In addition, the psychological support and functional aid available from neighbors might be expected to affect the impact of problems on an individual.[9] Furthermore, the degree to which the neighborhood is socially and physically disorganized might be expected to be a source of stress and related to the individual's health or her perception of it. Part of the research problem, then, focuses on the following questions:

> Does the degree of neighborliness relate to the presence or absence of non-medical needs and/or the use of medical services?

> Do the social and physical conditions of the neighborhood relate to the presence or absence of non-medical needs and/or the use of medical services?

Psychological Assets: Feelings of Failure

Feelings of failure refer to the individual's belief that she has fallen short in some domain of life, that she is unsuccessful. In a society such as America, in which achievement and self-reliance are values that receive strong emphasis, it might be expected that inadequate role performance or needing help with problems might give rise to such feelings. The inability to perform socially prescribed roles--as measured by one's own expectations or against the performance of others--or the inability to solve problems through one's own efforts may be sensed as indications of a lack of skill or competence to function independently.

The individual who fails to fulfill a socially defined role expectation or fails to handle problems by herself, however, is not blamed for these deficiencies if she is in poor health. Thus, it might be expected that individuals who feel they fall short of the dominant culture's view of success might be likely to perceive their health as poor to justify their self-defined failure. Part of the research problem, then, focuses on the following question:

> Do feelings of failure relate to the presence or absence of non-medical needs and/or the use of medical services?

Concepts Relevant to the Women as Patients

It has been suggested that individuals may rely upon the physician as a substitute to satisfy basic social needs not gratified through alternative sources. Furthermore, it has been suggested that in United States society the physician has the ultimate authority to legitimate illness and to sanction the adoption of the sick role. The use of medical services, then, may be a function of differential needs and predispositions. This study focuses on two such needs: the need for catharsis; and the need to cope with failure.

Need for Catharsis

The need for catharsis refers to the need for the kind of social contact that permits or encourages free communication. Theoretically, the physician's role seems ideally suited to this need since it involves communication in an uncritical, supportive atmosphere; during the course of diagnosing or managing patients' problems, the physician may provide the opportunity to talk about subjects that may or may not be related to the medical problem for which care is sought. Individuals who feel a need to express and cope with feelings and unmanageable difficulties, therefore, might be expected to seek medical care in an attempt to alleviate their concerns and problems. Part of the research problem, then, focuses on the following question:

> Does the individual's need for catharsis relate to the use of medical services?

Need to Cope with Failure

The need to cope with failure refers to the use of illness as a legitimizing mechanism. In western society, once an individual's illness is legitimized by medical sanction, the person occupies a special role, i.e., the sick role. According to cultural expectations, the incumbent of the sick role is exempted from responsibility for his or her condition and relieved of the usual demands and obligations that accompany his or her occupational and/or familial roles. Individuals who feel a need to escape from frustrating or untenable problems of life, therefore, might be expected to define their health as poor and to seek medical care in an attempt to obtain sanction for the avoidance of duties and responsibilities. Part of the research problem, then, focuses on the following question:

> Does the individual's need to cope with failure relate to the use of medical services?

Concepts Relevant to the Physician

It has been suggested that attitudes play a role in the orientation and responses of one actor to another (Parsons and Shils, 1959:159).[10] Furthermore, it has been suggested that the differential use of medical services may be a function of differences in physician's orientations and responses to patients. This study focuses on the physician's orientation toward dependent patients and on his response to them as he performs his manifest and latent functions.

Orientation to the Dependent Patient

The phrase orientation to the dependent patient refers to the position the physician adopts toward the patient who frequently seeks care in an attempt to satisfy non-medical needs. In dealing with patients, the physician is expected to maintain a balance between identification and dissociation and to deal with problems of health and disease by means of professional knowledge and skill: that is, he is expected to be affectively neutral and functionally specific. These are ideal norms, based on the expectation that the patient seeks care for an essentially medical problem.

Medical problems may be varyingly defined, however. Some physicians may define them in their narrowest, somatic sense. Others may define them broadly, considering socioemotional problems highly relevant to health. To the extent that the patient deviates from or conforms to the physician's expectations, it might be expected that his attitude toward her will change and that this change will be reflected in his orientation: that is, his affectivity will increase. On the one hand, the physician who believes his authority is limited to organic medical problems may feel he is being taken advantage of and dissociate himself completely from the patient and her plight. On the other hand, the physician who believes socioemotional problems are within the purview of his technical competence may increase his identification and involvement with the patient and her problems. In either case, it might be expected that the physician's orientation will influence the way in which he performs his manifest and latent functions. Part of the research problem, then, focuses on the following question:

> Does the physician's orientation to the dependent patient relate to his response to her?

Manifest Functions of the Physician

The phrase manifest functions of the physician refers to management activities related to the prevention and cure of disease, i.e., laboratory procedures and x-rays ordered, requests for return visits, and therapies prescribed. As suggested above, the physician is an individual who (1) is susceptible to emotional responses which as a professional he is supposed to inhibit; and (2) is likely to manage patients' problems differently on the basis of his orientation toward them. The physician who is unfavorably oriented toward the dependent patient might be expected to adopt one of two possible management strategies. He may order extensive tests and follow-up visits in an attempt to find an organic problem, thereby "making" the patient conform to his expectations. Or he may prescribe a psychotropic drug and dismiss the patient, thereby implying that her symptoms are not reflective of "bona-fide" or serious illness. Conversely, the physician who is favorably oriented toward the dependent patient might be expected to adopt a more psychologically-oriented management strategy, listening to the patient and exploring her difficulties with her.

Regardless of which management strategy is adopted, however, high use of services might be expected to occur. A continuing search for organic illness obviously will generate use as the patient must return to the physician for diagnostic testing. A dismissal with a prescription for a tranquilizer might be expected to generate use as the patient returns in an attempt to satisfy her frustrated needs. Similarly, an "invitation" to communicate personal problems might be expected to generate use as the patient returns for additional support and reassurance. Part of the research problem, then, focuses on the following question:

> Do the management strategies adopted by physicians relate to the use of medical services?

Latent Functions of the Physician

This study focuses on the relationship of the physician's role to two latent functions of the medical institution: the satisfaction of the need for catharsis; and the satisfaction of the need to cope with failure.

Satisfaction of the Need for Catharsis.

The phrase satisfaction of the need for catharsis is used to refer to the extent to which the physician feels he allows the patient who wants, to talk and unburden herself of problems. In the course of diagnosing and treating illness, the physician is required to devote time to listening to the patient's description of her problems. This aspect of his role, then, opens the way for the patient who feels a need to express difficulties to talk about them, i.e., to attempt to satisfy her need for catharsis. The extent to which her attempt is successful, however, might be expected to vary with the physician's definition of his role.

Some physicians may feel that listening to personal problems is a legitimate professional obligation, that satisfaction of the need for catharsis is part of their function. Others may feel that this is a function of other professionals such as a social worker or psychiatrist, that fulfilling this need is not within the purview of their role. Physicians define their role in different ways and it might be expected that they will respond differently to patients who wish to talk about problems that, from the doctor's viewpoint, may or may not be related to their health.

The physician who defines his role broadly is likely to allow patients freedom to talk. The physician who defines his role more narrowly is likely to impose limits on the subjects to be discussed during interaction. The extent to which the physician feels he satisfies the need for catharsis, therefore, might be expected to be related to the management strategies he adopts and to the use of services. Part of the research problem, then, focuses on the following questions:

> Does the physician's perception of his satisfaction of the need for catharsis relate to the management strategies he adopts and the use of medical services?

<u>Satisfaction of the Need to Cope with Failure</u>. The phrase satisfaction of the need to cope with failure is used to refer to the extent to which the physician feels he legitimates illness which he believes is being used to justify failure. Illness cannot be self-defined in Western society but must be certified by a physician. The doctor, therefore, plays a major role in helping a patient to

cope with failure when he defines a set of symptoms as a disease and prescribes a therapeutic regimen.

Patients often present with vague and ambiguous symptoms which the physician, rightly or wrongly, may assume are real or imaginary. Some physicians may feel that a patient of this type is a malingerer, demanding legitimation for her complaints out of some personal need. Such physicians are likely to dismiss the patient with a clean bill of health, thereby negating her right to adopt the sick role. Other physicians may feel that indeed the patient is not diseased but be sympathetic to her need to be sick. Such physicians are likely to respond medically to the patient, thereby sanctioning the adoption of the sick role and permitting her to cope with failure. The extent to which the physician feels he satisfies the need to cope with failure, therefore, might be expected to be related to the management strategies he adopts and to the use of services. Part of the research problem, then, focuses on the following questions:

> Does the physician's perception of his satisfaction of the need to cope with failure relate to the management strategies he adopts and the use of medical services?

Professional Experiences of Physician

The cultural definition of the physician's role has been a dominant theme throughout the above discussion. Yet, there have been indications that physicians do depart from this prototypic role and that such departures may be a function of a number of factors. This study focuses on three such factors: the type of medical school attended by the physician; his career stage; and the structure of the setting in which physician and patient interact.

Type of Medical School Attended. It has been argued that there are two distinct segments in American medicine--the scientifically-oriented and the practice-oriented (Miller, 1970)--and that different medical schools train students for careers in one or the other of these segments. The term academically-oriented medical school has been used to refer to the institution that (1) emphasizes the basic sciences and the acquisition of knowledge; and (2) prepares students for a career in scientific medicine (Perlstadt, 1972a, 1972b). The term practice-oriented medical school has been used to refer to the institution that (1) stresses the behavioral as well as the basic sciences and the application of knowledge as a service; and (2) prepares students for careers as practicing physicians (Perlstadt, 1972a, 1972b). Kendall and Selvin's (1957) study of Cornell medical students and Becker and his colleagues' (1961) study of Kansas medical students both demonstrate the impact that different institutional curricula and emphases have on the career choices of young graduate physicians.

It also has been argued that the medical school is the major socializing influence on physicians, that the culture learned there has primary significance for what he or she does or does not do in later practice (Becker, et al., 1961; Bloom, 1965). Indeed, Miller (1970:216) reports that administrators at a teaching hospital complained that graduates of academically-oriented medical schools "ordered more laboratory work than necessary" because of their "academic way of thinking." Graduates of academically-oriented schools, then, might be expected to be more technically-oriented, directing their efforts primarily to physical pathology at the expense of interpersonal aspects of patient care. Conversely, graduates of practice-oriented schools might be expected to be more human-oriented, channeling their efforts to physical as well as to social-psychological pathology and taking the time necessary to consider the social context within which illness develops. Part of the research problem, then, focuses on the following question:

> Does the type of medical school a physician attended relate to his orientation toward and response to dependent patients?

Career Stage. Hall (1948) has conceived of the medical career as a set of more or less successful adjustments to the network of institutions, formal organizations, and informal relationships within which medicine is practiced, and distinguished four stages of a medical career: (1) generating of an ambition; (2) gaining admittance to the various medical institutions; (3) acquiring, retaining, improving, and, perhaps, transferring a clientele; and (4) developing a set of informal relationships with colleagues. The physicians who participated in this study either were completing stage two of their career, or entering stage three: that is, they were residents in training or recent graduates of the training program just beginning a practice. The term career stage, therefore, is used to refer to the year of residency of the physician.

Much of the research on the impact of career stage on professional attitudes has been conducted with medical students and has emphasized the extent to which "humanitarism" decreases as the student progresses in his or her training (Becker, et al., 1961; Eron, 1955; Fox, 1957; Reisman and Platou, 1960). Millin (1975:4), in fact, has suggested that "medical schools admit incoming students who are interested in people and transform them into doctors interested only in diseases." Gray, et al. (1966), argue, however, that affiliating with patients during practice modifies the decrease in "humanitarianism" that develops in medical school. In a study of physicians with comparable "humanitarianism" scores at the time of their graduation, they found significant differences in scores after several years of practice. Those who had entered "high-interaction" specialities indicated greater "humanitarian" attitudes than those who entered "low-interaction" specialties. Gray and his colleagues attributed this increase in humanitarianism to more physician-patient interaction.

The stage or level of training of a physician, then, might be expected to affect his orientation toward dependent patients and response to them. A first year resident might be less favorable toward them because they frustrate his efforts to achieve success during the period his technical skills are given their first real test (Martin, 1957). A more advanced physician might be more favorable toward them because extended contact with patients may have heightened his awareness of the need to treat the "whole" person rather than just her symptoms. Part of the research problem, then, focuses on the following question:

> Does the career stage of the physician relate to his orientation toward and response to dependent patients?

Structure of the Medical Setting. It has been argued that the structure of the medical setting affects the behavior of physicians toward patients. Freidson (1960) suggests that in bureaucratic settings physicians have less freedom to deviate from ideal norms because they are more visible to colleagues than doctors in solo practice. Shuval, et al. (1970) agree with Freidson but suggest that the bureaucratic setting also may exert certain pressures on physicians to modify their professional roles. The inordinate amount of paper work required and the large numbers of instructions to be followed--including the requirement to see a given number of patients--often causes physicians to deviate from their "ideal nonaffectively oriented role" in response to their dissatisfaction.

This study was conducted with residents in training and it might be expected that the structure of the program will affect their orientations and responses to patients and, perhaps, modify the effects of other influential factors. First, faculty, intent on achieving defined goals, may stringently enforce norms. Second, these medical educators may continually scrutinize and monitor the trainees' medical practice. Residents, therefore, may be pressured to accept certain norms and less free to define their own professional role. Part of the research problem, then, focuses on the following question:

> Does the structure of the medical setting influence the orientation and response of physicians toward dependent patients?

Conceptual Model

The concepts presented above provide a starting point for the development of a social system model of the use of medical services. They suggest that variability in the life situations and needs of individuals and in the orientations and responses of physicians introduce important variations into patterns of utilization. Furthermore, they suggest that the social dynamics of the doctor-patient relationship influence the use of medical services.

Figure 2.1 shows the social system model of the use of medical services developed. In this figure, the doctor and patient can be seen acting in their respective roles (A and B) in a medical situation (C). The motivational-orientation of these interactants is pictured as deriving from the individual contexts in which they are located (D and E). For the patient, this orientation is seen to be influenced by her life situation (D): for the physician, the medical profession (E). Both patient and physician (A and B) and the separate contexts in which they are located (D and E) are based in the dominant culture (F). Together, these five (A + B + D + E + F) form the environment in which the social system (C) exists, a system generated by the process of interaction between physician and patient in a medical situation. It is argued that the use of medical services (G) is a product of the dynamics of this system.

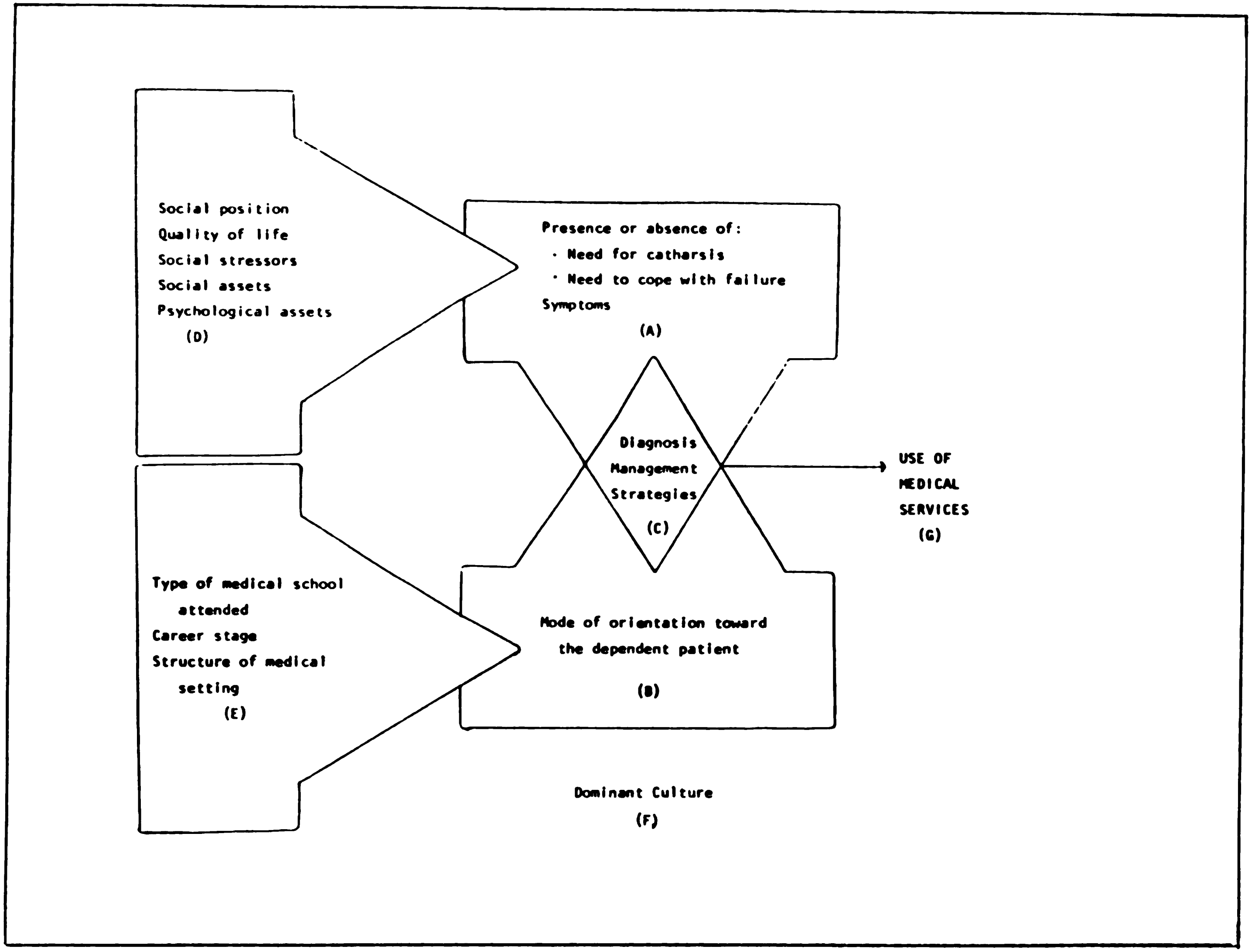

Figure 2.1.--A Social System Model of the Use of Medical Services.

Hypotheses to be Tested

The conceptual model presented above provides a mechanism by which the specific hypotheses to be tested are derived. A crucial question posed by this model is the extent to which variations relative to one sub-system will influence the others. This is an empirical question which only can be answered by the testing of the following hypotheses.[11]

1. Individuals who occupy a low social position will have a need to cope with failure and present multiple diffuse symptoms.
2. Individuals exposed to more social stressors will have a need to cope with failure and present multiple diffuse symptoms.
3. Individuals who perceive the quality of their life as poor will have a need to cope with failure and present multiple diffuse symptoms.
4. Individuals who sense feelings of failure will have a need to cope with failure and present multiple diffuse symptoms.
5. Individuals with limited or non-supportive social networks will have a need for catharsis and present multiple diffuse symptoms.
6. Patients with greater non-medical needs will use more medical services in the presence of multiple diffuse symptoms.
7. Physicians who attended an academically-oriented medical school will have a less favorable attitude toward dependent patients.
8. Physicians in an early career stage will have a less favorable attitude toward dependent patients.
9. Physicians will order more diagnostic procedures in the presence of patients with multiple diffuse symptoms.

GIVEN THE ABOVE:

10. Physicians' decisions will result in different patterns of use of medical services.
11. The conjunction of the needs of the patient and the response of the physician to these needs will result in high use of medical services.

Summary

This study is centrally concerned with variations in health and professional behavior and their effect on the use of medical services. The patient and the physician are seen as located in separate contexts from which their orientations toward the medical situation derive. Because the physician's orientation results from participation in a medical profession and the patient's orientation from participation in a socioeconomic millieu, their expectations may be in conflict with each other. Attention is focused on the nature of the expectations and goals these participants bring to the medical encounter, the sources of these phenomena and their subsequent effect on outcomes.

Parsons' formulation of the social system provides a base for the conceptual framework of the study. The social system, along with the cultural and personality systems, are seen as constituting three units in a system of action. The three systems interpenetrate and are interdependent with one another. Physician-patient interaction within a medical situation (i.e., the social system) is viewed as influenced by need-dispositions developed within a specific context (i.e., the personality system) and theoretically guided by societal standards of appropriate behavior (i.e., the cultural system). Attention turns in Chapter 3 to the body of methods devised to explore the research problem in a concrete setting.

CHAPTER II: NOTES

[1] Traditionally, definitions are offered that refer to the procreational unit, including father, mother, and offspring. Commonly these emphasize interacting personalities and roles, structural arrangements of positions, or institutions representing the performance of cultural tasks (Hill and Aldous, 1967; Nye and Berarado, 1966).

[2] See the papers included in Mitchell (1969) for a sampling of the situations to which the concept has been applied.

[3] See the second edition of Bott's 1957 book (1971:248-343) for a review of some of the research on social networks that has been done since her work first was published.

[4] See Salloway's study (1973) of the use of the urban medical system by Gypsies and McKinlay's research (1973) with lower working class pregnant women as examples of works that have attempted this task. These works, however, do not examine the impact of social networks on non-medical needs that may motivate use. Rather, they analyze the relationship between utilization of medical services and social networks in terms of Freidson's (1961) formulation of the "lay-referral" system.

[5] Primary consideration in the study was given to diffuse relationships that implied services and support of a general nature. Links with categories of people who might be expected to provide individuals with some specialized type of service or support were not investigated. Furthermore, no distinction was made between active or latent links in the network, that is, between relationships that were being used or those that could be mobilized for a specific purpose and then become inoperative when that purpose has been met.

[6] See Mitchell (1969:1-50) for a discussion of the characteristics of networks likely to be relevant to descriptions of social behavior.

[7] Bott (1971) in a new final chapter included in the second edition of her 1957 book, adopts the word "density" as a substitute for the term "connectedness."

[8] The neighborhood also is likely to be related to the density of social networks. That is, the density of a network is likely to be close-knit where an area is homogeneous (socially and economically similar) and where there is continuity (population stability or low population turnover) (Bott, 1957; Gans, 1962; Young and Willmott, 1957).

[9] Whether this support is supplementary to that received from kin and friends or compensatory remains an empirical question.

[10] Parsons (1951:109) equates the word attitude with the "need-dispositions" that form the core of the personality system.

[11] Hypotheses one through five each contain two dependent variables. However, in testing, the relationship between the independent variable and each dependent variable was treated as a separate hypothesis.

CHAPTER III

DATA AND METHODS

In order to explore the research problem presented in Chapter II, this study uses a retrospective research design employing data from four sources: (1) survey interviews; (2) in-depth interviews; (3) self-administered questionnaires; and (4) medical records. These data were provided by patients, and physicians in training at a family health care center in a mid-western, industrial city. This chapter presents a discussion of the research design and the assumptions that underlie it; the samples; the data; the measurement of variables; and the analysis plan.

Research Design

It is argued in this study that the doctor and patient are not an isolated dyad, and that social and professional factors provide a constant field in which they interact. Furthermore, it is argued that high use of medical services, in the absence of clinically defined morbidity, is a consequence of the non-medical needs of the patient and the response of the physician to these needs. In order to test the validity of these premises, a retrospective research plan was developed.

First, a sample of patients, stratified according to patterns of use during a six-month period, was selected and the data contained in their medical records for that period abstracted. Second, these patients were interviewed personally in their homes using a structured survey instrument. Third, a sub-set of these patients was interviewed in-depth using a standardized, but unstructured, format. Fourth, all residents at the center were asked to complete a self-administered questionnaire. The study thus was designed to examine the extent to which observed patterns of utilization of medical services could be accounted for by (1) aspects in the patient's social environment; (2) factors related to the patient qua patient; and/or (3) management strategies adopted by physicians to care for them. Two assumptions underlie this design.

Assumptions

1. Patterns of use of medical services are relatively consistent over time; patients have a tendency to repeat past utilization patterns in the future.
2. The objective circumstances of patients' lives remain relatively consistent over time; their life situations are not likely to change within a short time.

The findings of Densen, et al. (1959) lend support to the first assumption that patterns of utilization remain fairly constant over time. In a study of a random sample of families enrolled in a prepaid health care plan in New York, they found that (1) members followed for a three-year period were likely to remain at the same utilization level from year to year; and (2) the chances that individuals would have the same level of use from year to year were greater than would be expected if one year's experience was independent of the previous year's. Furthermore, Densen and his colleagues demonstrated that consistency of use was true for all patients, low utilizers, medium utilizers, and high utilizers.

The findings of several researchers lend support to the second assumption that the life situations of individuals tend to remain fairly immutable over time (Berle, 1958; Brandwein, et al., 1974; Fine, 1974). Individuals who lack the advantages of educational and vocational skills negotiable on the job market have poor objective chances to improve their economic situation. Limited economic resources to meet financial demands engender strains which place a burden on individuals and the family as a functioning unit. Victims of a poor distributive order, then, tend to be confronted by life problems from which they have difficulty escaping and which they cannot solve in a short time. With these assumptions in mind, attention turns to the selection of the samples for the study.

The Samples

The interview data for this study were provided by three categories of respondents: (1) a sample of patients who responded to a survey interview; (2) a sub-set of this sample which was selected for the purpose of in-depth interviews; and (3) a group of physicians who completed a self-administered questionnaire. The purpose of this section is to describe the way in which these respondents were selected.

The Survey Sample

A sample of 120 women (60 dependent and 60 non-dependent patients) was planned for this study. The selection of this sample was carried out in three stages. First, two populations of women, 18 to 40 years of age, who regularly sought medical services at the family health care center were created. Second, criteria were established for selecting two sub-populations. Third, two samples, stratified according to patterns of use, were drawn from the sub-populations. These three procedures are described in the following section and the rationale for the age and sex categories chosen is discussed.

Rationale for Selection of Females 18 to 40 Years of Age

The sex and age categories included in the study were chosen for both theoretical and pragmatic reasons. First, the members of this age group tend to visit a physician less than the old who consume more services because of a higher prevalence of chronic diseases, and the very young who use more services because of a high prevalence of acute conditions (Aday and Eichhorn, 1972). Thus, there was an interest in examining the possible roots of unexpectedly high utilization rates among some individuals in this presumably "healthy" age category. Second, excluding utilization of services associated with pregnancy and child birth, women should tend to visit a physician less than men since they have lower morbidity rates for most causes of death (Anderson, et al., 1972). Again, there was an interest in examining the possible roots of an unexpected phenomenon.

Third, women eighteen years of age are likely to be leading lives independent of their parents and those forty years of age, more likely to be premenopausal. Thus, these lower and upper age limits would eliminate the possible intervention of parental influence and physiological and/or psychological problems associated with menopause on visits. Finally, the majority of the patient population at the center is female. Thus, if men were included in the sample, too few cases would have been available for analysis.[1]

The Populations

The populations used in this study were defined by means of computerized data from the health information system in use at the center since January, 1975.[2] The first population was created prior to the survey phase of the study and the second, two weeks after interviewing had begun. Attempts to locate patients were only partially successful because (1) the addresses and telephone numbers on record at the center were highly inaccurate; and (2) the individuals selected were relatively mobile. Therefore, in order to ensure the required size sample, a second population was created from which potential respondents could be selected.

The first population was composed of patients who showed evidence of contact with the center before and after the defined observation period; it is a population of regular, rather than transcient, patients. Since data contained in the health information system were entered only through the middle of 1977, the most current period, bounded by a prior- and a post-six month period, was selected as the period of observation: July 1, 1976 to December 31, 1976. The following criteria were developed and used to select the population: (1) female only; (2) age eighteen or older and age forty or less on July 1, 1976; (3) one visit of record before July 1, 1976;[3] (4) one personal visit (PV) between July 1, 1976 and December 31, 1976; and (5) one visit of record after December 31, 1976.

The second population was composed of patients who showed evidence of contact before the defined observation period only; data contained in the health information system were not available to demonstrate a visit of record after the period. The six months that followed the first--January 1, 1977 to June 30, 1977--were selected as the second period of observation. The following modified criteria were used to define this population: (1) female only; (2) age eighteen or older and age forty or less on January 1, 1977; (3) one visit of record prior to January 1, 1977; and (4) one PV between January 1, 1977 and June 30, 1977.

The populations, created by using these two sets of criteria, are described in Table 3.1. Population A (7/1/76 - 12/31/76) is smaller than Population B (1/1/77 - 6/30/77) and recorded frequencies are somewhat different. The differences are due to the less rigorous selection criteria used to define the later population as well as to the exclusion of 141 patients from Population B; 115 of those excluded were acutely ill patients who had visited the center during both periods of observation but had been selected for inclusion in

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TABLE 3.1.--Number and Percent of Patients in the Populations.

Type of Patient	Population			
	A: 7/1/76 - 12/31/76		B: 1/1/77 - 6/30/77	
	Number	Percent	Number	Percent
Accutely Ill[a]	209	60.6	280	50.5
Chronically Ill[b]	29	8.4	27	4.9
Pre- or Post-Natal	73	21.2	132	23.8
Health Maintenance Only[c]	34	9.8	115	20.8
TOTALS	345	100.0	554	100.0

[a] An acutely ill patient was defined as one who had visited the center one or more times during the observation period primarily for the care of short-term problems. This category, of course, also includes dependent patients whose problems may be more long-term.

[b] A chronically ill patient was defined as one for whom any single diagnosis was entered as a label at 60 percent or more of all her visits.

[c] A health maintenance patient was defined as one who had visited the center only once or twice during the period of observation for routine or gynecological check-ups.

the first sample. Twenty-six were chronically ill patients who also had visited the center during both periods of observation.[4]

The Sub-Populations

This study focuses on the high use of medical services for diffuse symptomatology that cannot be explained by clinical morbidity. Therefore, all health maintenance, pre- or post-natal, and chronically ill patients were excluded from the populations. Such patients either had sought preventive care in the absence of somatic complaints or had sought care primarily for long-term conditions that might have accounted for high use. For purposes of the study, a health maintenance patient was defined as one who had visited the center only once or twice during the period of observation for routine or gynecological check-ups. A long-term or chronically ill patient was defined as one for whom any single diagnosis was entered as a label at 60 percent or more of all her visits.

This latter criterion separated out those with injuries, hypertension, diabetes, multiple sclerosis, malignancies, epilepsy, hyper- and hypothyroidism, systemic lupus erythematosis, and pylonephritis. In addition, it separated out patients with diagnostic listings such as anxiety, depression, migraine or tension headaches, back pain, and other ill-defined conditions. Since the literature had suggested, however, that emotional or social problems often were a contributing factor to some frequent utilization--and these diagnoses may be suggestive of such problems--all patients with the latter diagnostic listings in the populations were retained.[5]

In short, the exclusion of healthy, pre- or post-natal and chronically ill patients left two sub-populations of patients who had visited the center one or more times during two six-month periods for a combination of routine physical exams, acute illnesses, and/or psychosocial problems.[6]

Table 3.2 contains data on the total number and the rate of medical care utilization of these patients. Although the sizes and the total use of the sub-populations are different, the average number of visits is approximately the same: 2.8 visits for sub-population A and 2.3 visits for sub-population B. These rates are comparable to those reported for national samples, if one accepts the assumption that a majority of patients will have a similar pattern of use during the consecutive second six-month period. For example, excluding utilization of services associated with pregnancy and childbirth, averages of 5.6 visits a year (National Center for Health Statistics (1975b:25) and 4.8 visits a year (Nathanson, 1975:58) have been reported for women in the United States.

The Stratified Samples

In order to differentiate between average and frequent utilizers in the two sub-populations, a criterion of frequent use was established. Three or more visits during a six-month period was determined to indicate high use. But, these high users could not all be assumed to be dependent patients because some sought care due to recurrent episodes of acute illnesses. A group of average utilizers was included in the stratified samples, therefore, as a

TABLE 3.2.--Number and Percent of Patients in the Sub-Populations and Average Number of Visits per Patient.

Volume of Use	Sub-Population					
	A: 7/1/76 - 12/31/76			B: 1/1/77 - 6/30/77		
	Number of Patients	Total Number of Visits	Avg. Number of Visits per Patient	Number of Patients	Total Number of Visits	Avg. Number of Visits per Patient
1-2 Visits	117	178	1.5	196	298	1.5
3 or More Visits	92	411	4.5	84	342	4.1
TOTALS	209	589	2.8	280	640	2.3

comparative unit of analysis. It was hypothesized that high users who were acutely ill and average users would be similar to each other but be different from dependent patients.

The final criterion for inclusion in the stratified sample was volume of use during a defined six-month period. Since a total sample of 120 respondents was planned (60 dependent patients and 60 non-dependent patients), all patients with three or more visits automatically were included in the study. In addition, 36.5 percent and 30.6 percent of the patients with one or two visits in subpopulations A and B respectively were selected for inclusion in the stratified samples using a table of random numbers.

Table 3.3 contains information on the distribution and volume of use of the patients included in the stratified samples. Although the size of the samples and the volume of use by patients in them are different, the average number of visits by the members of each sample is approximately equal.

Table 3.4 contains data on the results of the survey phase of the study. These data indicate that the samples interviewed are fairly representative of the total stratified sample in terms of volume of use (see Table 3.3). In addition, the data show that the volume of use of the interviewed and non-interviewed patients is comparable, with one exception. The frequent users in sample B who were not located or refused to be interviewed, had a slightly lower volume of use than those who were interviewed. This difference remains unexplained. (Appendix A contains a comparison of the

TABLE 3.3.--Number and Percent of Patients in the Stratified Samples and Average Number of Visits per Patient.

Volume of Use	Stratified Sample					
	A: 7/1/76 - 12/31/76			B: 1/1/77 - 6/30/77		
	Number of Patients	Total Number of Visits	Avg. Number of Visits per Patient	Number of Patients	Total Number of Visits	Avg. Number of Visits per Patient
1-2 Visits	53	84	1.6	37	57	1.5
3 or More Visits	92	411	4.5	84	342	4.1
TOTALS	145	495	3.4	121	399	3.3

TABLE 3.4.--Number and Percent of Patients Interviewed and Not Interviewed and Average Number of Visits per Patient.

Volume of Use	Stratified Sample					
	A: 7/1/76 - 12/31/76			B: 1/1/77 - 6/30/77		
	Number of Patients	Total Number of Visits	Avg. Number of Visits per Patient	Number of Patients	Total Number of Visits	Avg. Number of Visits per Patient
INTERVIEWED PATIENTS						
1-2 Visits	23	37	1.6	19	29	1.5
3 or More Visits	46	203	4.4	39	171	4.4
TOTALS	69	240	3.5	58	200	3.5
NON-INTERVIEWED PATIENTS						
1-2 Visits	30	47	1.6	18	28	1.6
3 or More Visits	46	208	4.5	45	171	3.8
TOTALS	76	255	3.4	63	199	3.2

interviewed and non-interviewed samples on the basis of selected sociodemographic characteristics.)

Table 3.4 also illustrates the consequences of surveying primarily lower-class respondents (1) who are highly mobile; and (2) for whom addresses and telephone numbers on record are inaccurate. The completion rate of the survey was only 48 percent, for both samples as well as for the total sample.[7] Of the 52 percent of patients not interviewed, less than 10 percent refused to participate in the study; the remainder could not be located. The problem in locating potential respondents in part was due to incorrect telephone numbers and/or addresses listed at the center. In part, it also was due to lack of a supplementary information source. For example, the telephone company was unable to supply a new or correct telephone number in 59 percent of the cases. In 19 percent of the cases, the new telephone number was not given because it was unlisted. In 14 percent of the cases, someone was reached at the telephone number or address on record. But, this person was unable to give the caller the required information. Common responses were: "She picked up and pulled out. I don't know where"; or "I don't know where she is now. I get her mail and usually tear it up."[8]

The information listed at the center for respondents who finally were interviewed was also in most cases inaccurate. The address, telephone number, or both were incorrect for 46 percent of these patients (13 percent, 13 percent, and 20 percent respectively). Only the perseverance of the interviewers made even the low completion rate possible. (Appendix B includes a discussion of some of the problems involved in working with a sample of primarily lower class women.)

The In-Depth Interview Sample

In order to provide insights into the data collected through the survey interview, twenty-five respondents were selected for in-depth interviews. These women were chosen on the basis of an expressed interest in the study (as documented during the survey interview) and willingness to share their experiences. Problems also were encountered in completing interviews within these respondents. They were difficult to reach and almost one-third of the time not at home when an interviewer appeared for a scheduled appointment.

The Physician Sample

Thirty-three physicians were in training at the center in 1977-1978 when this study was conducted; seven first year residents; thirteen second year residents; and thirteen third year residents. All were asked by the medical director of the training program to participate in the study by completing a self-administered questionnaire. Twenty-five (75.8 percent) agreed: four (57.1 percent first year residents; twelve (92.3 percent) second year residents; and nine (69.2 percent) third year residents. In addition, eight physicians, graduates of the training program who had cared for patients during 1976-1977, were contacted by letter and asked to complete a questionnaire. Six (75 percent) completed and returned a questionnaire.

Data are available, however, for those physicians who chose not to participate in the study, but who cared for patients during 1976-1977. A pilot study had been conducted in 1976-1977 and eleven of these physicians had completed a questionnaire then: four first year residents; three second year residents; three third year residents; and one graduate of the program. The data, voluntarily provided in the pilot study, are used in this study.

In total, then, data were collected over a two-year period from forty-two physicians: eight (19.0 percent) first year residents; fifteen (35.7 percent) second year residents; twelve (28.6 percent) third year residents; and seven (16.7 percent) graduates of the program. Five of these physicians, however, had not cared for patients in 1976-1977: four of the first year residents in 1977-1978 and one second year resident who was new to the program the year the study was conducted. Thirty-seven of the physicians who completed questionnaires, therefore, were at the following career stages when they cared for patients in 1976-1977: fifteen (40.5 percent) in the first year; twelve (32.4 percent) in the second year; and ten (27.0 percent) in the third year of training.

The Data

The data for this study were derived from four sources: (1) patient medical records; (2) personal interviews with patients in their homes using a standardized, structured interview; (3) in-depth interviews with patients in their homes using a standardized, but unstructured format; and (4) self-administered questionnaires completed by physicians who cared for patients at the center. This section describes the data, the way in which they were collected, and their advantages and limitations.

Data Collection Procedures

As indicated above, potential respondents were identified employing computerized data from the health information system in use at the center. A letter was sent to these individuals by the medical director of the center. This letter (1) described the study; (2) requested participation in it; and (3) indicated that an interviewer would be calling to make an appointment to meet and speak with the woman. (Appendix C contains copies of the research materials used in the study.)

When a potential respondent was contacted, the study again was described to her and she was asked when it would be convenient to spend the thirty to forty-five minutes necessary to respond to the survey questionnaire. An agreement to meet with the interviewer was considered tacit consent to participate in the study. More formal consent was obtained, however, at the time of the interview itself; respondents were asked to sign a form indicating their willingness to be interviewed and to have their past and future medical records reviewed.

Medical records were abstracted at the center. All interviews were conducted in the patients' homes by female interviewers who ranged in age from twenty-three to forty-four years of age.

Answers were recorded on the survey instrument at the time of the interview. In addition, notes were taken during the in-depth interviews. The quotes of patients used in this report, therefore, are verbatim statements.

Medical Records

Medical records provide a chronological account of patient visits, their purposes, diagnoses, management, and outcomes; they reflect the patient's description of her illness as well as the physician's assessment of it. Thus, they offer a unique opportunity (1) to relate the presence of disease and the seriousness of illness to utilization of medical services; and (2) to link the treatment of patient problems to outcomes and use of services.

The abstract schedule used in the study was designed to organize data relevant to visits made during the observation period. A separate form was completed for each visit and information such as the following was abstracted: symptoms; physical findings; diagnoses; laboratory procedures and/or x-rays planned and performed; results of diagnostic procedures; and dispositions; i.e., requests for follow-up visits.

In addition, any information that was included in the medical record about the patient's background and/or difficulties she might be encountering was abstracted. Most records, however, contained limited, if any, social information about the patient. This omission represents a significant limitation of the medical record as a source of data. Thus, a survey questionnaire was developed to collect information about the individual and her situation.

Survey Questionnaires

Survey questionnaires provide an opportunity to collect data that can help link attitudinal and environmental factors to use of services and medical outcomes. The relatively structured nature of such instruments also provides an opportunity to collect comparable data from all respondents for use in quantitative analyses.

The questionnaire developed for this study consisted of a standardized interview guide and recording form that included many close-ended and some open-ended items. The instrument was designed to stimulate a conversation-like interaction between the interviewer and the respondent. This technique not only permitted probing, but also elicited relatively natural responses. These responses represented the individual's description of her social and personal condition and her perception of it.

The structured quality of this questionnaire, however, had its limitations. By its very nature, the instrument created a situation that provided few opportunities to obtain the serendipitous insights possible in a more free-flowing interview situation. Thus, in order to provide insights into the structured data, supplementary information was collected in a series of in-depth interviews.

In-Depth Interviews

In-depth interviews provide an opportunity to collect data that can illuminate and add richness to reported quantitative data.

In addition, they provide an opportunity to collect data that can help suggest alternative analytic strategies. The interview format used in this study was standardized, but flexible. During the hour in which the interviewer and respondent interacted, the following topics were covered: the role of the doctor; the role of the patient; the action taken in the presence of certain symptoms; and satisfactions and dissatisfactions with the center. The breadth of these topics led the interviews into far-ranging areas such as: the individual's situation and personal problems; her coping strategies; and her view of her life. These data, however, are qualitative and represent the views of only a few, albeit relatively representative, sub-set of the sample.

Self-Administered Questionnaires

Interviews with physicians offer a unique opportunity to develop data that can be used to relate the backgrounds and attitudes of doctors to their behavior in a clinical setting. Since such data usually are not available to researchers, their use in this study represents a distinct advantage. The questionnaire developed contained both close- and open-ended questions and was designed to elicit data that could be quantified as well as data that could be used to suggest potential insights into responses. It covered topics such as: the role of the physician; the role of the patient; attitudes about dependent patients; reasons for selecting family practice as a specialty; and satisfactions and dissatisfactions with medical practice.

Major Variables

Four major categories of variables are considered in this study: (1) characteristics of the individual; (2) characteristics of the patient; (3) characteristics of the physician; and (4) outcomes. These variables are tied to the concepts discussed in Chapter II; they are concepts translated into measures. The purpose of this section is to explain how this process was carried out.

Characteristics of the Women as Individuals

The characteristics of the individual reflect her life situation and her perception of it. Six major aspects of her situation were considered: (1) quality of life; (2) social position [i.e., (a) race; (b) education; (c) income; (d) marital status; (e) social role; and (f) family structure]; (3) social stressors; 4) social networks; (5) relations with neighbors and characteristics of the neighborhood; and (6) feelings of failure.

Quality of Life

Four attributes of respondents' perception of the objective circumstances of their lives were measured: (1) general state of life; (2) comparative family life; (3) comparative money situation; and (4) difficulty in living on income.

General State of Life. The respondent's perception of her overall life situation was operationalized as a question which asked if, in general, she felt her life was smooth or troubled. If a respondent described her life as smooth with little trouble, or smooth with occasional trouble, she was classified as having a smooth state of life. If a respondent described her life as frequently upset by trouble or most of the time upset, she was classified as having a troubled state of life.

Comparative Family Life. The respondent's perception of the functioning of her family as a social unit was operationalized as two questions that asked how well she felt her family life compared with that of her relatives and with that of her friends. Answers were recorded on a five-point scale with a score of one assigned to a response of "a lot better" and a score of five to an answer of "a lot worse." A low score, therefore, indicates that the respondent feels her family life is good in comparison with that of others she knows.

Comparative Money Situation. The respondent's perception of her family's financial condition was operationalized as two questions that asked how she felt her family's money situation compared with that of her relatives and with that of her friends. Answers were recorded on a five-point scale with a score of one assigned to a response of "a lot better" and a score of five to an answer of "a lot worse." A low score, therefore, indicates that the respondent feels her family's financial situation is good in comparison with that of others she knows.

Difficulty in Living on Income. The respondent's perception of her family's ability to manage on its income was operationalized as a question that asked, in general, how hard or difficult it was for her and her family to live on their present income. Answers were recorded on a five-point scale with a score of one assigned to a response of "very difficult" and a score of five to an answer of "not difficult at all." A low score, therefore, indicates that the respondent feels her family lacks economic stability.

Social Position

Six traits that might be expected to affect the individual's life chances were measured: (1) race; (2) education; (3) income; (4) marital status; (5) social role; and (6) family structure.

Race. Race was operationalized by interviewer observation. Respondents were categorized as caucasian or black.

Education. Education was operationalized as a question that asked respondents the last year they had completed in school. For purposes of analysis, responses were classified into the following six categories: (1) none to eight years; (2) some high school; (3) high school graduate; (4) some college; (5) college graduate; and (6) graduate school.

Income. Income was adjusted for family size and was operationalized as two questions that asked respondents (1) to name all the people who lived in their house full-time; and (2) to classify their total family income for the past twelve months before any taxes or other deductions. For purposes of analysis, respondents were classified as having: (1) an inadequate income; (2) a marginal income; or (3) an adequate income. The three categories were developed on the basis of criteria for poverty level income for non-farm families living in the county (see Table 3.5).

TABLE 3.5.--Criteria for Poverty Level Income for Non-Farm Families Living in the County.[a]

Family Size[b]	Income
1	$3,140
2	4,160
3	5,180
4	6,200
5	7,220
6	8,240

[a] Source: Bureau of Community Services, Department of Labor, the State, May 1978.

[b] For families of more than six members, $1,020 is added for each additional person.

An _inadequate income_ was defined as a total family income that was below poverty level. An _adequate income_ was defined as a total family income that was above poverty level. A _marginal income_ was defined as an income that could not be classified as either below or above poverty level; income was operationalized as a categorical variable in this study and, in several cases, the poverty level criterion fell between the upper and lower levels presented in the study's variable. For example, a respondent living in a two person household with an income between $3,000 to $4,999 was not classifiable as living below or above poverty level on the basis of the criterion, i.e., $4,160. Rather than assume at which end of the continuum her income was, the category "marginal income" was created for purposes of classification.

Marital Status. Marital status was operationalized as two questions that asked respondents (1) their relationship to the head of the household; and (2) if they were single or had not reported a husband as the head of the household, had they ever been married. For purposes of analysis, respondents were classified into three categories: (1) single; (2) married; and (3) disrupted marriage.

A single woman was defined as a female who never had been married and lived alone or with other relatives or friends. A married woman was defined as a female who lived with her husband or with a common-law husband whom she identified as the head of the household. A woman with a disrupted marriage was defined as a widowed or divorced female or a woman who was separated from her husband.

Social Role. The social role of a respondent was operationalized as a question that asked what she usually did most of the time. For purposes of analysis, respondents were classified into three categories: (1) housewife; (2) worker; and (3) dual roles. A housewife was defined as a woman who reported that she kept house only. A worker was defined as a woman who only reported that she was employed for pay at a job. A woman with _dual roles_ was defined as one who reported that she engaged in several activities, e.g., kept house and worked.

Family Structure. Family structure was operationalized as a question that asked respondents who was the head of the household.[9] For purposes of analysis, respondents were dichotomized into the categories male-headed household and female-headed household. A _male-headed_ household was defined as one in which a father, a husband, an uncle or a male friend was reported as the head. A _female-headed household_ was defined as one in which the respondent, a mother, or an aunt was reported as the head.

Social Stressors

The presence or absence of social stressors in respondents' lives was operationalized as a set of eleven questions that asked if any of several stress-related events had happened to them during the last year. The events selected were intended to represent family, personal, occupational, and financial situations that require or signify change in ongoing adjustment. Answers were recorded on a dichotomous scale: a positive response was assigned a score of one and a negative response, zero. The scores then were added together and a single index assigned to each respondent which ranged from zero to seven.

Social Networks

Five characteristics of kin and friendship networks were measured: (1) density; (2) content; (3) frequency of contact; (4) type of contact; and (5) location of kin and friends.[10] Each characteristic was measured separately for kin and for friends.

Density. The density of networks was operationalized as two questions that asked respondents (1) if they knew whether any of their friends and relatives got together when they were not with them; and (2) if so, how often.[11] A close-knit network was defined as one in which people got together regularly, a loose-knit network as one in which people got together only occasionally, not at all, or never. If a respondent was unable to identify the fabric of her networks, they were classified as loose-knit since it was assumed that in such a case her kin and friends probably did not get together regularly.

Content. The content of networks was operationalized as a series of questions that asked respondents: (1) whether they received psychological support such as friendliness, attention, encouragement, and understanding;[12] (2) whether they received functional support such as financial assistance, help with child care and personal problems, and aid when there was an illness in the family; and (3) if such support had been received, who had provided it. If a respondent mentioned kin and friends, she was classified as receiving support from these categories of people.

