The family health maintenance demonstration : a controlled long term investigation of family health. Proceedings of a round table at the 1953 Annual Conference of the Milbank Memorial Fund.

THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

A CONTROLLED, LONG TERM INVESTIGATION
OF FAMILY HEALTH

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MILBANK MEMORIAL FUND

PRICE $2.00

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PROCEEDINGS OF A ROUND TABLE
AT THE 1953 ANNUAL CONFERENCE OF THE
MILBANK MEMORIAL FUND

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FOREWORD

PUBLIC health measures have been increasingly successful in the prevention of disease, but less effective in maintaining [illegible] of individual fitness. [illegible] responsible [illegible] it. It [illegible] means [illegible] sufficient or unsatisfactory [illegible] definition of [illegible] years [illegible] World [illegible] well-being.

ERRATUM

The last sentence of the first paragraph of the Foreword should read:

> It would be an exaggeration to say that no effective ways and means exist, but it would also be a mistake to believe that they are sufficiently precise, reliable and inclusive to constitute a complete or satisfactory program.

It goes on in other paragraphs:

> the ability to live harmoniously in a changing total environment is essential to (child) development, and
>
> The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Finally the larger implications are emphasized in the statement:

> The achievement of any State in the promotion and protection of health is of value to all.

Some of these ideas were in the minds of the individuals who proposed a long term field study of families to determine whether special preventive methods and services added to comprehensive medical care might bring about demonstrable improvements in the continuing health of families.

FOREWORD

PUBLIC health measures have been increasingly successful in the prevention of disease, but less effective in maintaining and improving measurably the standard of health of individuals, families or communities. For health is not merely the absence of disease, nor does it find full expression in physical fitness. Perhaps the lack of a clear definition has been in part responsible for failure to find suitable ways and means of promoting it. It would be an exaggeration to say that no effective ways and means exist, but it would also be a mistake to believe that they are sufficiently precise, reliable and inclusive to constitute a complete or unsatisfactory program.

The progress of public health has invalidated one definition of health after another. Perhaps the most satisfactory in recent years is the description in the preamble to the Constitution of the World Health Organization. Beginning with the statement:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

It goes on in other paragraphs:

> the ability to live harmoniously in a changing total environment is essential to (child) development, and
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> The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Finally the larger implications are emphasized in the statement:

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Some of these ideas were in the minds of the individuals who proposed a long term field study of families to determine whether special preventive methods and services added to comprehensive medical care might bring about demonstrable improvements in the continuing health of families.

This investigation was initiated by the Health Committee of the Community Service Society. It involves a group of families receiving medical care from the Health Insurance Plan of Greater New York, known as HIP. A medical practice group from the staff of Montefiore Hospital was chosen to carry on the field work. The governing board consists of representatives of the Community Service Society, Montefiore Hospital, Health Insurance Plan of Greater New York, and Columbia-Presbyterian Medical Center.

Full information concerning the Demonstration will be found in the pages of this report. Suffice it to point out here that the team of workers consists of an internist, a pediatrician, a psychiatric social worker and a public health nurse. The specialized skills of this health team are brought to bear on the families with the aim of promoting a high level of physical, social, and emotional health. The working team is aided by a group of consultants consisting of a psychiatrist, a psychologist, a social scientist, and a specialist in health education.

It is not surprising that the Family Health Demonstration has become an educational process both for the families involved, the working team and the consultants. Whether its benefits can be extended to medical students and recent graduates without interference with its progress, is now under consideration.

In many ways the Demonstration is breaking new ground and encountering the difficulties and obstacles which are the usual accompaniments of this kind of pioneering. How to deal with the control group of families is a problem which has not been fully solved. A number of valuable suggestions on this point were made during the conference and will be found in the proceedings which follow. The measurement of family health is of course the key to the success of the undertaking. While competent biostatisticians have been at the service of the Demonstration from the beginning, the workers concerned have come to realize that they need the advice of a statistician qualified in medical statistics on a day to day basis, so that the data collected will bear directly on the problems they are attempting to solve.