Frequency of Contact. The frequency of contact with kin and friends was operationalized as a set of four questions that asked respondents (1) how often they had talked on the phone with kin and friends during the past month; and (2) how often they had met and talked with their kin and with their friends in the last month. Answers were recorded on a five-point scale that included the following categories: never; once; two or three times; one or two times a week; and nearly every day.

Type of Contact. The type of contact respondents had with kin and friends was operationalized by deriving variables from responses to questions about frequency of contact. If a respondent said that she had spoken with kin and friends on the telephone but had not met with them, she was classified as having had *phone contact only*. If a respondent said that she had met and talked with kin and friends but had not spoken with them on the telephone, she was classified as having had *personal contact only*. If a respondent had spoken with kin and friends on the telephone and also met and talked with them, she was classified as having had both *phone and personal contact*.

Location of Kin and Friends. The location of significant others was operationalized as a set of questions that asked respondents if their kin and friends lived mostly within their neighborhood or not. The neighborhood was defined for respondents as the area within walking distance of their home. If a respondent said that most of her kin and friends lived in the neighborhood, she was classified as having neighborhood-based networks. If a respondent said that some, but not all, of her kin and friends lived in the neighborhood, she was classified as having location-mixed networks. If a respondent said that none of her kin and friends lived in the neighborhood, she was classified as having non-neighborhood-based networks.

Relations with Neighbors and Characteristics of the Neighborhood

The neighborhood was defined for respondents as the area within walking distance of their home. Neighborliness as well as the nature of the neighborhood in which respondents lived were measured. Three aspects of this nature were considered: (1) stability; (2) homogeneity; and (3) frequency of contact.

Neighborliness. Neighborliness was operationalized as a set of questions that asked respondents how easy or hard it was to get the following four tasks done in their neighborhood: (1) having a neighbor watch the children for a few hours if she was called away suddenly; (2) getting a ride from a neighbor if she couldn't use other transportation; (3) getting information or help from a neighbor if she couldn't do something herself; and (4) getting together with neighbors for something like a barbecue or party. Answers were recorded on a five-point scale and an index of neighborliness created in the following manner.[13]

Responses such as "always very easy" or "fairly easy" were considered to indicate that the respondent felt free to call upon neighbors for assistance when she needed it and were given a score of three. A response such as "depends on the situation" was considered indicative of an unsurity about the value of the relationship and was assigned a score of two. Responses such as "fairly hard" or "always very hard" were considered to indicate that the respondent felt the relationship was almost completely dysfunctional and were given a score of one. The scores for the questions were added and a single index assigned to each respondent, on the basis of the following criteria:[14]

(a) high neighborliness - a score of eight or nine;
(b) equivocal neighborliness - a score of six or seven;
(c) low neighborliness - a score of three, four, or five.

Stability of Neighborhood. The stability of the neighborhood was operationalized as a question that asked respondents if, during the past year, there had been many people moving in and out of the neighborhood, a few or hardly any. A _stable_ neighborhood was defined as one in which there had been hardly any movement of people, an _unstable_ neighborhood as one in which many or a few people had moved in or out.

Homogeneity of Neighborhood. The homogeneity of the neighborhood was operationalized as a question that asked respondents if they thought people in the neighborhood had many things in common, some things in common, or only a few things in common. A _homogeneous_ neighborhood was defined as one in which neighbors had many things in common, a heterogeneous neighborhood as one in which neighbors had some or only a few things in common.

Frequency of Contact. The frequency of contact between neighbors was operationalized as a question that asked respondents if, during the year, neighbors got together many times, a few times, or hardly ever. The nature of the neighborhood was defined as characterized by high frequency of contact if neighbors got together many times, and by low frequency of contact if they got together only a few times or hardly ever.

Feelings of Failure

Two aspects of feelings of failure were measured: (1) comparative role performance; and (2) need for help with problems.

Comparative Role Performance. Comparative role performance was measured in terms of overall performance of tasks of daily living as well as in terms of performance of three major social roles: (1) housewife; (2) worker; and (3) student. Respondents who performed dual roles were asked to respond to all questions relative to them.

Overall performance of tasks of daily living was operationalized as a question that asked a respondent how well she felt she managed in doing all that had to be done in the day. Answers were recorded on a five-point scale with a score of one assigned to a response of "a lot better" and a score of five to an answer of "a lot worse." A low score, therefore, indicates that the respondent feels that she is successful in her overall performance. Performance of major social role was operationalized as a set of three questions that asked how good the respondent felt she was at: (1) taking care of a home; (2) doing the kind of work she did; and/or (3) getting along at school. Answers were scored on the same five-point scale as that used to measure overall performance of tasks of daily living.

Need for Help with Problems. The need for help with problems was operationalized as a follow-up question to one that asked respondents whether they received help from outside the household with certain day-to-day concerns. For example, if a respondent indicated that she did not receive help with an activity, she was asked whether she could use help with it. A positive response was assigned a score of one and a negative response, zero. The scores then were added together and an index assigned to each respondent which ranged from zero to six.[15]

Characteristics of the Women as Patients

The characteristics of the patient reflect her medical and non-medical needs. Both needs were operationalized as perceptual variables in the study. Non-medical needs, by definition, is a perceptual concept. Medical needs, however, may be a subjective or an objective concept. In this study the concept was measured subjectively by accepting the symptoms presented at physician visits as a measure of the individual's perception of her medical needs.[16]

Medical Needs

The symptoms presented by patients during the six-month observation period were classified in three ways: (1) by number; (2) by type of complaint; and (3) by number of different parts of the body in which symptoms were located.[17] Additive as well as average scores were calculated. That is, some variables were adjusted for variations in the number of visits among patients in order to account for the fact that those who had sought care more frequently had had more opportunities to report symptoms. In all cases, a summary index was assigned to each patient.

Number of Symptoms. The number of symptoms presented by the patient during the six-month observation period was operationalized in four ways: (1) number of symptoms; (2) average number of symptoms; (3) number of different symptoms; and (4) average number of different symptoms.

1. Number of Symptoms - total number of symptoms presented during the six-month period.
2. Average Number of Symptoms - total number of symptoms presented during the six months divided by the number of visits.
3. Number of Different Symptoms - total number of distinct symptoms presented during the six months.
4. Average Number of Different Symptoms - total number of distinct symptoms presented during the six months divided by the number of visits.

Type of Complaint. The type of complaints presented by the patient during the six-month period was operationalized using a typology developed by Zola (1966, 1973). In this typology, two types of complaints are distinguished: one type represents a rather specific organic dysfunctioning and reflects the way in which the patient restricts her difficulties; the second type represents a more global malfunctioning and reflects the way in which the patient emphasizes the more diffuse nature of her complaints:

> Two broad groups of symptoms are incorporated in this typology. The first may be designated as '<u>specific dysfunction</u>' and includes the separate categories of malfunctions (difficulty in hearing, seeing, etc.); discharge (drain, drip, bleeding, sneeze, etc.); inappropriate (hear rings, hums, sees spots, etc.); and involuntary (tics, blinks, throbs, etc.). The second group is called '<u>diffuse anomalies</u>' and includes the distinct categories of hurts (aches, pains, burns, sore, tender, etc.); form (swelling, breakout, puffing, etc.); countenance (color, weight, general appearance, etc.); energy level (tired, weak, etc.); and bodily state or condition (dizzy, sick, dry, nauseous, hot, nervous, etc.) (personal communication, I. K. Zola, December 9, 1977).[18]

All symptoms were coded, classified according to Zola's typology, and operationalized in four ways: (1) number of symptoms of specific dysfunction; (2) number of symptoms of diffuse anomalies; (3) proportion of symptoms of specific dysfunction; and (4) proportion of symptoms of diffuse anomalies.

1. Number of Symptoms of Specific Dysfunction - total number of symptoms of specific dysfunction presented during the six-month observation period.

2. Proportion of Symptoms of Specific Dysfunction - total number of symptoms of specific dysfunction presented during the six-months divided by the total number of symptoms.

3. Number of Symptoms of Diffuse Anomalies - total number of symptoms of diffuse anomalies presented during the six-month period.

4. Proportion of Symptoms of Diffuse Anomalies - total number of symptoms of diffuse anomalies presented during the six months divided by the total number of symptoms.

Number of Different Parts of the Body in Which Symptoms Located. The number of different parts of the body in which symptoms were located during the six months was operationalized in two ways: (1) number of different parts of the body; and (2) average number of different parts of the body.

1. Number of Different Parts of the Body - total number of distinct parts of the body in which symptoms located during the six-month observation period.
2. Average Number of Different Parts of the Body - total number of distinct parts of the body in which symptoms located during the six months divided by the number of visits.

Non-Medical Needs

Two non-medical needs of the patient were measured: (1) the need for catharsis; and (2) the need to cope with failure.

Need for Catharsis. The need for catharsis was operationalized as three questions that asked respondents: (1) if they knew enough people with whom they felt free to talk about personal problems; (2) if they sometimes felt that people around them were too busy to talk; and (3) if they sometimes felt that people were not paying attention to them when they talked.[19] A positive response to the first question, and negative responses to the second and third were considered indicative of the lack of a need for catharsis. That is, these responses were considered to indicate that the individual had sympathetic, understanding, and supportive listeners among the members of her social networks and did not need an alternative source to satisfy her need to express feelings. The following set of responses to the three questions above, therefore, operationalized the extent of the need for catharsis.

1. No Need for Catharsis - all three responses were congruent with the standard.
2. Some Need for Catharsis - one response was not congruent with the standard.
3. Greater Need for Catharsis - two or three responses were not congruent with the standard.

Need to Cope with Failure. The need to cope with failure was operationalized as a question that asked respondents how they would describe their general health. Responses of excellent or good were considered indicative of the lack of a need to use illness to justify failure, i.e., no need to cope with failure. Responses of fair or poor were considered indicative of a need to use illness to cope with failure.[20]

Characteristics of the Physician

The characteristics of the physician reflect his attitude toward the dependent patient and his response to her. Three aspects of his attitude were considered: (1) his orientation toward the dependent patient; (2) his perception of his satisfaction of the need for catharsis; and (3) his perception of his satisfaction of the need to legitimate failure. Four major aspects of physician response were considered: (1) assessment or diagnosis of patient problems; (2) diagnosis procedures ordered; (3) therapies prescribed; and (4) disposition of the patient. In addition, three characteristics that might be expected to relate to the physician's orientation were considered: (1) his career stage; (2) the type of medical school he had attended; and (3) the structure of the medical setting in which he functioned.

Physician's Attitude Toward the Dependent Patient

As indicated above, the physician's attitude toward the dependent patient was measured in three ways: his orientation toward her, and his perception of his satisfaction of two of her non-medical needs. These measures do not reflect the physician's actual response to the patient; they measure his perception of his behavior toward her.

Physician's Orientation Toward the Dependent Patient. The physician's orientation toward the dependent patient was operationalized as three sentence stems residents were asked to complete: (1) "when a patient persistently presents with vague or inconsistent symptoms . . ."; (2) "when physical laboratory examinations do not account for a patient's complaints . . ."; and (3) "to me, dealing with the social and emotional problems of patients is . . . ."[21] Responses were coded according to the following three categories:

1. Favorable - feeling tones such as "challenging" or "interesting" or approach tendencies such as "delve into social and/or psychological factors;"
2. Neutral - no definite, or ambivalent, feeling tones or no definite approach-avoidance tendencies expressed. This category included ambivalent responses such as, "may be rewarding but are time-consuming"; a re-evaluation is necessary"; or "differential diagnosis should be reviewed."

3. Unfavorable - feeling tones such as "frustrating," "disinterest," or "less satisfying," or avoidance tendencies such as "approach the situation from a medical viewpoint."

For purposes of analysis, favorable responses were assigned a score of one, neutral or ambivalent responses a score of two, and unfavorable responses a score of three. Thus, the lower a physician's score, the more favorable his orientation toward the dependent patient.

Physician's Perception of His Satisfaction of the Need for Catharsis. The physician's perception of his satisfaction of the need for catharsis was operationalized as a question that asked residents how they responded, under ordinary working conditions, when patients talked about problems which were only indirectly related to their health.[22] If residents indicated that they encouraged such patients to talk, they were classified as satisfying the need for catharsis. If they indicated that they tried to limit such discussion in general to subjects directly connected to the medical problem, they were classified as not satisfying the need for catharsis.

Physician's Perception of His Satisfaction of the Need to Legitimate Failure. The physician's perception of his satisfaction of the need to legitimate failure was operationalized as a question that asked residents how they generally behaved toward patients who became ill to justify failure.[23] If residents indicated that they responded to such patients with sympathy and understanding, they were classified as satisfying the need to legitimate failure. If they indicated that such patients annoyed them, they were classified as not satisfying the need to legitimate failure.

Physicians' Response to the Dependent Patient

The response of physicians to dependent patients was measured four ways: (1) assessment of problems or diagnoses; (2) diagnostic procedures ordered; (3) therapies prescribed; and (4) disposition of patients. These measures reflect physicians' actual behavior, the management strategies they adopt to care for patients.[24]

Assessment of Problems. Physicians' assessments of patient problems were operationalized by having three judges code diagnoses on the basis of criteria that differentiated (1) those that were psychological or symptomatic from (2) those that were organic.[25] (See Appendix E for a detailed description of the coding criteria and procedures and a discussion of the development of the diagnostic index described below.) The two diagnostic categories reflect physicians' appraisals of patients' problems and, with one exception, the extent to which these diagnostic appraisals were supported or were not supported by clinical evidence. That is, unsupported diagnoses refer to labels that indicated the presence of symptomatology that could not be clinically-defined and validated (e.g., headache, pain, malaise) and/or organic diagnoses that were not supported by positive physical findings or diagnostic procedures. Supported diagnoses refer to labels that indicated the presence of symptomatology that was supported by clinical evidence (e.g., urinary tract infection, strep throat). Psychological diagnoses, however, refer to labels that indicated the presence of socioemotional problems, whether or not these diagnoses were supported by recorded findings (e.g., anxiety, depression).

After the diagnostic data for the six-month period were coded, proportional scores for supported diagnoses and for psychological/unsupported diagnoses were calculated per patient using the following formula: total number of diagnoses within category divided by total number of diagnoses in the two categories. A diagnostic index for each of the two categories then was assigned to patients. When the findings of the study are discussed, therefore, the following two variables are used to refer to physicians' assessments of patients' problems:

1. Proportion of Psychological/Unsupported Diagnoses - number of psychological and/or unsupported diagnoses divided by the total number of diagnoses recorded for the six-month period;[26]
2. Proportion of Supported Diagnoses - number of supported diagnoses divided by the total number of diagnoses recorded for the six months.

Diagnostic Procedures Ordered. The diagnostic procedures ordered by physicians were measured in two ways: (1) the number of laboratory tests and/or x-rays planned per patient; and (2) the number of laboratory tests and/or x-rays actually performed per patient.

1. Number of Laboratory Tests and/or X-rays Planned - total number of diagnostic procedures recorded as part of the physician's management plan during the six-month observation period.

2. Number of Laboratory Tests and/or X-Rays Performed - total number of diagnostic procedures with results recorded during the six-month observation period.

Therapies Prescribed. Three types of therapies prescribed by physicians were considered: (1) psychotropic therapies; (2) symptomatic therapies; and (3) curative therapies. The term psychotropic therapies is used to refer to drugs that have an effect on the mind or are capable of modifying mental activity such as tranquillizers or antidepressants. The term symptomatic therapies is used to refer to drugs that have a palliative effect on symptoms such as analgesiacs, antihistomines, or antacids. The term curative therapies is used to refer to drugs that have a healing or remedial effect on disease such as antibiotics or antibacterials. These therapies were measured per patient in six ways: (1) number of psychotropic therapies; (2) proportion of psychotropic therapies; (3) number of symptomatic therapies; (4) proportion of symptomatic therapies; (5) number of curative therapies; and (6) proportion of curative therapies.

1. Number of Psychotropic Therapies - total number of psychotropic drugs prescribed during the six-month observation period;

2. Proportion of Psychotropic Therapies - number of psychotropic drugs prescribed divided by the total number of drugs prescribed during the six months;

3. Number of Symptomatic Therapies - total number of symptomatic drugs prescribed during the six-month observation period;

4. Proportion of Symptomatic Therapies - number of symptomatic drugs prescribed divided by the total number of drugs prescribed during the six months;
5. Number of Curative Therapies - total number of curative drugs prescribed during the six-month observation period;
6. Proportion of Curative Therapies - number of curative drugs prescribed divided by the total number of drugs prescribed during the six months.

Disposition of Patients. Physicians' disposition of patients was measured by the total number of return visits requested per patient during the six-month observation period.

Characteristics Expected to be Related to Physician's Attitude

Three characteristics that might be expected to relate to the physician's attitude toward the dependent patient were considered: (1) career stage; (2) type of medical school attended; and (3) structure of the medical setting in which physician and patient interact.

Career Stage. The physician's career stage was operationalized as a question that asked in which year of residency the doctor was. Answers were recorded on a five-point scale with a score of one assigned to a first-year resident and a score of five to a graduate of the program who was involved in practice.

Type of Medical School Attended. The type of medical school attended was operationalized by having two physicians--a dean and an associate dean of a medical school--classify the twenty different medical schools from which the residents had graduated into one of two categories: (1) academically-oriented; and (2) practice-oriented. Agreement between the physicians was 100 percent.

Structure of the Medical Setting. Data on the setting in which physician and patient interact were collected through a personal interview with the director of the residency training program and observations at the health care center. A description of this setting, and a discussion of the way in which its structure affects the behavior of physicians in training is presented in Chapter IV.

Outcome

Outcome is the dependent variable in the study. It refers to the number of face-to-face contacts between patients and providers that occurred during the six-month observation period, i.e., the actual use of medical services. Three aspects of this use were considered: (1) the total number of visits to the family health care center; (2) the number of visits that were doctor-initiated; and (3) the number of visits that were patient-initiated.

Total Number of Visits

The total number of visits to the family health center simply is a count of the number of times the patient sought care from a physician at the center during the six-month observation period. Number of visits ranged from one to ten.

Number of Physician-Initiated Visits

A physician-initiated visit is defined as one in which the patient visited the center at the physician's request. Figure 3.1 includes the criteria that were used to determine if a visit was physician-initiated. Number of physician-initiated visits simply is a count of the number of times the patient sought care in response to a physician's request for a follow-up visit. The number of physician-initiated visits ranged from none to six.

Number of Days in Which Patient Requested to Return to Center	Criterion
7 days	If the patient visits the center within 6 to 10 days of the specified time, i.e., one day earlier or 3 days later, the visit is defined as physician-initiated.
14 days	If the patient visits the center within 12 to 22 days of the specified time, i.e., 2 days earlier or 8 days later, the visit is defined as physician-initiated.
21 days	If the patient visits the center within 18 to 29 days of the specified time, i.e., 3 days earlier or 8 days later, the visit is defined as physician-initiated.
1 month	If the patient visits the center within 25 to 38 days of the specified time, i.e., 5 days earlier or 8 days later, the visit is defined as physician-initiated.

Figure 3.1.--Defining Criteria of a Physician-Initiated Visit.

Number of Patient-Initiated Visits

A patient-initiated visit is defined as one in which the patient visited the center of her own volition. Number of patient-initiated visits simply is a count of the number of times the patient presented for care without being requested to do so by the physician. The number of patient-initiated visits ranged from none to seven.

Analysis Plan

Two statistical techniques were used to analyze the data: Pearson product-moment correlations and multiple regression analysis. Pearson correlations indicate the way in which two variables vary together.[27] They provide a single number which summarizes the strength and the direction of the linear relationship between two variables. (Since this is done, however, at the sacrifice of the detail which is provided in cross-tabulations, data sometimes also are reported in contingency table form or in lists of frequencies.) The technique provides an easy means by which the strength of relationship between one pair of variables and a different pair can be compared. Thus, the correlations were used to select from among all the variables, those that were significant and might be expected to be good predictors of the differential use of medical services. These selected variables, then, were entered into the regression equations.

Multiple regression is a technique that evaluates and measures the overall dependence of a criterion variable on a set of independent or predictor variables.[29] The technique served a major research objective of the study by indicating how much of the total variation in the dependent variable was explained by all of the independent variables acting together. The stepwise method was used in all analyses. This method admitted variables into the regression equation according to their contribution to explain of variance in the dependent variable. Thus, the first variable admitted was the one which explained the most variance when all other independent variables were controlled, the second admitted was the one which explained most of the remaining variance and so on until the procedure was halted because the remaining independent variables no longer made a significant contribution to the explanation process.

Summary

A study was designed to examine the extent to which past utilization behavior could be accounted for by individual, patient, and physician characteristics. A sample of young "healthy" females, stratified according to patterns of use of medical services, was selected and the data for a six-month period abstracted from their medical records. Structured questionnaires were used in survey interviews with these women and standardized, but flexible, question formats used in in-depth interviews with a sub-set of them. In addition, self-administered questionnaires were completed by the physicians who had provided medical care for the women. The data collected permitted an examination of the relationship between four sets of variables: (1) individual; (2) patient; (3) physician; and (4) use of medical services. Analyses focused on patients' needs and their sources, physicians' responses to these needs, and patterns of utilization behavior.

CHAPTER III: NOTES

[1] The ratio of females to males in the 18 to 40 year old age category was approximately four to one.

[2] Data for this information system are collected through a one-page, multiple copy document that is an integrated billing and patient encounter form. The form that contains modified elements of the patient's chart (e.g., diagnosis, laboratory procedures and/or x-rays, treatments, provider of care) is attached to the patient chart, completed by the physician at the end of each patient visit, and the data then edited and submitted to computer processing.

[3] A visit of record is defined as any entry in the data system that indicates a contact with the center. Such an entry may show that an actual visit was made or that an appointment was cancelled or broken.

[4] If these patients were to be included in Population B, the percentages within its categories become more like those in Population A: that is, acutely ill, 56.8 percent; chronically ill, 7.6 percent; and pre- or post-natal, 19.0 percent. The percentage of health maintenance patients, however, remains higher (16.6 percent) in Population B, a reflection either of annual use for purposes of preventive care or transient use.

[5] Non-somatic complaints, of course, also can influence use patterns among pre- and post-natal and chronically ill patients. Nevertheless, since the possibility existed that these conditions themselves might exacerbate the predisposition to or create emotional problems, such patients were excluded from the sampling pool.

[6] Visits made for the purposes of preventive care were excluded in all analyses.

[7] The completion rates for the different categories of patients were not significantly different. In sub-sample A, 43.4 percent of the low users and 50.0 percent of the frequent users were interviewed. The respective figures for sub-sample B were 51.3 percent and 46.4 percent.

[8] The remaining 8 percent of the cases were accounted for by patients who had moved out of the county or state and patients who had no phone and for whom an accurate address could not be located.

[9] No respondent asked to have this term defined. Although the head of the household usually is considered the person who earns the most money, in this study respondents defined the term themselves. Thus, if a woman identified her husband as the head of the household and she was employed and he was not, her designation was accepted.

[10] The characteristics of the network were measured only from the point of view of the respondent. Furthermore, information about these characteristics was derived from survey interviews not by direct observation. Mitchell (1969) considers the latter a more reliable and accurate method to collect such data.

[11] The measures of the density of social networks were developed by Professor John B. McKinlay, Department of Sociology, Boston University. Professor McKinlay sent me a copy of an interview schedule being prepared for a study of family planning among young married couples in the Boston area. The questions on social networks included in the instrument were largely drawn from an earlier exploratory study he had conducted (McKinlay, 1973). I am grateful to Professor McKinlay for sharing his materials with me.

[12] The measures of psychological support used in this study were developed by Caplan, et al. (1976).

[13] Answers to only three out of the four questions in the set were used to create an index of neighborliness: i.e., having a neighbor watch the children for a few hours if you were called away suddenly; getting a ride from a neighbor if you couldn't use other transportation; and, getting information or help from a neighbor if you couldn't do something yourself.

[14] If a respondent did not have children, her index was based on responses to only two questions.

[15] The "need for help with problems" variable has an inherent weakness: that is, it is based on the assumption that those who receive assistance with specified activities are satisfied with the amount of help they receive and do not feel a need for any additional assistance. This, of course, may not be a valid assumption. It is suggested, therefore, that researchers who might wish to use this set of questions ask respondents who receive functional help whether more support would have been helpful.

[16] An attempt was made to measure medical needs objectively by developing a "level of illness" index based on clinical evidence recorded in the medical chart, e.g., physical findings and results of diagnostic procedures. The attempt was not successful. See Appendix D for a description of the techniques used to develop this index and a discussion of the reasons for the failure.

[17] Symptoms were coded employing the classification system developed for use in the National Ambulatory Medical Care Survey (National Center for Health Statistics, 1974).

[18] I am indebted to Professor Zola for taking the time when he was on sabbatical leave to provide me with the nine categories of malfunctioning by which he classified presenting complaints.

[19] The three questions used to operationalize the need for catharsis were developed by Shuval, et al. (1970). In a sense, these questions are a measure of the individual's perception of the "intensity" of her relationship with significant others. Intensity refers to the strength of the ties that bind individuals together, the willingness with which they are prepared to carry out the obligations associated with these ties (Mitchell, 1969:27-28). Shuval and her colleague's questions, then, imply that if significant others are perceived as not honoring the obligation implied in their link with the individual, she will feel a need for catharsis.

[20] None of the patients were chronically-ill. Furthermore, even those who sought care primarily for acute illnesses were, from the viewpoint of the physician, not very sick. Thus, a response of fair or poor health was not congruent with the patient's clinically-defined health state.

[21] The sentence stems were developed by Ford, et al. (1962). In addition, the coding techniques used were a modification of those suggested by these authors. That is, the coding of responses was based on the degree to which they expressed a positive or negative reaction to the subject matter. Both feeling tones and approach-avoidance tendencies were considered in assigning a code to a response.

The coding was done by three people: (1) a graduate physician about to begin his residency training program; (2) a professor of sociology involved in the training of the residents; and (3) a graduate student in psychology. The agreement among these coders was 89 percent. Differences in coding were resolved through discussion.

[22] The question used to define the satisfaction of the need for catharsis was developed by Shuval, et al. (1970). In their study in Israel, these researchers used three questions to operationalize this variable (1970:103-104). In a pilot study at the center, however, it was found that only the one question used here succeeded in differentiating among residents; 95 and 75 percent of residents indicated that they did not feel they satisfied the need for catharsis in response to the first and third questions respectively developed by Shuval and her colleagues.

[23] The question used to define the satisfaction of the need to legitimate failure was developed by Shuval, et al. (1970). In their study in Israel, these researchers used three questions to operationalize this variable (1970:119-120). In a pilot study at the center, however, it was found that only the one question used here succeeded in differentiating among residents; 100 percent of the residents indicated that they did not feel they satisfied the need to legitimate failure in response to the second and third questions developed by Shuval and her colleagues.

The American residents were classified as not satisfying the need because they felt they would attempt to deal with any underlying psychosocial components of the problem rather than just treating the patient medically. Shuval, et al., however, felt that only those doctors who managed such patients with medical therapies exclusively, satisfied the need to legitimate failure.

[24] Physicians' responses to patients were measured not on the basis of strategies adopted by individual doctors across patients, but rather on the basis of the strategies adopted by one or more doctors for individual patients. That is, all measures were operationalized as summary indices that were assigned to each patient in the sample, not to each physician. The discussion, then, focuses on the management strategies adopted by unidentified physicians to treat categories of patients.

The small number of physicians in the sample in combination with the relatively small number of patients and relatively short observation period, made it impossible to analyze the responses of individual physicians to patients in a statistically, meaningful way. A qualitative analysis was made, however, of the responses of several physicians with different orientations toward the dependent patient in order to see if these were related to different management styles.

[25] I am grateful to Professors C. W. Given and B. Given for developing the classificatory criteria used to code diagnoses.

[26] Diagnoses that indicated the purpose of the visit was health maintenance were not included in the total number of diagnoses.

[27] The technique assumes bivariate normal distribution, linearity and a set of interval-level variables. Several authors state, however, that the Pearson correlations can be used with "imperfect data" that do not meet these assumptions (Asher, 1976:26; Harris, 1975:7).

[28] The theory of multiple regression analysis assumes multivariate normal distribution and equal variance-covariance within groups. In practice, however, the technique is very robust, that is, insensitive to any but gross departures from the assumptions and they need not be strongly adhered to (Harris, 1975:7).

CHAPTER IV

THE SETTING

The social system approach adopted in this study views behavior of individuals in a medical situation in terms of phenomena beyond that immediate context. One, the behavior of patients is interpreted in terms of their life situations. Two, the behavior of physicians is interpreted in terms of their location within a medical profession. And three, the behavior of both is interpreted in terms of dominant cultural values. A key component of reality, however, is omitted in these three forms of interpretation: the setting within which the behavior occurs. This chapter, therefore, examines the site in which the study was conducted in order to provide a general social context for the material that follows. First, a brief history of the community is presented. Then, the medical facility in which the sample of patients seeks care is described. Finally, the structure of the family practice residency training program and the operation of the health center in which residents care for patients are examined.

A Brief Social History of the Community

The study was conducted in a large, mid-western industrial city that is the home of one of the major American manufacturing corporations. The city's economic life centers around the activities of this corporation which primarily involve the manufacture of automobiles and related products. As a result, the community has been very sensitive to national and international economic cycles.

The city's history, as that of all American cities, is characterized by a transition from the exploitation of natural resources to the development of industries. In the early nineteenth century, the area became a post for fur traders but as settlers started to move in, small enterprises were established to meet local demands for goods and services. By the 1850s, the area had become an important lumbering center which attracted laborers as well as other small entrepreneurs producing wagons and carts.

When logging ceased to be a profitable enterprise in the late 1800s, many workers were able to find employment in the city's burgeoning transportation trade. The destruction of forests made agriculture an important sector in the state and farmers needed vehicles. The vehicle industry flourished as demands for its products grew and a reservoir of skilled craftsmen began to settle in the city as its reputation as an important employment center increased.

With the advent of the motor car, however, the industry's viability became questionable and local entrepreneurs began to direct their energies toward the new and profitable automobile business. The first factory to manufacture autos was established in the city in 1903 and soon affiliated industries began to settle in the city as demands for direct access to supplies and control over their production grew. By 1909 a major corporation, organized locally, had assumed complete control and substantial ownership in twenty automobile or accessory companies in the city in order to ensure stable profits.

The subsequent growth and decline of the city's population has been a reflection of its almost complete dependence on this corporation and its enterprises. During the early years of this century, numbers of workers, many foreign born, were recruited into the industry and the city's population increased. In the 1930s, however, the city's population decreased as a decline in auto production led to the unemployment of many workers. With the outbreak of World War II, local factories ceased manufacturing civilian goods and became one of the principal sources of supply of war materials. As young men were drafted, women and unskilled workers moved in to replace them in the city's factories. The population of the city increased throughout the 1940s as a stream of migrants, many from the South, settled there to work.

After the second World War the city's factories returned to automobile manufacturing and large numbers of workers were attracted there for employment.[1] In the 1950s, however, the inner city began to experience a decrease in population as people moved out into the burgeoning suburbs in the previously rural out-country. This population decline has continued in the last twenty years as unemployment--resulting from national and international trends as well as the increasing mechanization of automobile plants--has impelled numbers of displaced workers to seek employment elsewhere.[2]

By the mid-1970s the slow, but steady, loss of inner-city residents had shifted the balance of population in the county and the populations of the city and out-county were 174,218 and 275,386, respectively.[3] Many of those left behind were the disadvantaged. More than twice as many people in the city lived below poverty level than in the out-county (16.9 and 6.8 percent, respectively). In addition, living below poverty level was part of a constellation of characteristics, i.e., poor, female heading a household, child living with one adult, and black.[4] In the next section the relationship of this population to that served by the center is considered and the ambulatory care center of Community Hospital is discussed.

Community Hospital and its Family Health Care Center

Community Hospital is a 423-bed, acute care facility in which all medical specialties are represented.[5] Its major residency is based in the Family Practice Training Program which was organized in 1971 to "improve the quality of care" at the hospital and, to train family physicians who, hopefully, would enter practice in the area or in the state. Although the program provides experiences in the management of hospitalized patients, its major objective is the training of family practice physicians who will provide primary care in an ambulatory setting.

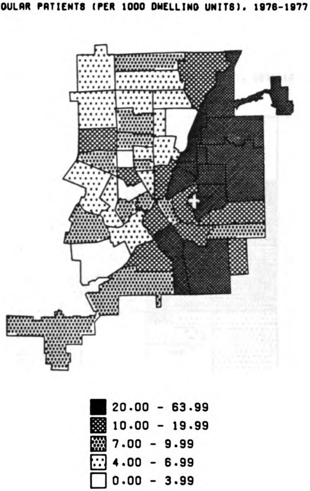
The Family Health Care Center occupies the entire third floor of the administration building which is located adjacent to the hospital. Its forty-six rooms are divided among practice "modules," that contain a consultation room with two to four adjacent examining and/or treatment rooms, and specialized rooms for performing ambulatory surgery, electrocardiography, sigmoidoscopy, cryotherapy, physiotherapy and laboratory procedures. In addition, the center has a large central waiting room, contiguous to the room in which the reception desk is located and the medical records are filed, and four internal waiting areas.

The Center Population

A large proportion of the patients at the center live in the general location of Community Hospital, an area predominantly inhabited by people of the caucasian race, living on middle incomes in privately-owned homes (see Maps 4.1 and 4.2). The center tends to attract fewer patients from areas in which other hospitals and large concentrations of physicians are located.[6]

Admissions to the center are open and patients are not screened for teaching purposes.[7] During 1976, a population of 1,042 patients had regular contact with the center.[8] Seven out of ten of these patients were women and more than half were twenty-five years of age and over (see Table 4.1). The higher proportion of adults in the population may be explained by the fact that many of these people had been patients of the director of the training program; when the center opened they followed him there.

Records on race and income of patients are not maintained at the center. It was estimated, however, that about 60 percent of the patients were white. Furthermore, in 1976, 18 percent of the patient population lived in areas marked by unemployment and poverty and approximately 20 percent were covered by Medicaid. In the county as a whole, during this same period, 77 percent of the residents were



Map 4.1.--City, Regular Patients per 1000 Dwelling Units, 1976-1977.[a]

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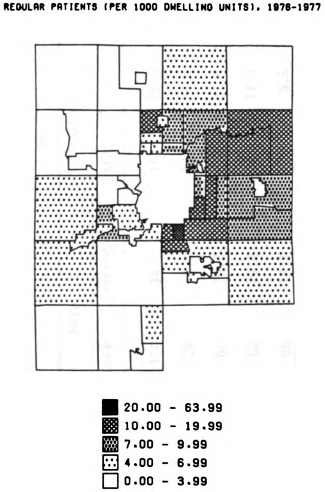
[a] Maps of the city and out-county are produced separately for reasons of clarity. Census tract boundaries are used in these maps. The cross (+) represents the location of Community Hospital.



Map 4.2.--Out-County, Regular Patients per 1000 Dwelling Units, 1976-1977.

TABLE 4.1.--Number and Percent of Patients of Family Health Care Center by Age and Sex, 1976.

Age	Sex					
	Male		Female		Both Sexes[a]	
	Number	Percent	Number	Percent	Number	Percent
Under 17 Years	110	34.4	161	22.3	271	26.0
17-24 Years	28	8.7	191	26.4	219	21.0
25-44 Years	62	19.4	176	24.4	238	22.8
45-64 Years	62	19.4	125	17.3	187	17.9
65 Years and Over	58	18.1	69	9.6	127	12.2
All Ages	320	30.7	722	69.3	1042	100.0

[a] The age distribution for the total county was: under 17 years, 35.6 percent; 17-24 years, 12.3 percent; 25-44 years, 25.9 percent; 45-64 years, 18.4 percent; and 65 years and older, 7.7 percent.

white, 12 percent lived in areas marked by poverty and approximately 12 percent were on Medicaid. The center, then, apparently tends to attract a number of the less economically stable members of the county population. This tendency may be due to the fact that the center, in contrast to some physicians in the county, will accept patients on Medicaid. (Only about one person out of twenty in the county was not covered by some form of health insurance plan in 1976. This high proportion of insurance coverage was accounted for by the fact that health insurance plans were a standard form of employee fringe benefits.)

During 1976 the patient population made 5,099 visits to the center, an average of 4.9 visits per patient. The number of visits per center patient ranged from 3.7 for children to 6.1 for persons 65 years of age and older. Females aged 17 to 44 years and 65 years and over made more physician visits than their male counterparts.

The volume of use for the total population was the same as that for a national sample (see Table 4.2). However, those center patients under 17 years of age, and those 25 to 44 years and 65 years and over visited the physician less than did those in the national sample. This is a paradoxical finding since one would have expected the national rates to be lower; they are based on respondents' recall rather than on data contained in a health information system. In general, however, the center population appears to use physician services at rates similar to that of other Americans.

TABLE 4.2.--Average Number of Physician Visits per Person Annually by Age and Sex: United States, 1974[a]; Family Health Care Center, 1976.

Age	Sex		
	Male	Female	Both Sexes
UNITED STATES:			
Under 17 Years	4.3	4.0	4.1
17-24 Years	3.2	5.8	4.5
25-44 Years	3.5	6.3	5.0
45-64 Years	4.9	6.1	5.5
65 Years and Over	6.8	6.9	6.9
All Ages	4.3	5.6	4.9
FAMILY HEALTH CARE CENTER:			
Under 17 years	4.4	3.5	3.7
17-24 Years	3.6	5.5	5.3
25-44 Years	2.8	5.0	4.5
45-64 Years	6.0	6.0	6.0
65 Years and Over	5.5	6.5	6.1
All Ages	4.4	5.1	4.9

[a] Source: National Center for Health Statistics. Current Estimates from The Health Interview Survey-United States-1974, Rockville, Md.: National Center for Health Statistics, September, 1975, p. 25.

The information from the health interview survey is based on data collected in a continuing nationwide survey conducted by household interview. During the 52 weeks in 1974, the sample was composed of approximately 41,000 households containing about 120,000 persons living at the time of the interview.

In the next section attention turns to the kind of care provided to these center patients. First, the factors that influence the behavior of physicians there are discussed. Then, the way in which these are manifested in the operation of the center are described.

The Family Practice Residency Training Program[9]

In order to understand the behavior of physicians in training as they care for patients, an examination of the institutions that mold behavior is necessary. The cultural norms operative in these institutions have bearing on the way in which residents are likely to respond to patients, in general, and dependent patients, in particular.

It has been argued that the medical school is the major socializing influence on physicians, that the culture learned there has primary significance for what he/she does or does not do in later practice (Becker, et al., 1961; Bloom, 1963). Indeed, physicians do bring certain behaviors to their residency that were inculcated by the cultures of the medical schools they attended and these will be discussed in this section. But, since socialization is an ongoing practice, the family practice residency training program also will be examined to see the ways in which its operation patterns behavior. Specifically, the study will explore the influence of the structure of this program upon the norms that govern the behavior of residents as they care for patients. (See Miller, 1970 and Mumford, 1970 for discussions of the influence of post-graduate training on physician behavior.)

The three-year residency program offered by the hospital is supervised by a director of medical education whose role has evolved primarily into one of administration because of problems in funding, although he does remain active in the education of residents. He is assisted by an associate director, who is involved with the teaching of internal medicine and with the development of evaluation programs, and an assistant director, who is in charge of the Family Health Care Center. In addition to these three physicians, the program's teaching staff includes the equivalent of four full-time associates; twenty-four local physicians who are preceptors in the ambulatory care experience of the residency; and a cadre of instructors who also teach at two other local hospitals. The hospital's medical staff and the faculty of a medical school located forty-five miles from the community also provide intermittent teaching and support of the training program.

The stated goal of the program is "the training of a physician able to render continuous and comprehensive care to the patient, along a continuum, throughout the patient's health and illness whether the disease be simple or complicated." In order to achieve this goal, the program requires that one-third of the residents' time be spent in an ambulatory care setting and the remainder in the hospital and at lectures, conferences, and seminars organized to improve their medical knowledge and ability to deal with illness. Although diagnostic and therapeutic skills are stressed, residents also are educated in the social and behavioral sciences in order to gain expertise "in the total management of the patient, including his/her physical and psychological needs."

In 1976-1977 there were thirty-seven residents enrolled in the program: fifteen in the first year, twelve in the second year, and ten in the third year. These residents were graduates of academically-oriented medical schools as well as practice-oriented schools. The former type school emphasizes the basic sciences and the acquisition and communication of knowledge; the latter, the behavioral as well as the basic sciences, and the application of knowledge as a service (Perlstadt 1972a and 1972b).

These differences created instructional problems for the family practice residency. On the one hand, graduates of the academically-oriented schools came to the program with "a body of knowledge that was solid," although they frequently lacked a "bedside manner." The major problem in training such residents was in managing to convince them to cut the ties that linked them to their prior socialization in academe. Not only did they tend to feel that no amount of knowledge was enough but they also were reluctant to accept initiative. As the director observes:

> They want somebody who is very knowledgeable at their elbow who will stimulate them, give them a little more and verify what they've learned . . . . [They] have a lot of problems . . . in becoming a family physician. They want to be that academic something or other that just isn't there in family practice.

Graduates of the practice-oriented schools, on the other hand, did not always come to the program with a solid basic science background. In the director's view:

> [They] appear to be brighter than what they are because they've got the verbal abilities. But, they don't have the scientific sense or know-how.

These two different types of deficiencies among the residents are tolerated due to two factors: (1) the way in which the program is organized; and (2) the problems with funding that this structure creates. The hospital pays the salaries of the program directors and covers the expenses of the center not met by revenue brought in through fees for services; third party payors will not pay for services residents perform in an ambulatory care setting. Most of the funds to operate the program, however, come from federal and state grants. These grants are awarded on the basis of the number of residents enrolled in the program. Thus, the program "must have warm bodies" to ensure its continued viability.

This means two things: if the program does not have enough residents, it does not receive grant monies to cover program expenses; if it does not have enough residents to care for patients at the center, it does not generate enough fees to cover the expenses of the facility. Since the hospital has difficulty in funding the expenses of the center--its total revenues in 1977 were less than the grant monies brought in by the program--the director receives pressure from the hospital administration to maintain full enrollment. The loss of too many residents means that the program, as its director notes:

> . . . is in trouble as far as the hospital goes. Everybody says they're forgiving . . . but just let this program come up short one year and the roof will cave in.

Moreover, lack of enrolled residents also leads to pressure from residents who resent the additional work load and night calls that a diminished staff requires them to carry. This resentment, on occasions, manifests itself in threats of withdrawal from the program, threats which the program director describes as "catching--like the domino theory."

The organizational structure of the program, then, imposes significant restraints on the behavior of the director and faculty toward residents. Pressures to maintain a full enrollment of residents compel them to moderate their demands for excellence and to tolerate certain undesirous behaviors. The director elucidates the constraints in fulfilling the goals of the program very well when he says:

> A community hospital just doesn't have the wherewithal to get real tough . . . . It's a buyer's and a seller's market. But, the resident has the edge.

The culture operative in an institution is an important determinant of behavior. Modes of response learned in medical school are brought to the residency. For some, past socialized behavior conflicts with the expectations in the new setting and attempts to teach residents to modify some of their previously learned behavior is not always successful (Becker and Strauss, 1956). In addition, the impingement of structural processes in this new setting results in a weak set of norms specifying what residents should, ought to, or are expected to do. Although norms of competency in the management of the physical and the psychological needs of patients exist, they tend to be rather flexible. The residents exploit this flexibility as will be documented in the following illustration of the operation of the Family Health Care Center.

The Operation of the Center

During an average half day, approximately thirty-five to forty patients present for care at the center. Ten residents, assisted by three registered nurses and four licensed practical nurses, usually are available to treat them. On the average, then, residents see few patients during a working day. In point of fact, an analysis of patient visits by doctor for 1976-1977 showed that on the average a third year, second year, and first year resident treated 2.56, 3.72, and 2.70 patients respectively during a three-hour working day.[10] Observations made at the center suggested that part of the residents' working day was spent talking among themselves and with faculty who are available for consultation and to supervise them as they treat patients.

The program is required to provide this supervision 100 percent of the time, although frequently "it falls down because the community preceptors, who have been assigned, don't show up." The director, however, prefers that the residents be as independent as possible as they care for patients. He considers individual responsibility and the ability to cope with any medical situation without direct supervision extremely important.

> Supervision is fine up to a point, but most of us have to have the direct responsibility or else we're not going to really learn. If you are weak and require a supervisor at your elbow all the time you're not going to learn much . . . . There are a lot of things out there that they're going to run into and there's not going to be anybody to tell them about it.[11]

A formal method does not exist, however, to ensure that residents are exposed to as many types of patients as possible during their three years of training. Perhaps it is assumed a priori that the laws of probability guarantee that residents will have the opportunity to manage patients with simple diseases as well as those with complicated diseases, or patients with purely medical needs as well as those with attendant non-medical needs. It is plausible that such an assumption is made since the director gives residents "permission to drop a couple of patients" a year.

There are no rules against such behavior, however, and certain internal mechanisms already exist that both allow residents to terminate relationships with patients whose problems are not amenable to the treatment they feel competent to provide and to initiate relationships with patients with whom they feel they have had insufficient experience. For example, the director notes:

> A resident will see a patient two or three times and then shift him off to somebody else. He'll see the patient two or three times and then move him on to somebody else. It's like, 'Come back Wednesday,' and the resident knows that he's not going to be there . . . . In the last half of the second year, they also can go out and say 'I need more obstetrical patients or more kids,' or 'I don't want any more fat ladies or hypertensives,' or 'I don't want any more sixty-five year olds.'

The range of clinical experiences residents have, then, appears to be dependent largely upon the relationship they are able to maintain with the clerks who arrange appointments. A good relationship with these people will provide them alternative types of patients, among whom they can select according to their preference.[12]

Regardless of the manner in which an individual becomes a patient of a resident, however, over time the faculty expects them to assume an increasingly larger patient load. Some residents do. But others do not. One explanation of such failure to attend to responsibilities can be found in the formulations of Becker, et al. (1961) and Miller (1970) concerning the perspectives physicians in training adopt toward their work. These authors suggest that students have a great deal to do in a limited time and must solve the problem of allocating time and effort in an advantageous way. Therefore, they reduce their effort in certain areas of study in order to devote time to work they consider of a higher priority. Miller (1970:180-207) states, however, that the trainees he studied reduced their participation in formal learning experiences, not in patient care. Moreover, their faculty tolerated this reduction of effort because it facilitated the institution's function as a service facility.

The center also is a service facility but in this setting there is not the same impetus for residents to expend their efforts on patient care. Specific formal penalties for non-compliance, as well as specific formal awards for compliance, do not exist. As a result, a low level of effort in the area of patient care is tacitly accepted by the faculty. The margin for alternative behavior is so wide in fact that the director notes:

> . . . a resident can do the minimum--200 patients--and get through the program. [By minimum I mean] just the initial work-up, not even a complete history and physical. Nothing. He can write his own history. He doesn't even have to have it that accurate. Who's going to find out.

The director's statement suggests another area of work in which delinquency is tolerated: that is, the resident who fails to take a careful history or to record relevant data in the patient's chart is not sanctioned.[13] The faculty instruct residents to collect representative histories and to make careful detailed entries in the medical records. But, high standards of chartwork are not enforced. Perhaps a major reason for this lack of attention to charts is that medical records do not serve as a primary teaching and evaluation tool at the center. In settings affiliated with an academic institution, records are received continually to help students clarify their actions and to alert them to deficiencies in their performance (Miller, 1970; Mumford, 1970). At the center, however, medical records are reviewed only sporadically and evaluation primarily is conducted through informal, personal means.

Mumford (1970:140) suggests that these differences are due to the disparate organizations of the two settings:

> Matters that in Gemeinschaft society (of which Community Hospital still has many characteristics) are accomplished through personal contact, are achieved through the chart in a large specialized hospital.

In a complex organization, then, competency tends to be assessed through the chart and comments or suggestions on care communicated in writing (Goss, 1969; Miller, 1970:169). In a less complex organization, ableness is evaluated through personal observation and recommendations communicated in informal discussions.

In both settings, however, superordinate physicians use influence, rather than authority, to affect the behavior of subordinate physicians (Goss, 1969: Miller, 1970).[14] Even though faculty have the right to give orders concerning the care of patients, Goss argues that they make suggestions because of a firmly institutionalized value of the medical profession: patient care is a professional activity that requires independence in decision making.

> Assumption of personal responsibility for patients would seem to account in large measure for physicians' unwillingness to take or give authoritative orders concerning patient care. For once this value was accepted--as it apparently was by physicians in both supervisory and non-supervisory positions--to give an order meant usurping another doctor's professional responsibility, as well as taking over the everpresent risk of being proved wrong by later events (Goss, 1969:286).

A formal method to evaluate the performance of residents does exist at the center, however. Once or twice a year faculty are asked to complete forms in which they assess the content of the residents' knowledge and their diagnostic and therapeutic skills.[15] Moreover, in these forms, they are asked to indicate any complaints they may have about residents. Three complaints are registered most frequently.

First, residents do not always attend scheduled conferences. Data showed that attendance at these events varied from ten to seventy percent, with the average being about fifty percent. Second, the residents exploit the flexibility of the program in order to avoid performing some of the required duties. Third, residents are unwilling to devote time and effort to areas that they feel will not be useful to them when they enter private practice. The director of the program illustrates this point clearly in the following excerpt:

> There's no way a family doctor is ever going to do a D & C in one area. So residents view this procedure as, 'Why should I do the scrub work for this character who is not going to let me tie a knot or do anything?' It becomes a one-on-one conflict and it's pretty hard to get around. My perception is, how could you treat anybody or diagnose a surgical disease if you don't know what the think looks like, what's a gall bladder? If I've never seen a gall bladder, I don't know how I'm going to diagnose one. I like to touch, feel, see the stones. Then I've got some idea of what's going on. Some of these students don't want to see anything. They don't want to see a gall bladder, an appendectomy. How are they going to diagnose it? I'm convinced I'm right. I'm convinced they're wrong. But, I can't get them to see it. They say, 'If I'm not going to do doing it, I don't want to learn it.'

The flexibility of the norms that evolve out of the program's structure, then, permits residents to engage in certain behaviors which will not be negatively sanctioned. For example, they are encouraged to exercise individual initiative and independence in caring for patients; admonished to attend to patients' socio-emotional needs; instructed to do careful histories and examinations; and expected to acquire technical competence. Yet, little, if anything, is done when residents shirk individual responsibility for their patients; "drop" those with whom they may be having difficulty; sketch haphazard notations in medical charts; or avoid activities organized to strengthen their ability to practice effectively.

The looseness of the norms also is the result of the agents of social control; not only is the ratio of faculty to residents low, but the frequent non-attendance of faculty brings it lower. As a result, the behavior of students at this center is not as visible as that of trainees at academically-affiliated settings (Merton, 1957b; Miller, 1970; Mumford, 1970). In the academic setting:

> . . . students and faculty alike are, in effect, under continued scrutiny of other medical experts, who set great store by critical appraisal of what is being done. This need not be wholly a matter of plan or of acknowledgment, but the structural pattern is so plain as to be generally acknowledged: peers and superiors in the teaching hospital continually serve in what amounts to the role of monitors of medical practice (Merton, 1957b:77).

In a community hospital, where supervision is provided by physicians who have busy practices, and who are not always available to monitor and evaluate students' activities, trainees' work is less visible and less subject to review. Their behavior, then, differs from the stated norms because the social structure does not induce conformity to them.

Summary

In the foregoing pages the city and county in which this study was conducted were examined. The community is dominated by a single industry which makes its economy extremely sensitive to national and international economic cycles. The presence of this industry is reflected in the county's population, consisting of large numbers of blacks and significant amounts of unemployed and poor. Furthermore, the policies of this industry affect the medical behavior of the population; widespread medical insurance means that, for many, cost is not a constraint on the use of health services.

In addition, the population of patients served by the center was presented. Although these patients come from selected areas within the county, the center appears to attract a number of the less economically stable members of its population.

Finally, the facility in which the sample of patients seeks care was examined. An effort was made to show the way in which the primary goal of the residency training program--the development of primary care physicians with a broad knowledge and ability to treat the whole patient--is compromised by its organizational structure. The weak norms that emerge from this structure impede the effectiveness of the program and limit its success in achieving its stated goal.

CHAPTER IV: NOTES

[1] According to the 1958 Federal Census, less than 20 percent of the city's population had been born in the country. More than 85 percent, however, were native-born.

[2] Seven and a half percent of the county's labor force was unemployed in 1976, one of the highest rates in the country. This rate, nevertheless, was lower than that reported for 1975 when about 12 percent of the active labor force was unemployed. (The major source of information on the city's population was data collected for a project of the local health department.)

[3] Even though only four out of every 10 people in the county live in the city, it continues to exert a centripetal force on area residents. Three out of every four persons in the county's active labor force work in the city, and it is the seat of county government as well as the location of centers of higher education, hospitals, and athletic and cultural centers.

[4] Approximately 54 percent of the households in the city were headed by females in comparison to 16 percent of the households in the out-county. Twenty-six percent of the children under 18 in the city were living with one adult in comparison to nine percent of their counterparts in the out-county. And 41 percent of the city's residents were black in comparison to six percent of the inhabitants of the out-county.

[5] Comunity Hospital is a pseudonym for the institution in which this study was conducted. The hospital is one of six in the city; one is located in the out-county. In addition to these hospitals, there are 617 physicians licensed to practice allopathic and osteopathic medicine in the county, 1.4 per 1,000 residents. This ratio of physicians to population is approximately equal to that for the state.

[6] The heaviest concentration of physicians is in the southwest part of the city and in that part of the out-county contiguous to it. These areas are in the location of three of the city's hospitals and in close proximity to a fourth.

[7] Approximately one-quarter of the women who were interviewed in-depth stated that they had been referred to the center by personnel at the emergency room of Community Hospital. It might be inferred, then, that such a pattern of referral is not uncommon for the general patient population.

[8] In actuality, approximately 6,000 patients presented for care at the center during this period. For purposes of this discussion, however, only some of these patients were defined as members of the center's population. Appendix F includes a discussion of some of the problems encountered in developing a definition of a population and makes clear why the number of patients described in this section is less than the number who actually sought care at the center.

[9] The material describing the health care center and residency training program was obtained from two sources: (1) a personal interview with the director of medical education who supervises the training program; and (2) a booklet written by the director which gives an overview of the program and which is sent to prospective residents. All quotes, therefore, are those of the director.

[10] An American Medical Association study, based on the responses of 190,000 doctors in office-based practice, reported that these physicians cared for 18.32 patients per working day (or 9.16 patients per half day) (American Medical Association, 1971:48).

[11] This emphasis on individual responsibility and the ability to cope is not unique to this training setting (see Miller, 1970; Mumford, 1970; Reader, 1957). Mumford (1970), for example, found that physicians trained in a community hospital were encouraged to develop initiative in preparation for their role as a clinician in private practice. In a university-affiliated hospital, however, she found that physicians were pressed to share responsibility in preparation for their role in academic medicine. Miller (1970), in contrast, found that at Boston City Hospital, a training unit of Harvard's Medical College, student physicians were urged to accept individual responsibility and "learn by doing." He argues that responsibility is extended, not limited, in this setting because the explicit purpose of the institution is the provision of patient care, not the education of physicians.

[12] Martin (1957), using data collected at the Cornell Comprehensive Care and Teaching Program, examined the bases of medical students' preferences for types of patients. He found that students who felt least equipped to meet the technical demands of the physician role tended to prefer certain types of patients to others, i.e., those with physical rather than emotional illness.

[13] In the modified problem-oriented medical record used at the center, the resident, at the time of each patient encounter, is supposed to enter the patient's symptoms and his or her own objective findings, assessment of the problem (diagnosis), and plan of management. The inadequacies of medical records at the center is not a phenomenon unique to it. See, for example, Freeman and Simmons, 1963:25 or Donnabedian, 1966:173.

[14] Goss (1969:248) argues that the characteristic which distinguishes the two forms of control is the subsequent course of action available to subordinates. Influence manifested in the form of advice may be legitimately rejected by recipients. Authority manifested in the form of supervisory decisions ordinarily cannot be.

[15] The director also conducts periodic reviews of the care residents provide for patients using data from the health information system in use at the center. These data, displayed in the form of "patient profiles," provide a chronological account of a patient's visits, their purpose, diagnoses, management, and outcome.

CHAPTER V

THE WOMEN AS INDIVIDUALS AND PATIENTS

It was suggested in Chapters I and II that difficult life circumstances or stress situations might lead to varied responses and that these variations are due to different definitions of and capacities to cope with exigencies. Furthermore, it was argued in Chapter II that the absence of viable psychosocial assets under deleterious life circumstances generates certain non-medical needs. In this sense, frequent use of medical services for multiple diffuse symptoms might be viewed as an adjustment to this deprivation. This chapter presents data relevant to this argument.

The chapter is divided into two parts. Part one presents the findings relevant to the women as individuals located in a social and economic context. Patient needs and orientations to the doctor-patient relationship develop at this individual level. Thus, before any meaningful statements can be made relative to the influence of the life situations of individuals on their need-dispositions as patients, the context in which they are located must be established. Part two presents the findings apposite to the women as patients. There, the patients' medical and non-medical needs are described, the hypotheses which posit the relationship between the environment of the individual and her attributes as a patient are examined and the patients' orientations toward the physician-patient interaction are discussed.

Part 1: The Women as Individuals

A characterization of a person's life circumstances should contain both an objective and subjective dimension. Marital status, income and level of education constitute objective characteristics that affect an individual's life chances. Similarly, the presence of stressful situations can impose in a very real way hardships on the individual. In contrast, the individual's perception of her life, especially its quality, is a subjective description of her circumstances. The findings on the women's views on these objective and subjective dimensions of their life circumstances are presented in this section.

Life Circumstances: Social Position

Nine out of every ten of the women included in the sample were white and almost eighty percent lived within the city at the time they were interviewed.[1] Twenty-four percent lived in hard core areas of poverty and unemployment (as compared to eighteen percent of the patient population at the center that was reported to live in such areas). Approximately two-fifths were married, two-fifths separated or divorced, and one-fifth single (see Table 5.1). Seven (25.9 percent) of the single women were living with a child born out of wedlock. Being separated or divorced tended to be part of a constellation of characteristics. Those whose marriages had been disrupted were likely to be living below poverty level

TABLE 5.1.--Percent of Women by Measures of Social Position.

Measure	Number	Percent
Marital Status		
Single	27	21.7
Married	49	39.5
Marriage disrupted	48	38.7
Household Structure		
Female-headed	64	51.6
Male-headed	60	48.4
Income		
Inadequate	31	25.0
Marginal	13	10.5
Adequate	79	63.7
Education		
None to eight years	5	4.0
Some high school	27	21.8
High school graduate	57	46.0
Some college	25	20.0
College graduate	9	7.3
Graduate school	1	0.8

($r = -.31$, $p < .001$) and to be less educated ($r = -.21$, $p < .02$) (see Table 5.2). More of these women, however, were employed (58.4 percent) than were unemployed and staying at home (41.7 percent). Apparently, their poor educational credentials tracked them into low-paying jobs.

TABLE 5.2.--Zero Order Correlations Between Measures of Social Position.

Measure	Measure: Marital Status	Income	Education	Major Activity
Income	-.31*			
Education	-.21**	.36*		
Major Activity	-.02	.12	.16	
Household Structure	-.21**	.33*	.09	-.11

*$p < .001$

**$p < .02$

Coding: <u>Marital Status</u>: 1 = single, 2 = married, 3 = marriage disrupted;
<u>Income</u>: 1 = inadequate income, 2 = marginal income, 3 = adequate income;
<u>Education</u>: 1 = 0 to 8 years, 2 = less than high school graduate, 3 = high school graduate, 4 = some college, 5 = college graudate, 6 = graduate school;
<u>Major Activity</u>: 1 = stays home, 2 = works, 3 = dual roles;
<u>Household Structure</u>: 1 = female-headed, 2 = male-headed.

Compared to their counterparts in the county as a whole, more of the women in the sample were living below poverty level and in households headed by a female (see Table 5.3). Furthermore, although the percentage of study women heading a household was approximately equal to that in the city, those in the sample tended to be poorer than other females 18 to 40 years of age living there. Approximately equal numbers, however, had received at least a high school education and were employed; 45 percent of the study women

TABLE 5.3.--Percent of Females 18-40 Years of Age by Selected Measures of Social Position: County, 1976; Study Sample, 1977.[a]

Measure	Samples			
	City[b]	Out-County[b]	County[b]	Study
Households by Poverty Level				
Above Poverty Level	79.2	92.4	85.5	72.6
Below Poverty Level	20.8	7.6	14.5	27.4
Households by Sex of Head				
Male	48.1	86.2	69.5	48.8
Female	51.9	13.8	30.5	51.2
Education				
Less than high school completion	26.3	19.4	22.7	25.2
High school graduate	49.6	54.1	51.9	47.2
Some college	19.4	20.4	19.9	19.7
College graduate	4.8	6.1	5.5	7.9

[a] The mean age of the study sample was 27.5 years.

[b] Data on the county are from a computerized information system maintained by the County Health Department at Michigan State University. Information for this system is obtained through: (1) annual health interview surveys conducted by the health department; and (2) records of other county agencies.

were working in comparison to 47 percent and 46 percent of their counterparts in the city and county as a whole.

The sample, then, included a slightly unrepresentative number of women whose lives might be characterized as socially disorganized. Yet, it also included many women whose lives might be considered stable. In the following pages, the relationships between these objective life circumstances and the women's perception of the quality of their life are considered.

Life Circumstances: Quality of Life

One-third of the women felt that the general state of their life was troubled and two-fifths considered it difficult to live on their incomes. A majority (52 percent) considered their money situation to be about the same as that of their friends; 18 percent felt that it was better and 30 percent that it was worse. Fewer women (39 percent), however, considered themselves to be on a financial par with their relatives; 41 percent felt that their money situation was worse than that of their kin and 20 percent that it was better. Equal percentages perceived their family life to be similar to that of significant others (44 percent) and more than two-fifths felt that it was better than that of kin and friends (43.5 and 44.2 percent, respectively). As a group, then, the women's sense of well-being seemed to be more affected by financial instability than by the functioning of their families as social units.

At the level of the individual, however, a woman's sense of well-being tended to be affected by a totality of factors (see Table 5.4). Those who felt that their lives were troubled also were likely to report that: (1) they found it difficult to live on their incomes ($r = -.31$, $p < .001$); (2) their family money situation was worse than that of their kin and friends ($r = .21$, $p < .02$ and $r = .33$, $p < .001$, respectively); and (3) their family life was worse than that of their kin and friends ($r = .28$, $p < .001$ and $r = .24$, $p < .008$, respectively).

Furthermore, women who perceived their quality of life as poor were likely to be separated or divorced, living on inadequate incomes and poorly educated (see Table 5.5). As measured by their own expectations or the situations of others, such women felt themselves to be socially and financially deprived. In short, the most disadvantaged had the least sense of well-being about their situations.

Life Circumstances: Social Stressors

Few of the women (10.5 percent) had not experienced some stressful event during the year; the mean number per person was 2.66. A major sickness or injury to a family member was the most frequently reported event (54 percent) followed by trouble with children (43.6 percent) and marriage trouble (34.8 percent). There was little relationship between the types of stress events experienced, although those who reported sexual problems also were likely to report marriage trouble ($r = .27$, $p < .03$) and the loss of a job by themselves or a family member ($r = .21$, $p < .01$).

TABLE 5.4.--Zero-Order Correlations Between Measures of Quality of Life.

	General State of Life	Family Life Compared With		Family Money Situation Compared With	
		Kin	Friends	Kin	Friends
Family Life Compared With:					
Kin	.28**				
Friends	.24**	.46**			
Family Money Situation Compared With:					
Kin	.21*	.39**	.22*		
Friends	.33**	.17	.15	.47**	
Difficulty Living on Income:	-.31**	-.26**	-.25**	-.64**	-.35**

$^{*}p < .02$

$^{**}p < .005$

Coding: General State of Life: 1 = very smooth with little trouble, 2 = smooth with occasional trouble, 3 = frequently upset by troubles, 4 = most of the time upset; Comparative Family Life and Money Situation: 1 = lot better, 2 = little better, 3 = about the same, 4 = little worse, 5 = lot worse; Difficulty Living on Income: 1 = very difficult, 2 = fairly difficult, 3 = somewhat difficult, 4 = not too difficult, 5 = not difficult at all.

TABLE 5.5.--Zero-Order Correlations Between Measures of Social Position and Quality of Life.[a]

Quality of Life	Social Position			
	Marital Status	Income	Education	Household Structure
General State of Life:	.21*	-.39*	-.28**	-.16
Family Life Compared With:				
Kin	.11	-.24**	-.15	-.26**
Friends	.05	-.19*	-.21*	-.22*
Family Money Situation Compared With:				
Kin	.16	-.45**	-.21*	-.33**
Friends	.21*	-.46**	-.25**	-.27**
Difficulty Living on Income:	-.34**	.65**	.32**	.40**

[a] The relationship between major activity and the measures of quality of life were not statistically significant.

*$p < .02$

**$p < .005$

Differences in experiences were related to social position. Those who reported more stress events were separated or divorced ($r = .30$, $p < .001$), living on inadequate or marginal incomes ($r = -.20$, $p < .02$), and less educated ($r = -.21$, $p < .01$). Most of the events such women experienced reflected interpersonal difficulties, for examples, difficulties with spouse, children or in-laws (see Table 5.6). Only the less educated were likely to report an event that reflected an economic hardship, i.e., the loss of a job ($r = .20$, $p < .02$). In addition, only the separated and divorced were likely to accept the option to report events that required changes in ongoing adjustment ($r = .21$, $p < .01$). The events they mentioned included specific problems with children (e.g., teenage pregnancy or juvenile delinquency), robberies and physical attacks (including one case of rape).[2]

Differences in experiences also were related to the individual's sense of well-being. Women who reported experiencing more stress events felt that their (1) lives were troubled ($r = .26$, $p < .004$); (2) income difficult to live on ($r = -.23$, $p < .009$); (3) money situation worse than that of their kin ($r = .20$, $p < .02$); and (4) family life worse than that of their friends ($r = .20$, $p < .02$). In short, those who assessed their life circumstances as poor and were socioeconomically disadvantaged were most likely to have experienced a series of events that challenged their resources and skills.

TABLE 5.6.--Zero-Order Correlations Between Measures of Social Position and Social Stressors.

Social Stressors	Social Position		
	Marital Status	Income	Education
Major sickness of injury to family member	-.04	-.09	.01
Death of close friend	-.10	-.05	.10
Death of close family member	-.05	.10	-.03
Individual or family member laid off or fired from work	.08	.14	.20*
Individual or family member had trouble with law	.00	.03	-.02
Sexual problems	-.24**	.21*	.27**
End of love affair	.03	.32**	.01
Marriage trouble	-.26**	.18*	.08
Trouble with in-laws	-.29**	.19*	.06
Trouble with children	-.66**	.34**	.30**
Other social stressors	.21*	-.05	-.05

*p < .03

**p < .007

Coding: Social Stressors (major sickness or injury to a family member to trouble with children): 1 = experienced event, 2 = did not experience event;
Other Social Stressors: 1 = experienced event with positive impact (i.e., start of love affair), 2 = experienced event with negative impact (e.g., specific problems with children such as juvenile delinquency, robberies and physical attacks).

Psychosocial Assets

The literature reviewed in Chapters I and II suggested that social and psychological assets contribute to an individual's ability to cope with deleterious life circumstances by buffering or cushioning her from their consequences. In Chapter II social assets were defined as systems of social support that may include (1) members of the kin network; (2) members of the friend network; and (3) neighbors. It was suggested that the members of such support systems help the individual to manage long-term privations or acute stress circumstances: (1) by providing psychological support that aids her in mastering her emotional burdens; and (2) by providing functional support that assists her in handling her situation. Psychological assets were characterized in Chapter II as feelings of self-worth that were defined by the presence of absence or feelings of failure. It was suggested that such negative or positive feelings about herself help the individual to manage distressful life changes or deprivations by acting as a defense between them and her ability to cope. These social and psychological assets are examined in this section.

Social Assets: The Neighborhood and Neighbors

Approximately one-third of the women had lived in their neighborhood less than two years; one-fourth had moved within the year. Those who had moved more recently had located in neighborhoods that were characterized as heterogeneous ($r = -.20$, $p < .02$), unstable ($r = .18$, $p < .04$), and by low frequency of contact among neighbors (r = -.22, p < .01). Although the relationships between stability of residence and marital status and income were not significant, those who lived in female-headed households and were less educated had lived a shorter time in their neighborhoods (r = .19, p < .03 and r = .17, p < .05, respectively).

The nature of the neighborhood was related to neighborliness, as might be expected. Help from neighbors was not felt to be readily available in neighborhoods that were characterized as heterogeneous (r = -.26, p < .003), unstable (r = .23, p < .01) and by low frequency of contact among neighbors (r = -.32, p < .001). There are several plausible explanations for this relationship.

First, it may be a function of conditions within the neighborhoods. Not a few women used the words "unfriendly," "anti-social," and "unpleasant" to describe their neighbors and several, in describing their neighborhoods, iterated the conditions illustrated in the following excerpt:

> There are fences and 'beware of dog' signs on most of the houses. There's a lot of animosity in the neighborhood. My husband works the night shift and our dog is a must.

This "animosity" may well be generated by crime in the neighborhood. A number of women reported that apartments and houses in their neighborhoods had been broken into, robbed, and vandalized. Under such conditions, it is not unexpected that neighbors would become guarded in their relationships with others.

Second, help sometimes is not forthcoming because neighbors have similar problems. As one woman said: "It's always hard to get a ride. No one in the neighborhood has a car that runs." Third, when people frequently move in and out of an area, it is difficult to establish reciprocal relations of obligations with them. Finally, efforts to establish relationships may be discouraged by people who believe that they may be reprehended for their situation. For example, one woman, in discussing her neighbors' possible reasons for rebuffing her overtures of friendliness, said:

> Maybe it was because there's a man who spends a lot of time there and she doesn't want me to find out. Or maybe it's because she's embarassed by all the cockroaches in her house.

Despite the low level of support perceived available from neighbors (only half of the women felt free to call upon them for help when they needed it), almost two-thirds of the women were satisfied with their neighborhood. Some, of course, were satisfied because they lived in "good" neighborhoods and had relationships with neighbors that were rich with friendliness and reciprocal obligations. Others were satisfied because they liked the house in which they lived or the school district in which it was located. Those who were dissatisfied with their neighborhood felt this way because the areas were socially and physically disorganized and their relationships with their neighbors limited in content and intensity. For most of these women, however, there were no alternatives. As one commented: "There are many break-ins in the area. Anybody can open doors with a credit card. But, it's very hard to get decent housing on ADC."

The neighborhood, then, had limited value for many as a pool of friends who could offer services and support when it was needed.

In the pages that follow, the degree to which kin and friends provided this assistance will be explored. First, however, the nature of these networks of primary relationships are described.

Social Assets: Kin Networks

Table 5.7 presents data on the distribution of women by the type of kin networks in which they were enmeshed. The networks of the majority tended to be loose-knit and most of their kin were not located in the neighborhood. Half of the women were in daily phone contact with their kin and two-thirds saw them at least weekly.[3] Only five women had had no contact with their kin during the month in which they were interviewed; they reported that their relatives all lived outside the community.

Almost three-fourths of the women had received psychological support from their kin. Of the 165 kin mentioned as providing this support, members of the family of orientation were cited most often (76.4 percent), with siblings reported most frequently (32.7 percent) followed by mothers (29.7 percent). Among other relatives who provided support, in-laws were mentioned 13.3 percent of the time. Functional support was not provided as liberally by kin as was psychological support. Still, more than half of the women reported that they had received some sort of practical assistance from relatives. Of the 112 kin mentioned as providing this support, mothers were cited most often (42.9 percent).

Contrary to Bott's (1957) findings, location of kin had no effect upon the density of the network (see Table 5.8). This means

TABLE 5.7.--Percent of Women by Characteristics of Kin Networks.

Characteristic	Number	Percent
Density		
Close-knit	55	44.4
Loose-knit	69	55.6
Location		
Neighborhood	21	16.9
Location-mixed	14	11.3
Non-neighborhood	89	71.8
Type of Contact		
Phone only	9	7.3
Personal only	2	1.6
Both phone and personal	108	87.1
No contact	5	4.0
Frequency of Phone Contact		
Nearly every day	63	50.8
1-2 times per week	30	24.2
2-3 times per week	17	13.7
Once	7	5.6
Never	7	5.6
Frequency of Personal Contact		
Nearly every day	21	16.9
1-2 times per week	60	48.4
2-3 times per week	23	18.5
Once	6	4.8
Never	14	11.3
Content of Relationship		
Psychological support	91	73.4
Functional support	68	54.8
Location of Kin Providing Support		
Psychological Support:		
Neighborhood	31	34.1
Location-mixed	15	16.5
Non-neighborhood	45	49.4
Functional Support:		
Neighborhood	24	35.3
Location-mixed	3	4.4
Non-neighborhood	41	60.3

TABLE 5.8.--Zero-Order Correlations Between Characteristics of the Kin Network.

	Characteristic				
	Density	Location	Frequency of Phone Contact	Frequency of Personal Contact	Psychological Support
Location	.07				
Frequency of phone contact	-.07	-.17*			
Frequency of personal contact	-.08	-.27**	.67**		
Content:					
Psychological support	.17*	.19*	-.33**	-.39**	
Functional support	-.07	.15	-.22*	-.37**	.15

*p < .05

**p < .003

Coding: Density: 1 = close-knit, 2 = loose-knit;
Location: 1 = neighborhood-based, 2 = location-mixed, 3 = non-neighborhood based;
Frequency of Phone and Personal Contact: 1 = never, 2 = once, 3 = two or three times, 4 = one or two times a week, 5 = nearly every day;
Content of Support: 1 = receives support, 2 = does not receive support.

that women with kin in the neighborhood were just as likely to be members of loose-knit networks as they were to be members of close-knit ones (47.6 and 52.4 percent, respectively). Living within walking distance, however, did encourage personal contact among relatives. Women with kin in the neighborhood met with them more often than those without relatives living in close proximity ($r = -.27$, $p < .003$). Furthermore, women with kin in the neighborhood had more frequent telephone contact with them than those who did not ($r = -.17$, $p < .05$).

Two explanations for the correlation between the regularity of telephone and personal contact appear plausible. Propinquity may facilitate the establishment of closer ties between kin and thus bring about frequency of contact. Frequency of telephone contact may facilitate the transmission of invitations to visit or requests for assistance. Indeed, women who had more regular telephone communications with their relatives were more likely to receive functional support from them than those without such frequent contact ($r = -.22$, $p < .01$).

Members of close-knit networks were more likely to receive psychological support from kin than were members of loose-knit networks ($r = .17$, $p < .05$). There was no statistically significant relationship, however, between the receipt of psychological support from kin and the receipt of functional support from them. Forty-two percent of those who received psychological support did not receive functional support and 44 percent of those who received functional support did not receive psychological support. Furthermore, members of close-knit networks tended to be slightly less likely to receive functional support from relatives than members of loose-knit networks; that is, 50 percent of the women who belonged to close-knit networks received functional support from kin in comparison with 58 percent of those who belonged to loose-knit networks.

This finding is difficult to explain. The data suggest, however, that the lack of relationship between density of network and receipt of functional support may be a reflection of the varying resources available to the women due to their different social positions. Those with more education were likely to be members of close-knit kin networks ($r = -.19$, $p < .04$) and there was a slight tendency for the more educated to receive less functional support from kin. (Fifty percent of those who had graduated from high school or attended college received tangible assistance from relatives in comparison to 59 percent of those who had less than a high school education.) Furthermore, the more educated were likely to be living on adequate incomes and the latter also tended to be members of close-knit networks and not to receive functional support from kin. (Fifty-one percent of those living above poverty level received tangible assistance from relatives in comparison to 59 percent of those whose financial situation was less secure.)

The lack of relationship between density of network and receipt of functional support, then, may be a consequence of differing resources. Women who were members of close-knit networks were more advantaged, educationally and financially, and probably more able to locate and pay for the services of non-relatives if they needed tangible assistance. Thus, they may have tended to report less functional aid from their kin.

Social Assets: Friend Networks

Table 5.9 presents data on the distribution of women by the type of friend networks in which they were enmeshed. The networks of most tended to be loose-knit and a majority of their friends were not located in the neighborhood. Approximately half of the women were in daily phone contact with friends and two-thirds saw them at least weekly. Only three women had had no contact with friends during the month in which they were interviewed. Four-fifths received psychological support from friends, but only half as many received functional support from them.

Location of friends had no statistically significant relationship to frequency of contact with them, but frequency of telephone contact was correlated with personal contact (see Table 5.10). Women who talked with their friends regularly also met with them frequently ($r = .57$, $p < .001$): "A phone call usually means a visit." Regularity of personal contact, however, did not ensure the individual of functional support. Nevertheless, those who met with their friends nearly every day tended to receive more tangible assistance from them than those without such frequent contact (54.8 and 38.5 percent, respectively). Furthermore, women who had frequent telephone and personal contacts with friends were likely to receive both psychological and functional support from them ($r = .20$, $p < .02$).

TABLE 5.9.--Percent of Women by Characteristics of Friend Networks.

Characteristic	Number	Percent
<u>Density</u>		
Close-knit	41	33.1
Loose-knit	83	66.9
<u>Location</u>		
Neighborhood	25	20.2
Location-mixed	23	18.5
Non-neighborhood	76	61.3
<u>Type of Contact</u>		
Phone only	5	4.0
Personal only	4	3.2
Both phone and personal	112	90.3
No contact	3	2.4
<u>Frequency of Phone Contact</u>		
Nearly every day	61	49.2
1-2 times per week	33	26.6
2-3 times per week	16	12.9
Once	7	5.6
Never	7	5.6
<u>Frequency of Personal Contact</u>		
Nearly every day	30	24.2
1-2 times per week	55	44.4
2-3 times per week	25	21.0
Once	5	4.0
Never	8	6.5
<u>Content of Relationship</u>		
Psychological support	98	79.0
Functional support	52	41.9
<u>Location of Friends Providing Support</u>		
Psychological Support:		
Neighborhood	25	25.5
Location-mixed	20	20.4
Non-neighborhood	53	54.1
Functional Support:		
Neighborhood	24	46.2
Location-mixed	6	11.5
Non-neighborhood	22	42.3

TABLE 5.10.--Zero-Order Correlations Between Characteristics of the Friend Network.

	Characteristic				
	Density	Location	Frequency of Phone Contact	Frequency of Personal Contact	Psychological Support
Location	.28*				
Frequency of phone contact	-.17**	-.11			
Frequency of personal contact	-.21**	-.09	.57*		
Content:					
Psychological support	-.02	-.07	-.28*	-.20**	
Functional support	-.04	.09	-.05	-.09	.20**

*p < .002

**p < .05

Members of close-knit networks were likely to have neighborhood-based friends (r = .28, p < .002) and to be in regular telephone contact (r = -.17, p < .05) and personal contact (r = -.21, p < .02) with them. Paradoxically, however, these women were no more likely to receive psychological and functional support from their friends than were members of loose-knit networks. Eighty percent of those who were members of close-knit networks and 78 percent of those who were members of loose-knit networks received psychological support from friends and 43 and 40 percent, respectively, received functional support from them.

This finding is difficult to explain. No statistically significant relationships were found between social position and density of network or the receipt of psychological and functional support. Women with differing educational, financial and marital statuses were as likely to be members of close-knit networks as they were to be members of loose-knit ones. However, those who were single tended to receive more psychological (95.0 percent) and functional support (51.8 percent) from friends and to have more frequent contact with them than other women (see Table 5.11).

Two explanations for the relationships between an unmarried status and receipt of support from and frequency of contact with friends appear plausible. First, the single may, in the process of asserting their independence from their family of procreation, establish more solidary relationships with friends. Thus, they may have frequent contacts and intense relationships with them that facilitate the provision of support. Second, the single may

TABLE 5.11.--Characteristics of the Friend Network by Measures of Social Position.

Characteristics of the Friend Network	Social Position						
	Marital Status			Education		Income	
	Single	Married	Marriage Disrupted	Less Than High School	High School Graduation and Over	Inadequate and Marginal	Adequate
Supportive Behaviors:							
Receives psychological support	95.0	66.7	85.7	78.1	88.6	75.0	81.0
Receives functional support	51.8	38.8	39.6	34.4	44.6	43.2	40.5
Frequency of Telephone Contact:							
At least weekly	85.0	78.4	71.4	65.6	79.4	65.9	81.0
Frequency of Personal Contact:							
At least weekly	80.0	72.6	62.5	59.4	71.7	70.5	67.1

have more time to visit with friends and to offer them support. Thus, they may receive more support as a result of shared expectations of behavior. The crucial difference between receiving support from friends or not, then, may be marital status. Essentially, however, the finding remains unexplained.

Relationship Between Kin and Friend Networks

It was seen in the proceeding discussion that few differences existed in the characteristics of the women's linkages with kin and friends. A majority were members of loose-knit networks and had daily telephone and weekly personal contact with significant others. Furthermore, although their kin and friends primarily lived outside the neighborhood, most of the women received psychological support from them. Apparently, the use of the telephone tends to minimize the importance of geographical distance and aid such as psychological support is not contingent on face-to-face contact. Fewer women, however, received functional support from kin and friends and, furthermore, kin tended to provide more tangible assistance than friends. Nevertheless, the characteristics of the two networks were, in general, quite similar.

An important question left untouched by the previous discussion, however, is the extent to which the nature of the linkages with one category of people--kin or friends--affects the nature of linkages with the other. This question is considered in the following pages as the relationship between the two networks is examined.

Kin and Friend Networks Compared. Contrary to Bott's (1957) findings, being a member of a close-knit kin network did not imply being a member of a loose-knit friend network. That is, 67 percent of those who were members of close-knit kin networks also were members of close-knit friend networks ($r = .30$, $p < .001$). Furthermore, those who were members of loose-knit kin networks also tended to be members of loose-knit friend networks (67.1 percent). Apparently, some women maintain individual, rather than group, relationships. In addition, some women apparently are more sociable than others. Those who had frequent telephone contacts with kin also were likely to have frequent telephone contacts with friends ($r = .21$, $p < .02$).

At the same time, there was no statistically significant relationship between the location of kin and the location of friends. Women with kin in the neighborhood were as likely to have friends there as those without relatives living in close propinquity (23.8 and 18 percent, respectively). Furthermore, women with kin in the neighborhood did not tend to have less frequent personal contact with friends than those with kin living elsewhere. Nineteen percent of those who had almost daily personal contact with friends had kin living within walking distance of their homes, in comparison with 23 percent with such regular contact whose kin were located outside of the neighborhood.

There also was no statistically significant relationship between the receipt of support from kin and friends. A majority of women (58.1 percent) received psychological support from both categories of significant others; less than one-fifth (17 percent) received emotional support only from kin and slightly over one-fifth (23.4 percent) only from friends. There was a slight tendency, however, for those who received psychological support from kin to receive less support from friends (77.4 percent) and those who did not receive support from relatives to receive more support from friends (85.3 percent). Psychological support from friends, then, may be compensatory to that of kin rather than supplementary.

This tendency was not evident for functional support, however. More women received tangible assistance only from kin (32.5 percent) than received it from both kin and friends (22 percent) or only from friends (19.5 percent). (One quarter of the women received no support from significant others.) Functional support from friends, then, may be supplementary to that of kin rather than compensatory.

Content of Psychological Support from Kin and Friends. During the month in which they were interviewed, all but five (4 percent) of the women received psychological support from kin and/or friends. Two-thirds reported that four or more times some significant other had shown warmth or friendliness toward them when they were troubled, listened carefully when they needed to talk about something and showed understanding when they were troubled. Less than half, however, reported that someone had encouraged them or showed approval for something they did as many times.

The density of the kin network was related to the receipt of certain types of support. Women who were members of close-knit networks reported more gestures of friendliness ($r = -.22$, $p < .03$), and careful listening ($r = -.21$, $p < .04$) than those who were members of loose-knit networks. In addition, although not statistically significant, the direction of the relationship between density of the kin network and the amounts of encouragement and understanding received followed the same pattern ($r = -.19$ and $r = -.10$, respectively). Perhaps, within a cohesive group, which a close-knit network may be considered, there is more pressure to fulfill obligations than there is when interaction is not as formally structured. In addition, since the relationship between density of network and quantity of support was not found to hold for women who were members of close-knit friend networks, it might be inferred that the norms of the kin group were more restrictive than those of the friend group.[4]

As might be expected, frequency of phone and personal contact was related to the number of times women reported receiving psychological support (see Table 5.12). However, there were differences between the persons with whom the women had contact and the quantity of support received. That is, frequency of contact with friends was more likely to result in a report of greater support than was frequency of contact with kin. Perhaps role expectations among kin, even when enjoined by norms, more often are violated, accidentally or intentionally.

TABLE 5.12.--Zero-Order Correlations Between Frequency of Contact with Kin and Friends and Quantity of Psychological Support.

Content of Psychological Support	Frequency and Type of Contact			
	Kin		Friends	
	Phone Contact	Personal Contact	Phone Contact	Personal Contact
Friendliness when Troubled	.17	.29*	.20**	.20**
Listened Carefully	.07	.09	.28*	.29**
Encouraged	.04	.18	.39*	.32*
Showed Understanding	.12	.15	.22**	.23**

*p < .006

**p < .05

Coding: Frequency of Contact: 1 = never, 2 = once, 3 = two or three times, 4 = one or two times a week, 5 = nearly every day;
Quantity of Psychological Support (i.e., number of times received during month of interview): 1 = not at all, 2 = once, 3 = twice, 4 = three times, 5 = four or more times.

Regardless of the amount of support they received, most of the women (97 percent) felt that it was helpful. Responses such as the following were common in answer to the question, "In what way did the support help?"

> It gave me self-confidence so I wouldn't put myself down. If you feel good about yourself then everyone else is going to feel good about you.
>
> It's not so much what they said. They showed concern. My problems seem so much smaller when I don't have to face them alone. It's good to get them off your chest.
>
> Talking to someone else always makes me feel better. It's hard to explain. If you're upset or worried about something and you talk to somebody, your headache goes away and you don't feel nervous or testy anymore.

All of these quotes suggest the importance to the women of support that sustains and validates their self-image or provides an emotional outlet. In addition, the last quote suggests a keen awareness of the relationship between the psyche and soma. That is, physical symptoms brought about by unhappiness or social problems can be "cured" when the individual is free to acknowledge her difficulties and express her feelings.

However, even though almost all of the women expressed satisfaction with the support that they had received, one-fifth felt that more support would have been helpful. In some instances, these women felt that they were unable to align their actions with the expectations of others and wanted to talk with someone who could help them assess their lives and goals. For example, one woman who was in the process of a divorce said:

> I'd like to talk about my divorce with somebody who hasn't decided so much about it. I don't have very understanding relatives. They think I'm wrong.

Others felt that obedience and submission were being asked of them at the expense of their individual preferences and they wanted to talk with someone who could help them explore alternatives. One woman, whose mother was pressuring her to give up a planned move to another state to join her husband, said:

> It would help if my mom would be more with me on this decision. It would be a whole lot easier. I don't know what I can do.

Still others felt that the support of their kin and friends had limited value and expressed a need for advice and solutions to their difficulties:

> My aunt listens to me. But sometimes she has lots of problems too so she can't help me much . . . I could use some good positive answers to my problems.

> I have friends and relatives who I can call but they've got so many problems themselves I feel worse when I hang up . . . . [Also,] they try to sway you to think their way or they have different advice and mix you up.

Almost two-thirds of the women who felt a need for more support were living on inadequate or marginal incomes ($r = .28$, $p < .003$) and were separated or divorced ($r = -.17$, $p < .05$). In addition, although there was not a statistically significant relationship between expressions of need for more support and education, 42.3 percent of those saying more support would have been helpful had less than a high school education. (The percentages for high school graduates and those who had attended or completed college were 30.8 and 26.9 percent, respectively).

In summary, kin and friends offered liberal amounts of emotional support to the women. Yet, for some, specifically the most socioeconomically disadvantaged, this support was found wanting.

Content of Functional Support from Kin and Friends. Significant others overwhelmingly were a source of tangible assistance for the women. Three-quarters (74.2 percent) reported receiving some support from kin and/or friends. Kin were mentioned most frequently as sources of help with problems when there was an illness in the family and with money matters (see Table 5.13). Friends were mentioned more frequently as sources of help with personal and family problems and with transportation and house repairs.[5] (Fifteen percent of the women reported receiving help from members of social service agencies, primarily aid with money matters and with personal or family problems.) In almost all instances, functional support from significant others was provided gratis. Six (16.2 percent) of the women who received help with children from kin or friends did pay them for this service, however.

Despite the many women who reported receiving some tangible assistance from kin and/or friends, there were still some among them who felt that not all their needs for support were being met by significant others. (It should be remembered that a woman automatically was categoriezed as receiving support from kin or friends if she reported help forthcoming from a relative or intimate in one area of concern.) The number of these women was not large. Yet, among those who received any assistance from kin and/or friends, 12.5 percent expressed a need for help with child care; 25 percent

TABLE 5.13.--Content of Functional Support by Provider of Support.

Content of Support	Provider of Support					
	Kin		Friends		Other	
	Number	Percent	Number	Percent	Number	Percent
Help with problems when illness in family	52	61.9	24	28.6	8	9.5
Help with money matters	17	58.6	1	3.5	11	37.9
Help with child care	24	32.9	13	17.8	36[a]	49.3
Help with personal or family problems	15	30.6	25	51.0	9	18.4
Help with transportation and house repairs	5	26.3	11	57.9	3	15.8

[a] Nine out of every ten of the other providers of help with child care mentioned were paid babysitters.

a need for help with problems when there was an illness in the family; 25.5 percent a need for help with personal or family problems; and 29.2 percent a need for help with money matters. In short, approximately one-quarter of the women found that the help of significant others was not sufficient to solve all of their problems.

Summary: Social Assets

The neighborhood was not a particularly effective field in which to meet with others, form friendships and establish relationships of mutual obligation. The data indicated that only half of the women had links with neighbors that implied services and support. The rest did not feel free to call upon neighbors for assistance when needed or felt that their relationships with them were almost completely dysfunctional. In large part, the paucity of functional ties among neighbors was a consequence of the nature of the neighborhoods in which the women lived. A real heterogeneity, population instability and social disorganization impeded the formation of intimate and cooperative relationships between residents.

Kin and friends were the primary source of help for the women. The data supported the view that (1) individuals in urban settings maintain considerable contacts with relatives and receive more than a modicum of support from them (Adams, 1968; Axelrod, 1956; Coult and Habenstein, 1962; Litwak, 1965; Parsons and Bales, 1955; Sussman, 1953; Sussman and Burchinal, 1962); and (2) urban contacts are rich with friendship and the content of these relationships is far from shallow (Adams, 1967; Cohen, 1961; Hunter, 1975).

The data on the nature of the kin and friendship networks, however, were only partially successful as a guide to the interpretation of social action.

Frequency of contact was related to the degree to which psychological and functional support were provided by kin. Women who had more telephone and personal communication with them were more likely to receive help than those without such regular contact. Furthermore, frequency of contact with friends was related to the receipt of psychological support from them. Women who had regular contact with intimates were more likely to receive emotional support than those in less frequent contact with them. Frequency of contact with friends, however, did not assure the individual of tangible assistance. But, friends, in general, provided such help less fully than did relatives. Apparently, the intensity of commitment is affected by the durability of the group and friends do not offer functional support as often as people bound by blood ties.

The data relevant to density of networks and supportive behaviors were inconsistent and essentially remain unexplained. Only members of close-knit kin networks were assured of aid, albeit only psychological support. The data suggested, however, that a close-knit network probably functions as a more effective channel for the transmission of information regarding need for assistance than a loose-knit one. Members of close-knit networks tended to have more frequent contacts with significant others and, as indicated above, such women were more likely to receive help from them.

The data also suggested that differences in the receipt of functional support, in part, may be a function of differential social position. Women who were less educated and less secure financially tended to receive slightly more tangible assistance from kin than their more advantaged counterparts. Women who were single tended to receive more functional support from friends than those who were married, separated or divorced.

Psychological Assets:
Feelings of Failure

Feelings of failure, as suggested in Chapter II, refer to the individual's belief that she has fallen short in some domain of life, that is, she is unsuccessful. The inability to perform socially prescribed roles--as measured by her own expectations or against the performance of others--or the inability to solve problems through her own efforts may be sensed as indications of a lack of skill or competence to function independently and give rise to such feelings. In the following pages the findings on the women's feelings of failure are presented.

Three-fifths of the women identified themselves as performing only one role. Of these women, 71.2 percent reported that they kept house and 28.8 percent that they worked. Although the relationship between the number of roles performed and perception of adequacy of performance as a housewife was not significant, there was evidence that performing dual roles placed certain strains on women (see Table 5.14). Among women who assessed their performance of the role of housewife highly, only one-third performed dual roles

TABLE 5.14.--Zero-Order Correlations Between Measures of Social Positions and Feelings of Failure.

Feelings of Failure	Social Position				
	Marital Status	Income	Education	Major Activity	Household Structure
Need Help with Problems:	.25*	-.38*	-.23**	-.07	-.24*
Comparative Role Performance:					
Housewife	-.54*	.01	.22**	.07	-.09
Worker	.15	-.09	-.27*	-.72*	.12
Student	-.01	.38	-.04	-.35*	.13
Tasks of Daily Living	.11	-.09	-.11	.03	-.08

*$p < .007$

**$p < .01$

Coding: Need Help With Problems: ranges from zero (no help needed) to four (help needed with problems in four areas of living);
Comparative Role Performance: 1 = lot better, 2 = little better, 3 = about the same, 4 = little worse, 5 = lot worse.

while two-thirds performed single roles. Women involved in more than one role, however, apparently devoted their efforts and energy to their work or studies at the expense of their chores at home. Those who identified themselves as workers and students as well as housewives were more likely to consider themselves successful in their performance of their roles outside, than inside the home ($r = -.72$, $p < .001$ and $r = -.35$, $p < .001$, respectively).

Women whose marriages were disrupted and whose level of education was low considered themselves successful in their present performance of roles as housewives ($r = -.54$, $p < .005$ and $r = .22$, $p < .01$, respectively). Such women tended to perform single roles, and as indicated above, those who engaged in one activity only were more likely to assess their performance as a housewife highly. For example, 76 percent of those with less than a high school education and 58 percent of those who were separated or divorced identified themselves as performing only one role.

The more highly educated, however, were likely to feel that they performed their role of worker better than others they knew ($r = -.27$, $p < .003$). Their perceived success, in contrast to the perceived failure of the less educated, may be a reflection of differences in occupation. On the one hand, the more educated may be employed in occupations where variations in abilities are more evident; thus, they may have had a better benchmark upon which to base their assessment than the less educated who tended to be employed in routine, unskilled jobs. On the other hand, the more educated may be employed in occupations that encourage them to excel;

thus, their perceived success may reflect the consequences of satisfactions derived from meeting a challenge successfully.

There was no statistically significant relationship, however, between assessment of role performance and a need for help with problems. Those who assessed their performance highly were just as likely to need help as they were to not need help. Approximately one-third of the women reported that they needed help with the concerns suggested. Of these women, 18.5 percent expressed a need for assistance with one concern, 10.5 percent with two concerns, 4.8 percent with three concerns and 1.6 percent with four concerns. Help with money matters was the most frequently cited assistance needed (33.3 percent), followed by need for help with personal or family problems (26.7 percent) and for help when there was an illness in the family (18.7 percent).

Women who were separated or divorced, living on inadequate or marginal incomes and less educated were more likely to have a need for help with an increasing number of problems than their more advantaged counterparts ($r = .25$, $p < .005$, $r = -.38$, $p < .001$ and $r = -.23$, $p < .01$, respectively). A majority of women whose marriages had been disrupted (52.1 percent), whose incomes were low (55.6 percent) and whose education had ceased before graduation from high school (62.5 percent) expressed a need for help with one or more problems (see Table 5.15). In short, women who were most socioeconomically disadvantaged were the least able to resolve problems successfully.

TABLE 5.15.--Percent of Women Needing Help with Problems by Social Position.

Social Position	Need for Help with Problems			
	None		Some	
	Number	Percent	Number	Percent
Marital Status				
Single	21	77.8	6	22.2
Married	36	73.5	13	26.5
Marriage disrupted	23	47.9	25	52.1
Income				
Inadequate and Marginal	20	44.4	25	55.6
Adequate	59	71.1	24	28.9
Education				
Less than high school graduation	12	37.5	20	62.5
High school graduate and attended college	68	73.9	24	26.1

Summary: Psychosocial Assets[6]

As might be expected, women who received functional support from kin and/or friends reported less need for help with problems than those who did not ($r = .24$, $p < .007$). Women who received tangible assistance from relatives, however, were likely to have less need for help ($r = .19$, $p < .03$) than those who received aid from friends; the relationship between the receipt of support from friends and an increasing need for help with problems was in a similar direction, but was not significant ($r = .16$). Kin, then, apparently contributed more to an individual's overall ability to handle material problems successfully than did friends.