While the growing interest and enthusiasm among all the par-

ticipants is a guarantee that many difficulties will be overcome and many obstacles removed, it would not be reasonable to expect that this first controlled study of family health would provide satisfactory answers to all the questions at issue. One of its many virtues is that it brings to public health and preventive medicine some of the interest and excitement which characterized pioneer attempts to explore the possibility of preventing disease in the early years of the present century.

For the success of this part of the Thirteenth Annual Conference, the Fund is indebted to the Chairman, Dr. George Baehr, the Secretary, Mr. Bailey B. Burritt, to the speakers and indeed to all the participants. Excellent reports on all aspects of the Demonstration were prepared and distributed well in advance so that the group of specialists in general and psychological medicine, in social work and public health nursing, and in biostatics, had ample time to formulate their opinions on the merits of the methods and procedures in use.

Even partial success of the Demonstration will bring substantial benefits to the families involved, but there is reason to hope that its influence will extend to a far wider circle.

FRANK G. BOUDREAU, M.D. AND JEAN DOWNES

INTRODUCTION

GEORGE BAEHR, M.D.

THE idea of a demonstration on family health maintenance arose some years ago in the councils of the Community Service Society which, as you know, is one of the largest and one of the oldest family welfare agencies in this country. The person who deserves the credit for its promotion is Mr. Albert Milbank, who was Chairman of the Health Committee of the Community Service Society and who had a deep interest in family health services in the broadest sense of the term as represented by this demonstration.

My own function in the demonstration has been to represent the Community Service Society, although by coincidence I happen to be a member of the Board of the Milbank Memorial Fund and of the Health Insurance Plan of Greater New York, of which the Montefiore medical group is a very important part, and of the Academy of Medicine.

You notice from the program which is before you that for the Milbank Memorial Fund conference this year Dr. Boudreau has selected two of the major activities in which the Milbank Memorial Fund is interested. They approach the subject of the health of society or social medicine from opposite poles. Our conference today is concerned with the family unit, and the conference which will be conducted in another room under the chairmanship of Dr. Lowell J. Reed approaches the problem from a totally different standpoint, the interrelations of demographic, economic, and social problems in selected underdeveloped areas of the world. Yet there is consistency in these two avenues of approach.

The demonstration which was instigated by the Community Service Society was assigned to a medical practice group of an excellent hospital with high standards, a medical group which is responsible for providing prepaid comprehensive medical care to families in-

sured under the Health Insurance Plan of Greater New York. In that way the family health maintenance demonstration was superimposed upon a complete family health service in which the families themselves with the aid of their employers are meeting the full cost of comprehensive medical care through prepayment. The funds made available for the demonstration by the Community Service Society and the Milbank Memorial Fund can therefore be concentrated entirely upon the demonstration itself.

We hope that out of this demonstration will come a better understanding of what may be done to supplement medical services so as to enhance the physical, mental, and social well-being of average families.

For all too long a period, community effort, particularly the effort of voluntary social agencies such as the Community Service Society and others like it, have been concentrated upon rehabilitating families approaching the end stages of social disaster. This orientation of family social and health work may perhaps be ascribed to the fact that these great agencies had their origin in the early days of the industrial era when aid had to be concentrated upon the rehabilitation of seriously broken families.

Today we should be more concerned with the other end of the spectrum, the study of normal families as they exist in a community. Our orientation should be directed increasingly upon prevention and early detection of socio-medical problems within the family unit.

Although this demonstration costs a good deal of money and must be carried on over a term of years and is not intended in its present pattern to be the final answer for the social and health problems that are being studied, out of this we hope will come a better understanding, not only of the major preventive problems in family health work but of how they can be detected and corrected at a reasonable cost so that it may be included as one of the essential preventive services of a family medical service.

We are going to ask each member of the working team to report on his methods of study and experience up to date. Then the consultants representing the fields of psychiatry, sociology, psychology, social sciences, and health education will report on their contribu-

tion. Later, time will be devoted to a critical appraisal of the program.