The extent to which the psychological support of kin helped the women mobilize their resources and master emotional burdens arising from unfulfilled concerns, however, was more equivocal. Women who did not receive psychological support from kin were more likely to express a need for help with problems when there was an illness in the family and/or help with personal or family problems ($r = -.20$, $p < .03$ and $r = -.22$, $p < .01$, respectively). Yet, among those who expressed a need for help with personal or family problems, 70 percent received emotional support from kin ($r = .20$, $p < .02$). (The percentage for those who expressed a need for help with personal problems and who received psychological support from friends was 75 percent, but the relationship between need for help and aid from friends was not statistically significant.)

Finally, although only half of the women felt free to call upon neighbors for help when they needed it, the support provided by these people did contribute to the individual's ability to handle problems successfully. Women who perceived aid readily available from neighbors were less likely to report any need for help with daily concerns than those who felt help was not as forthcoming ($r = -.21$, $p < .02$). The extent to which this help and that from kin and friends contributed to the individual's ability to manage long-term burdens or acute stress situations is explored in the following pages.

Relationship Between Life Circumstances and Psychosocial Assets

It was seen in the proceeding discussion that women who were socioeconomically disadvantaged were likely to have assessed their life circumstances as poor and to have experienced a series of stressful events that challenged their resources and skills. Furthermore, it was seen that the women received generous amounts of psychological and a fair measure of functional support from significant others. Yet, for some, particularly the disadvantaged, this support was found wanting. In addition, it was seen that the neighborhood was not a particularly effective field in which to meet with others, form friendships and establish relationships of mutual obligation and that only half of the women had links with neighbors that implied services and support. In this section, the relationship between varying psychosocial assets and life circumstances is discussed.

The data indicate that women who had a greater need for help with problems were likely to perceive the quality of their life as poor (see Table 5.16). Women who expressed the most difficulty in resolving problems within their environment reported the least sense of well-being about their situations. Furthermore, women who had a greater need for help with problems were likely to have experienced a series of stressful events that challenged their skills and resources ($r = .35$, $p < .001$). These women, however, had the least command of social and economic resources to facilitate the handling of their situations; they were the poor, the less educated, and the separated or divorced.

The disadvantaged did receive functional support from their kin and friends.[7] Yet, it was not adequate to help them successfully resolve the problems they encountered; 70 percent of those who reported some need for help with problems received tangible assistance from relatives and/or intimates. There are several plausible explanations for the inadequacy of the support of significant others. First, kin and friends, caught up in their own lives and concerns, may be able to extend only a limited amount of help. Second, relatives and intimates may be able to offer support, but the need is for the kind of expertise that only can be found in a professional setting.

Third, significant others may be unable to provide the required assistance because of their own limited resources. Approximately three-fifths of the women (58.9 percent) felt that their kin's financial situation was about the same or worse than their own. Similarly, 69.4 percent of the women felt that their friend's financial situation was about the same or worse than their own. In

TABLE 5.16.--Zero-Order Correlations Between Need for Help with Problems and Measures of Quality of Life.

Measures of Quality of Life	Need for Help With Problems
General State of Life	.38**
Family Life Compared with:	
Kin	.32**
Friends	.33**
Family Money Situation Compared with:	
Kin	.20*
Friends	.17
Difficulty Living on Income:	-.44**

*p < .02

**p < .001

such situations, the availability of help is at best equivocal and at worst impossible. In point of fact, kin perceived to have similar or worse financial situations were as likely to provide tangible assistance (53.4 percent) as not (47 percent) and friends felt to be in such circumstances were highly unlikely to provide support (62.8 percent).

The disadvantaged also received psychological support from their kin and friends. Yet, it was not fully adequate to help them successfully master their emotional burdens. The poor, the less educated and the separated or divorced had a greater tendency to express a need for help with personal or family problems than their more advantaged counterparts (see Table 5.17). Furthermore, 70 percent of the women who expressed a need for help reported that they received psychological support from kin.

There are two plausible explanations for the perceived inadequacy of the psychological support of kin. First, solidary ties with relatives may generate, rather than ameliorate, problems. For example, relatives, in an attempt to regulate or direct some aspect of the individual's behavior may create a situation in which the individual's desire to live up to other's expectations is in competition with her wish to follow her own preferences. Such support, then, even if offered in a spirit of good-natured persuasion, is likely to create a conflictive situation that exacerbates, rather than mitigates, the individual's distress. Second, kin may not have the expertise that is necessary for solving some problems which might be better addressed through professional counseling. Thus,

TABLE 5.17.--Percent of Women Needing Help with Personal or Family Problems by Measures of Social Position.

Social Position	Need for Help with Personal Problems					
	Receives Help with Personal Problems[a]		Does Not Receive Help with Personal Problems			
			Does Not Need Help		Needs Help	
	Number	Percent	Number	Percent	Number	Percent
Marital Status						
Single	15	55.7	9	33.3	3	11.1
Married	18	36.7	27	55.1	4	8.2
Marriage Disrupted	16	33.3	13	27.1	19	39.6
Income						
Inadequate and Marginal	17	38.6	16	36.4	11	25.0
Adequate	31	39.2	39	49.4	9	11.4
Education						
Less than High School Graduation	13	40.6	12	37.5	7	21.9
High School Graduate and Attended College	36	39.1	43	46.7	13	14.1

[a] The women who received help with personal or family problems were not asked if they needed help in this area.

even though they may empathize with the individual and offer her understanding and succorance, their support is likely to have limited value in providing solutions to her problems.

Finally, the disadvantaged lived in neighborhoods that tended to be physically and socially disorganized and were likely to consider their ties with neighbors to be equivocal or almost completely dysfunctional. Under such conditions, it is not surprising that those reporting less support from neighbors were likely to have experienced more stress events ($r = -.18$, $p < .04$), to have perceived the general state of their life as troubled ($r = -.25$, $p < .006$) and to have felt that their income was difficult to live on ($r = .20$, $p < .02$).

Summary: The Women as Individuals

Approximately one-third of the women in the sample were poor, relatively uneducated, separated or divorced. Such women were likely to assess their life circumstances as poor and to have experienced a series of events that challenged their resources and skills. Furthermore, such women were likely to feel that their psychological assets were limited and their social assets only nominally effective in mediating between them and the consequences of life difficulties. In short, women who were struggling with problems of low incomes and related difficulties had the least store of resources with which to manage their deleterious circumstances. In Part 2, findings are presented on the way in which their life situations, and those of the other women in the sample, influenced their need-dispositions as patients.

Part 2: The Women as Patients

The literature reviewed in Chapter I indicated that patients present for care with non-medical as well as medical needs. Furthermore, the review suggested that an individual who seeks to satisfy non-medical needs through the medical institution is likely to frequently seek care for multiple, diffuse symptoms. In Chapter II, it was argued that this behavior is an adjustment to the individual's particular life situation. If a person lacks necessary social and psychological assets to cope with difficult life circumstances, he or she will more likely rely on the physician to satisfy his or her unfulfilled social needs and to legitimate his or her feelings or failure. Part 2 explores these issues.

First, the patients are compared to their counterparts in the community in order to see if they are representative of this population. Second, the patient's medical and non-medical needs are described in order to establish a guideline for the distinction between what is typical and atypical for them. Third, follows an examination of the set of hypotheses presented in Chapter II relevant to the life situations of the women and their characteristics as patients. Fourth, the patients' orientations to the doctor-patient relationship are discussed. Finally, the hypothesis which posits the relationship between patient attributes and variations in use of services is examined.

Comparison of the Patients with Others in the Community

It was observed earlier that the women included in this study were not representative of their counterparts in the county in terms of sociodemographic characteristics. They were poorer and more likely to head their own households as a result of the disruption of their marriages. Their relative economic instability was reflected in the type of health insurance coverage they carried. More of the women in the sample were covered by Medicaid (29 percent) than were other women 18 to 40 years of age in the city and county as a whole (19.8 and 13.1 percent, respectively). In addition, the volume of use of medical services was higher for the sample than it was for their community counterparts, if one accepts the assumption that a majority of patients will have a similar pattern of use during a consecutive second six-month period. The women in the sample made an average of 6.8 visits per patient to the doctor during the year while those their age in the city and county made 5.0 and 4.7 visits per person, respectively.[8] The women in the sample, then, were not totally representative of others in the community in terms of their use of medical services. In the following pages the medical and non-medical needs of these women during the two six-month periods of observation are described.

Medical Needs

As discussed in Chapter III, the medical needs of the patients were assessed subjectively by accepting the symptoms presented at physician visits as a measure of the individual's perception of her need for medical care. These symptoms were characterized in three ways: (1) by number; (2) by number of different parts of the body in which they were located; and (3) by type of complaint. The following discussion focuses on the symptoms presented at 422 visits made during the observation periods.[9]

The number of symptoms presented by the patients ranged from one (8.9 percent) to 29 (0.8 percent), with 6.4 symptoms the average per patient. Approximately two-thirds of the patients (64.5 percent) presented six or fewer symptoms and one-third (35.5 percent) seven or more. The number and range of _different_ symptoms presented was, as might be expected, lower, ranging from one (0.8 percent) to 13 (0.8 percent). The average per patient was 4.8 different symptoms with slightly over half (54 percent) presenting four or fewer different symptoms during six months. Finally, the number of different parts of the body in which these symptoms were located ranged from one (17.7 percent) to 13 (0.8 percent) with an average of 3.8 per patient. Approximately half of the patients (53.2 percent) had symptoms that were located in three or fewer parts of the body.

Symptoms, as Zola (1966, 1973) has noted, may be dichotomized into types. One type represents a rather specific organic dysfunctioning and reflects the way in which the patient restricts her difficulties. Such complaints are called "symptoms of specific dysfunction." The second type represents a more global malfunction and reflects the way in which the patient emphasizes the more diffuse nature of her complaints. These are called "symptoms of diffuse anomalies." The number of "symptoms of specific dysfunction" presented ranged from zero (17.7 percent) to 13 (0.8 percent) with 2.6 the average per patient. Three-fifths of the patients (60.5 percent) presented two or fewer "symptoms of specific dysfunction" during six months. The number of "symptoms of diffuse anomalies" ranged from zero (12.1 percent) to 17 (0.8 percent) with 3.5 the average per patient. Approximately three-fifths of the patients (58.1 percent) presented three or fewer "symptoms of diffuse anomalies."

As a group, then, the patients tended to present more "symptoms of diffuse anomalies" than "symptoms of specific dysfunction." Yet, two-fifths tended to emphasize the more diffuse nature of their complaints. Furthermore, one-third tended to report more symptoms than others. Nevertheless, the patients were fairly evenly divided in terms of the number of different symptoms they presented and the number of different parts of the body in which these symptoms were located.

At the level of the individual, however, some patients tended to present a constellation of vague and multiple symptoms located in diffuse body systems. That is, those patients who presented a large average number of "symptoms of diffuse anomolies" also were likely to present: (1) a large average number of different symptoms ($r = .64$, $p < .001$); and (2) symptoms located in a large average number of different parts of the body ($r = .64$, $p < .001$). This constellation of symptoms is referred to as symptoms of dependency, since, as shown below, it tends to be the primary configuration of symptoms presented by dependent patients.[10] The phrase "symptoms of dependency" is used throughout this report to refer to the medical needs of the study patients. The indices of "symptoms of dependency" ranged from 0.8 (0.8 percent) to 12 (0.8 percent), with 3.8 the average index per patient. Approximately two-fifths (41.9 percent) of the patients presented four or more "symptoms of dependency" during six-months.

Non-Medical Needs

As noted in Chapter II, this study focuses on two non-medical needs of the patient: the need for catharsis; and the need to cope with failure. The need for catharsis refers to the need for the kind of social contact that permits or encourages free communication. The need to cope with failure refers to the use of illness as a legitimating mechanism to escape from frustrating or untenable problems of life.

Approximately one-third of the patients (30.6 percent) had a need to cope with failure and almost two-thirds (62.9 percent) a need for catharsis. The need to cope with failure was related to the need for catharsis ($r = .21$, $p < .02$). Approximately one-fourth (23.4 percent) of the patients with one non-medical need also perceived a need to satisfy the other.

Relationship Between Medical and Non-Medical Needs

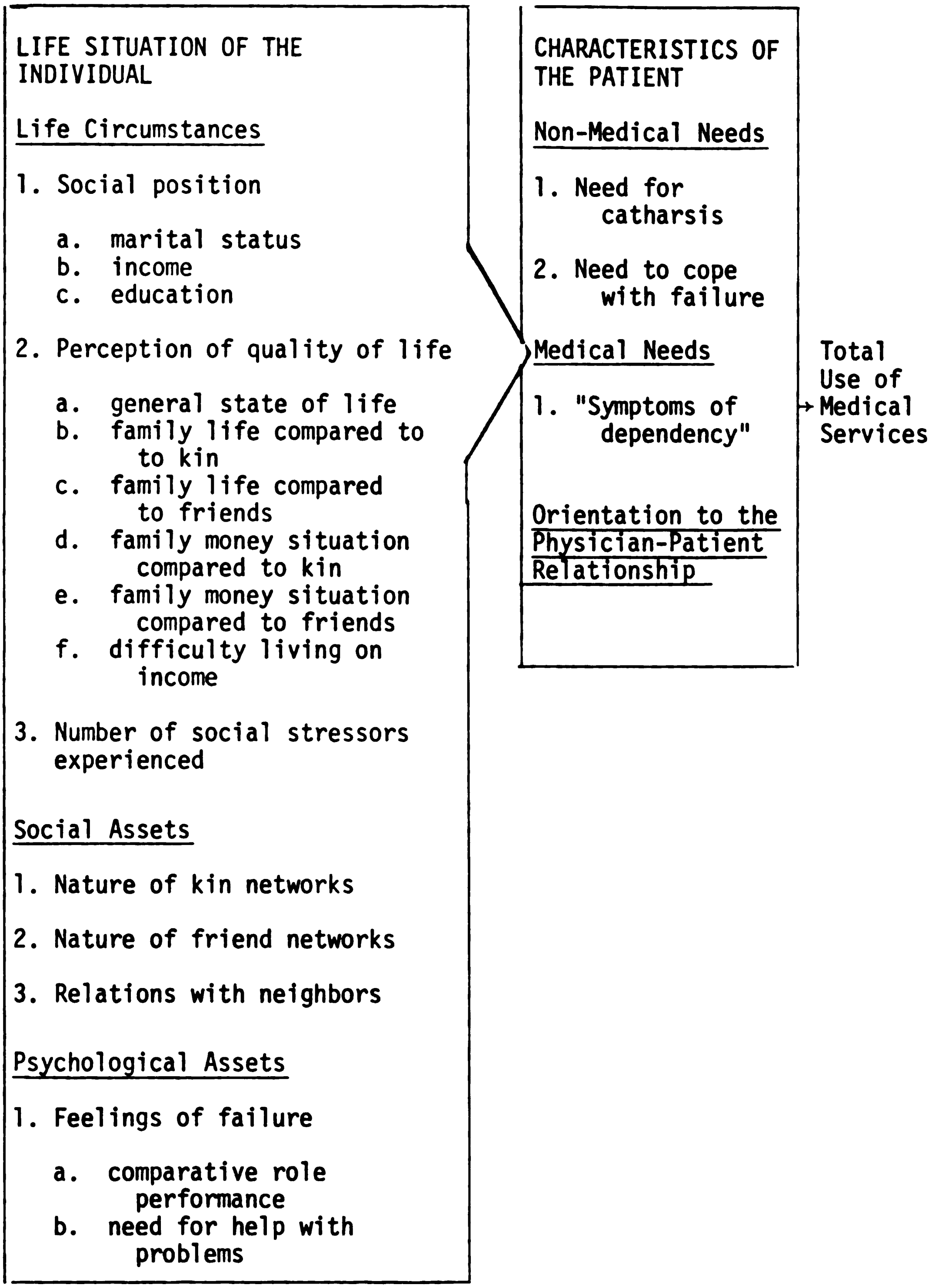
It has been suggested that the patient who seeks medical care to satisfy non-medical needs presents multiple diffuse symptoms in an attempt to justify her visit to the doctor or adoption of the sick role (Balint, 1957; Cole and Lejeune, 1972). The data only partially support this view. Patients with a need to cope with failure were likely to present more "symptoms of dependency" ($r = .19$, $p < .03$). But, those with a need for catharsis tended to present fewer "symptoms of dependency" ($r = -.03$, n.s.). For example, approximately three-fifths (61.5 percent) of the patients with a need for catharsis presented a below the average number of "symptoms of dependency." By contrast, only half (52.2 percent) of those with no need for catharsis presented a below the average number of "symptoms of dependency."

This finding is difficult to explain. The data suggest, however, that it may be a function of the relative weight of the patient's needs. The need for catharsis was correlated with the need to cope with failure and 29 patients (23.4 percent) had both needs. (The percentages for those with only one need and those with no needs were 46.8 and 29.8 percent, respectively.) At the same time, 30 patients (64 percent) who had a need for catharsis and 22 (57.9 percent) who had a need to cope with failure presented an above the average number of "symptoms of dependency." In one accepts the assumption that the same patients were members of the high need and above average symptom groups, then the crucial difference between having a need for catharsis and presenting or not presenting "symptoms of dependency" may be its coincidence with the need to cope with failure. That is, the need for catharsis may be greatest for those who also are burdened with the need to deal with feelings of failure. Such patients, then, may have a greater tendency to present "symptoms of dependency" than those with only the need for catharsis. Essentially, however, the finding goes unexplained.

Relationship Between the Womens' Life Situations and Their Characteristics as Patients

It was argued in Chapter II that non-medical needs are a product of experiential factors and perceptions of them. In this sense, the differential use of medical services in the presence of symptoms is a function of broad aspects of a person's life situation. A conceptual model was presented in Chapter II which included an outline of the relationship posited between this situation and the characteristics of the patient. Figure 5.1 shows a detailed representation of that part of the model.

In this figure, life situations are seen to have three dimensions: (1) life circumstances; (2) social assets; and (3) psychological assets. Social position, perception of quality of life, and number of social stressors experienced constitute the life circumstances of the individual. The nature of links with kin, friends, and neighbors constitute the social assets of the individual. The presence or absence of feelings of failure constitute the psychological assets of the individual. It is argued in this study that variations in life circumstances and in social and psychological assets will generate differences in (1) non-medical needs; (2) medical needs; and (3) orientations to the physician-patient relationship. Furthermore, it is argued that these differences in patient characteristics will be associated with variations in the total use of medical services. This section presents the findings relevant to these arguments.



LIFE SITUATION OF THE INDIVIDUAL

Life Circumstances

1. Social position
    - a. marital status
    - b. income
    - c. education
2. Perception of quality of life
    - a. general state of life
    - b. family life compared to to kin
    - c. family life compared to friends
    - d. family money situation compared to kin
    - e. family money situation compared to friends
    - f. difficulty living on income
3. Number of social stressors experienced

Social Assets

1. Nature of kin networks
2. Nature of friend networks
3. Relations with neighbors

Psychological Assets

1. Feelings of failure
    - a. comparative role performance
    - b. need for help with problems

CHARACTERISTICS OF THE PATIENT

Non-Medical Needs

1. Need for catharsis
2. Need to cope with failure

Medical Needs

1. "Symptoms of dependency"

Orientation to the Physician-Patient Relationship

→ Total Use of Medical Services

FIGURE 5.1.--Relationship Between the Women's Life Situations and Their Characteristics as Patients

Life Circumstances of the Individual and Characteristics of the Patient

It is not surprising that the data showed that those women who lived on inadequate or marginal incomes and had less educational credentials were likely to have a need to cope with failure ($r = .22$, $p < .005$ and $r = -.25$, $p < .009$, respectively) (see Table 5.18). Furthermore, although the data showed no statistically significant relationship between marital status and the need to cope with failure, women with disrupted marriages were more likely to express this need (44.7 percent) than married (34.2 percent) or single women (21.0 percent).

The data also showed no statistically significant relationship between social position and the need for catharsis. The direction of the correlations suggests, however, that the poor, less educated, separated or divorced tended to have this need. Furthermore, the data suggest that the disadvantaged presented more "symptoms of dependence" when they sought medical care than those who were more secure. For example, women with disrupted marriages had high perceived medical needs ($r = .18$, $p < .04$). In addition, the direction of the correlations for the poor and the less educated was in a similar direction ($r = -.15$ and $=.10$, respectively).

It also was not surprising to find that women who had the least sense of well-being about their life circumstances were likely to have a need to cope with failure. For example, those who felt that their life was troubled ($r = .22$, $p < .01$), their family life worse than that of their kin and friends ($r = .18$, $p < .05$ and

TABLE 5.18.--Zero-Order Correlations Between Live Circumstances of the Individual and Characteristics of the Patient.

Individual Characteristics	Patient Characteristics		
	Need to Cope With Failure	Need for Catharsis	Symptoms of Dependency
<u>Social Position</u>			
Marital Status	.01	.10	.18*
Income	-.22**	-.01	-.15
Education	-.25**	-.07	-.10
<u>Quality of Life</u>			
General State of Life	.22*	.28**	.01
Family Life Compared with:			
Kin	.18*	.20*	.22*
Friends	.17*	.18*	.09
Family Money Situation Compared with:			
Kin	.17	.16	.21*
Friends	.11	.09	.08
Difficulty Living on Income	-.35**	-.14	-.24**
<u>Number of Social Stressors Experienced</u>	.04	.13	.11

$^{*}p < .05$

$^{**}p < .008$

Coding: <u>Need to Cope with Failure</u> (perception of health): 1 = excellent, 2 = good, 3 = fair, 4 = poor; <u>Need for Catharsis</u>: 1 = none, 2 = some, 3 = high; <u>Symptoms of Dependency</u>: low to high.

$r = .17$, $p < .05$, respectively), and their income difficult to live on ($r = -.35$, $p < .001$) were likely to have a need to deal with feelings of failure. Furthermore, although the correlations were not statistically significant, women who felt that their financial situation was worse than that of their kin and friends were more likely to express a need to cope with failure (48.7 percent) than those who felt that their situation was comparable (38.2 percent) or better (13.2 percent) than that of significant others.

Perceived life quality also was found to be related to a woman's need for catharsis. For example, those who felt that the general state of their life was troubled ($r = .28$, $p < .002$) and their family life worse than that of kin and friends ($r = .20$, $p < .02$ and $r = .18$, $p < .04$, respectively) were likely to express a need for catharsis. In addition, perceived life quality was related to the women's medical needs. That is, those who felt that their family life and financial situation were worse than that of relatives ($r = .22$, $p < .01$ and $r = .21$, $p < .01$, respectively) and their incomes difficult to live on ($r = -.24$, $p < .008$) were likely to seek medical care for many "symptoms of dependency."

Finally, the number of social stressors experienced by the women was not found to be related to their characteristics as patients. Nevertheless, among those who had been exposed to a greater number of stressful situations, the majority had a need to cope with failure (57.9 percent) and a need for catharsis (55.1 percent). In addition, they had presented an above the average number of "symptoms of dependency" (55.8 percent).

In summary, differential social position, perceived life quality, and experience of stress were associated, albeit varyingly, with medical and non-medical needs. Women who were poor and less educated were likely to express a need to cope with failure. Women with disrupted marriages were likely to present many "symptoms of dependency." Furthermore, women who felt themselves to be socially and financially deprived were likely to have a need for catharsis and a need to cope with failure, as well as a tendency to present many "symptoms of dependency." Women who had experienced more stress events, however, were not necessarily more likely to have greater medical and non-medical needs than those who had experienced fewer such events.

As observed earlier, those who had the least sense of well-being about their circumstances were poor, less educated, separated or divorced. Similarly, those who had the least sense of well-being about their circumstances were likely to have experienced more stress events. Furthermore, as shown above, those who had the least sense of well-being about their circumstances were likely to express greater medical and non-medical needs. Thus, it was surprising to find a relatively weak association between social position and needs and a non-significant association between stressful events and needs. Nevertheless, the literature reviewed in Chapters I and II suggested that responses to difficult life circumstances or stressful situations might be varied and that these variations are due to different capacities to cope with exigencies. In the next section, then, the relationship between the coping resources of the women and their medical and non-medical needs is described.

Psychosocial Assets of the Individual and Characteristics of the Patient

Differences in psychological assets were related to the medical and non-medical needs of the patient. For example, women who felt a need for help with problems and unsuccessful in their performance of the tasks of daily life were likely to express a need to cope with failure ($r = .28$, $p < .001$ and $r = .18$, $p < .04$, respectively) (see Table 5.19). Furthermore, women who felt a need for help with problems and unsuccessful as housewives were likely to express a need for catharsis ($r = .20$, $p < .02$ and $r = .21$, $p < .01$, respectively). Similarly, women who felt unsuccessful as housewives were likely to present many "symptoms of dependency" ($r = .19$, $p < .04$). A need for help with problems or feelings of failure in overall performance of tasks, however, were not associated with "symptoms of dependency" at a statistically significant level. The direction of the correlations suggests, nevertheless, that women with limited psychological assets tended to present more "symptoms of dependency" than those with a greater sense of self-worth ($r = .15$ and $r = .10$, respectively).

Differences in social assets also were related to the medical and non-medical needs of the patient. Women who felt that their links with neighbors were equivocal or completely dysfunctional were likely to have a need to cope with failure ($r = -.21$, $p < .01$). In contrast, those who received functional support from kin were likely

TABLE 5.19.--Zero-Order Correlations Between Psychosocial Assets of the Individual and Characteristics of the Patient.

Individual Characteristics	Patient Characteristics		
	Need to Cope With Failure	Need for Catharsis	Symptoms of Dependency
Social Assets			
Psychological Support:			
Kin	-.10	-.06	-.08
Friends	.04	.01	.06
Functional Support:			
Kin	-.18*	.16	-.07
Friends	.07	.07	.27**
Neighborliness:	-.21*	-.14	-.01
Psychological Assets			
Need for help with problems	.28**	.20*	.15
Comparative performance of tasks of daily life	.18*	.05	.10
Comparative performance of role of housewife	-.02	.21*	.19*

*$p < .04$

**$p < .002$

to have a need to deal with feelings of failure ($r = -.18$, $p < .05$). These conflicting findings lose their paradoxity, however, when one remembers that those who received few services and little support from neighbors but aid from kin tended to occupy low social positions.

The findings did not show a statistically significant relationship between systems of social support and the need for catharsis. The direction of the correlations suggests, however, that the support of significant others might help the women to cope with feelings of distress and unmanageable difficulties (see Table 5.19, column 2). For example, women who did not receive tangible assistance from kin, friends and neighbors and psychological support from friends tended to express a need for catharsis. Surprisingly, however, those who received psychological support from kin were slightly more likely to express a need for catharsis (51.6 percent) than those who did not receive support from kin (44.4 percent). This unusual relationship, as suggested earlier in this chapter, may be a function of the quality of the support offered by kin; that is, sometimes emotional support may be limited in value or may exacerbate distress rather than mitigate it.

Finally, the findings showed but a vague relationship between the social assets of the women and their medical needs as patients. For example, women who did not receive functional and psychological support from friends were likely to seek medical care for many "symptoms of dependency" ($r = .27$, $p < .002$ and $r = .06$, n.s.). In contrast, women who received psychological and functional support from kin and little support from neighbors tended to present many "symptoms of dependency" (see Table 5.19, column 3). These disparate relationships may reflect the social positions of the women and the life situations associated with them. For example, those women who occupied positions near the bottom of the social hierarchy tended to receive more support from kin and less from friends and neighbors. Circumstances of life and social assets, then, may have a concomitant influence on the attributes of the patients.

Summary: Relationship Between the Women's Life Situations and Their Characteristics as Patients

Earlier it was shown that women who occupied a low social position had the least sense of well-being about their situation and had experienced a series of stressful events. Furthermore, it was shown that despite the received psychological and functional support, the disadvantaged tended to find this support wanting. Similarly, it was shown that the poor, the less educated and the separated or divorced did not believe in their ability to solve problems successfully. These life situations were associated with the medical and non-medical needs of the patient.

The association was moderate. Yet, a pattern emerged which suggested that women who felt socially and financially deprived tended to have a need to cope with failure and a need for catharsis, as well as a tendency to present many "symptoms of dependency." Furthermore, women who had limited psychological assets with which to cope with the demands of environmental pressures tended to have a need to legitimate failure and a need for catharsis.

The findings on the relationship between the social assets of the women and their attributes as patients were less clear. The data suggested, however, that the varying systems of support associated with different social class positions had a conjunct influence on non-medical and medical needs. The disadvantaged, who received support from kin but did not consider it sufficiently helpful, were likely to express a need to cope with failure. Furthermore, the disadvantaged, who tended to receive less support from friends, were likely to present many "symptoms of dependency." Those with less viable or few social assets, then, tended to have greater non-medical and medical needs.

In short, the findings have indicated a marked association between the life situations of the women and their characteristics as patients. The findings have not, however, isolated the elements of life situations that make the greatest contribution to variations in patient attributes. In the next section, the differential effects of these elements on variations in patient needs are examined.

Tests of Hypotheses

A set of five hypotheses which posited relationships between the characteristics of the individual and her attributes as a patient were presented in Chapter II. Four hypotheses postulated a relationship between objective and subjective life circumstances, psychological assets and non-medical and medical needs:

> H1. Individuals who occupy a low social position will have a need to cope with failure and present multiple diffuse symptoms.

> H2. Individuals exposed to more social stressors will have a need to cope with failure and present multiple diffuse symptoms.
>
> H3. Individuals who perceive the quality of their life as poor will have a need to cope with failure and present multiple diffuse symptoms.
>
> H4. Individuals who sense feelings of failure will have a need to cope with failure and present multiple diffuse symptoms.

One hypothesis postulated a relationship between social assets and non-medical and medical needs:

> H5. Individuals with limited or non-supportive social networks will have a need for catharsis and present multiple diffuse symptoms.

Pearson product-moment correlations were used to select from among all the individual variables those that were significant and might be expected to account for variation in patient variables. As a result, hypotheses two (H2) and five (H5) were rejected because the presence of a series of stressful events was not correlated at a statistically significant level with either the need to cope with failure or "symptoms of dependency." Furthermore, the supportive behavior of significant others was not correlated at a statistically significant level with the need for catharsis. The supportive behavior of significant others, however, was correlated with the need to cope with failure and with "symptoms of dependency." Moreover, perceived life quality was correlated with the need for catharsis. These independent variables, then, though not hypothesized to relate to the dependent variables in the manner in which they did, were entered into the appropriate multiple regression equations.

Three analyses were computed. The first included all the significant predictors of "symptoms of dependency." The second entailed all the significant predictors of the need to cope with failure. The third contained all the significant predictors of the need for catharsis. In the following discussion, each analysis is presented separately.

Symptoms of Dependency

Six predictors of "symptoms of dependency" were entered into the regression equation. Three were measures of perceived life quality: (1) family life compared to kin; (2) family life compared to friends; and (3) difficulty living on income. Two predictors reflected social position: (1) marital status; and (2) income. One predictor was a measure of social assets, i.e., functional support from friends.

Inspection of the data indicates that three of the variables exerted an effect on "symptoms of dependency" (see Table 5.20).[11] Women who presented many "symptoms of dependency" considered themselves deprived financially ($\beta = -.10$) and socially ($\beta = .11$) and had limited social assets ($\beta = .22$). Together, however, these three variables accounted for only 13 percent of the variance in "symptoms of dependency."

More than half of the variance explained was accounted for by the first variable entered into the equation. That is, the receipt of functional support from friends was the most powerful explanatory variable ($R^2 = .07$). A sense of financial insecurity

TABLE 5.20.--Step-Wise Regression of Symptoms of Dependency.

Order of Variables Entering*	Variable	β^{**}	Multiple R	R^2	F	p	df
1	Functional support from friends	.22	.27	.07	9.09	.000	1,122
2	Difficulty living on income	-.10	.33	.11	7.34	.001	2,121
3	Family life compared to kin	.11	.35	.13	5.60	.001	3,120

[*] Variables contributing at least one percent to explained variance are reported.

[**] β = standardized regression coefficient or beta weight.

explained an additional four percent of the variance. Feelings that the family's life was worse than that of kin contributed two more percent to the explained variance. In short, the lack of strong social assets was the best predictor of many "symptoms of dependency." But, perceived financial and familial instability, in conjunction with lack of social assets, contributed substantially to the prediction.

Need to Cope with Failure

Eight predictors of the need to cope with failure were entered into the regression equation. Four were measures of perceived life quality: (1) family life compared to kin; (2) family life compared to friends; (3) general state of life; and (4) difficulty living on income. One predictor, education, reflected social position. Two predictors were measures of psychological assets: (1) need for help with problems; and (2) comparative performance of tasks of daily life. The last predictor was a measure of social assets, i.e., functional support from kin.

Inspection of the data indicates that six of the variables exerted an appreciable effect on the need to cope with failure (see Table 5.21). Women with a need to deal with feelings of failure considered themselves financially ($\beta = -.20$) and socially ($\beta = .17$) deprived, were less educated ($\beta = -.13$), and had limited psychological ($\beta = .21$ and $\beta = .18$) and social assets ($\beta = -.23$). Together the six variables accounted for 24 percent of the variance in the need to cope with failure.

TABLE 5.21.--Step-Wise Regression of Need to Cope with Failure.

Order of Variables Entering*	Variable	β^{**}	Multiple R	R^2	F	p	df
1	Difficulty living on income	-.20	.35	.12	16.12	.000	1,122
2	Functional support from kin	-.23	.39	.15	10.46	.000	2,121
3	Comparative performance of tasks of daily life	.21	.43	.19	8.86	.000	3,120
4	Need for help with problems	.18	.46	.21	7.74	.000	4,119
5	Family life compared to friends	.17	.47	.22	6.52	.000	5,118
6	Education	-.13	.48	.24	5.78	.000	6,117

[*] Variables contributing at least one percent to explained variance are reported.

[**] β = standardized regression coefficient or beta weight.

Most of the variance was explained by the first three variables entered into the regression equation. Difficulty living on income was the most powerful explanatory variable ($R^2 = .12$). The receipt of functional support from kin and a poor assessment of overall performance of tasks explained an additional seven percent of the variance. In short, perceived financial insecurity was the best predictor of the need to cope with failure. But, the lack of strong psychological and social assets, in conjunction with this insecurity, contributed substantially to the prediction.

Need for Catharsis

Three predictors of the need for catharsis were entered into the equation: (1) general state of life; (2) family life compared to kin; and (3) family life compared to friends. All were measures of perceived life quality. Two of these variables exerted an effect on the need for catharsis (see Table 5.22). Those with a need for emotional support considered the general state of their life troubled ($\beta = .23$) and their family life worse than that of their kin ($\beta = .13$). The two variables, however, accounted for only nine percent of the variance in need. Furthermore, most of the variance was explained by the individual's perception of her overall life situation ($R^2 = .07$).

TABLE 5.22.--Step-Wise Regression of Need for Catharsis.

Order of Variables Entering*	Variable	β^{**}	Multiple R	R^2	F	p	df
1	General state of life	.23	.27	.07	9.31	.003	1,122
2	Family life compared of kin	.13	.30	.09	5.70	.004	2,121

[*] Variables contributing at least one percent to explained variance are reported.

[**] β = standardized regression coefficient or beta weight.

Discussion: Tests of Hypotheses About the Relationship Between the Women's Life Situations and Their Characteristics as Patients

A woman's sense of well-being about her life circumstances exerted an effect on her medical and non-medical needs. Perceived financial and familial instability were consistently good explanatory variables. The psychological and social assets available also exerted an effect on the woman's needs as a patient. For example, the lack of functional support from friends was a good predictor of "symptoms of dependency." By contrast, the receipt of functional support in combination with a poor assessment of overall performance of tasks were good predictors of the need to cope with failure. Thus, the data supported some, but not all, of the hypotheses.

H1. Individuals who occupy a low social position will have a need to cope with failure and present multiple diffuse symptoms. The data provide little support for this hypothesis. Social position contributed nothing to the explained variance in "symptoms of dependency." Furthermore, only education contributed to the explained variance in the need to cope with failure. But, this contribution added only two percent to that explained by the five variables previously entered into the regression equation. It appears, then, that the contribution of social position, when used in conjunction with other individual variables, is minimal.

These findings most probably derive from the close association between social position and perceived life quality and psychological and social assets. That is, those who occupied the lowest social position had the least sense of well-being about their circumstances and limited psychological assets. Furthermore, the poor, less educated and separated or divorced tended to receive more functional support from kin than their more advantaged counterparts. Thus, social position most likely was unable to contribute appreciably to the variance already explained by contextual variables with which it was closely associated.

H3. Individuals who perceive the quality of their life as poor will have a need to cope with failure and present multiple diffuse symptoms. The data provide strong support for this hypothesis. Perceived financial instability was a most powerful explanatory variable, followed in strength by feelings of poor family functioning. Both variables accounted for more than half of the variance explained in the need to cope with failure and almost half of that explained in "symptoms of dependency."

The efficacy of these variables most probably derives from the interdependency that exists between the health of the family as a functioning unit and the health of the individual. Since the family is the unit of "living," the degree to which it is socially or financially disadvantaged implicitly affects the individual's health as well as her perception of it. Thus, the strong contribution of perceived financial and familial instability to variance in medical and non-medical needs is not surprising.

H4. Individuals who sense feelings of failure will have a need to cope with failure and present multiple diffuse symptoms. The data provide only partial support for this hypothesis. Feelings of failure were not a significant predictor of "symptoms of dependency" and thus were not included in that regression analysis. They were, however, a significant predictor of the need to cope with failure and were entered into the regression equation. Together, a poor assessment of overall performance of tasks and a need for help with problems accounted for one-quarter of the variance explained in the need to cope with failure.

The emergence of feelings of failure as an explanatory variable in the analysis is not surprising. Past research (Beresford, et al., 1977; Cole and Lejeune, 1972) has shown them to be good predictors of need. Furthermore, in a society such as America, where the values of achievement and self-reliance receive strong emphasis, it is not surprising that individuals who feel they do not meet society's definition of success, would perceive their health as poor in order to rationalize their self-defined failure.

In summary, variations in the personal environment exerted considerable effects on the medical and non-medical needs of the patient. Not all elements of individual life situations contributed to explained variance across needs. Nevertheless, the data provided support for the hypothesis that patient needs are a product of experiential factors and perceptions of them. In the next section, attention turns to the expectations the women bring to the medical encounter and to the way in which these are influenced by varying life situations.

Patient Orientations to the Physician-Patient Relationship

Descriptions of the physician-patient relationship offered in Chapter I emphasized its asymmetry, the explicitness of the norms governing the behavior of the participants and the complementarity of their expectations. This section presents the findings on the women's views on this relationship.[12]

The Physician's Functions

The physician gives care to sick people by diagnosing and treating their problems. The women considered these institutionalized role obligations of the physician and described their expectations in predictive as well as normative terms. That is, the physician *will* diagnose problems and the physician *should* diagnose problems.[13] On occasion, however, these expectations were violated, giving rise to concern and/or vexation.

Women went to the physician for relief of their symptoms. But, they also were concerned with having their condition diagnosed and labeled.[14] For some, the physician's inability to diagnose the cause of their problem was a source of fear. The patients had tentatively defined their problem as a serious disease, and although they hoped this was not the case, most strongly feared that it was. The relationship between uncertainty and fear was articulated well by one woman who said: "Uncertainty seems to be the most damaging thing because people then imagine the worst."

For others, the physician's inability to name the etiology of their symptoms was a source of frustration and irritation. The patients tended to feel that the doctor was interested, not in the cause of their problem, but in their symptoms. The following excerpts illustrate the emotions aroused when the doctor was unable to fulfill expectations associated with diagnosis:

> I want to know the cause. There's a cause for every effect . . . . I'm so uncomfortable and that makes me irritable. It bothers me. I'm so frustrated. I get no answer to the cause, just treatment.
>
> Doctors should not push pills. They shouldn't just write a prescription and say, 'This will take care of it.' They should get to the real cause. It seems as if there's got to be something other than pills to make you feel good. He doesn't really know so he says, 'These pills will help your symptoms.' I really want to know so I'll know there's something to work with!

The women, then, had specific expectations of the physician role. When the physician did not fulfill these role expectations, they were inclined to lose faith in him. But the women also had less formalized expectations of the physician. When he performed these tasks, he earned the appelation, "good doctor."

The "Good Doctor." The women were asked the question: "What makes a good doctor?" Table 5.23 shows that a majority mentioned attributes which characterize the physician's ability to show a personal concern for the patient. Only one-fourth of the characteristics relate to the physician's technical knowledge or skill or to the breadth of his authority. These data support those of Friedson (1961), Ben-Sira (1976), King (1962), and Koos (1955), which indicate that the patient is more interested in the affective than the

TABLE 5.23.--Characteristics of the "Good Doctor."

Characteristic	Percent of Responses
Takes his time and is friendly	24
Communicates	19
Respects the patient	18
Devoted to people, not personal enrichment[a]	12
Inspires trust and confidence	8
Concerned with preventive as well as curative medicine	8
Skilled and knowledgeable	8
Admits his fallibility and is comfortable with referring	4

---

[a] This characteristic is similar to that which Parsons (1951) had in mind when he used the phrase collectivity orientation; the physician sets aside his immediate interests and needs, as well as other considerations, that might conflict with his acting in the patient's best interest. Thus, the doctor does not capitalize on the patient's situation to his own financial advantage.

instrumental component of the physician-patient interaction. Moreover, these data contrast the belief of the director of medical education at the family health center who noted:

> Patients are really not interested in a nice kind of doctor. They would prefer to feel within them that he's very knowledgeable and intelligent.[15]

According to the women, a "good doctor" takes his time with patients and is friendly. He conveys his willingness to take time by his physical behavior and his friendliness by his verbal behavior. For example, the women characterized these ideal behaviors as:

> He doesn't move fast. He sits down. If a doctor stands up I don't say much because he looks like he's in a hurry.
>
> He looks me right in the face when I talk to him. He doesn't make me feel like I was taking his time.
>
> He doesn't just come in and say, 'What's the problem?' He takes time to put you at your ease. He asks, 'How are you feeling? How's everything else?' Then, after friendship he'll ask, 'Why are you here? What's the problem?'

Thus, the physician's willingness to extend the encounter, coupled with a conversational manner, is labeled as a personal physician-patient relationship.

In addition, the women also felt that a "good doctor" respects his patients. He conveys this respect by "listening" and responding to what they say and by empathizing with them and their problems. An empathic physician is one who is sensitive to the needs and values of others: for example, he ". . . tries to put himself in my position like how he would feel." Furthermore, he is sensitive to what the patient is saying and does not dismiss her complaints as products of her imagination.[16] The following excerpts explicate the meanings women attached to these attributes:

> He couldn't see my pain but I was hurting . . . . No matter what I said, he wasn't listening . . . . A good doctor listens fully to what you have to say and attempts to do something about it.
>
> Sometimes you hurt but they can't believe you hurt because they can't find anything wrong. One time the doctor was doggarned irritated. He was mad at me because he didn't know why I was hurting. He made me feel stupid for being there.

These women's problems may have been induced by the mind, rather than by a pathogen. Nevertheless, they were ailments that caused real pain and were undeserving of the contempt with which they were met. The physician's failure to "hear" what the patient is saying and/or to explore alternative ways to help her, then, impede the therapeutic relationship.

The women also thought that a "good doctor" communicates with the patient by giving understandable explanations:

> I like them to explain so I can understand. He can give me a big long word but then talk to me so I can understand. I have a right to know. It's my body.
>
> If you don't know what's happening you're scared. You need to cooperate for effective treatments. The treatment might do you good, but you might not think it was doing good. A person is scared when she goes to the doctor and needs to get over it.

As other studies have shown, when a patient is kept in ignorance, she is excluded from being a partner in the therapeutic process and a dearth of knowledge makes a less "compliant" patient (David, 1968; Rosenstock, 1975; Sapolsky, 1965).[17]

Finally, the women felt that a "good doctor" inspires trust and confidence in the patient: "He has the responsibility to see that the patient has trust in him." He "earns" this trust by indicating that he is interested in the person as a whole, not just her body. When the physician establishes a relationship of trust and understanding with the patient, she is more likely to cooperate with him in treatment without fear or skepticism.

In summary, the women saw a distinction between the physician role and the "good doctor." That is, diagnosis and treatment were behaviors required of the physician. By contrast, personalized care was a behavior desired of the physician. Thus, the "good doctor" was defined as one who (1) was affective; (2) showed a relaxed manner; (3) provided health education; and (4) inspired trust in the patient.

The Breadth of the Physician's Authority

Almost all of the women (88 percent) believed that the physician should be responsible for socioemotional as well as for physical problems.[18] Among these women, 60 percent felt that the physician should accept this responsibility himself, rather than referring patients to another professional.

Most women, however, said that they did not spontaneously initiate a discussion with the physician of non-medical problems. Instead, they waited for the physician to create a climate in which they felt free to divulge their concerns. The following excerpt describes the manner in which this climate was created and permission granted for expressing such concerns:

> My doctor seems to sense something's wrong. He asks me what's wrong so I automatically start talking.

Although the women presented for care with physical problems, it was evident in both sets of interviews that many had socio-emotional problems for which they wanted help.[19] Thus, the women were defining their patient role in such a way that it would correspond to the physician's expectations. Yet, all of the women recognized that health problems were inextricably entwined with their life situations, e.g., financial concerns and marital or family problems. In other words, the women recognized that psychological distress frequently manifests itself in somatic illness:

> If the mind is sick, the body will be sick.
>
> Worry saps your energy and makes you vulnerable.
>
> I've noticed with my friends, if they're worried their stomachs hurt or they have headaches all the time.[20]

For this reason, the women felt that it was very important that the physician have a knowledge of the environment in which they were located:

> It is important that the doctor have a good understanding of the patient's environment in order to understand the stresses impinging on her. Living style and environment play a big part in the general health of the patient.
>
> The doctor should know your family history and have a grasp on how you think and feel about things. Most of that has to do with being sick or healthy.

In short, in order to effectively diagnose and treat their problems, the women believed that the physician should know them as social beings located in a social and economic environment. All believed that such information was important in the diagnosis of both somatic and socioemotional problems.

Variations in Definitions of the Physician's Functions

Twelve percent of the women interviewed did not believe that the doctor should be responsible for the care of socioemotional problems. These women were not dependent patients, as most of those who held the opposing view were. They were patients who had sought care during the two six-month periods for acute somatic problems only. In order to explore the representativeness of these women's different beliefs, quantitative data obtained from the total sample was examined.

The survey interview concluded with a question asking the women: "If you had a half-hour during which you could talk to your doctor about anything you wanted, what would you talk about?" The women's answers had been coded into three categories: (1) personal problems; (2) other; and (3) don't know. Those who mentioned personal problems (48 percent) mentioned problems such as marital or sexual difficulties, specific problems with children, and other interpersonal problems. Those who mentioned other problems (38 percent) mentioned subjects such as special health problems and general health information about menopause, pregnancy or child rearing. It was hypothesized that women whose life situations were different would wish to discuss dissimilar subjects with the physicians and that their desires would reflect varying orientations to the breadth of the physician's authority.

The data provided support for this hypothesis. For example, women who had experienced more stressful events during the year in which they were interviewed were likely to want to communicate personal problems to the doctor ($r = -.26$, $p < .003$). Furthermore, the desire to talk about personal problems with the physician was particularly strong for those who reported sexual problems ($r = .21$, $p < .02$), marriage trouble ($r = .30$, $p < .01$) and trouble with children ($r = .24$, $p < .02$). Women who felt that the general state of their life was troubled or who reported a need for help with personal or family problems also were likely to want to talk with the doctor about these difficulties ($r = -.27$, $p < .002$ and $r = .39$, $p < .001$, respectively). Similarly, those who had a need for catharsis and a need to cope with failure expressed a desire to talk about personal problems with the physician ($r = .27$, $p < .003$ and $r = -.18$, $p < .04$, respectively). In addition, although "symptoms of dependency" were not significantly related to type of subject mentioned, 61 percent of those who presented an above the average number of "symptoms of dependency" wanted to talk with the physician about personal problems.

In short, those patients with greater non-medical needs and those women whose life situations were difficult were likely to want to discuss personal problems with the physician. On the basis of these surrogate data, then, it was concluded that dependent patients are likely to consider personal problems apposite to the physician-patient interaction. By contrast, non-dependent patients are likely to believe the physician's authority is limited to biophysiological problems.

The Patient's Functions

A patient is any individual who is sick, needs help, and wants to get well.[21] Individuals know they are sick and require professional help when: (1) they are in severe pain; (2) their complaints persist; (3) their symptoms interfere with normal functioning; and (4) they are unable to cope with their problems themselves, i.e., home remedies are not efficacious in relieving symptoms.[22]

In discussing the meaning of illness and their response to it, the women frequently spoke of the need to triage their complaints, to accept responsibility for the care of minor problems. Self-care for "little aches and pains" was necessary because the physician ". . . is very busy and is there to take care of sick people." Sick people almost always were defined as individuals with organic illness. Yet, as indicated above, there was ample evidence in the interviews to suggest that the women felt that socioemotional illness also was within the breadth of the physician's authority. Furthermore, there was evidence to suggest that the women held beliefs about the role obligations of the patient and if fulfilled, she was a "good patient."

The "Good Patient." Table 5.24 presents the women's responses to the question: "What makes a good patient?" The data

TABLE 5.24.--Characteristics of the "Good Patient."

Characteristic	Percent of Responses
Follows the doctor's advice	30
Communicates honestly	25
Pays her bills	17
Accommodates the physician's busy schedule	16
Acknowledges the physician's superior knowledge	12

show that the women defined the "good patient" in much the same way that social scientists and practicing physicians do, that is, as a cooperator with a guiding partner (Ford, et al., 1967; Lorber, 1975; Ort, et al., 1964; Szasz and Hollender, 1975).

According to the women, a "good patient" is an individual who facilitates the doctor's work by communicating her symptoms to him frankly and honestly (25 percent). The following example illustrates the way in which the women felt honesty facilitates the therapeutic relationship:

> Tell him your problem. Don't keep him guessing if you have an idea what's wrong. If you have a problem with your boyfriend or kids it could make you sick to your stomach. He could be giving you pills for nausea but if he knew you were nervous he could look another way at it.

In addition, the women thought that a "good patient" cooperates with the physician by accepting and following his advice (30 percent). The physician is more able to cure if the patient complies with his instructions, as the following excerpt illustrates.

> A doctor is there to help people. If the patient comes in with a problem they should work on it together. Some people sit back and expect a cure without any effort. The patient should accept her responsibilities and follow the doctor's orders.

Thus, not only does the good patient cooperate with the physician, but she also acknowledges that the doctor is in control (see also Ford, et al., 1967; Ort, et al., 1964; Parsons, 1951; Szasz and Hollender, 1975). She trusts and relies on his judgment because he has special skill and knowledge. Responses such as the following indicate the degree to which the "good patient" accepts a subordinate role in the therapeutic relationship:

> They're the docs -- they know.
>
> She listens to the doctor and goes with whatever he says . . . . He knows.
>
> Accept what's wrong with you and trust that your doctor will take care of you.

The women also thought that a "good patient" is punctual, avoids cancelling or breaking appointments and acknowledges that the physician's time is restricted (16 percent).[23] Finally, the women felt that a "good patient" acknowledges the contractual nature of the physician-patient relationship and pays her bills (17 percent). In short, the elements of a "good patient" seemed to be the following in terms of importance: (1) follows the physician's advice; (2) communicates honestly; (3) fulfills her financial obligations; and (4) acknowledges the physician's superiority.

Summary: The Physician-Patient Relationship

The physician-patient relationship has been defined in the sociological literature as a dyadic system in which interaction is patterned by the congruence of the norms for both actors. Furthermore, the interaction is defined as functionally specific, i.e., oriented toward biophysiological phenomena, and affectively neutral. As observed above, the women's definitions of the roles of the physician and the patient partially supported this definition.

There was ample evidence in the interviews to suggest that the women considered the relationship asymmetrical but desired it to take a symmetrical character. Their definition of the patient role indicated that its adoption involved a loss of self-determination. In addition, their characterization of the physician's actual role also suggested that the physician exerted social control in the interaction. For example, when they spoke about physicians using "big words" that made medicine incomprehensible to them, the women in an oblique way had identified the strategy used by physicians to assert such control. By shrouding their work in mystery, physicians conveyed to patients the message that they possessed knowledge unreachable by laymen, thereby not only maintaining but reaffirming the unequal relationship.[24] Similarly, the women's descriptions of the physicians' approach to problems that they were unable to diagnose implied a loss of control by participants who considered themselves more powerful. That is, according to physicians, their resources are superior to patients, a circumstance that should enable them to discern the cause of a problem and institute effective treatment. Thus, when a physician could not exercise control, he became angry with the patient, making her "feel stupid . . . like he had better things to do with his time."

There also was evidence in the interviews to suggest that the women had internalized the view that medicine is oriented toward "the application of scientific knowledge to the problems of illness and health, to the control of 'disease'" (Parsons, 1951: 432). They explicitly stated that the diagnosis and treatment of physical problems was an institutionalized role obligation of the physician and became angry when these expectations were not fulfilled. Furthermore, although most felt that socioemotional problems constituted a legitimate condition for which to seek care, the fact that so few spontaneously presented their concerns implies that they viewed non-somatic problems as illegitimate.

Similarly, the data show that the women had internalized the norm that defines the physician's role as affectively neutral. Personalized care, including expressions of human warmth and interest, was a desired behavior, not a required behavior. Thus, the physician who responded to the patient in an expressive manner earned the appelation "good doctor."

Data from the interviews also document that certain expectations guided the women's definitions of their role as patients. Their descriptions of both their specific and general role obligations suggested that they had internalized the traditional belief that the "ideal" patient is:

> . . . someone who is able to assess symptomatology with sufficient expertise to know _which_ conditions he should present, and _when_ he should present them to the GP, but at the same time one who, having assessed . . . his condition, will defer to the doctor's assessment on presentation (Bloor and Horobin, 1975:276, emphases in original; see also Parsons, 1951:441 and 1964:275).

Furthermore, the data suggest that the women felt they could be negatively sanctioned if they did not adhere to the physicians' norms for behavior. For example, a "good patient" pays her bills: "If you want him [the physician] to do anything next time, you have to pay your bills." Moreover, she fits the medical model: "Some doctors if they don't know what's going on they don't want to deal with it."

Finally, there were indications, both in the in-depth and survey interviews, that orientations to the physician-patient relationship were modified by different life situations. Dependent patients were likely to define the physician's functions broadly, extending his authority to socioemotional phenomena. Non-dependent patients were likely to define his functions narrowly, limiting his authority to somatic problems only. The findings, then, support the view that varying need-dispositions derive from the different contexts in which the patient qua individual is located. In the final section, attention turns to the way in which these differing need-dispositions are related to the total use of medical services.

The Patient's Contribution to the Total Use of Medical Services

It was hypothesized in Chapter II that patients with greater non-medical needs would use more medical services in the presence of multiple diffuse symptoms (see hypothesis six). In order to test this hypothesis, a step-wise regression of the total use of medical services during the two six-month periods of observation was carried out. Three variables were entered into the equation: (1) "symptoms of dependency"; (2) need to cope with failure; and (3) need for catharsis. The results of this analysis are presented below.

Test of Hypothesis

Inspection of the data indicates that the medical and non-medical needs of the patient exerted an effect on the total use of services (see Table 5.25). Those who had a high volume of use during the two six-month periods presented many "symptoms of dependency" ($\beta = .24$) and had a need to cope with failure ($\beta = .31$) and a need for catharsis ($\beta = .14$). Together these variables accounted for 16 percent of the variance in the use of services.

More than half of the variance was explained by the first variable entered into the equation. That is, the need to cope with failure was the most powerful explanatory variable ($R^2 = .09$). Many "symptoms of dependency" explained an additional six percent of the variance. But, the need for catharsis contributed only one more percent to explained variance.

The inability of need for catharsis to account for more explained variance is difficult to unravel. The relationship between

TABLE 5.25.--Step-Wise Regression of the Patient's Contribution to the Total Use of Medical Services.

Order of Variables Entering*	Variable	β**	Multiple R	R^2	F	p	df
1	Need to cope with failure	.31	.29	.09	11.53	.001	1,122
2	Symptoms of dependency	.24	.38	.15	10.33	.000	2,121
3	Need for catharsis	.14	.40	.16	7.80	.000	3,120

*Variables contributing at least one percent to explained variance are reported.

**β = standardized regression coefficient or beta weight.

need and use is virtually a truism in the literature and Shuval and her colleagues (1970) did demonstrate a relationship between need for catharsis and high rates of utilization.[25] Perhaps, as suggested earlier, the need to communicate feelings of distress is greatest for those who also are burdened with the need to cope with feelings of failure. Thus, because a high need for catharsis was closely associated with the need to cope with failure, it was unable to contribute more to explained variance.

The efficacy of the need to cope with failure and "symptoms of dependency" as predictors of use of services is not surprising. Self-defined poor health by implication suggests a concomitant self-defined need for medical care. Furthermore, if, as Cole and Lejeune (1972:355) have suggested, ". . . people who define their health as poor are more likely to search for symptoms to justify their taking the sick role," the frequent use of medical services for large numbers of symptoms that are difficult to deny appears a plausible eventuality.

Although the amount of variance explained in total use of services was not great, the findings represent an important attempt to test a set of axioms that pervade the literature. They provide empirical support for the view that health-related behavior may be strongly influenced by motives that are not health related. Furthermore, they provide support for the view argued in this report that utilization behavior may be an adjustment to a general life situation. When opportunities for the satisfaction of basic social needs are blocked or not fully available in the personal environment, the individual with limited resources is likely to attempt to satisfy these needs through the medical institution.

Summary: The Women as Individuals and Patients

In the foregoing pages, the life situations and need-dispositions of the study sample have been examined. Approximately one-third of the sample was poor, relatively uneducated, separated or divorced. These women tended to have little sense of well-being about their circumstances and to have experienced a series of stressful events. Furthermore, these women tended to feel that their psychological assets were limited and their social assets only nominally effective in mediating between them and the consequences of life difficulties.

It was shown that there was a marked association between these life situations and patient characteristics. Women who perceived the quality of their life as poor tended to have a need to cope with failure and a need for catharsis, as well as a tendency to present many "symptoms of dependency." Multiple regression analysis indicated that perceived financial and social deprivation exerted the most consistent influence on medical and non-medical needs. Psychological and social assets available, however, also exerted an effect on the women's needs as patients.

Furthermore, it was shown that differing life situations were related to orientations toward the physician-patient relationship. An analysis of the qualitative interview data, and a more limited analysis of the quantitative data, indicated that dependent patients were more likely to consider personal problems apposite to the physician-patient interaction than non-dependent patients.

Finally, it was shown that the high use of medical services was influenced by the medical and non-medical needs of the patient. Multiple regression analysis indicated that the need to cope with failure and many "symptoms of dependency" were good predictors of the total use of medical services. The contribution of the need for catharsis to explained variance, however, was minimal. In the next chapter, attention turns to the way in which the response of the physician to patient needs influences patterns and volume of use of medical services.

CHAPTER V: NOTES

[1] The following discussion is based on data collected from 124 women in the sample. Although 127 patients were interviewed, the data for three women were omitted from all analyses after information from their medical records was processed. One of these women had cancer in situ and the other two had sought care at the center for one or two routine checkups only. Thus, they did not meet the criteria for inclusion in the sample.

Race was not included as a variable in any of the analyses because of the small number of blacks in the sample, i.e., 14 women. Fewer of the blacks were separated or divorced (28.6 percent vs. 40 percent for whites) but more were living on inadequate incomes (35.7 percent vs. 23.9 percent for whites). The distribution of blacks across education levels, however, was more even than it was for whites. Fifty percent of the blacks had at least a high school education and 50 percent a college education. The percentages for whites were 74.5 percent and 25.5 percent, respectively.

[2] Twenty-one women (16.9 percent) responded to the question, "Did anything else happen that I didn't mention?" Nine out of every ten reported the occurrence of an event with negative impact. Only two (9.5 percent) mentioned an event that connoted a positive impact on their lives, i.e., the start of a love affair.

[3] Since almost nine out of ten of the women had both telephone and personal contact with kin and friends, type of contact was not included as a variable in any of the analyses (see Table 5.7 and 5.9).

[4] Although the relationships were not statistically significant, members of close-knit friend networks also tended to report receiving most types of support more frequently: friendliness when troubled ($r = -.05$); listened carefully ($r = -.04$); and encouraged ($r = -.06$). The only item which did not follow this pattern was "showed understanding" ($r = .10$).

[5] A specific question was not asked about these latter two activities, however. Reports of such help were elicited by a question that asked if the respondent received help from outside the household with anything else besides the activities mentioned. Perhaps, then, if the question had been asked directly, the distributions would have been different.

[6] No relationship was found between the women's assessment of their role performance and their social assets. The discussion, therefore, focuses on the relationship between feelings of failure that arise from a need for help with problems and the social support systems of the women.

[7] None of the relationships between measures of quality of life or social stressors and supportive behaviors of kin and friends were statistically significant.

[8] A direct comparison of the volume of use of the two groups was difficult because of the way in which the country data were recorded. Six to fourteen visits and fifteen or more visits were treated as categorical variables in the county study and it was impossible to analyze how many women had six, fourteen or "n" number of visits during the year. Therefore, in order to calculate the averages reported: (1) all persons with fifteen or more visits were excluded; and (2) the median number of visits for those reporting six to fourteen visits was used in calculating the average per community resident.

[9] Visits ranged from one (14.5 percent) to ten (0.8 percent), with 3.4 visits the average per patient. Seventy-six patients (61.3 percent) visited the center between one to three times and 48 (38.7 percent), four or more times. The figures for the sample patients interviewed are comparable to those reported in Chapter III, Table 3.4. The slight differences noted are due to the distinct sources from which the data were obtained. The material used in this chapter was derived from patient medical records; that in Chapter III, from data contained in the center's health information system.

[10] Since the correlation between the various classifications of symptoms was so high, a reliability coefficient was computed. The results of this computation yielded an alpha of .89. Given this high coefficient, an index of symptoms of dependency was calculated and assigned to each patient. This index was used in all analyses.

[11] Variables were omitted from discussion if they did not meet one of two criteria. The first criterion omitted variables that were never entered into the regression equation because they did not meet three statistical criteria specified by the computer program (Nie, et al., 1975:345-346). The second criterion omitted variables that had been entered in to the equation, but had added less than one percent to the total variance explained.

[12] The following discussion is based on the responses of 25 women to questions asked in the in-depth interviews. Approximately three-quarters (72 percent) of these women were dependent patients. In part, the discussion relies on their responses to queries about the responsibilities of the doctor and the patient and the characteristics of a "good doctor" and "good patient." In part, it also relies on responses to other questions posed during the unstructured interview.

[13] Two out of every three of the doctor's responsibilities cited by the women were "diagnoses." In the survey interviews, less than ten percent of the women did not mention diagnosis when asked, "What did you want the doctor to do the last time you visited him or her?" Those who did not mention diagnosis answered that they wanted advice and/or reassurance.

[14] Reader, et al. (1957) found that the major concern of most of the study patients seeking care at the New York Hospital-Cornell Medical Center was learning about the seriousness of their condition and a name for it. Less than one-third were <u>not</u> concerned with a diagnosis. In a similar vein, Ley and Spelman (1965) noted a tendency in patients interviewed after a medical visit to recall the diagnosis better than the advice.

[15] The extent to which the director's belief receives emphasis in the training of residents is unknown. Given his beliefs, however, it is not surprising that a number of women felt a lack of personal care.

[16] The lack of male physicians' empathy for and sensitivity to female patients is discussed in Campbell, 1973; Cooperstock, 1971; Corea, 1978; Ehrenreich and English, 1973.

[17] Reader, et al. (1957) found that the patients they studied also wanted explanations from the doctor but did little, if anything, to obtain information. They hypothesized that patients do not expect doctors to attempt to fulfill this need. The study data suggest, however, that patients frequently do not seek information because the doctor does not give them the opportunity (see Tagliacozzo and Mauksch, 1972, for a discussion of this point).

[18] In the survey questionnaire, 56 percent of the women said that they felt the doctor was a suitable person to talk with about personal problems. (Thirty-one percent responded that he was not suitable and 13 percent were uncertain or qualified a positive answer with remarks such as ". . . if you feel comfortable with him.") Sixty percent of the survey sample, moreover, indicated that they had

talked with their doctor about personal problems. Gurin, et al. (1960) report that 30 percent of patients with acknowledged "mental problems" first sought the aid of a general practitioner. Such explicit use, documented by surveys, suggests definite expectations of the doctor to deal with the psychological and social problems of patients.

[19] Perhaps because they did not feel free to discuss situational problems with the physician, only four (1.0 percent) out of the 422 visits made during the two six-month periods were solely for socioemotional problems. However, although only four visits were made solely for socioemotional problems, data in the medical records indicate that non-medical problems were discussed at 53 (12.6 percent) of the visits. The most frequently discussed problems recorded were marital problems (23.1 percent) followed by economic problems (18 percent) and parent-child conflict (15.4 percent).

[20] Although all of the women agreed that worry can make you sick, several indicated that they had been surprised when their physical problem had been interpreted for them in this way by their doctors.

All also agreed that they would attempt to cope with mild depression by situational adjustments before seeking care from a physician. Responses such as the following were common: "Take the day off"; "Do something I like with people I enjoy being with"; or "Occupy my mind and not dwell on it."

[21] The women's definition of the patient role closely parallels that formulated by Parsons (1951). Using physician expectations of patients as a reference, he states that the ill person has the obligation to seek technically competent help and to try to get well as quickly as possible.

[22] See Baumann (1961) and Apple (1960) for material relative to the definition of "being sick."

[23] Many women talked about the long wait they must endure to see the doctor at scheduled appointments. Only two, however, suggested that their time also was valuable and that an effort should be made to contact them and apprise them of a delay.

[24] See Moore and Tumin (1949) for a discussion of this point: "Ignorance on the part of a customer of specialized services (for example, medical or legal advice) helps to preserve the privileged position of a specialized dispenser of these services" (1949:788-789).

[25] The findings of Shuval, et al. (1970), however, are reported in frequency distributions only. It is difficult to assess, therefore, if the observed differences were tested for statistical significance.

CHAPTER VI

THE PHYSICIANS AND THE PHYSICIAN-PATIENT INTERACTION

The focus of this study is the nature of patient and physician behavior and the effect of this behavior on the use of medical services. The material presented in the previous chapter indicated that differences in the women's life situations influenced their need-dispositions as patients and their overall use of medical services. This chapter examines the influence of the medical profession on physicians' attitudes and the way in which the residents' definitions of disease and determination of treatment influence the patients' utilization of medical care.

The chapter is divided into two parts. Part one presents the findings relevant to the physicians and explores the way in which role definitions and orientations toward the dependent patient are affected by the context of medical work. Part two examines the data concerning the physician-patient interaction as well as analyzes the way in which medical decisions affect the use of medical services.

Part 1: The Physicians

According to Parsons' (1951) formulation, the role of the physician is oriented toward the application of scientific knowledge to the control of somatic illness. The physicians in this study, however, were training for careers in a medical specialty--family medicine--which has been defined by its proponents as one where the "doctor spends most of his time thinking about the patient and the impact of various forces [i.e., social and psychological] on his health or illness over a period of time" (Alpert and Charney, 1973:3). Thus, departures by the residents from the expected norms of traditional physician behavior would in fact be in line with the definition of their specialty. It was argued in Chapter II that departures from prototypic role definitions are a product of a host of factors experienced at the level of medical practice. Furthermore, it also was argued that differences in attitudes toward the dependent patient derive from such contextual variables. The findings apposite to this argument are presented below.

Overview: The Physicians

A majority (56.8 percent) of the 42 residents were graduates of academically-oriented medical schools. Thirty-six were males and six females.[1] Their decision to choose a residency in family medicine, in large part, had been prompted by the variety in patient types and medical problems the specialty provided (see Table 6.1). This attraction had drawn one-quarter of the residents into the field by default. They, as for example one of them said, ". . . liked all aspects of medicine to some degree, but no one specialty enough to spend a lifetime in it."

The residents' emphasis on personal, rather than humanitarian, reasons for choosing family medicine was reflected, in general, in

TABLE 6.1.--Physicians' Reasons for Choosing a Residency in Family Medicine.[a]

Reason	Percent of Responses
Variety	44.9
By default	20.4
Personal affiliation with patients	16.3
Impact on people's health as a primary care physician	14.3
Need for physicians who treat the whole person	4.1

[a] These reasons were offered in response to the question: "Why did you decide on a residency in family practice?"

their answers to the question: "What do you enjoy most about being a doctor?" Approximately one-third (36.4 percent) of the responses emphasized the satisfactions derived from the technical aspects of the role, i.e., diagnosis, treatment, and completion related to therapeutic results, and one-fifth (20 percent) indicated the satisfactions derived from the professional position, i.e., independence, prestige, power, and financial rewards. Only one-third of the responses (34.5 percent) stressed the satisfactions derived from the help-giving or supportive elements of the role and one-tenth (9.1 percent) the satisfactions obtained from an "on-going" relationship with patients.

Most of the residents' dissatisfactions with medicine derived from the work environment. Two-thirds (63.4 percent) of the responses to the question "What do you like least about being a doctor" referred to night calls, hours of work, paper work, and lack of privacy or time for themselves and/or their families. A further one-fourth of the responses referred to dissatisfactions created by problem patients, i.e., "crocks" (21.9 percent) and potential litigants (4.9 percent). Finally, one-tenth (9.8 percent) referred to dissatisfactions that derived from the uncertainties involved in medicine and their attendant responsibilities. As one resident wrote: "The thing I like the least about medicine is the constant pressure to perform, produce, and do the right thing in a field where most aspects are fraught with uncertainties."

In summary, the residents had chosen a specialty in which emphasis was placed on the total management of the patient's physical and socioemotional needs. Yet, only a few indicated that they had any interest or responsibility in this domain. We must, however, consider one limitation of this finding. The residents had been asked to express their views on medicine as a career rather than on the role obligations of a family practitioner. In the next section, attention turns to their views on the ideal behaviors expected of the physician and the patient.

The Physician and the Patient Roles

The physician interview schedule contained two sets of pair-comparisons (see Appendix C). One set contained six items relevant to the physician's functions. The other set contained six items apposite to the patient's responsibilities. Each set of six items was presented to the residents in all possible pairs and they were asked to judge which one of the pair helped them to practice medicine effectively. The results of the analysis of their responses are presented below.[2]

The Physician's Functions

Table 6.2 presents the data on the residents' judgments of the relative importance of the six physician functions which they were asked to compare. Inspection of these data indicates that the residents considered health education and the establishment of rapport their two most important functions and the greatest contributors to their effectiveness as physicians (scale value [sv] = .7735 and sv = .7297, respectively). Furthermore, the data show that the residents attached more significance to these two items than to items that referred to the technical aspects of their functions. For example, a greater distance separates the values given the first two items on the scale from those given the fourth item (insists on a thorough work-up, sv = .1726) and the sixth item (requires the patient to return for follow-up, sv = .0000). Thus, the residents judged affectivity, rather than instrumentality, more helpful in effective practice.

The data also show that the residents attached more significance to the first two items on the scale--health education and the establishment of rapport--than to items that referred to the breadth of their authority. For example, a great distance separates the values given the first two items from those given the third item

TABLE 6.2.--Proportion Matrix for Six Functions of the Physician Judged in Terms of Effective Medical Practice.

Function	1	2	3	4	5	6
1. Explains and interprets to patients	.00	.42	.42	.26	.19	.26
2. Develops rapport with the patient	.58	.00	.32	.36	.29	.13
3. Devotes time to social and emotional factors	.58	.68	.00	.45	.39	.36
4. Insists on a thorough work-up	.74	.65	.55	.00	.39	.58
5. Focuses on the treatment of physical problems	.81	.71	.61	.61	.00	.45
6. Requires the patient to return for follow-up	.74	.87	.65	.42	.55	.00
SCALE	.7735	.7297	.3639	.1726	.0331	.0000

(devotes time to social and emotional factors, sv = .3639) and the fifth item (focuses on the treatment of physical problems, sv = 0331). Furthermore, the values assigned to the third and fifth items suggest that the residents defined their role broadly. That is, they considered socioemotional problems within their purview and indicated that directing attention to such problems was far more important for effective practice than focusing on physical problems. As one resident noted elsewhere in the interview, dealing with social and emotional problems ". . . is a cure for more than 70 percent of my patients' complaints."

In short, the elements of the physician's role the residents considered most helpful in terms of effective practice were, in order of importance: (1) health education; (2) establishment of rapport; (3) treatment of socioemotional problems; (4) diagnoses; (5) treatment of somatic problems; and (6) continuous care. On the basis of these rankings, then, the following conclusions seem warranted: First of all, the residents identified themselves as practitioners, not research scientists. Second, as practitioners, they considered their primary obligations to be the solution of patient problems, not technical problems. Finally, they thought that the success with which they solved these problems principally was a function of the mode of their response to patients, not its content.

The Patient's Responsibilities

Table 6.3 presents data on the residents' judgments of the relative importance of the six patient functions they were asked to compare. The data indicate that the residents considered the first four items in the scale relatively inseparable and attached almost equal importance to them as contributors to effective practice. A very short distance separates the four items from each other: (1) gives an honest and accurate history (sv = 1.2871); (2) is self-reliant and willing to help him/herself (sv = 1.2165); (3) does what the doctor advises (sv = 1.2002); and (4) entrusts him/herself to the care of the doctor (sv = 1.1463).

Together, however, these four items suggest an inherent contradiction in the residents' expectations (see also Bloor and Horobin, 1975). On the one hand, they expect the patient to be an active partner in the therapeutic process; he or she is supposed to evaluate and present symptoms in a way that allows the doctor to arrive at a diagnosis and institute proper treatment. On the other hand, the residents expect the patient to be a passive cooperator in the process; he or she is supposed to defer to the doctor's opinion, follow his advice, and accept responsibility for adherence to the prescribed regimen.

The data also show that a great distance separates the first four items on the scale from the fifth, i.e., responds to treatment (sv = .7346). The relative unimportance that the residents attached to the patient's response to treatment is not surprising, however. Logically, the patient should respond to the doctor's intervention

TABLE 6.3.--Proportion Matrix for Six Functions of the Patient Judged in Terms of Effective Medical Practice.

Function	1	2	3	4	5	6
1. Gives an honest and accurate history	.00	.43	.53	.37	.33	.10
2. Is self-reliant and willing to help him/herself	.57	.00	.50	.37	.33	.13
3. Does what the doctor advises	.47	.50	.00	.40	.43	.13
4. Entrusts him/herself to the care of the doctor	.63	.63	.60	.00	.13	.13
5. Responds to treatment	.67	.67	.57	.87	.00	.17
6. Shows his/her gratitude for the doctor's help	.90	.87	.87	.87	.83	.00
SCALE	1.2871	1.2165	1.2002	1.1463	.7346	.0000

if he or she fulfills his or her first four responsibilities. Indeed, there were indications in the interviews to suggest that most residents believed that non-response to treatment was, in varying degrees, a consequence of "non-compliance" on the part of the patient. Furthermore, the data suggest that patient gratitude is a distinct concept that, in the judgment of the residents, has little to do with effective medical practice. That is, the last item on the scale (sv = .0000) is quite separate from all others.

In short, the elements of the patient's role, considered most helpful for an effective practice, were in order of importance: (1) honest communication; (2) self-reliance; (3) compliance; (4) trust; (5) response to the physician's intervention; and (6) gratitude. On the basis of these rankings, then, one can conclude that the residents perceived themselves as controlling the physician-patient relationship. In addition, in the capacity of the more powerful actor, they could impose their norms and pattern the interaction. Finally, non-adherence to these norms by patients impeded the residents' ability to practice effectively.

Comparative Definitions of the Physician-Patient Role Relationship

The data collected from the residents and patients are not conceptually equivalent. The resident data reflect judgments about the contribution of physician and patient behaviors to the effective functioning of medical practice. The patient data, on the other hand, reflect prescriptions for the behavior attached to the physician and patient roles. If one accepts the assumption that the residents' rankings are definitions of ideal behaviors, then some comparisons of the two sets of data are possible.

For example, both the residents and patients indicated that the physician-patient relationship should be one of partnership. The data, however, documented that residents and patients considered this relationship currently asymmetrical. That is, the physician was more powerful; he provided the guidance and leadership and the patient was expected to cooperate. Furthermore, the data showed that both thought that personalized care, including expressions of human warmth and interest, facilitated the therapeutic relationship. Similarly, the data showed that both, in general, thought that the physicians' responsibility should extend to care for socioemotional illness.

The complementarity of expectations implied by the data above, however, may be misleading. Excerpts from patient interviews, presented in Chapter V, suggest that the residents' actions are not always congruent with their views on ideal behavior. For example, the women's perceptions of the physicians' approach to their problems indicate that at least some residents failed to convey this as they cared for patients. That is, according to the women, not all residents felt they were required to show a personal concern for the patient. Furthermore, the women thought that not all residents felt that they were required to offer explanations to the patient. Finally, the women also thought that not all residents felt that they were required to deal with the socioemotional problems of patients. In short, according to the women, not all residents brought the same expectations to the physician-patient interaction. In the next section, attention turns to the sources of these differences.

Physicians' Attitudes Toward the Dependent Patient

The dependent patient was defined in Chapter II as an individual who frequently uses medical services to satisfy needs over and above the need for specific diagnosis or treatment of illness. In Chapter V it was observed that such patients had little sense of well-being about their situations and that these feelings were a relatively accurate reflection of the objective circumstances of their lives. Furthermore, it was shown that such patients tended to seek medical care frequently for many "symptoms of dependency."

It was argued in Chapter II that physicians' attitudes toward such patients were related to: (1) the medical school attended; (2) the career stage; and/or (3) the setting of medical practice. In Chapter IV, where the residency training program was described, it was shown that although skills in the management of the socioemotional needs of patients were taught, the residency setting did not generate such professional behavior. The extent to which the medical school attended or career stage influenced attitudes toward dependent patients is explored below.

Orientations Toward the Dependent Patient

As described in Chapter III, the physician's orientation toward the dependent patient was operationalized as three sentence stems the residents were asked to complete: (1) "when a patient persistently presents with vague or inconsistent symptoms . . . ;" (2) "when physical and laboratory examinations do not account for a patient's complaints . . . '" and (3) "to me, dealing with the social and emotional problems of patient is . . . ." The analysis of the residents' answers showed that the first and second stems tended to elicit ambivalent or neutral responses and the third stem positive responses (see Table 6.4). The analysis also showed that no statistically significant relationships existed between the stems; the first and third stems, however, were positively associated with each other and negatively correlated with the second. Furthermore, although there was a good distribution of residents within each category, this distribution was fairly random. That is, no statistically significant relationships existed between contextual variables and responses to the sentence stems.

Nevertheless, differences in the residents' orientations may be a product of their career stage. There was a tendency for residents further advanced in their careers to be more unfavorably oriented toward the dependent patient than those in the early stages. For example, 60 percent of the third year residents and 40 percent of the graduates of the program expressed a negative reaction to the first and third stems. By contrast, the percentages for first year residents were 20 and 30 percent, respectively.[3] Furthermore, the correlation between year of residency and response to the patient who persistently presents with vague and inconsistent symptoms was almost significant ($r = .27$, $p < .06$).

TABLE 6.4.--Percent of Residents' Responses to Three Sentence Stems.

Stems	Responses					
	Favorable		Ambivalent or Neutral		Unfavorable	
	Number	Percent	Number	Percent	Number	Percent
1. When a patient persistently presents with vague or inconsistent symptoms . . .	10	23.8	19	45.2	13	31.0
2. When physical and laboratory examinations do not account for patients complaints . . .	15	35.7	18	42.9	9	21.4
3. To me dealing with the social and emotional problems of patients is . . .	18	43.9	12	29.3	11	26.8

The relationship between career stage and response to the patient who presents vague symptoms cannot be explained as a product of the training received in medical school. Although 50 percent of the more advanced physicians and 55 percent of the first year residents had attended academically-oriented schools there was no relation between this education and a negative view of the patient. Instead, physicians in advanced stages of their careers might have given unfavorable responses because of frustrations experienced with the realities of family practice.

For example, the data showed that the more unfavorable a physician's response to patients who present vague complaints, the more likely he was to derive his greatest satisfactions in medicine from the technical aspects of his role ($r = .37$, $p < .05$). The data also showed that more advanced residents tended to derive their greatest satisfaction in medicine from this aspect of their role. That is, 40 percent of the more advanced physicians, in contrast to 17 percent of the first year residents, indicated that the major satisfaction they found in medicine was in diagnosis and treatment. If one accepts the assumption that one cohort of residents will share similar attitudes with other cohorts of residents, then it might be deduced that experiences in practice temper the "humanitarianism" the residents bring with them to their residency. Thus, residents become more technically-oriented as they advance in their training and less favorably oriented toward patients who impede them from satisfying their scientific interests (see also Adler and Shuval, 1978).

In summary, the data suggest that career stage may have an influence on a physician's orientation toward the dependent patient. They do not support, however, the relationship between career stage and attitude hypothesized in Chapter II and found to exist by Gray and his colleagues (1966). More extended contact with patients in a "high-interaction" specialty did not appear to heighten a physician's awareness of the need to treat the "whole" person rather than just her symptoms. Rather, extended contact with patients, particularly those with vague and inconsistent symptoms, appeared to intensify a physician's: (1) frustration because of the absence of the professed sources of work satisfaction; and (2) disinterest in dealing with any socioemotional problems that might underlie patients' problems.

Perception of the Performance of Latent Functions in Medical Work

As observed earlier, the latent functions of the physician's role examined in this study are (1) the satisfaction of the patient's need for catharsis; and (2) the satisfaction of the patient's need to cope with failure. The satisfaction of the need for catharsis was measured by the extent to which the physician felt he allows the patient to talk about herself and her problems. The satisfaction of the patient's need to cope with failure was defined as the extent to which the physician views his work as part of legitimation of illness which is being used to justify the patient's failure.

The data indicated that slightly more than half of the residents (54.8 percent) felt that they satisfied the patient's need for catharsis. By contrast, almost three-quarters (71.4 percent) felt that they did not satisfy the patient's need to cope with failure. In other words, residents were more likely to extend sympathy to patients who talked about problems related only indirectly to their health than they were to patients who used illness explicitly to justify failure.

No statistically significant relationship was found between perceived satisfaction of the patient's need for catharsis and perceived satisfaction of the patient's need to cope with failure. This lack of relationship most probably was due to the small number of physicians, i.e., 12, who felt they satisfied the patient's need to cope with failure. In addition, no statistically significant relationship was found between the physicians' orientations toward the dependent patient and perceived satisfaction of the patient's non-medical needs. This lack of relationship might be a function of the questions used to operationalize these concepts. Apparently each set tapped a different cognitive dimension.

The residents' career stage was not found to be related to perceived satisfaction of the patient's need for catharsis. More advanced physicians were as likely to feel that they satisfied this need (50 percent) as residents in the early stages of their career (55 percent). But, perceived satisfaction of the need for catharsis was found to be related to the type of medical school the physician had attended. That is, physicians who were graduates of practice-oriented schools were likely to feel that they allowed patients freedom to talk about problems only indirectly related to their health ($r = .35$, $p < .02$). This finding supports the view of Becker and his colleagues (1961) and Bloom (1963) that the medical school has a socializing influence on physicians. The emphasis given to the social and behavioral sciences in practice-oriented medical schools apparently does affect the expectations their graduates bring to the physician-patient interaction.

The data also showed that the residents considered the use of illness to legitimate failure to be widespread among patients on welfare (83.3 percent), women (65.1 percent) and non-whites (56.1 percent). The dependent patients in this study, then, both poor and female, were at high risk to be considered clients who became ill to escape from life difficulties.

No statistically significant relationship was found, however, between perceived satisfaction of the need to cope with failure and contextual variables. For example, more advanced physicians were as likely as those in the early stages of their career to feel they satisfied the patient's need to cope with failure (40 and 35 percent, respectively). Furthermore, graduates of academically-oriented schools were as likely as graduates of practice-oriented schools to feel that they responded sympathetically to patients who used illness to justify failure (26 and 31 percent, respectively). These findings were not surprising because the residents' responses were so negatively skewed. In short, then, neither training in medical school nor career stage appeared to have bearing on a physician's perceived response to patients he felt became ill to justify some sort of failure in their lives.

Summary

The residents had chosen a specialty in which the physician is expected to provide continuous care to patients whom he knows and understands as social beings located in a socioeconomic environment. The data showed that the residents, as a group, held views congruent with this expectation. That is, they described themselves as practitioners who had a primary obligation to solve the somatic and socioemotional problems of their patients.

By contrast, the data showed that certain individuals among the residents held views that were in conflict with these expectations. That is, some residents were more interested in solving technical, than patient, problems, particularly dependent patients' problems. Only a weak relationship was found, however, between the attitudes of physicians and contextual variables.

Residents in a more advanced stage of their career tended to be unfavorably oriented toward the dependent patient. It was argued that their negative attitudes were a product of a decreasing "humanitarianism" that develops as physicians attempt to cope with the realities of family practice. Graduates of academically-oriented medical schools were less likely to feel they satisfied the patient's need for catharsis than graduates of practice-oriented schools. It was suggested that the difficult curricula of medical schools apparently do influence the expectations their graduates bring to the physician-patient interaction.

The findings documented the view that physicians' orientations toward patients differ. They provided only partial support, however, for the relationships hypothesized to exist between these different orientations and the context of the medical profession.

Part 2: The Physician-Patient Interaction

It was observed in Chapter V that during the two six-month periods of observation the patients made 422 visits to the family health care center. Furthermore, it was shown that patients with greater non-medical needs and many "symptoms of dependency" made more visits to the center than did other women in the sample. The major argument of this study, however, is that the high use of medical services is a consequence not only of patient needs but of physicians' responses to these needs as well. This part presents the findings on the way in which physicians' definitions of illness and determination of treatment influenced the women's use of medical services.

The findings are organized into four sections. In the first section, the patient-physician interaction is described. Next follows an examination of the relationship between the different elements of the interaction. Then, the outcomes of physicians' decisions about patients are analyzed. Finally, in the last section, the women's views on the physician-patient interaction are discussed.

Overview: The Physician-Patient Interaction

Of the 422 visits the patients made to the center during the two six-month periods, 284 (67.3 percent) were initiated by the patient and 138 (32.7 percent) initiated by the physician. The number of patient-initiated visits ranged from zero (3.2 percent) to seven (0.8 percent), with an average of 2.3 visits per patient. The number of physician-initiated visits ranged from zero (39.5 percent) to six (1.6 percent), with an average of 1.1 visits per patient. In short, 49 patients (39.5 percent) initiated all of their visits and four (3.2 percent), none of their visits.

The physician-patient interaction during these visits followed a pattern which approximated entries in the medical record. First, the patient presented her symptoms. Next, the physician performed an examination and recorded physical findings. Then, he arrived at and assigned a diagnosis. Finally, he decided on a management plan. The following materials are organized in a way that parallels this pattern of interaction.

Physical Findings

It was observed in Chapter V that the patients presented their symptoms in different ways. Some tended to restrict their difficulties while others emphasized the more diffuse nature of their complaints. Furthermore, approximately two-fifths (41.9 percent) of the patients presented an above the average number of "symptoms of dependency." Regardless of the way in which patients presented symptoms, however, few were considered to be very ill (see Appendix D). The average number of physical findings recorded per visit was 1.2 per patient, although most of these findings were objective (77.2 percent). Furthermore, less than one-quarter (23.4 percent) of the results of the diagnostic procedures performed were positive. In short, the findings indicated that the patients, in general, sought care for ailments that were judged by their physicians to be relatively minor.

Diagnoses

The faculty at the center require residents to record their assessments of the patient's problems at the time of each visit, be they presumptive or definitive. Approximately three-quarters (76.6 percent) of the diagnoses recorded were considered by the residents to be definitive. Nevertheless, only 55.5 percent of all diagnoses were supported by physical findings and/or positive diagnostic procedures (see Appendix E). Slightly less than one-third of the diagnoses (29.1 percent) were unsupported and ten percent were psychological.[4]

For purposes of analyses, diagnoses were dichotomized into the categories (1) unsupported/psychological diagnoses; and (2) supported diagnoses. Approximately two-fifths (41.3 percent) of the diagnoses fell into the first category and three-fifths (58.7 percent) into the second. The diagnoses of 12 patients (9.7 percent) were all unsupported/psychological and the diagnoses of 46 patients (37.1 percent) all supported. In short, almost two-thirds of the patients had been assigned one or more unsupported/psychological diagnosis during the two six-month periods.

Physician's Plan

The physician's plan constitutes the management strategies adopted for the care of the patients. As described in Chapter III, three aspects of this plan were considered: (1) diagnostic procedures planned and performed; (2) therapies prescribed; and (3) disposition of patients.

Diagnostic Procedures Planned and Performed. Of the 828 diagnostic procedures planned by the residents, 405 (48.9 percent) were performed.[5] The number of procedures planned per patient ranged from zero (14.5 percent) to 25 (0.8 percent), with an average of 6.7 procedures per patient. The number of procedures actually performed per patient ranged from zero (16.1 percent) to 25 (0.8 percent), with 3.3 the average per patient. Thus, tests were planned and performed for more than four-fifths of the patients (85.5 and 83.9 percent, respectively).

Therapies Prescribed. As described in Chapter III, three types of therapies prescribed by physicians were considered: (1) psychotropic therapies; (2) symptomatic therapies; and (3) curative therapies. Four hundred and eight therapies were prescribed during the two six-month periods, an average of 3.3 per patient. Half (50.7 percent) of these therapies were symptomatic, two-fifths (40 percent) curative and one-tenth (9.3 percent) psychotropic. Approximately two-thirds of the patients received some symptomatic (63.7 percent) and some curative (64.5 percent) therapy during the six months. In addition, 15.6 percent of the patients received psychotropic therapies.[6]

Only 14 patients (11.3 percent) received no therapies. Two-thirds of these patients (64.3 percent) had sought care at the center only once during the two six-month periods. One-fifth (21.4 percent) had visited the center twice and two patients (14.2 percent) had sought care three and four times, respectively. In short, almost all the patients left the doctor's office with a prescription in hand.

Disposition of the Patient. The residents requested patients to return to the center for follow-up visits 225 times during the two six-month periods, an average of 1.8 requests per patient. One-quarter (25 percent) of the patients were never asked to return to the center. The compliance rates with physician requests for follow-up visits was very high. Almost two-thirds (61.3 percent) of the patients returned to the center at the physician's request. In short, residents asked patients to return to the center slightly over half (53.3 percent) of the time they sought care and most patients complied with this request.

Relationship Between Elements of the Physician-Patient Interaction

Table 6.5 presents data on the relationship between patient characteristics and the results of the residents' physical examinations. Inspection of these data indicates that there was no statistically significant relationship between a patient's perceived medical needs and the severity of the condition for which she sought care. For example, patients with many "symptoms of dependency" were as likely to have a dearth of physical findings as those with few

TABLE 6.5.--Zero-Order Correlations Between Patient Characteristics and Physical Findings.

Physical Findings	Patient Characteristics		
	Symptoms of Dependency	Need for Catharsis	Need to Cope with Failure
Average number of physical findings	.00	-.10	.03
Proportion of objective findings	-.10	-.04	-.07
Proportion of subjective findings	.17	-.13	.18*
Proportion of positive results diagnostic procedures	-.04	.03	.08

$^*p < .05$

"symptoms of dependency." There was a tendency, however, for the physician to observe a below the average number of objective physical findings (35.9 percent) and an above the average number of subjective physical findings (57.8 percent) among patients with many "symptoms of dependency." "Symptoms of dependency" apparently were difficult for the physician to document objectively.

Since patients with a need to cope with failure also were likely to present many "symptoms of dependency," it was not surprising to find that physicians had difficulty in documenting these patients' symptoms objectively. Thus, the need to cope with failure was positively correlated with the proportion of subjective physical findings the physician observed ($r = .18$, $p < .05$). Patients with the need to legitimate failure, however, had approximately the same number of physical findings as those without the need. By contrast, patients with a need for catharsis tended to have fewer physical findings recorded than those without this need. In general, though, the data showed but a weak relationship between the patients' perceived medical needs and the severity of the conditions for which they sought care.

The data did show, however, that patients' needs were related to the diagnoses their physicians assigned to them (see Table 6.6). In other words, patients with both many "symptoms of dependency" and the need to cope with failure were likely to be assigned unsupported/psychological diagnoses ($r = .22$, $p < .01$ and $r = .19$, $p < .03$, respectively). By contrast, patients with fewer "symptoms of dependency" and no need to cope with failure were likely to be

TABLE 6.6.--Zero-Order Correlations Between Diagnoses and Patient Characteristics.

Patient Characteristics	Diagnoses	
	Proportion Unsupported/ Psychological Diagnoses	Proportion Supported Diagnoses
Physical Findings:		
Average number of physical findings	-.56**	.56**
Proportion of subjective findings	.12	-.12
Proportion of objective findings	-.25**	.25**
Proportion of positive results diagnostic procedures	.04	-.04
Medical Needs:		
Symptoms of dependency	.22*	-.22*
Non-Medical Needs:		
Need for catharsis	.09	-.09
Need to cope with failure	.19*	-.19*

*$p < .03$

**$p < .006$

assigned supported diagnoses ($r = -.22$, $p < .01$ and $r = -.19$, $p < .03$, respectively).

The data also showed that the physician's observations were related to his definition of the patient's illness. Unsupported/psychological diagnoses were likely to be assigned to patients for whom few physical and few objective physical findings were found ($r = -.56$, $p < .001$ and $r = -.25$, $p < .006$, respectively). Supported diagnoses were of course assigned to patients for whom many physical and many objective physical findings were found ($r = .56$, $p < .001$ and $r = .25$, $p < .006$, respectively). In short, the physician's observations played a large role in his definition of the patient's illness. But, the way in which the patient presented her problems apparently also made a contribution to his definition.

The patient's manner of presentation apparently also played a role in the physician's management decisions (see Table 6.7). For example, patients with many "symptoms of dependency" and a need to cope with failure were likely to receive a prescription for a psychotropic therapy ($r = .17$, $p < .05$ and $r = .19$, $p < .03$, respectively). Furthermore, patients with many "symptoms of dependency" were less likely to be requested to return to the center for follow-up visits ($r = -.25$, $p < .006$).

Thus, those patients with the highest perceived medical needs were likely to be judged least in need of follow-up, despite the fact that the physician tended to plan more diagnostic procedures for them. For example, approximately two-thirds of the patients who presented an above the average number of "symptoms of dependency"

TABLE 6.7.--Zero-Order Correlations Between Patient Characteristics and Management Plans.

Management Strategies	Medical Needs	Non-medical Needs	
	Symptoms of Dependency	Need for Catharsis	Need to Cope with Failure
Average number of diagnostic procedures planned	.11	.08	-.02
Average number of diagnostic procedures performed	.10	.09	-.01
Proportion of psychotropic therapies	.17*	.03	.19*
Proportion of symptomatic therapies	-.09	-.06	.06
Proportion of curative therapies	-.05	-.01	-.08
Proportion of requests to return to center	-.25**	.01	.01

$^{*}p < .05$

$^{**}p < .006$

had diagnostic procedures planned (63.5 percent) and performed (65.4 percent). By contrast, only two-fifths of the patients who presented a below the average number of "symptoms of dependency" had diagnostic procedures planned (41.7 percent) and performed (40.3 percent).

The physician's observations and definition of the patient's illness also influenced the planned management. For example, patients with more objective physical findings were likely to receive a prescription for a curative therapy ($r = .18$, $p < .04$). Furthermore, patients assigned a supported diagnoses were (1) likely to receive prescriptions for curative therapies ($r = .39$, $p < .001$) and requests to return to the center for follow-up visits ($r = .27$, $p < .003$); and (2) unlikely to receive prescriptions for symptomatic therapies ($r = -.20$, $p < .02$) and psychotropic therapies ($r = -.29$, $p < .001$) (see Table 6.8). By contrast, patients who were assigned an unsupported/psychological diagnosis were (1) likely to receive prescriptions for psychotropic therapies ($r = .29$, $p < .001$) and symptomatic therapies ($r = .20$, $p < .02$) and (2) unlikely to receive curative therapies ($r = -.39$, $p < .001$) and requests to return for follow-up visits ($r = -.27$, $p < .003$).

In summary, there was a marked association between the characteristics of the patient, the physician's definition of her illness and his determination of treatment. It was found that those with many "symptoms of dependency" and a need to cope with failure tended to show few objective physical findings. Such patients were likely to be assigned unsupportive/psychological diagnoses, to be

TABLE 6.8.--Zero-Order Correlations Between Diagnoses and Management Plans.