The reason for this conference is not merely to bring the activities to date to the attention of those who have been invited to this conference. Those who have been invited have been carefully selected by Dr. Boudreau and the staff because of the contribution they can make to the improvement and further development of the project. We invite your criticism, both constructive and destructive, if that seems necessary, so that this demonstration may proceed in the future along more fruitful channels.

OBJECTIVES OF THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

GEORGE A. SILVER, M.D., M.P.H.

THE Family Health Maintenance Demonstration really took its root years ago in the minds of many people, before it flowered into the program in operation today. Like so many other socially designed experiments, this one stands on the shoulders of the past, where the view is a little better, but of course the fellow on our shoulders will see even farther. As long ago as 1913, Mrs. Elizabeth Milbank Anderson in establishing a Department for Social Welfare in the New York Association for the Improvement of the Condition of the Poor, wrote in her letter of award, "I wish to make it clear that the proposed Department of Social Welfare is to concern itself . . . with a social program based upon preventive and constructive measures." (1) It is no accident that both the Community Service Society, heir of the New York Association for the Improvement of the Condition of the Poor, and Milbank Memorial Fund share in a Demonstration that epitomizes "preventive and constructive measures" Mrs. Anderson would certainly have approved.

Within the past fifty years a number of events have taken place, in and out of medicine, that have made it possible for an experiment to be designed to test the feasibility of preventing physical and emotional disease in families, and promoting health.

For example, public health practice changed the pattern of disease incidence and prevalence, removed the fear of periodic pestilence as a motivating factor in human behavior. Now chronic illness and emotional disease are in the forefront of social concern.

Again, in the field of medical service, organizational needs were becoming apparent. Mounting scientific development together with specialization, had forced the growth of group practice, or at least

pointed to the advisability of its development. (2) And mounting costs, underlined in the plight of the family caught in the economic net of illness, had spurred the growth of prepayment plans in the sickness field.

At the same time, revolutionary changes have taken place in social attitudes toward health. Where the emphasis was on disease, for so many centuries, *health* now takes the center of the stage. We need not go so far as to say with Shaw (3), that the whole concern of medicine should shift to health, and do away with the doctor's vested interest in disease. But the Peckham Experiment (4) dramatically portrayed the positive aspects of health service, health evaluation, health promotion. As a result of the meshing together of family research, health promotion practice and prepayment, the Family Health Maintenance Demonstration was born, and the process is well described in a report of a previous Milbank conference. (5) The broad objective then outlined, "to determine what services can reasonably be added to a comprehensive medical care program which would result in favorably influencing the health of the families concerned," can now be more specifically presented.

Morris (6) says there are two approaches to health promotion and disease prevention. "First, to identify and practice healthy ways of living. Second, to discover and apply specific techniques of health protection."

The objectives of the Demonstration at the Montefiore Hospital actually merge these two approaches, and divide into three categories. First among the objectives there is a general category of information collection, in which the families and their habits, practices, evidences of health or types of disease and disorder are described. The second category is one of method, in which there is to be demonstrated the use of the health team, the role of its members and consultants, and the validity of the health education principles used. The third category of objectives is in the demonstration of community values inherent in the first two objectives. For example, there will be the demonstration of the value of such a project for education in various professional fields, and demonstration of

the need for providing many such Demonstrations to cope with the social and medical needs of the community.

To reach these objectives, procedures had to be established, forms created, standards accepted. We had to be prepared to develop a working hypothesis that enabled all the team members to understand each other in talking about "health," "normal," "good practice in child rearing" and so on.

The criteria were arrived at gradually.