Management Plans	Diagnoses	
	Proportion Unsupported/ Psychological Diagnoses	Proportion Supported Diagnoses
Average number of diagnostic procedures planned	.01	-.01
Average number of diagnostic procedures performed	.01	.04
Proportion of psychotropic therapies	.29**	-.29**
Proportion of symptomatic therapies	.20*	-.20*
Proportion of curative therapies	-.39**	.39**
Proportion of requests to return to center	-.27**	.27**

*$p < .02$

**$p < .003$

given prescriptions for psychotropic and symptomatic therapies, and to be dismissed. By contrast, patients who were found to have more physical and objective physical findings were likely to be assigned supported diagnoses, to be given prescriptions for curative therapies, and to be requested to return to the center for follow-up visits.

The data showed, however, only a weak relationship between patient attributes and physician's plans for diagnostic procedures. Physicians tended to plan more diagnostic procedures for patients with more "symptoms of dependency," but the relationship was not statistically significant. Apparently, even though the physician believed such patients' problems were minor, he harbored some fear that he might be mislabeling and mistreating a physical problem that could deteriorate to a more clear-cut, but late stage problem.

The Physician-Patient Interaction: Tests of Hypotheses

The set of hypotheses presented in Chapter II included one which posited a relationship between patient attributes and the physician's plan:

> H9. Physicians will order more diagnostic procedures in the presence of patients with multiple diffuse symptoms.

This hypothesis was rejected because "symptoms of dependency" were not a predictor of the average number of diagnostic procedures planned.

This finding was surprising since the literature reviewed in Chapter I had suggested that patients who frequently present for care with vague and multiple symptoms located in diffuse body systems undergo extensive diagnostic procedures (Kaywin, 1973; Kuch, et al., 1977; Malcom, et al., 1977). The literature reviewed, however, also had suggested that patients who seek medical care for such a distinct constellation of symptoms are at high risk to be assigned a psychiatric diagnosis (Farmer and Harvey, 1975; Matarrazzo, et al., 1961; McCranie, et al., 1978; Stewart, et al., 1975) and to receive more therapies (Kaywin, 1973; Lipsitt, 1968, 1970; Schuller, 1977). The findings in this study supported these suppositions. Therefore, a set of alternative hypotheses was developed to evaluate the contribution of selected variables to physicians' decisions and responses to patients:

Ha. Physicians will assign more unsupported/psychological diagnoses to patients who present many "symptoms of dependency" and who have greater non-medical needs.

Hb. Physicians will prescribe more therapies for patients who present many "symptoms of dependency" and who have greater non-medical needs.

Hc. Physicians will make fewer requests for follow-up visits of patients who present many "symptoms of dependency" and who have greater non-medical needs.

All of the independent variables hypothesized to relate to physicians' decisions were entered into the regression equations. In addition, all variables which were significantly correlated with the dependent variables were entered into the appropriate equations. The six multiple regression analyses computed are described below.

Diagnoses Assigned to Patients

Two multiple regression analyses were computed. In the first analysis, proportion of unsupported/psychological diagnoses was the dependent variable. In the second analysis, proportion of supported diagnoses was the dependent variable.

Proportion Unsupported/Psychological Diagnoses. Five predictors of unsupported/psychological diagnoses were entered into the regression equation. Three reflected the characteristics of the patient: (1) "symptoms of dependency;" (2) need to cope with failure; and (3) need for catharsis. Two predictors were relevant to the observations made by the physician: (1) average number of physical findings; and (2) proportion of objective physical findings.

Inspection of the data indicates that three of the predictors exerted an effect on the proportion of unsupported/psychological diagnoses assigned to a patient (see Table 6.9). That is, patients assigned a greater proportion of such diagnoses had few physical findings ($\beta = -.57$) and presented for care with many "symptoms of dependency" ($\beta = .19$) and a need to cope with failure ($\beta = .18$). Together, these three variables accounted for 40 percent of the variance in the proportion of unsupported/psychological diagnoses.

Most of the variance was explained by the first variable entered into the equation. That is, a paucity of physical findings was the most powerful explanatory variable ($R^2 = .32$). Many "symptoms of dependency" explained an additional five percent of the variance and a need to cope with failure contributed three more percent to

TABLE 6.9.--Step-Wise Regressions of Diagnoses Assigned Patients.

Order of Variables Entering*	Variable	β^{**}	Multiple R	R^2	F	p	df
<u>Proportion Unsupported/ Psychological Diagnoses</u>							
1	Average number of physical findings	-.57	.56	.32	56.95	.000	1,122
2	Symptoms of dependency	.19	.61	.37	35.30	.000	2,121
3	Need to cope with failure	.18	.63	.40	26.48	.000	3,120
<u>Proportion Supported Diagnoses</u>							
1	Average number of physical findings	.57	.56	.32	56.98	.000	1,122
2	Symptoms of dependency	-.19	.61	.37	35.31	.000	2,121
3	Need to cope with failure	-.18	.63	.40	26.47	.000	3,120

*Variables contributing at least one percent to explained variance are reported.

**β = standardized regression coefficient or beta weight.

explained variance. In short, a small number of physical findings was the best predictor of a large proportion of unsupported/psychological diagnoses. But, many symptoms of dependency and a need to cope with failure, in conjunction with this dearth, contributed substantially to the prediction.

Proportion Supported Diagnoses. Five predictors of supported diagnoses were entered into the equation. Three reflected the characteristics of the patient: (1) "symptoms of dependency;" (2) need to cope with failure; and (3) need for catharsis. Two predictors were relevant to the observations made by the physicians: (1) average number of physical findings; and (2) proportion of objective physical findings.

Analysis of the data indicated that three of the predictors exerted an effect on the proportion of supported diagnoses a patient was assigned (see Table 6.9). The data showed that those who were assigned a greater proportion of such diagnoses had many physical findings ($\beta = .57$) and presented for care with few "symptoms of dependency" ($\beta = -.19$) and no need to cope with failure ($\beta = -.18$). Together, these variables accounted for 40 percent of the variance in the proportion of supported diagnoses.

Most of the variance was explained by the first variable entered into the equation. That is, a large number of physical findings was the most powerful explanatory variable ($R^2 = .32$). Few "symptoms of dependency" explained an additional five percent of the variance and the lack of a need to cope with failure contributed three more percent to explained variance. In short, a large number of physical findings was the best predictor of a large proportion of supported diagnoses. But, few "symptoms of dependency" and no need to cope with failure, in conjunction with many findings, contributed substantially to the prediction.

Therapies Prescribed

Three multiple regression analyses were computed: in the first analysis, proportion of psychotropic therapies prescribed was the dependent variable; in the second analysis, proportion of symptomatic therapies prescribed was the dependent variable; and in the third analysis, proportion of curative therapies was the dependent variable.

Proportion of Psychotropic Therapies Prescribed. Five predictors of psychotropic therapies prescribed were entered into the equation. Three reflected the characteristics of the patient: (1) "symptoms of dependency;" (2) need to cope with failure; and (3) need for catharsis. Two predictors reflected the diagnoses assigned by the physician: (1) proportion of unsupported/psychological diagnoses; and (2) proportion of supported diagnoses.

Inspection of the data indicates that two of the predictors exerted an effect on the proportion of psychotropic therapies prescribed for a patient (see Table 6.10). That is, those who received prescriptions for a higher proportion of such drugs had been assigned a high proportion of unsupported/psychological diagnoses ($\beta = .26$) and had a need to cope with failure ($\beta = .14$). The two variables,

TABLE 6.10.--Step-Wise Regressions of Therapies Prescribed.

Order of Variables Entering[*]	Variable	β[**]	Multiple R	R^2	F	p	df
Proportion of Psychotropic Therapies							
1	Proportion of unsupported/ psychological diagnoses	.26	.29	.09	11.25	.001	1,122
2	Need to cope with failure	.14	.32	.10	7.04	.001	2,121
Proportion of Symptomatic Therapies							
1	Proportion of supported diagnoses	-.34	.20	.04	5.27	.02	1,122
2	Symptoms of dependency	.18	.25	.06	3.90	.02	2,121
Proportion of Curative Therapies							
1	Proportion of unsupported/ psychological diagnoses	-.39	.39	.15	22.04	.000	1,122

[*] Variables contributing at least one percent to explained variance are reported.

[**] β = standardized regression coefficient or beta weight.

however, accounted for only ten percent of the variance in prescription of psychotropic therapies. Furthermore, most of the variance was explained by the high proportion of unsupported/psychological diagnoses assigned to the patient.

Proportion Symptomatic Therapies Prescribed. Five predictors of symptomatic therapies prescribed were entered into the equation. Three reflected the characteristics of the patient: (1) "symptoms of dependency;" (2) need to cope with failure; and (3) need for catharsis. Two predictors were relevant to the diagnoses assigned by physicians: (1) proportion of unsupported/psychological diagnoses; and (2) proportion of supported diagnoses.

Inspection of the data indicates that two variables exerted an effect on the proportion of symptomatic therapies prescribed (see Table 6.10). For example, patients who received prescriptions for a larger proportion of symptomatic therapies were assigned a smaller proportion of supported diagnoses ($\beta = -.34$) and presented many "symptoms of dependency" ($\beta = .18$). The two variables, however, accounted for only six percent of the variance in symptomatic therapies prescribed. Furthermore, most of the variance was explained by the low proportion of supported diagnoses assigned to the patient ($R^2 = .04$).

Proportion of Curative Therapies Prescribed. Six predictors of curative therapies prescribed were entered into the equation. Three reflected the characteristics of the patient: (1) "symptoms of dependency;" (2) need to cope with failure; and (3) need for catharsis. Two predictors were relevant to the diagnoses assigned by physicians: (1) proportion of unsupported/psychological diagnoses; and (2) proportion of supported diagnoses. One predictor was relevant to the observations made by the physician: proportion of objective physical findings.

Inspection of the data indicates that only one variable exerted an effect on the proportion of curative therapies prescribed (see Table 6.10). The findings show that patients who received prescriptions for a large proportion of such therapies were assigned a small proportion of unsupported/psychological diagnoses ($\beta = -.39$). This one variable accounted for 15 percent of the variance in the proportion of curative therapies prescribed.

Requests for Follow-up Visits

Five predictors of requests for follow-up visits were entered into the equation. Three reflected the characteristics of the patient: (1) "symptoms of dependency;" (2) need to cope with failure; and (3) need for catharsis. Two predictors were relevant to the diagnoses assigned by physicians: (1) proportion of unsupported/psychological diagnoses; and (2) proportion of supported diagnoses.

Inspection of the data indicates that three predictors exerted an effect on the proportion of requests for follow-up visits made by the physician. Patients who were asked to return to the center often were assigned a small proportion of unsupported/psychological diagnoses ($\beta = -.24$), presented few "symptoms of dependency" ($\beta = -.21$) and expressed a need to cope with failure

TABLE 6.11.--Step-Wise Regression of Requests for Follow-up Visits.

Order of Variables Entering*	Variable	β^{**}	Multiple R	R^2	F	P	df
1	Proportion of unsupported/ psychological diagnoses	-.24	.26	.07	9.20	.003	1,122
2	Symptoms of depencency	-.21	.33	.11	7.29	.001	2,121
3	Need to cope with failure	-.10	.34	.12	6.28	.002	3,120

*Variables contributing at least one percent to explained variance are reported.

**β = standardized regression coefficient or beta weight.

($\beta = -.10$). The three variables, however, accounted for only 12 percent of the variance in requests for follow-up visits.

Most of the variance was explained by the first variable entered into the equation. A small proportion of unsupported/psychological diagnoses was the most powerful explanatory variable ($R^2 = .07$). Few "symptoms of dependency" explained an additional four percent of the variance and the need to cope with failure added one more percent to explained variance. In short, a small proportion of unsupported/psychological diagnoses was the best predictor of a small proportion of requests for follow-up visits. But, few "symptoms of dependency" and a need to cope with failure contributed to the prediction.

Discussion: Tests of Hypotheses About the Physician-Patient Interaction

The patient's medical and non-medical need exerted an effect on the physician's definition of her illness. However, the results of the physical examination the physician performed were better predictors of the diagnoses he assigned to the patient. Furthermore, once the physician had arrived at a diagnosis, patient variables were able to explain only a small amount of variance in his decisions. The findings, nevertheless, provide partial support for the hypotheses which implicitly posit that definitions of illness and plans of treatment will vary across patients.

Ha. Physicians will assign more unsupported/psychological diagnoses to patients who present many "symptoms of dependency" and who have greater non-medical needs. The data provide partial support for this hypothesis. A small average number of physical findings was the most powerful predictor, explaining one-third of the variance in the proportion of unsupported/psychological diagnoses assigned to patients. The need for catharsis made no contribution to the explained variance as compared to many "symptoms of dependency" and a need to cope with failure which both contributed substantially to the prediction.

The explanatory power of a small average number of physical findings is not surprising given the way in which the diagnoses variable was operationalized (see Appendix E). For example, the fewer physical findings recorded, the less evidence there was to validate a diagnosis. Thus, patients with few physical findings were at higher risk to be classified as having unsupported diagnoses than patients with more physical findings. The two variables--average number of physical findings and proportion of unsupported/psychological diagnoses--were not completely independent. Their lack of independence, then, detracts from the strength of the prediction.

The differential explanatory power of "symptoms of dependency," the need to cope with failure, and the need for catharsis, is more difficult to explicate. Their varying efficacy is not a function of differences in the average number of physical findings observed in patients. For example, those with a need for catharsis tended to have few physical findings. By contrast, patients with many "symptoms of dependency" and a need to cope with failure tended to have neither less nor more physical findings than others.

The varying efficacy of these variables, however, may be a function of physicians' responses to the different ways in which patients present their complaints. For example, it was shown in Chapter V that patients with a need for catharsis tended to present few "symptoms of dependency." By contrast, those with a need to cope with failure were likely to present many "symptoms of dependency."[7] Furthermore, it was observed in Part One of this chapter that residents were more likely to extend sympathy to patients who wanted to talk about personal problems than they were to patients whom they believed were using illness to justify some sort of failure in their lives. Similarly, it was observed that approximately one-third of the physicians were unfavorably oriented toward the patient who persistently presented vague symptoms. As a result of these varying attitudes, the physicians may have defined the patients' problems differently.

For example, the small proportion of unsupported/psychological diagnoses assigned to patients with a need for catharsis may have been a function of the physicians' more accepting attitude toward these patients. Assuming that the presentation of a minor problem was the patients' way of seeking reassurance or support, residents may have assigned benign and earily validated diagnoses to their problems, thereby supporting the patients' need to ventilate their concerns. By contrast, the high proportion of unsupported/psychological diagnoses assigned to patients who presented many "symptoms of dependency" and/or had a need to cope with failure may have been a function of the physicians' less accepting attitude toward such patients. That is, some residents, assuming that patients' multiple vague symptoms were not reflective of bona-fide illness, may have assigned psychological labels, thereby implying that the patients were not really somatically ill. Other residents, unwilling to accept responsibility for socioemotional problems, may have assigned organic but less supportable diagnoses, thereby "making" the patients conform to the medical model. Finally, perhaps a few physicians, sympathetic to the patients' need to be sick, may have assigned organic, but less supportable diagnoses, thereby sanctioning the patients' adoption of the sick role.

Thus, the difference found between the proportion of unsupported/psychological diagnoses assigned to certain patients may have been a function of physicians' varying responses to the way in which the patients presented their problems. These variations, then, may be responsible for the different contributions "symptoms of dependency," the need to cope with failure and the need for catharsis made to the variance explained in proportion of unsupported/psychological diagnoses assigned.

In summary, physicians were likely to assign more unsupported/psychological diagnoses to patients who presented many "symptoms of dependency" and who expressed a need to cope with failure. They were not as likely, however, to assign such diagnoses to patients with a need for catharsis. Furthermore, physicians were more likely to assign supported diagnoses to patients who presented few "symptoms of dependency" and expressed no need to legitimate failure.

Hb. Physicians will prescribe more therapies for patients who present many "symptoms of dependency" and who have greater non-medical needs. The findings provide qualified support for this hypothesis. Diagnoses were the best predictors, accounting for almost all of the variance explained in the proportion of different therapies prescribed. For example, the need to cope with failure added only one percent to the variance explained in proportion of psychotropic therapies. Similarly, many "symptoms of dependency" added only two percent to the variance explained in proportion of symptomatic therapies. None of the patient variables, however, contributed to explained variance in proportion of curative therapies.

It appears, then, that the contribution of patient characteristics, when used in conjunction with diagnoses, is minimal. This finding most probably derives from the close association between "symptoms of dependency," the need to cope with failure and the proportion of unsupported/psychological and supported diagnoses assigned. It was found that patients who presented many "symptoms of dependency" and who expressed a need to cope with failure were likely to be assigned a high proportion of unsupported/psychological and a low proportion of supported diagnoses. Thus, the two patient variables probably were unable to contribute appreciably to the variance already explained by variables with which they were closely associated.

The emergence of diagnoses as explanatory variables is not surprising; the institution of appropriate therapy logically occurs after a diagnostic decision is made. The data suggest, however, that once having assigned a diagnosis, the physician rules out one type of therapy before prescribing the other type of therapy. For example, having assigned the patient an unsupported/psychological diagnosis, the physician rules out the use of curative therapies, and prescribes a symptomatic drug. On the one hand, he may feel that he must respond to the patient's problems, if not medicinally, at least symbolically. Thus, the physician satisfies her with a dosage of a palliative drug. On the other hand, he may feel he wants to terminate the interaction. Thus, the physician gives the patient a palliative prescription as a disengaging and dismissing tactic.

In summary, residents prescribed therapies for almost all their patients. Those who were assigned supported diagnoses, i.e., patients with few "symptoms of dependency" and non-medical needs, were likely to receive curative therapies. By contrast, patients who were assigned unsupported/psychological therapies, i.e., patients with many "symptoms of dependency" and/or a need to cope with failure, were likely to receive psychotropic or symptomatic therapies. Physicians, then, did not prescribe more therapies for patients who presented many "symptoms of dependency" and who had greater non-medical needs. They did, however, prescribe more therapies of a specific type to these patients.

Hc. Physicians will make fewer requests for follow-up visits of patients who present many "symptoms of dependency" and who have greater non-medical needs. The findings provide support for this hypothesis. A high proportion of unsupported/psychological diagnoses was the best predictor, accounting for almost three-fifths of the variance explained in non-requests for follow-up visits. But, many "symptoms of dependency" and a need to cope with failure contributed appreciably to the prediction.

The ability of many "symptoms of dependency" and the need to cope with failure, in conjunction with proportion of unsupported/psychological diagnoses, to contribute to explained variance is not completely unexpected. It was suggested earlier that physicians' attitudes toward types of patients may influence their definitions of the patients' illness. More specifically, it was suggested that the high proportion of unsupported/psychological diagnoses assigned to patients with many "symptoms of dependency" and with a need to cope with failure was a product of physicians' unfavorable attitudes toward them. Thus, physicians probably were likely to give such patients a prescription to terminate their interaction and not to request them to return for follow-up visits. Since they are patients with whom most physicians do not like to deal, the residents apparently attempt to establish an "advoidance" relationship with them.

Summary: Tests of Hypotheses About the Physician-Patient Interaction

The findings indicate that physicians' observations were the best predictors of the diagnoses assigned to patients. These diagnoses, in turn, contributed most to explained variance in physicians' management plans. Patient characteristics, however, did exert an effect on physicians' definitions of illness and determination of treatment. Furthermore, this effect was differential. For example, the need for catharsis did not explain the variance in diagnoses, therapies prescribed or disposition. By contrast, the need to cope with failure and many "symptoms of dependency" explained the variance across all dependent variables. It was argued that the differential effects of patient attributes on physicians' decisions were a function of residents' attitudes toward different types of patients. Residents were more likely to respond symptathetically to the patient with a need for catharsis than to patients who presented many "symptoms of dependency" and had a need to legitimate failure. Thus, they assigned different diagnoses to and made different plans for the former group of patients.

Outcomes of the Physician-Patient Interaction: Tests of Hypotheses

As described in Chapter III, outcome refers to the number of face-to-face contacts between patients and physicians that occurred during the two six-month observation periods, i.e., the actual use of medical services. Three aspects of this use were considered in this study: (1) the number of visits that were physician-initiated; (2) the number of visits that were patient-initiated; and (3) the total number of visits made to the family health care center.

Two hypotheses which posited relationships between physicians' decisions, patient characteristics and the use of medical services were presented in Chapter II. One hypothesis postulated a relationship between physicians' definitions of illness and determination of treatment and volume of use by type of visit:

> H10. Physicians' decisions will result in different patterns of use of medical services.

The second hypothesis postulated a relationship between physicians' decisions, patient characteristics and total volume of use:

> H11. The conjunction of the needs of the patient and the response of the physician to these needs will result in high use of medical services.

Three regression analyses were computed to test these hypotheses. All of the independent variables hypothesized to relate to the dependent variables were entered into the appropriate equations.

The Physicians' Contribution to Patterns of Use of Medical Services

Two regression analyses were computed to examine the physicians' contribution to patterns of use of medical services. Number of patient-initiated visits was the dependent variable in the first analysis and number of physician-initiated visits was the dependent variable in the second analysis. Seven independent variables which reflected physicians' decisions were entered into the two multiple regression equations: (1) proportion of unsupported/psychological diagnoses; (2) proportion of supported diagnoses; (3) average number of diagnosic procedures planned; (4) proportion of psychotropic therapies; (5) proportion of symptomatic therapies; (6) proportion of curative therapies; and (7) proportion of requests for follow-up visits.

Patient-Initiated Visits. The data show that three of the variables exerted an effect on the volume of patient-initiated visits (see Table 6.12). Patients who had a high volume of self-initiated use were assigned a low proportion of supported diagnoses (β = -.14) and received prescriptions for a high proportion of psychotropic (β = .18) and symptomatic therapies (β = .11). The three variables, however, accounted for only eight percent of the variance in patient-initiated visits. Furthermore, most of the variance was explained by a low proportion of supported diagnoses (R^2 = .05).

Physician-Initiated Visits. The data indicate that three of the variables exerted considerable effect on the volume of physician-initiated visits (see Table 6.12). Patients who had a high volume of physician-initiated use were frequently requested to return to the center for follow-up visits (β = .43) and received a high proportion of prescriptions for symptomatic (β = .28) and curative therapies (β = .18). Together, the three variables accounted for 23 percent of the variance in physician-initiated visits.

Almost four-fifths of the explained variance was accounted for by the first variable entered into the regression equation. It was found that a high proportion of requests for follow-up visits was the most powerful explanatory variable (R^2 = .18). A high proportion of symptomatic therapies explained an additional two percent of the variance and a high proportion of curative therapies contributed three more percent to the variance explained. In short, requests for follow-up visits was the best predictor of physician-initiated visits. But, a high proportion of symptomatic and curative

TABLE 6.12.--Step-Wise Regressions of the Physician's Contribution to Patterns of Use of Medical Services.

Order of Variables Entering*	Variable	β**	Multiple R	R^2	F	p	df
Patient-Initiated Visits							
1	Proportion of supported diagnoses	-.14	.21	.05	5.74	.01	1,122
2	Proportion of psychotropic drugs	.18	.26	.07	4.36	.01	2,121
3	Proportion of symptomatic therapies	.11	.28	.08	3.38	.02	3,120
Physician-Initiated Visits							
1	Proportion of requests for follow-up visits	.43	.42	.18	22.88	.000	1,122
2	Proportion of symptomatic therapies	.28	.44	.20	14.84	.000	2,121
3	Proportion of curative therapies	.18	.48	.23	8.84	.000	3,120

[*] Variables contributing at least one percent to explained variance are reported.

[**] β = standardized regression coefficient or beta weight.

therapies, in conjunction with such requests, contributed to the prediction.

Discussion: The Physicians' Contribution to Patterns of Use of Medical Services. Physicians' definitions of illness and determination of treatment exerted an effect on patterns of use of services. The findings indicate that patients who were assigned a low proportion of supported diagnoses and received a high proportion of prescriptions for psychotropic and symptomatic therapies had a high volume of patient-initiated use. By contrast, patients who received a high proportion of requests for follow-up visits and a high proportion of prescriptions for symptomatic and curative therapies had a high volume of physician-initiated use.

The emergence of a low proportion of supported diagnoses as a predictor of patient-initiated visits is not unexpected. It was found that those who were assigned few supported diagnoses were unlikely to be requested to return to the center for follow-up visits. Thus, their use of medical services was more likely to be self-initiated. Furthermore, the data showed that patients who received a high proportion of prescriptions for psychotropic therapies also were unlikely to receive requests to return to the center. This means that their visits too were likely to be self-initiated.

The data also showed that those who received a high proportion of requests to return to the center had a high volume of physician-initiated use. Of course, the two variables are highly dependent. Furthermore, compliance with such requests was high.

Thus, it is not unexpected that a high proportion of requests to return for follow-up visits would predict physician-initiated visits. Moreover, patients who received more requests to return for follow-up visits also received more prescriptions for curative therapies. Thus, the visits of patients who received a high proportion of curative therapies also were likely to be physician-initiated.

The contribution of a high proportion of symptomatic therapies to the explained variance in both physician- and patient-initiated visits is difficult to explicate, however. For example, those who received prescriptions for a high proportion of symptomatic therapies tended to be less likely to receive requests to return to the center ($r = -.03$, n.s.). The low value of the correlation suggests, however, that patients who received a high proportion of prescriptions for symptomatic therapies were almost as likely to receive requests to return for follow-up visits as not to receive such requests. Consequently, a high proportion of symptomatic therapies probably was able to add a small percentage to the explained variance in both physician- and patient-initiated visits. Essentially, however, the finding remains unexplained.

In summary, the findings provide support for the hypothesis that physician's decisions influence patients' patterns of use. Furthermore, the findings suggest that the physicians contribution to the use of services may not be limited only to visits brought about at his initiation. That is, his contributions to use may include visits initiated by patients in response to his actions. For example, it was observed earlier that physicians' decisions were influenced by the way in which patients present their problems. In addition, it was found that patients with many "symptoms of dependency" and a need to cope with failure were (1) unlikely to be assigned supported diagnoses or to be requested to return to the center; and (2) likely to be given prescriptions for psychotropic and symptomatic therapies. The high volume of patient-initiated use among such patients, then, suggests that the response of the physician to their needs may increase overall utilization rates. This hypothesis is examined below.

The Physicians' and the Patients' Contributions to the Total Use of Services

The regression analysis computed to test H11 included ten independent variables. Three of these variables reflected the characteristics of the patient: (1) "symptoms of dependency;" (2) need to cope with failure; and (3) need for catharsis. Seven of these variables reflected physicians' decisions: (1) proportion of unsupported/psychological diagnoses; (2) proportion of supported diagnoses; (3) average number of diagnostic procedures planned; (4) proportion of psychotropic therapies; (5) proportion of symptomatic therapies; (6) proportion of curative therapies; and (7) proportion of requests for follow-up visits.

The results document that six of the variables exerted an effect on the total volume of use (see Table 6.13). Patients who sought care often presented many "symptoms of dependency" (β = .21) and had a need to cope with failure (β = .26) and a need for catharsis

TABLE 6.13.--Step-Wise Regression of the Physicians' and Patients' Contribution to the Total Use of Services.

Order of Variables Entering*	Variable	β**	Multiple R	R^2	F	P	df
1	Need to cope with failure	.26	.29	.09	11.53	.001	1,122
2	Symptoms of dependency	.21	.38	.15	10.33	.001	2,121
3	Proportion of psychotropic therapies	.17	.41	.17	8.04	.000	3,120
4	Proportion of symptomatic therapies	.17	.43	.19	6.94	.000	4,119
5	Need for catharsis	.15	.46	.21	6.27	.000	5,118
6	Proportion of requests for follow-up visits	.14	.48	.23	5.79	.000	6,119

*Variables contributing at least one percent to explained variance are reported.

**β = standardized regression coefficient or beta weight.

(β = .15). Furthermore, patients who sought care often received a high proportion of prescriptions for psychotropic (β = .17) and symptomatic therapies (β = .17) and a high proportion of requests to return to the center (β = .14). Together, the six variables accounted for 23 percent of the variance in the total use of medical services.

Most of the variance was explained by the first two variables entered into the equation. This means that a need to cope with failure explained nine percent and many "symptoms of dependency" an additional six percent of the variance. The last four variables entered into the equation each accounted for an additional two percent of the variance explained. In short, a need to cope with failure and many "symptoms of dependency" were the best predictors of the high use of medical services. But, a need for catharsis, a high proportion of prescriptions for psychotropic and symptomatic therapies, and many requests for follow-up visits contributed substantially to the prediction.

Discussion: The Physicians' and the Patients' Contribution to the Total Use of Medical Services. Patients' medical and non-medical needs as well as physicians' decisions exerted an effect on the total use of medical services. The findings suggest that patients with many "symptoms of dependency," a need to cope with failure and a need for catharsis frequently sought medical care at the family health care center. Furthermore, the findings also indicate that patients who received a high proportion of prescriptions for psychotropic and symptomatic therapies and patients who received a high proportion of requests to return for follow-up visits had a high volume of use.

The efficacy of these patient and physician variables to predict utilization was observed earlier. For example, in Chapter V it was shown that patients with greater non-medical needs were likely to frequently seek care for large numbers of diffuse symptoms that were difficult to deny. Furthermore, it was shown that there was a marked association between these patient characteristics and the life situations of the women. Those with a need to cope with failure and a need for catharsis as well as a tendency to present many "symptoms of dependency" were likely to consider themselves socially and financially deprived. In addition, such patients tended to feel that their psychological assets were limited and that their social assets were only nominally effective in mediating between them and the consequences of life difficulties. It was argued that these patients' high volume of use was an adjustment to their deliterious life situations. That is, they were patients seeking care from the physician in the hope that he would legitimate their feelings of failure and provide the support that was lacking in their personal environment.

It was observed in this chapter that the residents only partially satisfied the patients' expectations of the interaction. For example, it was shown that physicians were more likely to prescribe a high proportion of psychotropic therapies for patients with a need to cope with failure than for patients with a need for catharsis. Similarly, it was shown that physicians were likely to prescribe a high proportion of symptomatic therapies for and to request few follow-up visits of patients who presented many "symptoms of dependency." It was argued that these behaviors were "approach" and "avoidance" strategies that reflected physicians' attitudes toward a specific type of patient. Residents, in general, were sympathetic to patients with a need for catharsis and, thus, likely to allow them to talk and unburden themselves. By contrast, residents, in general, were unsympathetic to patients with a need to cope with failure and, thus, likely to dismiss them with prescriptions for psychotropic therapies. Similarly, residents, in general, did not like to deal with patients who presented many "symptoms of dependency" that were difficult to document or deny. Thus, they were likely to dismiss such patients with prescriptions for symptomatic therapies and few requests for follow-up visits.

Given these observations, the high use of medical services by patients with multiple diffuse symptoms and greater non-medical needs can be viewed as a consequence of their actions as well as the actions of their physician. That is, patients with a need for catharsis frequently sought medical care because (1) they were looking for reassurance and support from the physician; and (2) they were encouraged to revisit the physician because of his willingness to allow them to ventilate their concerns. By contrast, patients with a need to cope with failure frequently sought medical care because (1) they were looking for sanction of the sick role by the physician; and (2) they were impelled to revisit the physician because of his unwillingness to legitimate their illness. Similarly, patients with many "symptoms of dependency" frequently sought medical care because (1) they were looking for help with their ailments; and (2) they were moved to revisit the physician because of his unwillingness to acknowledge the veracity of their illness.

In short, the high use of medical services was a consequence of patients' desires to satisfy needs that developed within their personal environment. But, the high use of medical services also was a consequence of physicians' responses to these needs. On the one hand, frequent utilization occurred as the physicians' welcoming behavior encouraged patients to return to the center for the purpose of additional satisfaction of their non-medical needs. On the other hand, frequent utilization occurred as the physicians' rejecting behavior moved patients to return to the center in a continuing attempt to satisfy their frustrated needs. The findings, then, support the hypothesis that the nature of the interaction between physicians and patients influences the utilization of medical services.

Patients' Views of the Physician-Patient Interaction

Approximately four-fifths (78 percent) of the eighteen dependent patients interviewed in-depth were separated or divorced. All, however, were struggling with problems of low incomes and related difficulties. Furthermore, all had frequently sought care at the family health care center, in large part on their own initiative.

During the interviews, these women spontaneously shared the experiences they had had with the residents. Eight spoke about the residents' unsympathetic responses to their problems. Ten women spoke about the residents' sympathetic responses to their problem.

Unsympathetic responses appeared to have been elicited when residents were insensitive to or encountered difficulties in dealing with psychological distress that manifested itself in somatic illness. According to the women, in such cases physicians were likely to respond in one or more of the following ways. Some physicians denigrated the patients' problem:

> The last doctor I had played things down with his remarks. He belittled what I said. I was hurting. I hurt so bad I could have sat and cried. He said, 'There's a new study by a French doctor that says that a person gets four new pains a day. I get pains too!'

Other physicians dismissed the patient's complaints as products of a neurotic imagination:

> He said it was all in my mind. He told me it was due to 'nerves' and 'aggravation.' That made me mad to hear that. They should know when they're dealing with mature adults who is or isn't a hypochondriac.

Most physicians, however, prescribed psychotropic drugs for these patients, a circumstance which was resented by most of the women. Some were resentful because they were afraid of becoming addicted. Indeed, two of the women were convinced that they were addicted and vividly described withdrawal symptoms they had experienced when they had attempted to abstain from the drugs. Other women, however, were resentful because they felt that drugs did not solve their problems:

> He gave me tranquilizers. I don't think they're helping me. They just make me dopey [sleepy]. They say sleep is the only thing to do for nerves. But, when you wake up the problem is still there.
>
> The doctor should talk to you a little bit--not say here are some tranquilizers. That wasn't what I wanted when I went. He's just given me pills to feel happy.

The physicians' non-sympathetic responses, then, did little, if anything, to help the individual cope with or regain control of her life. Denigrating the problem or defining it as "hysterical" behavior tends to reinforce the idea in the patient's mind that the problem is organically based. Prescribing psychotropic therapies masks the problem. None of these responses allow the patient to articulate her concerns and explore alternative ways to solve her problems.

Sympathetic responses might help the patient to face the actual problem, but such responses apparently were quite rare. According to the women's descriptions, however, when they did occur sympathetic responses were likely to take one or more of the following forms: (1) ventilation; (2) education; (3) clarification; (4) advice; and (5) triage.[8]

"Ventilation" refers to a situation in which the physician allowed the patient to talk about her concerns, to "get it out," a procedure which the women themselves viewed as therapeutic. Sharing sad or painful feelings with an "objective" person such as the physician made them feel better. Furthermore, discussing personal concerns with a "non-judgmental" person such as the physician protects the woman from potentially conflictive situations that may occur when help is sought from kin. For example, one woman articulated well the value of the emotional catharsis provided by the physician when she said:

> I talk a lot about my problems with relatives. But it comes easier to talk in the doctor's office than with my mom. He can't tell me what to do--no one can--but he's easier to talk to than my mom. [Why is that?] He's not always around me. I'm close to my mom and she can bring it up later. Maybe months later she brings it up when I want to forget. He doesn't. We talk about it too but I know I won't get yelled at or told you should have done this or that.

"Education" refers to a situation on which the physician provided an explanation to the patient as to why she was ill or felt the way she did. He assumed that the problem was socioemotional and tried to help her understand its etiology. When complaints that had an underlying social or emotional component were responded to in this manner--rather than unsympathetically dismissed--the outcome was much more favorable as the following excerpt documents:

> I had a headache and Dr. B. asked, 'Why are you nervous? What do you think is causing it? Are you and your boyfriend having trouble?' When he asked me about trouble with my boyfriend I said, "I sure am having problems with that fool!" I was so tickled. He made my headache go away.

Much more than the disappearance of a headache was accomplished during the interaction, however. The patient gained insights into the etiology of her complaints and learned how to cope with them. She articulated these benefits when she said:

> I went for a terrific headache. I thought it was maybe sinus. [And when you left? She laughed.] I thought it was what he was suggesting. I liked that he asked me questions but it might rub someone else the wrong way. He had a right to ask. If you have a personal problem and he talked about it then you won't be back in his office with the same headache week after week.

"Clarification" refers to a situation in which the physician helped the patient to understand her problem and to make a decision. He did not tell her what to do but placed the problem in perspective. Two excerpts from interviews illustrate this process.

> He listens and doesn't tell you what to do. He just asks leading questions to make you think it out for yourself.
>
> He made me realize that I had no control over the situation--that I shouldn't let it get me down. He made me feel as if I was strong enough to cope with it.

"Advice" refers to a situation in which the physician provided guidance with what to do in personal or social matters. He suggested to the patient what was the "best" or "wisest" thing to do. The need for such advice by women faced with problems, and the value of the advice of a professional to them, is suggested in the following excerpt:

> Doctors know about that sort of thing [distress caused by difficult life circumstances]. It would be better to tell a doctor your problem and get good advice than to tell your relatives and have them tell you the wrong thing to do.

Finally, "triage" refers to a situation in which the physician acted as a resource and referred the patient to another professional who could provide the help she needed. In the case of one woman, this referral was to Community Hospital's Department of Social Services. During the interview the woman spoke of the way in which her doctor had helped her shape her goals after her divorce and then had helped her to obtain financial assistance so she could attend college.

In summary, regardless of which sympathetic response was reported, the women stated, or implied, that the physician had helped them. In some instances, his help had been primarily succorance; the resident had become involved in the patient's problem, had showed her that someone cared for her and had provided comfort during a difficult time. In some instances, his help had been more direct. The resident had served as a source to other professionals for a woman who did not know how to locate these people. And in some instances, the resident had provided aid for a woman who did not have the funds to purchase the services of another professional. Patients faced with personal problems with which they feel helpless to cope, "seek help where they can find it." For such women, then, the physician may satisfy a need that might otherwise continue unreconciled.

Summary: The Physicians and the Physician-Patient Interaction

As a group, the residents defined their role broadly. They believed that socioemotional problems were within their purview and that their effectiveness as physicians was principally a function of the mode of their response to patients rather than its content. As individuals, however, the residents held different views about the breadth of their authority. Some believed their functions were limited solely to biophysiological problems. Others believed their authority extended to socioemotional problems. These different beliefs were reflected in orientations toward the dependent patient and the residents' responses to them.

Patients with high perceived medical needs and a need to cope with failure were likely to be assigned unsupported/psychological diagnoses, to be given prescriptions for psychotropic therapies, and not to be requested to return to the center for follow-up visits. Patients with a need for catharsis, however, were no more likely to be responded to in this manner than patients without the need for catharsis. It was argued that these differing responses were a product of the residents' attitudes toward types of patients. That is, residents were more likely to be favorably oriented toward patients with a need for catharsis than toward patients who presented many "symptoms of dependency" and/or had a need to legitimate failure.

Responses of residents toward patients influenced patterns of utilization and the total volume of use of medical services. That is, patients who were assigned a low proportion of supported diagnoses and received prescriptions for a high proportion of psychotropic and symptomatic therapies had a high volume of self-initiated use. By contrast, patients who received many requests for follow-up visits and a high proportion of prescriptions for symptomatic and curative therapies had a high volume of doctor-initiated use. The total volume of use was highest, however, among patients who (1) expressed a need to cope with failure and/or a need for catharsis; (2) presented many "symptoms of dependency;" and (3) received a high proportion of prescriptions for psychotropic and symptomatic therapies.

On the basis of the findings, it was concluded that the high use of medical services was a consequence of the conjunction of the needs of the patients and the residents' responses to these needs. That is, when the physician responded sympathetically to the patient's needs, she was encouraged to return to the center for the purpose of additional reassurance and support. By contrast, when the physician responded unsympathetically to the patient's needs, she was moved to return to the center in a continuing attempt to satisfy her frustrated needs.

These conclusions received support from qualitative data collected in in-depth interviews. Dependent patients--women likely to have a poor sense of well-being about their circumstances and less viable psychological and social assets--were likely to have a high volume of patient-initiated use and a high volume of total use of services. Their experiences with their physicians, however, had been varied. According to some women, their physicians had responded sympathetically to their distress, offering them emotional catharsis as well as more direct assistance. According to other women, their physicians had responded unsympathetically to their distress, dismissing their problems as well as them. "Approach" and "avoidance" strategies of residents, then, both tended to induce the use of medical services among women attempting to deal with difficult life situations.

NOTES: CHAPTER VI

[1] No statistically significant differences were found in the responses of male and female physicians.

[2] I am indebted to Professor W. Crano for suggesting the method used to analyze these data and for computing the scales employed in the discussion. The method of pair-comparison described in Guilford (1954:154-176) was used in order to derive interval-scale measurements of the two sets of items relevant to the physician's and the patient's functions.

[3] Ten percent of the more advanced residents and 30 percent of the first year residents responded favorably to the stem, "when a patient persistently presents with vague or inconsistent symptoms. . . ." The percentages of favorable responses to the third stem--"to me, dealing with social and emotional problems of patients is . . ."--for more advanced residents and first year were 30 and 40 percent, respectively.

[4] Twenty-eight (5.4 percent) of the diagnoses recorded indicated that the purpose of the visit was health maintenance. Visits made solely for this purpose were excluded from all analyses.

[5] It is impossible to know whether these procedures were never ordered by the physician or the patient did not appear to have them performed.

The most commonly performed procedure was a PAP test (14.1 percent), followed by a complete blood count (10.6 percent) and a urine culture (8.2 percent). These low percentages suggest that the residents employ a vast array of procedures as they care for their patients.

[6] Counseling, although an appropriate therapy for dependent patients, was not included in the analyses. Only eight (6.4 percent) of the patients were counseled during the two six-month periods. Five of these patients were counseled once, and three, twice.

[7] It was observed in Chapter V that patients with a need for catharsis and patients with a need to cope with failure both expressed a wish to discuss their personal problems with the doctor if given a half-hour in which to do so. Apparently, then, patients with a need for catharsis had less difficulty in presenting their personal problems in an undisguised form than patients with a need to cope with failure.

[8] These categories were adapted from a classificatory system developed by Frank, et al. (1978) to study requests made by patients who sought care at an ambulatory acute psychiatric service in Boston.

CHAPTER VII

SUMMARY AND CONCLUSIONS: THE HIGH USE OF PRIMARY CARE SERVICES

This report has presented the results of a study about female patients who use high levels of medical services and their physicians' responses to them. It has attempted to place these individuals within the different contexts that condition their orientations to and behavior in the physician-patient interaction. The purpose of the study has been to examine some neglected areas of research on utilization behavior. It has attempted to raise issues rather than settle them, to be suggestive rather than definitive.

Based on a review of the sociological and medical literature (see Chapter I), a social system model of the use of medical services was developed (see Chapter II). In this model, the physician and patient were seen, not as an isolated dyad, but as actors whose expectations about the physician-patient interaction were guided by motivational-orientations that developed within their separate environments. For the patient, this orientation was seen to be influenced by her life situation. For the physician, this orientation was seen to be influenced by the context of medical work. It was argued that (1) variations in the background factors of the patient and the context of the medical profession influenced the nature of the interaction between physician and patient; and (2) variations in the use of primary care services was a product of the dynamics of their interaction in a medical situation.

To explore these variations, a retrospective research plan was developed (see Chapter III). A sample of young, "healthy" females, stratified according to patterns of use during a six-month period, was selected and the data contained in their medical records for that period were abstracted. These patients were interviewed in their homes, using a structured survey instrument, to collect data that could link attitudinal and situational factors to health behavior. In addition, a sub-set of these patients was interviewed in depth, using a standardized but unstructured format, to gather material that could illuminate the quantitative data. Finally, the family practice residents who cared for the patients completed a self-administered questionnaire to acquire information that could relate the attitudes and backgrounds of physicians to their behavior in a clinical setting. This chapter presents a summary of findings based on these three samples.

Summary of Findings

The findings of this study relate to the individual contexts in which patients and physicians are located and the way in which these influence behavior in and outcomes of the medical encounter. The summary of these findings follows the chapter organization of this report.

The Setting

This study was conducted in a large-midwestern city that is the home of one of the major American manufacturing corporations (see Chapter IV). The presence of this industry in the community makes its economy extremely sensitive to national and international economic cycles. Furthermore, the policies of this industry affect the medical behavior of the population. That is, widespread medical insurance means that, for most of the population, cost is not a constraint to the use of health services.

The study sample was selected from a population of patients which seeks care at the family health care center in the city's Community Hospital. This center is the ambulatory care training site for residents in the family practice training program at the hospital.

The stated goal of the program is the development of primary care physicians with a broad knowledge and ability to treat the whole patient. It was found, however, that this goal was compromised by the program's organizational structure. That is, pressures to maintain a full enrollment of residents resulted in a flexible set of norms specifying what residents were expected to do.

The data also showed that the residents exploited this flexibility. For example, although norms of competency in the management of the physical and socioemotional needs of patients existed, the residents knew that little, if anything, would be done if they engaged in behaviors contrary to these expectations. Their behavior, then, differed from the stated norms because the social structure did not induce conformity to them.

The Women as Individuals

The data showed that the women were not a homogeneous group and that distinctions of income, marital status, education and social role existed among them (see Chapter V, Part 1). The data also showed that these distinctions were related to differing life situations. For example, women who were poor, less educated, separated or divorced had less sense of well-being about their circumstances than their more advantaged counterparts. That is, they considered themselves financially and socially deprived and the general state of their lives troubled. Furthermore, they had experienced a series of stressful events that challenged their resources and skills.

The data showed, however, that the women, regardless of social position, maintained considerable contacts with kin and friends. For example, a majority had daily telephone and weekly personal contact with significant others. Furthermore, the data showed that the content of their relationships with relatives and intimates was far from shallow; that is, most women received psychological support from them. Furthermore, half received functional support from kin and two-fifths tangible assistance from friends.

The data suggested, nevertheless, that variations in the receipt of functional support tended to be associated with different social positions. For example, women who were less educated and less financially secure tended to receive slightly more tangible assistance from kin than their more advantaged counterparts. By contrast, women who were separated or divorced tended to receive less functional support from friends. It also was found that, despite the received support, differences existed in the extent to which the women felt it was helpful. That is, the disadvantaged tended to feel that the emotional and material support of significant others was not sufficient to help them master their emotional burdens or handle their situations.

The data also showed that the neighborhood was not a particularly effective field in which to meet with others, form friendships and establish relationships of mutual obligation. For example, a areal heterogeneity, population instability and social disorganization impeded the formation of intimate and cooperative relationships between neighbors and only half of the women had links with neighbors that implied services and support.

Finally, the data showed a strong association between variations in psychological assets and the life circumstances of the women. For example, women who expressed difficulty in resolving problems within their environments were likely to have a poor sense of well-being about their circumstances. Furthermore, women who expressed a need for help with problems were likely to have experienced more stressful events. These women, however, had the least command of social and economic resources to facilitate the handling of their situations. They were the poor, the less educated, the separated or divorced.

In short, the data showed that the disadvantaged were likely to feel that their psychological assets were limited and their social assets only nominally effective in mediating between them and the consequences of life difficulties. Thus, women who were struggling with problems of low incomes and related difficulties had the least store of resources with which to manage their deleterious circumstances.

The Women as Patients

The data showed that differences in women's life situations were predictive of variations in patients' medical and non-medical needs (see Chapter V, Part 2). For example, women who considered themselves financially and socially deprived and who did not receive functional support from friends presented for care with multiple vague symptoms located in diffuse body systems, i.e., many "symptoms of dependency." In addition, women who considered themselves financially and socially deprived and women who were less educated expressed a need to cope with failure. Similarly, women who felt unsuccessful in the performance of tasks of daily life, who voiced a need for help with problems, and who received functional support from kin also expressed a need to legitimate failure. By contrast, women who considered the general state of their lives troubled and their family life worse than that of their kin expressed a need for catharsis. In short, the women's sense of well-being about their life circumstances and the viability of their psychological and social assets exerted an effect on their perceived medical and non-medical needs. That is, women whose life situations were difficult expressed greater perceived medical and non-medical needs than those whose situations were less burdened.

The data also showed that differences in life situations were associated with orientations to the physician-patient interaction. For example, dependent patients were likely to define the physician's functions broadly, extending his authority to socio-emotional phenomena. By contrast, non-dependent patients were likely to define the physicians' functions narrowly, limiting his authority to somatic problems only. Few women, however, spontaneously presented their social or emotional problems to the physician. Rather, they waited for him to grant permission for them to divulge their concerns.

Finally, the data showed that patients with greater perceived medical and non-medical needs frequently sought care at the family health care center. For example, patients with many "symptoms of dependency," a need to cope with failure and/or a need for catharsis had a high volume of use of medical services. It was argued that such behavior was an adjustment to the patients' general life situations. That is, the high use of services reflected the patients' attempts to gratify needs not satisfied within their personal environments.

The Physicians

The data showed that the residents, as a group, defined themselves as practitioners with a primary obligation to solve patient problems (see Chapter VI, Part 1). For example, they considered the following elements of the physician's role most helpful in terms of effective practice: (1) health education; (2) establishment of rapport; (3) treatment of social and emotional problems; (4) diagnosis; (5) treatment of somatic problems; and (6) continuous care. Data from the in-depth interviews with the patients, however, suggested that the residents' actions were not always congruent with these ideal behaviors (see also Chapter V). According to the women, not all residents showed personal concern for the patient, offered her explanations, or dealt with her social and emotional problems. In other words, according to the women, varying expectations guided the residents as they cared for patients.

The data suggested that the career stage of the physicians might be related to these variations. That is, more advanced residents and physicians just starting a practice tended to be less favorably oriented toward the dependent patient. For example, they were likely to derive their greatest satisfaction in medicine from the technical aspects of the role and found patients who persistently presented vague and inconsistent symptoms both frustrating and irritating to deal with. It was argued that the relationship between career stage and orientation toward the dependent patient was a product of a decreasing "humanitarianism" that developed within a "high-interaction" specialty. That is, extended contact with patients, particularly those with multiple vague symptoms, appeared to intensify a physician's (1) frustration as the satisfaction of his scientific interest was blocked; and (2) disinterest in dealing with any socioemotional problems that might underlie patients' problems.

The data also showed that the training received in medical school was related to residents' perceived satisfaction of the patient's need for catharsis. For example, graduates of practice-oriented medical schools were likely to feel that they encouraged patients with a need to express personal concerns to talk about them. The data showed, however, that the residents, in general, were more likely to extend sympathy to patients who talked about problems only indirectly related to their health than to patients they believed used illness to justify some sort of failure in their lives.

In short, a majority of the residents described themselves as practitioners who had a primary obligation to solve patient problems, not technical problems. Moreover, they considered the success with which they solved these problems principally a function of the mode of their response to patients, not its content. Some residents, however, held views that were in conflict with these expectations.

The Physician-Patient Interaction

The data showed that physicians' decisions were affected by factors other than the physical signs of illness alone (see Chapter VI, Part 2). For example, although the results of physical examinations were predictive of diagnoses and diagnoses predictive of management plans, it was found that patient characteristics had an effect on the residents' definitions of illness and determination of treatment. Moreover, the data showed that this effect was differential. For example, the need for catharsis was not predictive of diagnoses or management plans. By contrast, "symptoms of dependency" and the need to cope with failure were. That is, patients who presented many "symptoms of dependency" and expressed a need to legitimate failure were assigned a high proportion of unsupported/ psychological diagnoses and received a high proportion of psychotropic and symptomatic therapies and a low proportion of requests to return for follow-up visits.

It was argued that the differential effects of patient attributes on physicians' decisions were a function of residents' attitudes toward different types of patients. For example, patients with a need for catharsis tended to have few physical findings. By contrast, patients with many "symptoms of dependency" and a need to cope with failure tended to have neither less nor more physical findings than others. Furthermore, residents felt that they were more likely to extend sympathy to patients with a need for catharsis than to patients who presented multiple vague symptoms and had a need to legitimate fialure. Thus, residents probably assigned different diagnoses to and decided upon dissimilar management plans for patients toward whom they were favorably or unfavorably oriented.

The data also showed that the residents' decisions had an effect on patterns of use of medical services. That is, patients who were assigned a low proprotion of supported diagnoses and received a high proportion of prescriptions for psychotropic and symptomatic therapies had a high volume of patient-initiated use.

By contrast, patients who received a high proportion of requests for follow-up visits and a high proportion of prescriptions for symptomatic and curative therapies had a high volume of physician-initiated use.

Finally, the data showed that patients' medical and non-medical needs, in conjunction with physicians' decisions, exerted an effect on the total use of services. For example, patients with many "symptoms of dependency," a need to cope with failure and/or a need for catharsis frequently sought care at the family health care center. Furthermore, patients who received a high proportion of prescriptions for psychotropic and symptomatic therapies also had a high volume of use. In short, the high use of medical services was a consequence of patients' desires to satisfy needs that derived from their peculiar life situations. But, the high use of medical services also was a consequence of the physician's responses to these needs. On the one hand, frequent utilization occurred as the residents' welcoming behavior encouraged the patients to return to the center for the purpose of additional satisfaction of their non-medical needs. On the other hand, frequent utilization occurred as physicians' rejecting behavior moved the patients to return to the center in a continuing attempt to satisfy their frustrated needs. Thus, the dynamics of the interaction between physicians and patients partially explains the high use of primary care services.

Summary of Test of Hypotheses

The preceding discussion highlighted the findings of the study, pointing out the relationships documented between the major variables employed in the study. These relationships were posited in four sets of hypotheses that were tested using multiple regression analysis. The results of these tests are discussed below in order to evaluate the statistical significance of the findings.

The first set of hypotheses tested postulated relationships between the characteristics of the women as individuals and their attributes as patients.

> H1. Individuals who occupy a low social position will have a need to cope with failure and present multiple diffuse symptoms.
>
> H2. Individuals exposed to more social stressors will have a need to cope with failure and present multiple diffuse symptoms.
>
> H3. Individuals who perceive the quality of their life as poor will have a need to cope with failure and present multiple diffuse symptoms.
>
> H4. Individuals who sense feelings of failure will have a need to cope with failure and present multiple diffuse symptoms.
>
> H5. Individuals with limited or non-supportive social networks will have a need for catharsis and present multiple diffuse symptoms.

Pearson product-moment correlations were used to select from all the individual variables those that were significant and might be expected to account for variations in patient attributes. As a result, the second hypothesis (H2) was rejected because the presence of a series of stressful events was not correlated at a statistically significant level with either the need to cope with failure or "symptoms of dependency." In addition, the fifth hypothesis (H5) was partially rejected because the supportive behavior of significant others was not correlated at a statistically significant level with the need for catharsis.

To test the other hypotheses, three analyses were computed. The first included all the significant predictors of "symptoms of dependency." The results showed that three variables exerted an effect on the criterion variable: (1) family life compared to kin; (2) difficulty living on income; and (3) functional support from friends. Together, however, these three variables accounted for only 13 percent of the variance explained in "symptoms of dependency."

The second analysis entailed all the significant predictors of the need to cope with failure. It was found that six variables exerted an effect on need: (1) family life compared to friends; (2) difficulty living on income; (3) education; (4) need for help with problems; (5) comparative performance of tasks of daily life; and (6) functional support from kin. Together, the six variables accounted for 24 percent of the variance in the need to cope with failure. The third analysis contained all the significant predictors of the need for catharsis. The results showed that two variables accounted for nine percent of the variance in need: (1) general state of life; and (2) family life compared to kin.

The results of the analyses, therefore, provided but weak support for the first hypothesis (H1). That is, only one measure of social position, education, was able to account for variation in the need to cope with failure and none of the measures contributed to explained variance in "symptoms of dependency." The results, however, provided support for the third hypothesis (H3) and partial support for the fourth (H4). Women who perceived the quality of their life as poor did express a need to cope with failure and presented many "symptoms of dependency." Furthermore, although women who voiced feelings of failure did not present many "symptoms of dependency," they did express a need to cope with their feelings of failure. The analysis, therefore, provided partial support for the general hypothesis that patient needs may be a product of (1) the individual's perception of the objective circumstances of her life; and (2) the functional support available to her from intimates.

A second set of hypotheses posited relationships between the professional background of physicians and their attitudes toward dependent patients.

> H7. Physicians who attended an academically-oriented medical school will have a less favorable attitude toward dependent patients.
>
> H8. Physicians in an early career stage will have a less favorable attitude toward dependent patients.

Inspection of the Pearson product-moment correlations showed few statistical relationships between the criterion variable and the independent variables. The correlations suggested, however, that the training received in medical school and the physician's career stage may have an effect on their attitude toward patients.

Nevertheless, the correlations did not provide support for hypotheses seven and eight (H7, H8).

A third set of hypotheses tested posited relationships between physician decisions and patient attributes.

H9. Physicians will order more diagnostic procedures in the presence of patients with multiple diffuse symptoms.

Ha. Physicians will assign more unsupported/ psychological diagnoses to patients who present many "symptoms of dependency" and who have greater non-medical needs.

Hb. Physicians will prescribe more therapies for patients who present many "symptoms of dependency" and who have greater non-medical needs.

Hc. Physicians will make fewer requests for follow-up visits of patients who present many "symptoms of dependency" and who have greater non-medical needs.

All of the independent variables hypothesized to relate to physician decisions were entered into the regression equations. In addition, Pearson product-moment correlations were used to select those variables that were significant and might be expected to account for variations in physician decisions. As a result, the ninth hypothesis (H9) was rejected because patient attributes were not correlated at a statistically significant level with the average number of diagnostic procedures planned for patients.

To test the other hypotheses, a series of five analyses was computed. The first included all the predictors of unsupported/ psychological diagnoses. The results showed that three variables exerted an effect on the criterion variable: (1) average number of physical findings; (2) "symptoms of dependency;" and (3) need to cope with failure. Together, the three variables accounted for 40 percent of the variance in diagnoses. But, most of the variance (32 percent) was explained by a paucity of physical findings.

The second, third and fourth analyses entailed all the predictors of therapies prescribed, i.e., proportion of psychotropic therapies; proportion of symptomatic therapies; and proportion of curative therapies. It was found that a high proportion of unsupported/psychological diagnoses and the need to cope with failure together accounted for ten percent of variance explained in the proportion of psychotropic drugs prescribed. But, the need to cope with failure contributed only one percent to explanation. Similarly, of the six percent of variance explained in the proportion of symptomatic therapies prescribed, "symptoms of dependency" contributed only two percent to explanation and proportion of supported diagnoses contributed four percent. Furthermore, none of the patient variables exerted an effect on the proportion of curative therapies prescribed. That is, only the proportion of unsupported/psychological diagnoses assigned contributed to the 15 percent of variance explained.

The fifth analysis contained all the predictors of requests for follow-up visits. The results showed that three variables exerted an effect on the criterion variable: (1) proportion of unsupported/psychological diagnoses; (2) "symptoms of dependency;" and (3) need to cope with failure. Together, however, the three variables accounted for only 12 percent of the variance explained in requests for follow-up visits. Furthermore, less than half (5 percent) of this variance was explained by patient variables.

The results of the analyses, therefore, provided but weak support for hypotheses a, b, and c (Ha, Hb, Hc). That is, physicians' observations were the best predictors of the diagnoses assigned to patients. Furthermore, these diagnoses contributed most to explained variance in physicians' management plans. The results, however, suggested that patient characteristics do play some part in physicians' definitions of illness and determination of treatment.

The fourth set of hypotheses tested posited relationships between patient attributes, physicians' decisions and the use of medical services.

H6. Patients with greater non-medical needs will use more medical services in the presence of multiple diffuse symptoms.

H10. Physicians' decisions will result in different patterns of use of medical services.

H11. The conjunction of the needs of the patient and the response of the physician to these needs will result in high use of medical services.

To test these hypotheses, a series of four analyses was computed. The first included the three patient variables: (1) "symptoms of dependency;" (2) need to cope with failure; and (3) need for catharsis. The results showed that these variables accounted for 16 percent of the variance in the use of services. The second and third analyses entailed all the physician predictors of patient- and physician-initiated visits, respectively.

It was found that three variables exerted an effect on patient-initiated visits: (1) proportion of supported diagnoses; (2) proportion of psychotropic therapies; and (3) proportion of symptomatic therapies. Together, however, these three variables accounted for only eight percent of the variance in patient-initiated visits. It also was found that only three variables exerted an effect on physician-initiated visits: (1) proportion of requests for follow-up visits; (2) proportion of symptomatic therapies; and (3) proportion of curative therapies. These variables explained 23 percent of the variance in physician-initiated visits. But, most of the variance explained (18 percent) was accounted for by physician requests for follow-up visits.

The fourth analysis contained all the patient and physician predictors of the total use of services. The results showed that six variables exerted an effect on the criterion variable: (1) need to cope with failure; (2) "symptoms of dependency;" (3) proportion of psychotropic therapies; (4) proportion of symptomatic therapies; (5) need for catharsis; and (6) average number of requests for return visits. Together, the six variables accounted for 23 percent of the variance in the total use of medical services. But, the need to cope with failure and "symptoms of dependency" contributed almost two-thirds (15 percent) to this explanation.

The results of the analysis, therefore, provided support for the sixth, tenth and eleventh hypotheses (H6, H10, H11). For example, patients with greater perceived medical and non-medical needs had a high volume of total use of services. Furthermore, physicians' decisions affected patterns of use of services. In addition, patients and physicians together both made a contribution to the use of medical services.

In summary, the data provided support for most, but not all, of the hypotheses. In addition, the support provided was fairly weak. That is, the amount of variance explained in the criterion variables ranged from a low of six percent to a high of 40 percent. Nevertheless, although the amount of variance explained was not great, the findings represent an important attempt to test a set of axioms that pervade the literature. Furthermore, they provide empirical support for the view argued in this report that variations in the use of primary care services are, in part, a consequence not only of the behavior of patients but of physicians' actions as well.

The Problem of Generalizability

The extent to which the findings above might be generalized is open to question. The universe to which they can be applied is partly circumscribed by (1) the location of the research site in a residency training center; (2) the restriction of the sample to females 18 to 40 years of age; (3) the high proportion of lower- and lower-middle income respondents in the sample; and (4) the low proportion of blacks in the sample. Under these circumstances, one can only speculate to what extent the findings would apply to a population of physicians more advanced in their careers or physicians working in a different type of setting. Moreover, one should be careful in generalizing the findings to a more affluent population or one that included males and a wider range of ages and race. The findings, then, must be taken as suggestive of leads for further research and their generalizability left to future research.

Implications: Sociology

Some of the findings presented above seem more important than others from the point of view of their implications for further research in sociology. Some of these concerns are highlighted below in the form of questions which are judged especially worthy of exploration.

1. What is the process by which systems of social support "buffer" the individual from the consequences of difficult life circumstances or stressful events?

In this study it was found that the disadvantaged felt that the emotional and material support of kin and friends was only nominally effective in helping them cope with the burdens of their environment. The data suggested that the ineffectiveness of systems of social support might be a product of several factors. First, kin and friends may have been able to offer only a minimal amount of support because their circumstances were as limited or difficult as that of the person needing help. Second, kin and friends may have been able to offer support, but the need was for the kind of expertise that only can be found in a professional setting. Third, kin and friends may have offered support, but it created a conflictive situation that exacerbated, rather than mitigated, the individual's distress.

Further research is needed on these findings because they leave untouched important issues that need to be considered. For example, do perceptions of the quality of support differ among other disadvantaged women? Do perceptions of the quality of support vary between women living in different circumstances? In what way does the emotional support of kin and friends help a person to mobilize his or her psychological resources and master his or her emotional burdens? In what way does the tangible assistance of significant others improve an individual's ability to handle his or her situation or manage demanding aspects of his or her environment? Systematic research is needed to delineate the process by which systems of social support mediate the individual's response to long-term burdens or acute stress situations.

2. Is the high use of medical services dispositional or reactive?

The findings of this study were unable to assess the extent to which high utilization is a short-term pattern of behavior in response to transient life stresses or a long-standing pattern of behavior in response to life situations that are relatively immutable over time. The data showed that a full year after a six-month period of concentrated use, the disadvantaged were confronted by financial demands and life problems that taxed their resources and skills. The data did not show, however, whether a high use of services was associated with these difficult situations. Moreover, the data did not show whether these women's situations had been substantially similar during the period they frequently sought medical care at the family health care center.

Further research is needed to address a number of questions left unanswered by this study. For example, do patterns of utilization remain fairly constant over time? Do patterns of utilization vary at particular points in time correspondent with the extent of personal or social misfortune suffered? Do patterns of utilization vary at particular points in time correspondent with the individual's capacities to cope? The answers to these questions must be left to future research incorporating improvements in research design.

3. How adequate is Parson's formulation of the doctor-patient relationship and what are the limits of applicability of his theory?

In this study it was found that physicians and patients held a normative view of the doctor-patient relationship different from Parsons' description. For example, both residents and patients thought that the physician's responsibility should extend to care for socioemotional illness. Furthermore, both, in general, thought that personalized care, including expressions of human warmth and interest, facilitated the therapeutic relationship. In addition, residents and patients indicated that the doctor-patient relationship should be one of partnership. It also was found, however, that residents' actions were not always congruent with these views but rather adhered to the normative structure described by Parsons. That is, many residents tended to limit their attentions and activities to areas that were strictly medical. In addition, many adopted an impersonal attitude toward patients and avoided any emotional involvement with them or their plight. Moreover, most residents tended to treat patients as undifferentiated members of a universe of health.

The data also showed that adherence by the physician to Parsons' normative structure tended to create strains which impeded, rather than facilitated, the doctor-patient relationship. For example, the adoption of a narrow definition of a medical problem led patients to believe that the physician was not trying to understand their problems. Furthermore, emotional detachment was interpreted by patients as disinterest. Similarly, a universalistic attitude caused patients to believe that they were regarded, not as special individuals, but rather just as "bodies." More importantly, however, such behavior on the part of physicians was dysfunctional in terms of the outcome of the doctor-patient interaction. That is, the findings showed that the use of medical services was highest among patients who expressed a need to cope with failure and presented many "symptoms of dependency," i.e., patients to whom the physician's response was likely to correspond to Parsons' normative structure.

Systematic research is needed, therefore, to unravel the contradictions in the findings. For example, what norms are applicable to the performance of medical tasks? Is their applicability specific to certain situations or categories of patients? Under what conditions does the behavior of physicians correspond to their beliefs? Is such correspondence situation or physician specific? Under what conditions is Parsons' normative structure functional in terms of medical outcomes? Research is needed to answer the questions raised by the discrepant findings of the study as well as to examine the applicability of a theory that has dominated much of the research in medical sociology.

4. Do decisions of individual physicians influence the volume of use of medical services?

The findings of this study suggested that physicians' attitudes toward patients and approaches to medicine determine, in part, their definition of illness and determination of treatment. Furthermore, the data showed that physicians' decisions about patients contributed to variations in the use of medical services. The findings, however, refer to the plans adopted by a group of residents to manage the problems of categories of patients; the small number of physicians in the sample, in combination with the relatively small number of patients and relatively short observation period, made it impossible to analyze the responses of individual physicians to patients in a statistically meaningful way. Given these limitations, it is not known to what extent differences in physicians' behavior generate variations in utilization behavior. Further research might find that the efforts of some physicians with patients encountering difficulty are related to a lower volume of use. Systematic research is needed to specify the approaches adopted by physicians toward patients and to find the extent to which different approaches are associated with variations in the use of medical services.

In summary, this study has examined some neglected areas in past research on utilization behavior. It has identified some of the components of high utilization of health services and shown that the behavior of health care providers has an effect on the use of services. Much work remains to be done, however, before the generality of the findings can be established. Furthermore, much work remains to be done before the issues raised by this study can be settled. The findings, then, constitute promising leads for future research in sociology.

Implications: Medical Care

In addition to the questions discussed above, the findings of this study have implications for medical care. Many of these implications are not new to providers of health care, but it may be useful to make them more explicit.

Most physicians are aware that the family background of the patient has much to do with his or her health. The family is the unit of "living" and the extent to which it is socially or financially deprived will affect the individual's health as well as his or her perception of it. Most physicians also are aware that somatic illness often has an underlying socioemotional component. The presentation of symptoms may be the patient's way of seeking reassurance and support when it is difficult for him or her to present the underlying problem in an undisguised form.

Many physicians, however, find it difficult to maintain awareness of these influences when patients make extensive and intensive demands on their time and role and frustrate their efforts. This loss of awareness may result in the castigation of the patient for his or her illogicality. The utilization behavior of clients such as dependent patients, however, is not illogical. It is an adjustment to a general life situation marked by social and financial hardship. Seeking aid from the physician is an attempt to make a challenging situation more manageable by a person who may have neither the skills to locate nor the funds to purchase the sources of other professionals.

Furthermore, although these patients' problems may be induced by the mind rather than a pathogen, they are ailments that cause real pain. Denying the patient's problem tends to reinforce in his or her mind that it is organically-based. Dismissing the problem tends to evoke behavior that is substantially similar to the original pattern. Neither response allows the patient to articulate his or her concerns and explore alternative ways to solve his or her problems.

Finally, to return to a point made in the first chapter: to the extent that physicians accept their own actions as a given, they may overlook the impact their decisions have on the therapeutic relationship and the outcomes of care. The health care provider is not only a member of a physician-patient dyad, but also an actor in a social system located within a sociocultural environment. This study has examined this system and raised questions that have implications for both sociology and medicine.

APPENDICES

APPENDIX A

A COMPARISON OF THE INTERVIEWED AND NON-INTERVIEWED SAMPLES

APPENDIX A

A COMPARISON OF THE INTERVIEWED AND NON-INTERVIEWED SAMPLES

In order to assess the representativeness of the interviewed sample, it was compared to the non-interviewed sample using socio-demographic data accumulated as part of a local health department project.[1] The comparison is based on the type of census tract in which individuals in the two samples lived: that is, a characteristic of the tract was used to represent a characteristic of the individual. Of course, not all people living in a tract will share the same characteristics as its other residents. Nevertheless, given the absence of other data, a comparison based on area of residence is a legitimate, albeit fallible, surrogate.

The following method was used to carry out the comparison. First, the addresses of the patients on record at the center were geocoded inorder to identify the tract in which individuals lived.[2] Second, the distributions on a selected characteristic for the area were examined and a norm established. Third, each tract within the area was categorized on the basis of the percentage of people reported to be above or below the established norm. Fourth, the number of people in each sample living in a tract was added to determine the percentage falling into a category.

Table A.1 presents the distributions on selected sociodemographic characteristics that were used to establish the norms. For example, it can be seen that in the city the percentage of households not on welfare was 82.9 percent. This figure, then, was accepted as the characteristic's norm and if 82.9 percent or more of the people living in a tract were reported to not be on welfare, the tract was labeled equal to or above the norm on that characteristic.[3]

Table A.2 contains data on the interviewed and non-interviewed samples by the type of tract in which they were reported to live. The only statistically significant difference found between the two samples was the number of people living in racially-mixed tracts ($\chi^2 = 4.23$, $p < .05$, df = 2). Most lived in tracts that were predominantly white and half or more lived in tracts in which residents tended not to be on welfare and children under age eighteen lived with at least two adults. Moreover, with the exception of the interviewed sample who lived in the out-county, half resided in tracts in which a majority of persons age eighteen or over were employed. Finally, and paradoxically, the members of both samples were reported to live in tracts that were relatively stable in terms of the movement of people.

On the basis of these comparisons, then, the interviewed sample may be considered to be reasonably representative of the non-interviewed sample. This conclusion may be open to question. But, in the absence of more reliable data, it can be argued that it is justified.

TABLE A.1.--Percent of Population in County by Area and Selected Sociodemographic Characteristics, 1976.

Sociodemographic Characteristics	Area		
	City	Out-county	County Totals
Race:			
White	59.4	94.7	77.4
Black/other	40.6	5.5	22.6
Households on Welfare:			
Not on welfare	82.9	93.9	88.3
On welfare	17.2	6.1	11.7
Structure of Household with Children under Age 18:			
More than one adult	74.1	91.1	83.0
One adult only	25.9	8.9	17.0
Persons Age 18 or Above Employed:			
Employed	87.7	92.1	90.0
Unemployed	12.3	7.9	10.0
Length of Residence of Head of Household:			
Two years or more	69.1	72.3	70.7
Less than two years	30.9	27.7	29.3

TABLE A-2.--Percent of Interviewed and Non-Interviewed Samples by Area and Selected Socio-demographic Characteristics.

Type of Tract by Selected Characteristics	Sample by Area					
	Interviewed			Non-Interviewed		
	City	Out-county	County Totals	City	Out-county	County Totals
<u>Race</u>:						
Predominantly White	76.1	58.2	68.0	71.2	75.0	73.7
Predominantly Black	16.4	30.9	23.0	22.5	21.2	22.0
Racially Mixed	7.5	10.9	9.0	6.3	3.8	5.3
<u>Households on Welfare</u>:						
Equal to or above Norm	59.7	61.8	60.7	58.0	63.5	60.2
Below Norm	40.3	38.2	39.3	42.0	36.5	39.8
<u>Households with Children Under Age 18 Living with Two Adults</u>:						
Equal to or above Norm	77.6	50.9	65.6	71.3	53.8	64.4
Below Norm	22.4	49.1	34.4	28.7	46.2	35.6
<u>Persons Age 18 or Above Employed</u>:						
Equal to or above Norm	50.8	45.4	48.4	61.2	55.8	59.1
Below Norm	49.2	54.6	51.6	38.8	44.2	40.9
<u>Length of Residence by Head of Household</u>:						
Two years or more	68.7	56.4	63.1[a]	58.7	55.8	57.6
Less than two years	31.3	43.6	36.9	41.3	44.2	42.4

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[a] Sixty-four percent of the interviewed respondents reported that they had lived in their neighborhood two years or more. In the case of this variable, then, there is a good correlation between the proxy measure and the actual data.

NOTES: APPENDIX A

[1] The basic purpose of this project is the evaluation of the way in which environmental, social, and medical factors influence health. Trained interviewers are employed to collect sociodemographic and health-related data annually from adult respondents of randomly selected households in the city and out-county.

[2] These addresses, of course, were found to be inaccurate. However, an analysis of the movement of respondents--made on the basis of changes in addresses--indicated that moves tended to be horizontal, that is, within and between similar type tracts.

[3] The method used to categorize tracts on the basis of race was slightly different. Since 59.4 percent of the city was white, this figure was accepted as the norm and any tract in which 60 percent or more of the residents were reported to be white was categorized as predominantly white. Conversely, any tract in which 60 percent or more of the residents were reported to be black was categoriezed as predominantly black. Those tracts, then, in which the distribution of the races was between 40 percent to 50 percent were categorized as racially mixed.

APPENDIX B

PROBLEMS IN THE FIELD

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PROBLEMS IN THE FIELD

Locating a sample for whom correct telephone numbers and addresses were not always available was extremely time consuming and frustrating. The study had been introduced to the women in a letter which described it, asked for their participation, and informed them that a research interviewer would be calling to make an appointment to visit their homes and talk with them. (Appendix C contains copies of the materials used in the study.) Forty-two (7.7 percent) of these letters were undeliverable, either because the women did not live at the address on record or had moved from it without filing a forwarding address.[1] A second letter subsequently was sent to women in the sample. That letter indicated that the telephone numbers on record at the center were not current and asked the women to enter their numbers on an enclosed postcard and return it to the center. Only 17 percent of these cards were returned. (The return rates for frequent and average users were 52 percent and 48 percent, respectively.)

Locating women via the telephone numbers on record at the center was equally frustrating, as already indicated. On the average an interviewer had to make 3.5 telephone calls before she was able to set up an appointment with a respondent. Although this average may sound low, when a telephone number was correct an interviewer usually was able to set up an appointment within one or two calls. When the number was incorrect, six or more calls sometimes were necessary before the interviewer's efforts met with success.

Some of these calls were made before a correct number could be located. Some, however, were made because respondents had others screen their calls for them; there appeared to be an association between the inaccuracy of information at the center and an individual's efforts to remain incognito. Almost 20 percent of the non-interviewed subsample, for example, had unlisted phone numbers. The following excerpts from interviewers' call sheets illustrate these points.

Call	Date	Time	Result
1	1/27/78	10:10 a.m.	No answer
2	1/27/78	3:11 p.m.	Line busy
3	1/27/78	4:15 p.m.	Mother answered. R hasn't lived there in over a year. Gave R.'s #.
4	1/27/78	4:30 p.m.	No answer
5	1/27/78	7:05 p.m.	Friend answered. R not in. Will give her a message.
6	1/28/78	9:30 a.m.	Friend answered. Hostile. "I already gave her message once ..." I was sympathetic about what a nuisance this was, etc. and finally she asked what this was about. Said "Oh, if it isn't about a bill she'll probably call. I'll tell her."
7	1/30/78	11:15 a.m.	R calls. Set up appt. for 2/6/78 at 10:30.
8	2/ 6/78	10:00 a.m.	Call to confirm. "Had a late night." Could I come later? Reset appt. 2:30 p.m.

Call	Date	Time	Result
1	2/ 7/78	9:05 a.m.	Busy
2	2/ 7/78	10:20 a.m.	Busy
3	2/ 7/78	11:05 a.m.	No answer
4	2/23/78	11:22 a.m.	Man answered Referred to new #.
5	2/23/78	11:25 a.m.	Set up appt. 2/27. R. divorced. New phone/address.
6	2/27/78	12:30 p.m.	No answer. Call to confirm appt.
7	2/27/78	1:00 p.m.	No answer. Call to confirm appt.
		1:15 p.m.	Stopped by - no one at home
8	2/27/78	4:08 p.m.	Da. answered. Mrs. W. had to visit school in afternoon. Suggest I call another time.
9	2/28/78	1:25 p.m.	No answer
10	3/ 1/78	12:00 p.m.	Set interview 1:30.

These examples were selected for several reasons. First, both document the time consumed in locating a correct telephone number. Second, the earlier example provides support for the supposition that fear is responsible, in part, for the individual's desire to remain "lost" to all but a select few. Third, both examples illustrate a final problem encountered in working with the women in the sample: their unreliability.

Of the 127 women interviewed, 27 (21 percent) failed to keep their first appointment, most because they had forgotten it. Only on two occasions did a respondent call an interviewer to say that she would be unable to meet with her. The rest of the time the interviewer's trip was for naught. They soon learned, as illustrated above, to call to reconfirm appointments before setting out. But, this technique often gave the respondent the opportunity to renege on her commitment.

Are there any strategies, then, that future researchers can adopt to mitigate some of the problems encountered? Requesting potential respondents to supply correct information did not prove to be a fruitful stratagem. Seeking help from the telephone company also was relatively unsuccessful; 78 percent of the time operators were unable to supply a new telephone number. Searching the city directory for accurate addresses was almost completely ineffective; only two respondents were located via this source.[2] Checking an address when in the area was equally unprofitable; only three respondents were located by this technique. And, contacting individuals with the same name by telephone was completely disappointing; no individuals in the sample were located using this device.

In combination, however, these strategies were effective enough to allow the planned sample size to be realized. Future researchers, then, should anticipate the additional time and expense that may be required if they plan to work with a similar sample. In addition, they should take the utmost care when they hire interviewers; the success of this study is based on the dedication and perseverance of the interviewers.

NOTES: APPENDIX B

[1] Letters to thank respondents for participating in the study were mailed two months after the survey phase of the study began. Two were undeliverable.

[2] The city directory lists street names and addresses with occupant and telephone numbers. Data contained in it are collected by actual door-to-door canvass. Unfortunately, by the time the directory is published, the information sought frequently is outdated.

APPENDIX C

RESEARCH MATERIALS

PATIENT INTERVIEW
FALL, 1977

RESPONDENT INFORMATION: R's ID NO. ____________

R's NAME ____

ADDRESS ____

CITY __________________________ PHONE NO. ________

SCHEDULED APPOINTMENT WITH R

	DATE	DAY	TIME
(1)	____	____	____
(2)	____	____	____
(3)	____	____	____

INTERVIEWER CALL RECORD

CALL	DATE	DAY	TIME	RESULT
(1)				
(2)				
(3)				

RESEARCH INTERVIEWER

TIME STARTED ________ a.m. p.m.

TIME ENDED ________ a.m. p.m.

TOTAL TIME __________

COMPLETED INTERVIEW ________

EDITED INTERVIEW ________

REASON FOR NON-COMPLETION

1. No contact made at residence
2. Refused interview
3. Other (specify) ______________

____

INTRODUCTION

(INTRODUCE YOURSELF AS A RESEARCH INTERVIEWER WORKING FOR DR. S OF THE FAMILY HEALTH CENTER.)

As we explained earlier, we're trying to learn about the families and situations of people who visit the Health Center so that we can provide better care for our patients.

I'm going to ask you some questions about your experiences at the Health Center and your activities with others. I'll keep notes of your answers that will be part of the research findings for this study. But, as we said in the letter we sent you, the things we talk about will be kept strictly confidential and your name will never be used.

(EXPLAIN, IF NECESSARY: This means I won't discuss anything you tell me with other people, and we won't give out your name.)

The important thing is that your help with answering questions will make it possible for better help to be given to our patients, yourself included. Before we begin, I want to be sure you sign this consent form. It says that the study has been described to you and that you agree to participate in it.

(HAND R CONSENT FORM AND PEN. Give R a chance to look over the form. If she asks further questions, <u>repeat</u> phrases from this script or from the interviewer's booklet.)

You see, medical and health workers are learning that the best people to ask about health and medical care are the patients themselves, people like you.

Shall we begin?

<u>INTERVIEWER INSTRUCTION</u>:

Take back signed consent form from R and place with your personal belongings.

A R may wish to delay the interview until she gives our request consideration, discusses it with others or checks on the legitimacy of the study. In such a case, provide all the information you have, and ARRANGE AN APPOINTMENT for a time in the very near future. Record the reason for delay on the "Interviewer Call Record" along with the new appointment date.

If a R wants to satisfy curiosity about "what kinds of things" she will be asked about before giving her consent, you may ask her the first page of questions only. Do not proceed any further, without her signing consent form, however.

Patient Questionnaire
Fall, 1977

BEGIN CARD 07

INTERVIEWER INSTRUCTION:
R's I.D. Number (WRITE IN) ________________ ___ ___ (1-6) ___ ___

Card Number 0 7

1. First of all, let's talk about the last time you visited the Family Health Center? When was that? (WRITE IN)

   ____ (8)

2. What illness or condition was your visit for? (WRITE IN)

   ____ (9)(10)

3. Was that the first time you'd seen the doctor for that problem?

   1. Yes 2. No (11)

4. When you saw the doctor on that particular occasion, what did you want him/her to do? (DO NOT READ CATEGORIES. CIRCLE AS MANY AS MENTIONED)

   1. medication/prescription (12)
   2. exam/check-up (13)
   3. referral to specialist/hospital (14)
   4. advice/reassurance (15)
   5. text/x-ray (16)
   6. other (specify) ________________________ (17)(18)

5. Did he/she do that (any of those things)?

   1. Yes 2. No (19)

6. Do you think your visit with the doctor was long enough for you to tell him/her all he/she needed to know?

   1. Yes 2. No (20)

7. Now I'd like to know about what you do when you're not feeling well. In general, do you usually. . .

   1. see a doctor right away,
   2. wait a while to see if the problem will go away, or
   3. put off seeing a doctor as long as you possibly can? (21)

8. Next I'm going to read you a list of health conditions that people sometimes have. As I read them, please look at this card and tell me whether you think a person should see a doctor about it immediately, should take care of it herself unless it keeps up or gets worse, or if she should just leave it alone. (HAND R CARD A. READ CATEGORIES. CIRCLE THE APPROPRIATE ANSWER FOR EACH ITEM)

	See Doctor Immediately	Self Care Unless Gets Worse	Leave Alone	Don't Know	
a. Bad cough for several weeks	1	2	3	4	(22)
b. Diarrhea or constipation for a couple of days	1	2	3	4	(23)
c. Frequent headaches	1	2	3	4	(24)
d. Coughing up blood	1	2	3	4	(25)
e. Feeling tired all the time, no special reason	1	2	3	4	(26)
f. Feeling very depressed and blue	1	2	3	4	(27)
g. An unusual lump on the body	1	2	3	4	(28)
h. Shortness of breath	1	2	3	4	(29)
i. Sore throat, running nose, for a couple of days	1	2	3	4	(30)
j. Pain in the chest	1	2	3	4	(31)

9. Now I'd like to ask you a few things about the members of your household.

Let's start with their names - just the first name or nickname will do so we can keep them straight when I record information.

(LIST EACH PERSON MENTIONED IN COLUMN A BY NAME)

A. What is the name of the head of the household? What are the names of all the other people who live full-time in the house? (PROBE: Is there anyone else living there?)

FOR EACH PERSON LISTED, ASK:

B. How are you (is ____________) related to the head of the household? (RECORD RELATIONSHIP IN COLUMN B)

C. How old were you (was ____________) on your (his/her) last birthday? (RECORD THE PERSON'S AGE IN COLUMN C)

D. What do you usually (does he/she) do most of the time - keep house, work, go to school or what? (RECORD EACH ANSWER IN COLUMN D)

FOR EACH PERSON 17 OR OVER, ASK:

E. What was the last year (or grade) you (he/she) completed in school? (RECORD EACH ANSWER IN COLUMN E)

FOR ALL MEMBERS OF HOUSEHOLD, ASK:

F. How would you describe your (his/her) general health - excellent, good, fair or poor? (RECORD EACH ANSWER IN COLUMN F)

THE HOUSEHOLD

A NAME	B RELATIONSHIP TO HEAD	C AGE	D MAJOR ACTIVITY	E EDUCATION	F HEALTH (excellent, good, fair or poor)	B C D E F
1. Respondent						— — — — — (32-38)
2.						— — — — — (39-45)
3.						— — — — — (46-52)
4.						— — — — — (53-59)
5.						— — — — — (60-66)
6.						— — — — — (67-73)

10. Now let's change the topic for a moment, and talk about the people you know and get together with. First of all, how often have you talked on the phone with your relatives in the last month?

1. Never
2. Once
3. Two or three times
4. One or two times a week
5. Nearly every day

(74)

11. (Besides the times you've talked with them on the phone,) how often have you met and talked with your relatives in the last month?

1. Never
2. Once
3. Two or three times
4. One or two times a week
5. Nearly every day

(75)

12. Do the relatives you met and talked with live mostly within your neighborhood, that is, within walking distance of your home, or not?

1. Yes, most do
2. Some do and some don't
3. No

SKIP TO PAGE 5, Q. 14

(76)

13. Do you have any relatives who live within your neighborhood, that is, within walking distance of your home?

1. Many 2. Some 3. None

(77)

END OF
CARD 07

BEGIN CARD 08

KEYPUNCH: Duplicate columns 1-6

Card Number 0 8 (7)(8)

14. What about close friends - how often have you talked on the phone with any of these friends in the last month?

    1. Never
    2. Once
    3. Two or three times
    4. One or two times a week
    5. Nearly every day

(9)

15. (Besides the times you've talked with them on the phone,) how often have you met and talked with your friends in the last month?

    1. Never
    2. Once
    3. Two or three times
    4. One or two times a week
    5. Nearly every day

(10)

16. Do the close friends you met and talked with live mostly within your neighborhood or not?

    1. Yes, most do
    2. Some do and some don't
    3. No

SKIP TO PAGE 6, Q. 18

(11)

17. Do you have any close friends who live within your neighborhood?

    1. Many 2. Some 3. None

(12)

18. Do you know whether any of the friends or relatives we've talked about get together <u>when you're not with them</u>?

1. Yes 2. No → (SKIP TO Q. 20) (13)

↓

19. How often would you say they get together? (ASK FOR BOTH RELATIVES AND FRIENDS. CRICLE THE APPROPRIATE ANSWER IN <u>COLUMNS A AND B</u> BELOW)

	(A) Relatives	(B) Friends
Regularly	1	1
Occasionally	2	2
Hardly at all	3	3
Never	4	4
Don't know	5	5

A B

(14)(15)

20. Now I'm going to read you a list of things that people sometimes do for one another. As I read them, I'd like you to look at this card and tell me how often <u>any of your friends or relatives</u> did the following for you during <u>the last month</u>? (<u>HAND R CARD B</u>. CIRCLE THE APPROPRIATE ANSWER FOR <u>EACH ITEM</u>. PROBE: That includes relatives with whom you live.)

	NOT AT ALL	ONCE	TWICE	THREE TIMES	FOUR OR MORE TIMES	
For instance, during the <u>last month</u>, how often did any of your friends or relatives:						
(a) show warmth or friendliness toward you when you were troubled about something	1	2	3	4	5	(16)
(b) listen carefully to you when you needed to talk about something	1	2	3	4	5	(17)
How often during the <u>last month</u> did any of them:						
(c) encourage you or show approval for something you did	1	2	3	4	5	(18)
(d) show understanding when you felt upset or irritable	1	2	3	4	5	(19)

21. INTERVIEW INSTRUCTION: CIRCLE R's <u>PSYCHOLOGICAL SUPPORT</u> STATUS

1. R received psychological support.
2. R did <u>not</u> receive psychological support. → SKIP TO PAGE 9, Q. 27

___ (20)

22. Who were these people? I don't need to know their names, just if each of these people is your husband, a relative, a friend, or what? How about the <u>first person you think of</u>, who did any of these things for you?
(PROBE: Anyone else?)

(A) FOR EACH PERSON MENTIONED, RECORD HIS/HER RELATIONSHIP TO R IN <u>COLUMN A</u> BELOW, e.g., SPOUSE, RELATIVE (Specify kind of <u>relative</u>), FRIEND.

(A) RELATIONSHIP TO R	(B) LIVES IN R's NEIGHBORHOOD		
	YES	NO	A B
1.	1	2	___ ___ ___ (21-23)
2.	1	2	___ ___ ___ (24-26)
3.	1	2	___ ___ ___ (27-29)
4.	1	2	___ ___ ___ (30-32)
5.	1	2	___ ___ ___ (33-35)

(B) Do any of these people live in your neighborhood? (FOR EACH PERSON MENTIONED ABOVE, CIRCLE THE APPROPRIATE ANSWER IN <u>COLUMN B</u> ABOVE)

23. Do you feel that their support helped you in any way?

1. Yes 2. No ⟶ (SKIP TO Q. 25) ($\overline{36}$)

24. In what way did their support help you? (WRITE IN)

($\overline{37}$)($\overline{38}$)

25. Do you feel that <u>more</u> support would have been helpful?

1. Yes 2. No ⟶ (SKIP TO PAGE 9, Q. 27) ($\overline{39}$)

26. What kind of support would have been helpful? (WRITE IN)

($\overline{40}$)($\overline{41}$)

27. Now let's talk about some day-to-day concerns for which people can often use help from outside of the household. For each of the following things, could you tell me whether or not you get any help from people outside of your household? (READ EACH ITEM IN THE LIST BELOW)

	IF YES IN COLUMN A							IF NO IN COL. A		
	A R GETS HELP		B R PAYS FOR HELP		C WHO PROVIDES HELP	D IN NEIGHBORHOOD		E R NEEDS HELP		
	YES	NO	YES	NO		YES	NO	YES	NO	
(A) Do you get any outside help with:										A B C D E
IF R HAS CHILDREN: (a) Child care, baby sitting or looking after the kids?	1	2	1	2		1	2	1	2	— — — — — (42-46)
(b) Problems when there's an illness in the family?	1	2	1	2		1	2	1	2	— — — — — (47-51)
(c) Taking care of money matters?	1	2	1	2		1	2	1	2	— — — — — (52-56)
(d) Personal or family problems?	1	2	1	2		1	2	1	2	— — — — — (57-61)
(e) Anything else? (specify) __________ __________	1	2	1	2		1	2	1	2	— — — — — (62-66)

● FOR EACH YES ANSWER IN COLUMN A ABOVE, ASK:

(B) Do you usually pay for this help? (CIRCLE APPROPRIATE ANSWER IN COLUMN B ABOVE)

(C) Who usually provides you with this help? (RECORD THE TYPE OF RELATIONSHIP TO R, e.g., relative, friend, professional person, IN COLUMN C ABOVE)

(D) Does this person live in your neigborhood? (CIRCLE APPROPRIATE ANSWER IN COLUMN D ABOVE)

● FOR EACH NO ANSWER IN COLUMN A ABOVE, ASK:

(E) Could you use some help with this? (CIRCLE APPROPRIATE ANSWER IN COLUMN E ABOVE)

28. Just to round off this discussion, lots of people like to have someone they can discuss things with when something goes wrong or when they are simply fed up. Do you know enough people with whom you feel free to talk about your personal problems?

1. Yes 2. No (67)

29. Do you sometimes feel that people around you are so rushed and busy that they never have a chance just to sit down and talk or chat?

1. Yes 2. No (68)

30. Do you sometimes feel when you're talking with people that they're paying no attention to you?

1. Yes 2. No (69)

31. Now I'd like to change the topic and ask you some questions about doctors. Do you think a doctor is a suitable person to talk with about problems such as trouble getting along with other people or difficulties between husband and wife?

1. Yes 2. No 3. Uncertain (70)

32. If you were worried about a personal problem that wasn't a strictly medical one, do you think you might discuss it with your doctor?

1. Yes 2. No 3. Uncertain (71)

33. Have you ever talked about personal problems with your doctor?

1. Yes 2. No (72)

34. Why haven't you talked about them with your doctor?
(WRITE IN)

____

____

____ (73)(74)

SKIP TO PAGE 11, Q. 36

35. Did you feel good as a result of having talked over your problems with your doctor?

1. Yes 2. No (75)

END OF
CARD 08

BEGIN CARD 09

KEYPUNCH:
Duplicate
Columns 1-6

Card Number 0 9
(7) (8)

36. Now I'm going to read you a list of problems that often come up in life. As I read them, I'd like you to look at this card and tell me what you would suggest a relative or friend do to handle the matter. (HAND R CARD C. READ CATEGORIES. CIRCLE THE APPROPRIATE ANSWER FOR EACH ITEM)

	TALK WITH MINISTER	CONSULT FAMILY DOCTOR	CONSULT PROFESSIONAL	TALK WITH RELATIVES FRIENDS	SOMETHING ELSE	
a. For instance, suppose a husband and wife were having marriage problems. If they were relatives or friends of yours, what would you suggest they do to get help?	1	2	3	4	5	(9) (10)
b. Suppose your relatives or friends had trouble with their children, what would you suggest they do to get help?	1	2	3	4	5	(11)(12)
c. Now imagine a friend or member of your family was having trouble getting along with others, what would you suggest they do to get help?	1	2	3	4	5	(13)(14)

● FOR EACH SOMETHING ELSE ANSWER ABOVE, ASK: What would you suggest they do? (WRITE IN IN APPROPRIATE SPACE BELOW)

a.(5).

b.(5).

c.(5).

37. Now I'd like you to think about the way you feel your situation compares with that of others you know. As I read the next few questions, if you'd look at this card and tell me how well you feel you compare with others. (HAND R CARD D. READ QUESTIONS. CIRCLE THE APPROPRIATE ANSWER FOR EACH QUESTION)

	LOT BETTER	LITTLE BETTER	ABOUT THE SAME	LITTLE WORSE	LOT WORSE	
a. For instance, how well do you feel your family life compares with your relatives?	1	2	3	4	5	(15)
b. What about compared to your friends, how well do you feel your family life compares with theirs?	1	2	3	4	5	(16)
c. How would you compare your family's money situation with your relatives?	1	2	3	4	5	(17)
d. What about the families of your friends - how would you compare your money situation with theirs?	1	2	3	4	5	(18)
Taking all things together, how good would you say you are at:						
IF R IS A HOUSEWIFE:						
e. taking care of a home?	1	2	3	4	5	(19)
IF R IS A WORKER:						
f. doing the kind of work you do?	1	2	3	4	5	(20)
IF R IS A STUDENT:						
g. getting along at school?	1	2	3	4	5	(21)
ASK ALL R's:						
h. How well would you say you manage in doing all that has to be done in the day?	1	2	3	4	5	(22)

38. In general, would you say your life was. . .

 1. very smooth with little trouble
 2. smooth with occasional trouble
 3. frequently upset by troubles, or
 4. most of the time upset?

(23)

39. Now, I'm going to read a list of things that can happen to people at any time. As I read them, I'd like you to tell me if any of these things happened to you <u>during the last year</u>.

	Yes	No	
(a) A major sickness or injury to a member of your family?	1	2	(24)
(b) The death of a close friend?	1	2	(25)
(c) The death of a close family member?	1	2	(26)
(d) Did you or anyone else in your family get laid off or fired from work?	1	2	(27)
(e) Did you or anyone else in your family have any trouble with the law?	1	2	(28)
(f) Any sexual problems or difficulties in the last year?	1	2	(29)

IF R IS SINGLE:

(g) The end of a love affair?	1	2	(30)

IF R IS MARRIED:

(h) More arguments with your husband or marriage trouble?	1	2	(31)
(i) Trouble with your in-laws?	1	2	(32)

IF R HAS CHILDREN:

(j) More disagreements or trouble with your kids?	1	2	(33)

ASK ALL R's:

(k) Did anything else happen that I didn't mention? (<u>IF YES</u>, specify) ______________________________	1	2	(34)

40\. Now I'd like you to think about the people who live in this neighborhood, the area within walking distance of your front door. First, how long have you lived in this neighborhood?

1. less than 6 months
2. 6 to less than 12 months
3. 1 to less than 2 years
4. 2 to 4 years
5. 5 or more years

___ (35)

41\. Do you think people in this neighborhood have <u>many</u> things in <u>common</u>, <u>some</u> things in common, or only a <u>few</u> things in common?