In 1949, Dublin and Fraenkel (7) held the function of health maintenance to be "enabling people to live a complete life as a member of the social community." For our purposes health had to have physical, emotional and social meaning. And there we abandoned the concept of health as an independent variable. Health is obviously a process, not a state. Alcmeon of Croton, who said so many centuries ago that health was harmony, is hard to improve upon. We consider health to imply a similar dynamic relationship, in which health is conceived of as functioning to the best of one's capacity in the general areas of work, play, sex, and family life. It therefore includes adaptability to stress, and maturity in interpersonal relationships, really a Hippocratic balance of forces. In this way prevention of diphtheria, heart disease, emotional disorders and broken homes are all matters within our concern.

However, in the area of emotional needs and the handling of them, because of the many and contradictory theories of psychodynamics, it was necessary to make a choice of a working hypothesis. We have accepted Bowlby's (8a) rather general expressions of psychodynamics and noted events accordingly, accepting affectionate and permissive attitudes of parents as more wholesome. There is nothing novel in the concept, for in his recent study of changing fashions in child care, Davidson (9) points out that while swings have taken place in the accepted pattern of child care and feeding over the centuries, in every generation someone has spoken up for kindness and affection as the paramount measure of value in child rearing.

There is no doubt about the average family's concern for their

children's welfare. We believe that the wholesale acceptance of the Demonstration on the part of all those approached for the definitive study group, is most likely based on the family's eagerness to obtain the specialized, amplified health services for their children.

Early in the study, frequent comments from the doctor or social worker or nurse appeared in the record regarding the existence of tension or anxiety in the families. Theories of action in which the norm would be absence of anxiety would be obviously foolish. The idea generally put forth in this connection is that the natural man is anxiety free, and in our present decade or era man is cursed with dreadful anxiety because of progress, or civilization. This theory is based on the illusion that the natural state of man is calm and blissful. In addition to the contrary evidence of the anthropologists, there is a charmingly pointed analysis by Altschule (10) of the 18th century in medical writings that puts this concept of anxiety in its proper perspective. Every century is probably an "Age of Anxiety" to those living in it. For our purposes, the degree of anxiety considered abnormal would be measured indirectly, in the inhibition or interference with the functioning of the individual in those areas mentioned previously—work, play, sex and family life.

The description of the families, their physical, emotional, and social consistency then became a matter of record. Before we discuss the application of health promotion, I would like to explore the mechanism of delivery of services—examination and study, therapeutic and health educational. The "team," doctor, social worker and public health nurse is an idea that has been in the air a long time. The Home Care Program fully demonstrated the work of a multi-disciplinary team operation. The team of doctors in group practice is widely accepted and the setting of the Family Health Maintenance Demonstration in the environment of the Health Insurance Plan, in the Montefiore Hospital Medical Group, was natural. But the fact of the modification of the doctor's role to include other professional workers is not so generally accepted.

If I may be permitted a small digression, it would be to emphasize that the family doctor, currently the object of acute concern,

cannot be recalled with incantations. Sociological changes have engineered his gradual disappearance. (11) The same changes in our society that have ordered the change in the doctor's role have not replaced the social need for a "family doctor." The role has expanded, and the full expression of the doctor's job must now pass to the "team," who serve in their combined capacity what was once an individual job: family advisor, guide and confidant, as well as medical supervisor.

The origin and utility of another member of the team is graphically described by Richard Cabot (12) who writes "in the course of these efforts for a complete and exact diagnosis which should do justice to the actual needs of the patient, I found myself blocked. I needed information about the patient which I could not secure from him as I saw him in the dispensary—information about his home, about his lodgings, his work, his family, his worries, his nutrition." Cabot's solution to this dilemma was the development of the medical social worker. She has grown in stature and importance, through the years, but in hospitals and social agencies, not as the doctor's colleague in the office.

The social worker in general is coming to be recognized as an indispensable member of the health team, as can be seen in the job descriptions currently accepted (13). But still these represent a function dependent on disease evidence.

The public health nurse, third member of the health team, also represents a new departure, yet a natural facet of the doctor's job. Recognition of this role is expressed in Sheehan's concise description (14) of "family nursing service . . . embracing the threefold function of promotion of health, prevention of disease, and instructive visiting nurse service to the sick." She supplements and complements the medical and teaching aspects of the doctor's job.

Yet for both the nurse and social worker, as previously indicated for the physician, the Demonstration concentration on *health,* getting to people *before* they ask for help, is changing the picture of their professional function radically. The doctor, the social worker, the public health nurse are acting to prevent a breakdown inherent in a bad situation by correcting the situation before the breakdown

occurs. People are *offered* help and support before the traumatic need causes them to cry out for help.

And the health team then shares responsibility in the whole area of what was the doctor's job, although each tends to specialize in those matters where his greatest training and experience obtains. Medical care, diagnosis and treatment of sickness is clearly to be carried on by the physician; interpersonal relationships and mobilizing capacities by the social worker; information and education in the fields of nutrition, accident prevention, and environmental control by the public health nurse. But in child rearing practices, health education and preventive services generally, anyone or all the three might be active. There are no rigid categories, and each of the team members will act as the team decides, in some families in one capacity, in other families in another, since many functions overlap professional concepts.

This health team, combined functionally with the group practice team of medical specialists on the one hand and with the Demonstration consultants on the other, is actually the substance of the operation of Family Health Maintenance Demonstration. The health team, selecting areas of weakness and stress to work in, and distributing the work, has a natural procedure that will be described by others. But an outstanding objective of the Demonstration is the team operation, tapping sources of disharmony, preventing illness, and handling disease when present in the accepted manner of the particular profession. Perhaps we may see the physician visualized by Sigerist, (15) "scientist, educator and social worker ready to cooperate in team work, in close touch with the people he disinterestedly serves, a friend and leader who directs all his efforts toward the promotion of health and prevention of disease and becomes a therapist when his previous efforts have broken down."

And out of this type of operation grows the role of the team consultants also to be discussed more fully later.

The consultants played several parts before the team operation began—formulating ideas and assisting in the planning and evaluation procedures. The psychologist and psychiatrist, for example,

had to be concerned with definitions, establishment of psychodynamic principles and standards. The sociologist and health educator had to plan the group study and discussion framework.

And inasmuch as their consultant roles may differ sharply from their ordinary roles, the Demonstration may realign ideas. For example, if the psychiatrist is discovered to have primarily a teaching role, instructing and guiding the *team* to provide emotional care in the bulk of instances where families need help in neurotic difficulties, then, from the standpoint of society, the Demonstration will enormously multiply the reach of psychiatry.

As for the principles of action in fostering health, here again the team relied on accepted standards. In physical health, as for instance in nutritional status, the weight standards of the Metropolitan Life Insurance Company were used. And for a standard of emotional maturity, that epitomized in the phrase "ability to make and sustain confident, friendly, and cooperative relations with others." (8b) The emphasis of the teaching program was on the children, or the parents of young children (8c)—through the techniques of personal counselling, or through group meetings on subjects of common interest.

In the final category of objectives we mentioned the community values. Actually, much of what we have already discussed entails community values, too. But specifically, the medical school will be interested in curriculum modification that may aid the development of a family internist or pediatrician who is trained to play his part linked with colleagues of the medical profession on the one hand, and with colleagues from the "health team"—Social Work and Public Health Nursing, on the other. The medical schools will be interested in the role assigned to the psychiatrist, and its connotations. After all, a few thousand psychiatrists working with and assisting in the work of a hundred thousand doctors, social workers, and public health nurses will be able to offer psychiatric help to millions of people. All the professional schools, the nursing school, the school of social work, as well as the medical school, will undoubtedly see the Family Health Maintenance Demonstration as a proper teaching area within which to place students to learn their

parts in their respective professions—a reality situation in which knowledge is accumulated and judgment can be exercised.

Perhaps not among the least important objectives is the information collected. Because the cooperation of the family was enlisted at the time of registration, and the time consuming history taking and examinations were expected, no difficulty or falling off of enrollment was encountered.

So the tests and record forms give us a picture of the family and its constitution that we can use as a working base for estimating at the end of five years, whether there has been any change in the health of the families, and by comparison with control families, if it was our intervention that accomplished the change.