1\. Many things   2. Some things   3. Few things   ___ (36)

42\. During the year, do people in this neighborhood get together <u>many</u> times, a <u>few</u> times, or <u>hardly ever</u>?

1\. Many times   2. A few times   3. Hardly ever   ___ (37)

43\. During the <u>past year</u>, have there been <u>many</u> people moving in and out of the neighborhood, a <u>few</u>, or <u>hardly any</u>?

1\. Many   2. A few   3. Hardly any   ___ (38)

44\. Next, let's talk about how easy or hard it is to get things done in this neighborhood. If you'd look at this card and tell me how easy or hard it would be to get the following things done? (HAND R <u>CARD E</u>. CIRCLE THE APPROPRIATE ANSWER FOR EACH QUESTION)

	ALWAYS VERY EASY	FAIRLY EASY	DEPENDS ON THE SITUATION	FAIRLY HARD	ALWAYS VERY HARD	
a. Having a neighbor watch the children for a few hours if you were called away suddenly?	1	2	3	4	5	___ (39)
b. Getting a ride from a neighbor if you couldn't use other transportation?	1	2	3	4	5	___ (40)
c. Getting information or help from a neighbor if you couldn't do something yourself?	1	2	3	4	5	___ (41)
d. Getting together with neighbors for something like a barbecue or party?	1	2	3	4	5	___ (42)

45. In general, how <u>satisfied</u> are you with this neighborhood? Would you say. . .

    1. very satisfied
    2. satisfied
    3. neither satisfied nor dissatisfied
    4. dissatisfied, or
    5. very dissatisfied?

(43)

46. Now let's talk about where you go when you're not feeling well. During the past year, did you <u>only</u> use the Family Health Center for your medical care or did you use <u>more than one place</u>?

    1. Only used FHC

    SKIP TO Q. 49

(44)

    2. Used more than one place

47. Where else did you go for medical care? (WRITE IN)

____

____

(45)(46)

48. Why did you go there for medical care? (WRITE IN)

____

____

(47)(48)

49. How long have you been going to the Family Health Center for your medical care?

    1. Less than a year
    2. One year to less than two years
    3. More than two years

(49)

50. Now I'm going to read you a list of things that people sometimes say about visits with their doctor. As I read them I'd like you to tell me how true they are for you - whether they're true or not true for you.

		TRUE	NOT TRUE	
a.	After I visit the Family Health Center, I generally feel good as a result of having talked over my problems freely with the doctor.	1	2	___ (50)
b.	I generally manage to talk with my Family Health Center doctor about problems that are difficult or awkward for me to discuss with others.	1	2	___ (51)
c.	When I tell my Family Health Center doctor about my illness, I find that he/she often tells me that I'm just complaining about nothing.	1	2	___ (52)

51. Now I'd like to ask you some questions about your background. First, do you have health insurance of any kind. . .or Medicaid or Medicare coverage?

1. Yes, private health insurance
2. Yes, Medicaid
3. Yes, Medicare
4. No health insurance

___ (53)

52. INTERVIEWER'S OBSERVATION:

52a. Race of R (CIRCLE ONE) 1. White 2. Black or other

___ (54)

53. Do you have any religious preference?

1. Yes 2. No ——→(SKIP TO PAGE 17, Q. 55)

___ (55)

54. Is it Protestant, Catholic, Jewish, or what?

1. Protestant (specify denomination) ____________________
2. Catholic
3. Jewish
4. Other (specify) ____________________

___ (56)

54a. IF R IS SINGLE OR REPORTS NO HUSBAND, ASK:

Have you ever been married?

1. Yes 2. No

55. Next I'd like to show you a table of levels of income and have you tell me which level is closest to your family's total income. (PROBE: This includes all wages, public assistance, and so forth for all the people who live with you.) (HAND R CARD F) These are only broad ranges of income. We don't need the specific amount of your income. Just think of your family's total income for the past 12 months before any taxes or other deductions.

YEAR	MONTH	WEEK
1. Less than $3,000	1. Less than $250	1. Less than $60
2. $3,000 to $4,999	2. $250 to $416	2. $60 to $99
3. $5,000 to $6,999	3. $417 to $583	3. $100 to $139
4. $7,000 to $9,999	4. $584 to $833	4. $140 to $199
5. $10,000 to $14,999	5. $834 to $1,249	5. $200 to $299
6. $15,000 or more	6. $1,250 or more	6. $300 or more

(57)

56. In general, how hard or difficult is it for you and your family to live on your present income? Would you say. . . (READ CATEGORIES)

1. very difficult
2. fairly difficult
3. somewhat difficult
4. not too difficult, or
5. not difficult at all?

(58)

57. Now a final question. If you had a half hour (30 minutes) during which you could talk to your doctor about anything you wanted, what would you talk about? (WRITE IN)

(59)(60)

58. Have you ever talked to your doctor about this kind of thing?

1. Yes   2. No   (61)

59. Why haven't you? (WRITE IN)

____

____

________________________________   (62)(63)

END OF INTERVIEW

60. What happened when you talked to your doctor? (WRITE IN)

____

____

________________________________   (64)(65)

That's all the questions I have. I'd like to thank you very much for your time and cooperation. We really appreciate your help with this research.

61. Name of Interviewer ________________________________   (66)

62. Date of Interview ____/____/____   (67-72)
month / day / year

INTERVIEWER'S OBSERVATIONS: COMPLETE AFTER YOU LEAVE THE HOUSEHOLD OF RESPONDENT

63. Respondent

1. lacked interest in interview
2. showed mild interest
3. showed high interest
4. interest varied during interview (specify)

____

____

_ (73)

64. Respondent was. . .

1. Hostile
2. Suspicious
3. Friendly
4. Extremely friendly
5. Attitude varied during interview (specify)

____

____

_ (74)

65. Privacy in interview situation

(A) PERSON	(B) TIME
1. No one else around	1. From time to time
2. Minor children around	2. Often
3. Older children or adults within earshot	3. Continually

_ (75)

66. Were there any questions especially hard for the Respondent to understand?

1. Yes   2. No ⟶ (SKIP TO PAGE 20, Q. 68)

_ (76)

67. Write in the number of these questions.

____

____

_ _ _ _ (77-80)

END OF CARD 09

68. Respondent's comments on interview (if volunteered):

69. Interviewer's Comments:

MEDICAL RECORD ABSTRACT
FALL-WINTER, 1977

BEGIN CARD 05
↓

1. Patient I.D. Number ____________ ______
(1-6)

2. Date of Visit ____________ ______
(7-12)

Card Number 0 5
(13)(14)

3. Type of Visit ___
(15)

   1. Patient-initiated
   2. Doctor-initiated

4. Name of Doctor Who Cared for Patient at This Visit (specify) ___ ___
(16)(17)

____

Name of Auditor: ____________________

Date of Audit: ____ / ____ / ____
mo. / day / yr.

Completed Audit: ____________

Edited Audit: ____________

Audit Coded: ____________

5. Diagnosis(ses) or active problems for which patient sought care on this visit (M.D.'s diagnosis)

A DIAGNOSIS	B DIAGNOSIS IS QUESTIONABLE	
	YES	NO
1.	1	2
2.	1	2
3.	1	2

A B

— — — — — (18-22)

— — — — — (23-27)

— — — — — (28-32)

A. List each diagnosis recorded in <u>Column A</u> Above.

B. Is diagnosis considered questionable or only a possibility? Circle appropriate answer in <u>Column B</u> above.

6. Is problem(s) considered to be psychophysiological? (Doctor's opinion) (33)

1. Yes 2. No

7. Is illness related to a medical intervention (e.g., bleeding due to birth control pills or IUD; adverse reaction to medication; etc.)? (34)

1. Yes 2. No

↓ ↓

SKIP TO PAGE 2, Q. 9

8. <u>CODER INSTRUCTION</u>:

For each consecutive diagnosis listed in 5(A) above, enter the appropriate <u>H-ICDA Anatomical Systems codes</u>.

1. Diagnosis No. 1 (35)(36)
2. Diagnosis No. 2 (37)(38)
3. Diagnosis No. 3 (39)(40)

9. **Principal Problem(s), Complaint(s) or Symptoms(s) Presented (patient's own words).**

Circle the appropriate number below <u>or</u> list each symptom recorded.

001. **No symptoms recorded at time of visit (e.g., healthy individual seeking check-up).**

002. **All symptoms recorded are social-psychological.**

003. **Visit was physician requested (i.e., return visit per doctor's orders) and patient reported that a) previous symptoms were improving or absent; and b) she was experiencing no new symptoms.**

↓ GO TO Q. 10

004. ______________________ ___ (41-43)

005. ______________________ ___ (44-46)

006. ______________________ ___ (47-49)

007. ______________________ ___ (50-52)

008. ______________________ ___ (53-55)

009. ______________________ ___ (56-58)

010. ______________________ ___ (59-61)

011. ______________________ ___ (62-64)

10. **What is the nature of the problem(s) for which patient sought care this visit? (Patient's own words. NOTE: Non-medical-related problems include <u>any</u> financial, family or work difficulties volunteered by patient, spontaneously or in response to an inquiry).**

1. **Medical-related problem(s)** → SKIP TO PAGE 5, Q. 18 ___ (65)
2. **Non-medical-related problems**
   ↓ SKIP TO PAGE 3, Q. 11

11. **What type of problems were recorded as present in the patient's psychosocial environment?**

Problems	Present	Absent	
1. Marital problems	1	2	(66)
2. Parent-child problems	1	2	(67)
3. Other interpersonal difficulties	1	2	(68)
4. Economic (financial) problems	1	2	(69)
5. Role dissatisfaction	1	2	(70)
6. Other (specify) ________________ ________________	1	2	(71)
	SKIP TO PAGE 5, Q. 18		

12. <u>CODER INSTRUCTION</u>:

Code nine (9) in columns 72-75.

(72)

(73)

(74)

(75)

END OF CARD 05

BEGIN CARD 06

KEYPUNCH: Duplicate columns 1-12

Card Number 0 6 (13)(14)

16. CODER INSTRUCTION:

Code each of the nine (9) types of malfunctioning that were presented by the patient in question nine, above.

(15)(16)

(17)(18)

(19)(20)

(21)(22)

(23)

16A. CODER INSTRUCTION:

Code the type of symptoms presented: that is, specific dysfunction (1-4 above), diffuse anomalies (5-9 above), or both specific dysfunction and diffuse anomalies.

(24)

17. CODER INSTRUCTION:

Code each part of the body in which presenting symptoms were located.

(25)(26)(27)

(28)(29)(30)

(31)(32)(33)

(34)(35)(36)

(37)(38)(39)

(40)(41)(42)

18. Physical Findings Recorded by Physician. $(\overline{43})(\overline{44})$

Circle the appropriate number below <u>or</u> list each abnormal finding recorded.

88. All Findings normal
99. No findings recorded

GO TO Q. 19

01. __________
02. __________
03. __________
04. __________
05. __________
06. __________
07. __________
08. __________

19. Were any laboratory procedures and/or x-rays <u>planned</u> by the physician? $(\overline{45})$

1. Yes → SKIP TO PAGE 6, Q. 20
2. No → SKIP TO PAGE 7, Q. 21

20. Laboratory Procedures and/or X-rays Planned and Results.

A Procedure(s) Planned	B Result			
	Positive	Negative	Not Done	
1.	1	2	3	(46)
2.	1	2	3	(47)
3.	1	2	3	(48)
4.	1	2	3	(49)
5.	1	2	3	(50)
6.	1	2	3	(51)
7.	1	2	3	(52)
8.	1	2	3	(53)
	SKIP TO PAGE 7, Q. 21			

A. List each lab procedure and/or x-ray planned by physician in <u>Column A</u> above.

B. Was the result of the procedure positive, negative, or was the procedure not done? Circle appropriate answer in <u>Column B</u> above.

21. **Therapy and Medications.**

Circle the appropriate number(s) <u>and/or</u> list each medication prescribed below.

99. No treatment prescribed (54)(55)

01. No drugs or other therapy prescribed <u>but</u> advice regarding symptom relief given (e.g., rest, fluids, aspirin, exercise, and so forth). (56)(57)

02. Counseling, reassurance and/or advice (58)(59)

03. Physical therapy

04. Injection (specify) ____________________ (60)(61)

05. Office surgery (specify) ____________________

06. Work excuse (including change in duties)

07. ____

08. ____

09. ____

10. ____

11. ____

22. **Disposition of Patient**

1. Return to Center within specified time period (62)
2. Return to Center PRN
3. Admit to hospital

↓

SKIP TO PAGE 8, Q. 25

4. Referral

↓

SKIP TO PAGE 8, Q. 23

23. Referral Disposition.

To whom, and for what purpose, was the patient referred? ___ (63)

1. Referred to psychiatrist for treatment
2. Referred to psychiatrist for consultation
3. Referred to community agency for counseling
4. Referred to other specialist for treatment
5. Referred to other specialist for consultation
6. Other (specify) ____________________

24. Did the patient have contact with the specialist or agency to which she was referred? ___ (64)

1. Yes
2. No
3. Information not found in record

25. Did the patient seek care at the emergency room for the condition for which she is now visiting the Center? ___ (65)

1. Yes   2. No → GO TO Q. 26

↓ If more than once, write-in number of visits made to ER: _____ visits

26. How many appointments did the patient break during the specified six months? ___ (66)

_____ broken appointments   0. none

27. How many times did the patient contact the Center by telephone during the specified six months? ___ (67)

_____ times   0. Never

28. Not including ER visits that were related to illness episodes abstracted, how many times did the patient visit the emergency room during the specified six months? ___ (68)

_____ times   0. Never

29. CODER INSTRUCTION:

Cost of Physician Services

Code cost of visit and costs of visits to emergency room for care related to this illness episode.

__ __ __ __ (69-72)

30. CODER INSTRUCTION:

Code total costs of all tests and/or x-rays that were performed.

__ __ __ __ (73-76)

31. CODER INSTRUCTION:

Code total costs of all medications and/or therapy prescribed.

__ __ __ __ (77-80)

END OF CARD 06

BEGIN CARD 11

KEYPUNCH: Duplicate Columns 1-12

Card Number 1 1 (13)(14)

32. CODER INSTRUCTION:

For each consecutive laboratory procedure and/or x-ray listed in question 20A (p. 6), enter the appropriate codes found in Appendix 6.

Procedure(s) Planned

1. ______________________ ____(15-18)
2. ______________________ ____(19-22)
3. ______________________ ____(23-26)
4. ______________________ ____(27-30)
5. ______________________ ____(31-34)
6. ______________________ ____(35-38)
7. ______________________ ____(39-42)
8. ______________________ ____(43-46)

33. CODER INSTRUCTION:

Enter the total number of abnormal physical findings recorded in question 18 (p. 5) which were subjective (e.g., tenderness, pain). __(47)

34. CODER INSTRUCTION:

Enter the total number of subjective findings which were positively qualified (e.g., very, severe, great, much). __(48)

35. CODER INSTRUCTION:

Enter the total number of subjective findings which were negatively qualified (e.g., slight, minimal, moderate, minor). __(49)

36. CODER INSTRUCTION:

Enter the total number of objective findings which were positively qualified (e.g., very, severe, great, much). __(50)

37. CODER INSTRUCTION:

Enter the total number of objective findings which were negatively qualified (e.g., slight, minimal, moderate, minor). __(51)

END OF CARD 11

PHYSICIAN QUESTIONNAIRE
WINTER, 1978

This questionnaire is part of an overall study of a selected group of ambulatory patients being conducted by the Center. The objectives contained in the following pages have been reviewed by Dr. S who requests your assistance in giving candid and thoughtful attention to the enclosed questions.

In order to make your participation as convenient for you as possible, we ask that you complete the questionnaire and return it to Dr. S in one week. In addition, we ask that you do not discuss the questionnaire with anyone else until the study is completed.

We will take all precautions to preserve the confidentiality of respondents. You will never be mentioned by name or identified in any way as an individual in any presentations. If you wish, a summary of the results of this study will be given to you upon its completion.

We need hardly stress that the intentions of the Director for an objective study of this important subject depends entirely upon your cooperation. We express our sincere thanks for your help.

IN WORKING WITH PATIENTS, PHYSICIANS FIND THAT CERTAIN CONDITIONS HELP THEM PRACTICE EFFECTIVELY. THIS FIRST QUESTION DEALS WITH YOUR OPINION OF WHAT IS IMPORTANT FOR EFFECTIVE MEDICAL PRACTICE--WHAT WORKS FOR YOU.

BEGIN
CARD 12
↓

1. Listed below is a series of paired statements. Please check the one (1) statement from each pair that you believe best helps you practice effectively. (Answer for all pairs, placing a check before the one statement from each pair which describes what works best for you.)

THE DOCTOR.... 1 (1) 2 (2)

A.1 ___ focuses on the treatment of physical illness
A.2 ___ explains and interprets to the patient (3)

B.1 ___ requires the patient to return for follow-up visits as needed
B.2 ___ develops rapport with the patient (4)

C.1 ___ insists on a thorough work-up to establish a diagnosis
C.2 ___ devotes time to social, emotional and familial factors in working with patients (5)

D.1 ___ explains and interprets to the patient
D.2 ___ insists on a thorough work-up to establish a diagnosis (6)

E.1 ___ develops rapport with the patient
E.2 ___ focuses on the treatment of physical illness (7)

F.1 ___ devotes time to social, emotional, and familial factors in working with patients (8)
F.2 ___ requires the patient to return for follow-up visits as needed

G.1 ___ insists on a thorough work-up to establish a diagnosis
G.2 ___ focuses on the treatment of physical illness (9)

H.1 ___ explains and interprets to the patient
H.2 ___ develops rapport with the patient (10)

I.1 ___ requires the patient to return for follow-up visits as needed
I.2 ___ insists on a thorough work-up to establish a diagnosis (11)

J.1 ___ devotes time to social, emotional, and familial factors in working with patients (12)
J.2 ___ explains and interprets to the patient

K.1 ___ focuses on the treatment of physical illness
K.2 ___ requires the patient to return for follow-up visits as needed (13)

L.1 ___ develops rapport with the patient
L.2 ___ insists on a thorough work-up to establish a diagnosis (14)

M.1 ___ explains and interprets to the patient
M.2 ___ requires the patient to return for follow-up visits as needed (15)

THE DOCTOR....

N.1 ___ devotes time to social, emotional and familial factors in
working with patients (16)
N.2 ___ focuses on the treatment of physical illness

O.1 ___ develops rapport with the patient
O.2 ___ devotes time to social, emotional, and familial factors in
working with patients. (17)

THE PATIENT....

a.1 ___ entrusts him/herself to the doctor's care
a.2 ___ responds to treatment (18)

b.1 ___ gives an honest and accurate history
b.2 ___ is self-reliant and willing to help him/herself (19)

c.1 ___ does what the doctor advises
c.2 ___ shows his/her gratitude for the doctor's help (20)

d.1 ___ is self-reliant and willing to help him/herself
d.2 ___ entrusts him/herself to the doctor's care (21)

e.1 ___ shows his/her gratitude for the doctor's help
e.2 ___ gives an honest and accurate history (22)

f.1 ___ responds to treatment
f.2 ___ does what the doctor advises (23)

g.1 ___ entrusts him/herself to the doctor's care
g.2 ___ shows his/her gratitude for the doctor's help (24)

h.1 ___ is self-reliant and willing to help him/herself
h.2 ___ does what the doctor advises (25)

i.1 ___ responds to treatment
i.2 ___ gives an honest and accurate history (26)

j.1 ___ does what the doctor advises
j.2 ___ entrusts him/herself to the doctor's care (27)

k.1 ___ is self-reliant and willing to help him/herself
k.2 ___ responds to treatment (28)

l.1 ___ gives an honest and accurate history
l.2 ___ entrusts him/herself to the doctor's care (29)

m.1 ___ responds to treatment
m.2 ___ shows his/her gratitude for the doctor's help (30)

n.1 ___ gives an honest and accurate history
n.2 ___ does what the doctor advises (31)

o.1 ___ shows his/her gratitude for the doctor's help
o.2 ___ is self-reliant and willing to help him/herself (32)

2. Next, we would like you to complete each of the following sentences from your point of view as a physician. Please write in the first thought that immediately comes to mind after reading the statement. You should try to make sense, though your sentence need not be long. The idea is to get down a complete thought as rapidly as you can.

   a. When a patient persistently presents with vague or inconsistent symptoms (33)

   b. When a patient does not respond to treatment (34)

   c. Patients "shop" for doctors because (35)

   d. When physical and laboratory examinations do not account for a patient's complaints (36)

   e. When patients want to tell me their personal problems (37)

   f. When patients don't follow instructions (38)

   g. To me, dealing with the social and emotional problems of patients (39)

ALTHOUGH SOME PHYSICIANS FEEL THAT THE REACT TO AND ARE EQUALLY COMFORTABLE IN TREATING ALL KINDS OF PATIENTS, MOST FIND THAT THERE ARE SOME TYPES OF PATIENTS TO WHOM THEY REACT NEGATIVELY OR WITH WHOM THEY ARE NOT AS COMFORTABLE AS WITH OTHERS. THE NEXT QUESTIONS DEAL WITH YOUR FEELINGS TOWARD DIFFERENT TYPES OF PATIENTS.

3. First, we would like to know about the kinds of patients with whom you like to deal. Listed below are five different types of patients. Please rank them from 1 to 5, according to the type of patient you prefer. (Rank all five, placing the number <u>one (1)</u> before the type of patient you <u>most prefer</u> to deal with, and so on.)

____ "worried well" patients (40)

____ terminally ill patients (41)

____ patients with life-threatening disease (42)

____ patients with functional syndromes (43)

____ patients with clear-cut physical illnesses (44)

4. Please explain why you <u>most prefer</u> and <u>least prefer</u> to deal with the type of patients you ranked number 1 and number 5. (WRITE IN)

5. Next, we would like to know about your reactions to different types of patients. Listed below are four different types of patients. Please rank them from 1 to 4, according to the way you feel you react to these different types of patients. (Rank all four, placing a <u>one (1)</u> before the type of patient to whom you react <u>least negatively</u>, and so on.)

____ patients who are overly concerned with symptoms (45)

____ patients who seek personal advice (46)

____ patients who make no real effort to get well (47)

____ patients who have ill-defined problems (48)

6. Please explain why you feel <u>least negatively</u> and <u>most negatively</u> to the types of patients you ranked number 1 and 4. (WRITE IN. USE BACK OF PAGE IF NECESSARY)

SOME PATIENTS LIKE THE DOCTOR TO SIT AND LISTEN TO THEM AS THEY TALK AND POUR THEIR HEARTS OUT ABOUT ALL SORTS OF PROBLEMS RELATING BOTH TO THEIR HEALTH AND TO OTHER SUBJECTS. IN THIS NEXT QUESTION WE WOULD LIKE TO KNOW HOW YOU RESPOND TO SUCH PATIENTS.

7. Under ordinary working conditions, when such patients talk about problems which are only indirectly related to their health, do you (CHECK ONE)

   1. ___ encourage them to talk,
   2. ___ permit them to talk, (49)
   3. ___ try to limit them, or
   4. ___ limit them exclusively to subjects directly connected to the medical problem?

SOME PHYSICIANS BELIEVE THAT PEOPLE OFTEN BECOME ILL BECAUSE SICKNESS PROVIDES A WAY TO JUSTIFY SOME SORT OF FAILURE IN THEIR EVERYDAY LIFE. WE WOULD LIKE TO KNOW YOUR OPINION ABOUT AND RESPONSE TO SUCH PATIENTS.

8. From your experience how widespread would you say this cause of illness is for the following types of patients? (CHECK ONE FOR EACH TYPE OF PATIENT)

	Extremely Widespread (1)	Somewhat Widespread (2)	Not Particularly Widespread (3)	Rare (4)	
a. female patients	___	___	___	___	(50)
b. male patients	___	___	___	___	(51)
c. non-white patients	___	___	___	___	(52)
d. caucasion patients	___	___	___	___	(53)
e. well-to-do patients	___	___	___	___	(54)
f. middle-income patients	___	___	___	___	(55)
g. patients on welfare or just managing to get by	___	___	___	___	(56)

9. How do you generally behave toward patients who become ill to justify failure? (CHECK ONE)

   1. ___ With sympathy and understanding

   2. ___ They annoy you but you try not to show it

   3. ___ They annoy you and you think the patient should know it

(57)

10. Next we have listed a series of health conditions that people sometimes have. From your point of view as a physician, please check whether you think a person should see a doctor about the condition immediately, should take care of it him/herself unless it keeps up or gets worse, or if he/she should just leave it alone. (CHECK ONE FOR EACH CONDITION)

	See Doctor Immediately (1)	Self Care Unless Gets Worse (2)	Leave Alone (3)	
a. Bad cough for several weeks	___	___	___	(58)
b. Diarrhea or constipation for a couple of days	___	___	___	(59)
c. Frequent headaches	___	___	___	(60)
d. Coughing up blood	___	___	___	(61)
e. Feeling tired all the time, no special reason	___	___	___	(62)
f. Feeling very depressed and blue	___	___	___	(63)
g. An unusual lump on the body	___	___	___	(64)
h. Shortness of breath	___	___	___	(65)
i. Sore throat, running nose, for a couple of days	___	___	___	(66)
j. Pain in the chest	___	___	___	(67)

NOW, WE ARE INTERESTED IN THE ASPECTS OF MEDICAL PRACTICE WHICH ARE PERSONALLY SATISFYING TO YOU.

11. What do you enjoy <u>most</u> about being a doctor? (WRITE IN)

(68)

(69)

(70)

(71)

12. What do you enjoy <u>least</u> about being a doctor? (WRITE IN)

(72)

(73)

(74)

(75)

(76) (77)

END OF
CARD 12

THE TERM "PROBLEM PATIENT" OR "CROCK" FREQUENTLY IS USED TO DESCRIBE PATIENTS WITH CERTAIN CHARACTERISTICS.

BEGIN
CARD 13
↓
1 3
(1) (2)

13. If the term "problem patient" or "crock" is used in this Center, of whom do you think? (PLEASE WRITE IN THE NAMES OF SPECIFIC PATIENTS)

14. Why do you consider them "problem patients" or "crocks"? (WRITE IN)

(3) (4)

(5) (6)

(7) (8)

(9) (10)

(11) (12)

15. What proportion of your patients would you classify as "problem patients" or "crocks"? (WRITE IN)

_____ Percent

(13) (14)

THIS FINAL SECTION DEALS WITH YOUR BACKGROUND. THE INFORMATION YOU PROVIDE HERE WILL PERMIT A COMPARISON OF THE OPINIONS OF PHYSICIANS WITH DIFFERENT KINDS OF BACKGROUNDS.

16. What is your age? (WRITE IN) ____ years old (15) (16)

17. What is your sex? (CHECK ONE)

1. ____ Male
2. ____ Female (17)

18. What is your marital status? (CHECK ONE)

1. ____ Single
2. ____ Married
3. ____ Divorced
4. ____ Other (What? WRITE IN) (18)

19. In which year of residency are you ? (CHECK ONE)

1. ____ 1st year resident
2. ____ 2nd year resident
3. ____ 3rd year resident
4. ____ graduate of program
5. ____ staff (19)

20. From which medical school did you graduate? (WRITE IN)

(20)

21. How difficult was it for you to finance your medical education? (CHECK ONE)

1. ____ very difficult
2. ____ fairly difficult
3. ____ not very difficult
4. ____ not at all difficult (21)

22. Why did you decide to take a residency in family medicine? (WRITE IN)

(22) (23)

(24) (25)

(26) (27)

(28) (29)

23. In what field did you major as an undergraduate? (WRITE IN)

(30) (31)

24. If you had it to do over again, in what would you major in undergraduate college? (WRITE IN)

(32)(33) (3

25. What was the total annual income of your family when you were 16? (CHECK ONE)

1. ____ under $5,000
2. ____ $5,000 up to $10,000
3. ____ $10,000 up to $15,000
4. ____ $15,000 up to $20,000
5. ____ $20,000 up to $25,000
6. ____ $25,000 up to $35,000
7. ____ $35,000 or above (35)

26. What was your father's occupation when you were 16? (WRITE IN)

(36)

27. How much education did you father have? (CHECK ONE)

1. ____ Less than 7 years
2. ____ 7-9 years
3. ____ some high school
4. ____ high school graduate
5. ____ some college
6. ____ college graduate
7. ____ graduate or professional school (37)

28. How would you characterize the place where you were raised? (CHECK ONE)

1. ____ urban
2. ____ suburban
3. ____ non-suburban small town
4. ____ rural (38)

AGAIN, MANY THANKS FOR YOUR COOPERATION AND HELP.

Your Name (WRITE IN) ____ (39) (40)

(Although we are asking you to put your name on this questionnaire, we again would like to assure you that you will never be mentioned by name nor identified in any way as an individual in any presentations.)

We welcome any comments you might have on this questionnaire or related topics. Please use the rest of this page if you have any.

APPENDIX D

PROBLEMS IN DEVELOPING A LEVEL OF ILLNESS LEVEL

APPENDIX D

PROBLEMS IN DEVELOPING A LEVEL OF ILLNESS INDEX

In order to differentiate between patients on the basis of the severity of the conditions for which they sought care during the six month observation period, an attempt was made to develop a "level of illness" index. The attempt was not successful. The purpose of this section is (1) to describe the methods employed to develop the index; and (2) to discuss the reasons for the failure.

Components of the Index

The classificatory index was based on clinical evidence recorded in the medical chart during the observation period, that is, on physical findings and positive results of investigative procedures (laboratory tests, x-rays, and other diagnostic procedures). Duration was not included as a component of the index since available evidence reflected a subjective judgment based upon an unknown mixture of patient complaints and physician assessments.[1]

Method

The data on physical findings had been coded in three different ways: (1) by number; (2) by type; and (3) by degree. Number of physical findings is self-explanatory. Type of physical findings refers to the character of the finding: that is, subjective (e.g., pain, tenderness) or objective (e.g., drainage, erosion, inflammation). Degree refers to the qualifier appended to the finding: that is, negative (e.g., small, minimal) or positive (e.g., large, many).

For the purposes of the index, the findings and test results were assigned the following weights:

1. no findings;[2]
2. negatively qualified subjective finding;
3. subjective finding;
4. positively qualified subjective finding;
5. negatively qualified objective finding;
6. objective finding; and positive test results; and
7. positively qualified objective finding.

The weighted data for each visit were added and a summary index assigned to the visit. Forty percent of the visits were assigned a score of five points or less, and 60 percent, six points or more. The scores ranged from one to 37 points per visit, with one and six being the most frequently occurring scores.[3]

Three decision rules then were established and applied to the data in order to categorize patients on the basis of level of illness.

Rule I

The criteria developed for Rule I classified patients on the bases of the relationship of their average score for six months to that of the group as a whole.[4] Patients were assigned to dichotomous categories on the basis of the following criteria:

- If an individual's mean score was equal to or above the grand mean, she was considered to have presented for care with clinically justifiable morbidity and was assigned to the high illness level group;
- If an individual's mean score was below the grand mean, she was assigned to the low illness level group.

Rule II

The criteria developed for Rule II classified patients on the basis of proportions of visit scores. Patients were assigned to dichotomous categories on the basis of the following criteria:

- If 49 percent or more of the individual's visit scores were equal to or more than six points, she was considered to have presented for care with clinically justifiable morbidity and was assigned to the high illness level group;[5]
- If 51 percent or more of her visit scores were equal to or below five points, she was assigned to the low illness level group.

Rule III

The criteria developed for Rule III were similar to those used in Rule II, except that patients were assigned to dichotomous categories on the basis of different proportional criteria:

- If 51 percent or more of the individual's visit scores were equal to or more than six points, she was considered to have presented for care with clinically determinable morbidity and was assigned to the high illness level group;
- If 49 percent or more of her visit scores were equal to or below five points, she was assigned to the low illness level group.

Results

The material presented in Table D.1 shows the inconsistent results obtained when the three rules were applied to the data. Rule I (based on the relationship of the individual's average to the grand mean) produced the most even distribution of patients within categories. Rules II and III (based on proportions) produced much more skewed distributions, heavily weighted toward the high level of illness category. In point of fact, among those first assigned to the low level of illness category, 36 individuals (52.9 percent) moved into the high level of illness category, when Rules II and III were applied to the data. There was much less movement out of the high level category. But when Rules II and III were applied to the data, seven (12.7 percent) of the patients first assigned to the high level of illness category moved into the low level category. In total, only 80 of the 123 patients remained within the same category when the different rules were applied to the data (32 in the low level category and 48 in the high level category).

Discussion

First attempts to develop a measure of illness level were not successful in categorizing patients. Thus, an attempt was made to develop an independent criterion that could be used to categorize the 43 individuals who were "unstable." The first set of criteria had been based on objective evidence. The second criterion was subjective, based on the judgments of three people: a nurse

TABLE D.1.--Distribution of Sample Using Three Different Methods to Categorize Illness Level.

Illness Level by Number of Visits	Rule					
	I[a]		II[b]		III[c]	
	Number	Percent	Number	Percent	Number	Percent
3 or More Visits:						
High level of illness	35	44.9	54	69.2	49	62.8
Low level of illness	43	55.1	24	30.8	29	37.2
1 to 2 Visits:						
High level of illness	20	44.4	34	75.6	25	55.6
Low level of illness	25	55.6	11	24.4	20	44.4
All Visits:						
High level of illness	55	44.7	88	71.5	74	60.2
Low level of illness	68	55.3	35	28.5	49	39.8

[a] If an individual's mean score was equal to or above the grand mean, she was assigned to the high illness level group.

[b] If 49 percent or more of an individual's scores were equal to or more than six points, she was assigned to the high level illness group.

[c] If 51 percent or more of an individual's illness scores were equal to or more than six points, she was assigned to the high level illness group.

clinician, involved in teaching and research; a graduate physician about to begin his residency training; and a second year medical student just entering the clinical years of his training. These people read the medical record abstracts of ten "stable" patients in the high level of illness category and ten "stable" patients in the low level category. The purpose of this reading was to determine if the patients assigned to one (or the other) category shared certain clinical characteristics that could be established as a set of criteria and applied to the data contained in the abstracts of the 43 "unstable" patients.

All three reviewers concluded that most of the patients in the high level category seemed little different from those in the low level category. In addition, although the purpose of the classificatory scheme had been to differentiate between patients on the basis of severity of illness, all three felt that most of the patients assigned to the high level category were not very ill. As one reviewer noted: "They had findings and got a prescription. But, the whole thing was of little medical consequence." The reviewers, then, were unable to establish any criteria on the basis of their readings. Moreover, they concluded that there were several inherent problems in attempting to develop a classificatory scheme based on the data available.

First, there was a dearth of physical findings recorded in the medical records. On the one hand, they felt these data might represent the small number of findings detected by the physician or only the number he or she considered significant enough to enter.

On the other hand, they felt these data recorded over time and in the presence of vague complaints, might reflect the onset of a severe organic problem.[6] Differences in modes of recording data and/or the insidious course of some illnesses, then represented obstacles to the development of a level of illness index.

Second, there was a great deal of variation in the number of tests ordered for patients. On the one hand, the reviewers felt that entries of large numbers of tests might represent a thoroughness of workup (or an overutilization of tests). On the other hand, they felt that entries of small numbers of tests might reflect the physician's ability as a diagnostician (or an underutilization of tests). These differences, regardless of their bases, meant that the probability of having tests was not the same for all patients and thus represented an impediment to the development of an index.

Finally, there were large numbers of entries of "all findings normal" in the medical records. On the one hand, the reviewers felt that such an entry might represent the actual health status of a patient who had complied with her physician's request for a follow-up visit. On the other hand, they felt that such an entry might reflect, not the health status of the patient, but the philosophy of the physician toward psychosocial pathology. As one reviewer noted:

> Many physicians keep their assessment of the patient's psychosocial debility in their minds, not in the medical chart. As a consequence, they reschedule visits, enter a benign organic diagnosis and "normal" in the chart, and use the visit as a counseling session.

Entries of "all findings normal," then distorted the scores of some patients, obfuscated the scores of others, and represented a hinderance to the development of an index.

In conclusion, an attempt was made to develop an index that would permit illness level to be related to other sociobiological factors. Component variables were selected that were felt to be well-defined and reliable. The data, however, were strongly influenced by physicians' clinical abilities as well as judgments and the effort was thwarted. As Balinsky and Berger (1975:286) have noted: "Even in the class of data referred to as clinical evidence . . . problems of diagnostic accuracy and prognosis often skew measures."

NOTES: APPENDIX D

[1] Diagnoses were examined to see if they could be used as a measure of duration (i.e., an illness episode). These, however, reflected both a knowledge of the course of disease as well as an inference based upon presenting complaints (that is, symptoms presented over time in a similar way). Thus, the idea of including duration as a component of the scheme was abandoned because the diagnostic data available were based on clinical knowledge as well as the doctor-patient interaction.

[2] In calculations based upon the additive method, one was treated as a zero. "No findings" was assigned the weight of one, however, to permit calculations based upon the multiplicative method. The use of these methods is discussed below.

[3] The scores described here were calculated using the additive method. Scores also were calculated using the multiplicative method but the range was so large (1.0 to 1296.0), that a few high scores inflated the grand mean for the group. As a consequence, Rule I (see below), when applied to the data, produced a skewed distribution.

[4] The grand mean (total number of points divided by total number of visits) for all women was 7.48. The mean scores for individuals ranged from 0.0 (5.7 percent) to 19.3 (0.8 percent).

[5] Six points was established as the cutting point in this rule because (1) this number represented one solid objective finding; and (2) it was the most frequently occurring score per visit.

[6] In the instance of one patient, this was the case. The ill-defined abdominal pains for which she sought care over a period of months were diagnosed as ulcerative colitis after emergency surgery. Only one such case occurred, of course, but it does represent an inherent problem when dealing with a paucity of data. Moreover, it should represent a caveat to physicians; dependent patients--as this patient had been labelled by her physician--also get sick.

APPENDIX E

DEVELOPMENT OF A DIAGNOSTIC INDEX

APPENDIX E

DEVELOPMENT OF A DIAGNOSTIC INDEX

In order to differentiate between patients on the basis of the diagnoses assigned to them, a "diagnostic index" was developed. The index is based on the judgments of three people: two nurse clinicians involved in teaching and research and a graduate physician about to begin his residency training. These people read the medical record abstracts of all patients and coded the diagnoses on the basis of a set of criteria (see below). Proportions then were calculated using the coded data in order to categorize physicians' assessments of patients' problems. This section describes the methods used to develop the diagnostic index.

Components of the Index

The diagnostic index is based on four sets of data: (1) the diagnoses entered by the physician; (2) the symptoms presented by the patient; (3) the physical findings recorded; and (4) the results of diagnostic procedures.

Method

The data for each patient visit had been recorded in a separate medical abstract schedule. The reviewers read the abstracts and, using the criteria listed below, assigned each visit an appropriate code.

Coding: Codes and Criteria

1. Psychological. The diagnoses and findings that the physician recorded and the symptoms that the patient reported are strictly psychological. Diagnoses of anxiety and depression are most common. Findings or symptoms such as moody, labile, crying, or emotional outbursts are recorded. A diagnosis of anxiety or depression automatically are coded psychological, even in the absence of findings to support this diagnosis.

2. Symptomatic. The diagnosis recorded by the physician or the symptoms reported by the patient are not validated by either one physical finding or one positive diagnostic procedure. Symptoms such as headaches, nausea, vomiting, fatigue, tired all over, or weakness are most common. If the physician has entered a definitive diagnosis such as "flu" or "anemia," it is categorized as symptomatic if the diagnosis is not validated.

3. Organic. The diagnosis entered by the physician of the symptoms reported by the patient are validated by physical findings and/or positive diagnostic procedures. For example, if a patient reports a temperature and "achy" feelings and these are supported by findings such as a red throat and/or a "wheezing chest," the diagnosis is categorized as organic. If a diagnosis has been validated at one visit, it need not be validated at follow-up visits, i.e., it is categorized as organic.

4. Psychological and Symptomatic. Two or more diagnoses are entered. In combination, they meet the criteria described in one and two above.

5. Psychological and Organic. Two or more diagnoses are entered. In combination, they meet the criteria described in one and three above.

6. Symptomatic and Organic. Two or more diagnoses are entered. In combination, they meet the criteria described in two and three above.

7. Psychological, Symptomatic and Organic. Three diagnoses are entered. In combination, they meet the criteria described in one, two and three above.

8. Health Maintenance. The purpose of the visit is preventive care, e.g., physical exam, PAP test, or request for birth control pills.

9. Symptomatic and Health Maintenance. Two or more diagnoses are entered. In combination, they meet the criteria described in two and eight above.

10. Organic and Health Maintenance. Two or more diagnoses are entered. In combination, they meet the criteria described in three and eight above.

Five hundred twenty-two diagnoses were coded and there was 92 percent agreement among the three coders. Agreement became total once discrepancies had been resolved through discussion. Of the 522 diagnoses coded, 10 percent were categorized as psychological; 29.1 percent as symptomatic (unsupported); 55.5 percent as organic (supported); and 5.4 percent as health maintenance.

Scoring

In order to categorize patient diagnoses on the basis of physicians' assessments the following tasks were performed:

1. All diagnoses within the health maintenance category were excluded in the calculations;

2. The number of psychological and symptomatic (unsupported) diagnoses were added to form one category;

3. A proportional score for organic (supported) diagnoses and a proportional score for psychological/symptomatic (unsupported) diagnoses was calculated using the following formula: total number of diagnoses within category divided by total number of diagnoses in the two categories; and

4. A single summary index for each of the two categories was assigned to the patient.

Discussion

Essentially, the index dichotomizes diagnoses into categories that differentiate (1) those that are psychological or symptomatic (unsupported) from (2) those that are organic (supported). These are categories that reflect physicians' assessments of patients' problems and the extent to which their diagnostic assessments were supported or not supported by clinical evidence. Several caveats are necessary, however.

First, the sub-category symptomatic (unsupported) may be interpreted several ways. For example, the sub-category subsumes labels which reflect symptomatology that cannot be definitively diagnosed (e.g., pain, malaise). It also subsumes labels which may reflect physicians' attitudes toward socioemotional problems. That is, the physician may have entered an organic label, rather than a psychological one, and counseled the patient. Such an organic label, however, was categorized as symptomatic because it was not supported by clinical evidence. Finally, the sub-category subsumes labels which may reflect physicians' diagnostic expertise. That is, a physician may have entered an organic label which, because it could not be supported by clinical evidence, was categorized as symptomatic. The sub-category, then, does not elucidate the cognitive process by which a physician made a diagnostic decision. Rather it indicates that patients did not have clinically defined morbidity.

Second, the category organic (supported) indicates only that patients were assigned a diagnosis that could be supported by clinical evidence. Certain diagnoses, however, have a greater tendency to be supported by diagnostic procedures than others.[1] For example, a vaginal culture automatically will result in the growth of flora. Vaginitis, therefore, may have been judged an organic diagnosis more often than a urinary tract infection because the former is associated with more positive test results. Furthermore, the category organic does not reflect the severity of patients' conditions. Severity ranges along a continuum, and diagnosis may be supported by one, two or "n" number of findings for different patients. In short, the category organic reflects only the presence of definitively defined clinical morbidity.

NOTES: APPENDIX E

[1] I am indebted to R. E. Sturm, M.D., for suggesting this point to me.

APPENDIX F

PROBLEMS IN DEVELOPING A DEFINITION OF A PATIENT POPULATION

APPENDIX F

PROBLEMS IN DEVELOPING A DEFINITION OF A PATIENT POPULATION[1]

A statistical population consists of the totality of the observations about which relevant inquiries are to be made (Walpole, 1974:122). Populations in this sense are arbitrary and must be carefully defined:

> Clearly, there is nothing natural about a statistical population because it is defined to satisfy specific research objectives . . . . Statistical methodology comes into play only after the relevant populations have been defined to suit the research objectives at hand (Thomas, 1976:35).

The objective for this research was to define a population with a common characteristic. This was a complex undertaking. Did the population consist of all people who had contact with the center during a specified period of observation? Or did it consist of people who were known to have had contact over a prolonged period of time? What were the parameters of the group? The answer was neither simple nor obvious since the characteristic chosen to define the patient population may have considerable consequences for the data that are developed. This section elucidates these consequences by describing the way in which different definitions create variations in statistics.

In order to develop a definition of the patient population of the health center, a characteristic that a group of patients might have in common had to be discovered. An obvious one was evidence of contact during a common period of time. Since the period of observation for the sample of this study was the twelve months between July 1, 1976 and June 30, 1977, the first criterion established stated that an individual must have shown evidence of contact with the center during this period in order to be considered a member of its patient population. This criterion created a shared quality among individuals. But, it also aggregated together people who had contact with the center over a prolonged period of time as well as those whose contacts had been more ephemeral.

Thus, in order to differentiate between regular and transient patients, one additional criterion was established that stated that an individual must have had contact with the center during a six-month prior- and/or post-observation period in order to be considered a member of its patient population. Together, the criteria created a set of mutually exclusive definitions that described all combinations possible. Figure F.1 contains the five definitions that reflect the most plausible descriptions of a patient population.[2]

Method A, in which the only characteristic of interest is the defined period of observation, produces the largest population. This size, however, begins to decrease when additional criteria are included in the definition. In Method B, the decrease is small. But since no selection criteria are applied during the period of

Method	Definition			Number of Patients	Average Number of Visits per Patient
	Prior	Period of Observation	Post		
A	Any[a]	One or more VOR[2]	Any	6029	3.0
B	One or more VOR	Any	Any	5042	1.7
C	One or more VOR	Any	One or more VOR	1257	4.1
D	One or more VOR	One or more VOR	Any	2250	3.7
E	One or more VOR	One or more VOR	One or more VOR	1042	4.9

[a] The word "any" is used to indicate that no selection criteria were applied during a time period, that is a patient could have had no contact or one to any number of contacts with the center during that period.

[b] VOR is an abbreviation for the compound term "Visit of Record." A visit of record is defined as any entry in the data system which indicates that a contact has been made with the center. This entry may indicate an actual visit in which medical care was sought or a broken appointment.

FIGURE F.1.--Comparison of Different Methods of Defining a Population of Patients.

observation, a small mean results. In Methods C through E, the decrease is appreciable but the more rigorous criteria applied produce a larger mean.

The demand for evidence of continued contact, then, decreases the size of a patient population. However, the statistic it produces describing the volume of use of this population may reflect reality more accurately. Developing a definition of a patient population is a complex undertaking, and one which the researcher should approach with caution. Including transient patients in the group will increase its size. But, it will also tend to lower the average number of visits reported per patient.

NOTES: APPENDIX F

[1] I am indebted to Robert J. Sprafka for the material described in this Appendix. He made me aware of the problems involved in developing a definition of a patient population and created the methodology and data discussed herein.

[2] The data included in this figure were derived from the health information system in use at the center.

APPENDIX G

BACKGROUND INFORMATION ON THE RESIDENTS

APPENDIX G

BACKGROUND INFORMATION ON THE RESIDENTS

The residents ranged in age from 26 to 41 years, with 29.8 years the average age. Almost three-quarters (71.4 percent) were married (see Table G.1). Slightly over one-third (38.4 percent) came from families in which their fathers had occupied high social positions; five (11.9 percent) were the sons of physicians. An approximately equal percentage (35.9) grew up in homes in which their fathers occupied relatively low social positions. Almost three-quarters (69.1 percent) of the residents, however, felt that they had had difficulty in financing their medical education.

Most (95 percent) of the residents had majored in the physical or natural sciences in college. About one-third (31.6 percent) felt that they would have chosen another major if they had the opportunity. Of these residents, three-quarters (75 percent) would have preferred to major in the social or behavioral sciences.

Only one statistically significant relationship was found between the background characteristics of the residents and their attitudes. That is, physicians who expressed greater difficulty in financing their medical education were likely to feel that they extended sympathy to patients whom they felt used illness to legitimate failure ($r = .32$, $p < .03$). In short, the environment in which residents were raised seemed to have little bearing on their subsequent attitudes as physicians.

TABLE G.1.--Percent of Residents by Selected Sociodemographic Characteristics.

Characteristic	Percent of Residents
Marital Status:	
Single	26.2
Married	71.4
Marriage Disrupted	2.4
Social Class:[a]	
I	20.5
II	17.9
III	25.6
IV	33.3
V	2.6
Type of Place Where Raised:	
Rural area	16.7
Non-suburban small town	21.4
Suburban area	38.1
Urban area	23.8

[a] Social class is based on Hollingshead's (1967) "Two Factor Index of Social Position." Class I represents the highest index of class position on the scale and Class V the lowest position. The index is based on the educational level and occupation of the residents' fathers at the time the residents were 16 years of age.

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