The information touches on many areas of peripheral interest.

For example, many people believe that the physical examination, routinely performed in a conscientious fashion, carries concrete values for the family and for the community. (16) This can be established from such data. All the material on the 150 families in the study—information on health, disease, family background, and cultural, social and economic factors in health and disease will be available. It can be mined by psychologists, sociologists, medical administrators and medical program planners for a long time.

We will have an opportunity of learning too, how acceptable health promotion is, and if accepted, how valuable. No matter how attractive a research demonstration is to the sponsors, or the investigators, results must be measured in the effect on the families. René Sand was thinking of this when he said, "Health cannot be simply given to the people; it demands their participation."

In conclusion, then, the Family Health Maintenance Demonstration in operation at the Montefiore Hospital is aiming toward objectives in three categories:—

1. In the first category, on procurement of data, it is attempting to show the needs of families in the area of physical and emotional health.

2. In the second category, it is providing health promotion and education, and preventive medicine by means of an interdiscipli-

nary team, aided by team consultants, within the framework of a group practice unit. The standards of physical and emotional health measured and taught are based on generally accepted terms within the field. Health teaching is part of the team function as a whole, as well as of individual members of the team. The roles of the team members and consultants represent a fresh approach to the organization of health services. The group meetings organized on the framework of family interest represent an important teaching medium.

3. The third category comprises those objectives in which the community will derive special benefits from the actual practice of health promotion. These are in relation to medical education, nursing and social work training, and also the accumulation of family life data which may offer information for further research and investigation by others.

All of these, of course, are in addition to the positive values we hope to add to 150 families who may benefit from the creative efforts of the health team members working with them in the Family Health Maintenance Demonstration.

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Solo or Symphony? Medical Group Practice Council, New York, 1946. "It has evolved from the necessity of bringing together *in an organized fashion* the great variety of special knowledge, skills, and technical procedures which together make up the modern medicine that students must be taught." (page 4)

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(a) "For the moment it is sufficient to say that what is believed to be essential for mental health is that the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment." (page 11)

(b) "The vast majority of cases, however, comprising all the neuroses and so-called personality disturbances have remained a mystery and the source of controversy. This is now changing as evidence accumulates pointing to the child's experience in his family in his early years as being of central importance for his healthy emotional development. The outstanding disability of persons suffering from mental illness, it is now realized, is their inability to make and sustain confident, friendly and cooperative relations with others." (page 91)

(c) ". . . giving of psychiatric help to parents, especially the parents of very young children, who are in a plastic phase of emotional development and who therefore respond rapidly."

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THE WORKING TEAM—
WHAT IS DONE—HOW IT IS DONE

THE PHYSICIAN IN THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

ROBERT S. AARON, M.D.

THE evolution of medical thought has brought us from the consideration of disease as simply symptoms, organs involved, and systems involved, to the consideration of a disease as it pertains to the entire individual. The phrase "the patient as a person" has become well-known and is currently popular in medical school curricula. We recognize that each individual responds to his illness in his own way and moreover, that illness affecting one member of the family has profound effects on the other family members. Depending upon which member of the family is ill and the past relations of the family members, the results of the illness will vary. When the country doctor diagnosed and treated he had the personal family background of his patient in mind. Today most of us usually do not have this knowledge. The increasing demand for social workers and public health nurses demonstrates the need for such information. The Family Health Maintenance Demonstration is geared to obtain and use such information on a practical basis.

After a new family has been contacted by a member of our team, the entire family receives a complete physical examination, the children by the pediatrician, the adults by me. Each adult completes a Cornell Medical Questionnaire which is used as an aid in obtaining a complete medical history. This history is quite complete since the time is available and we are interested in knowing the entire individual. It includes the conventional medical history plus social and sexual history. Each patient then receives a complete physical examination and necessary laboratory procedures. These include dental examination, complete blood count, urinalysis, sedimentation rate, electrocardiograph, fluoroscopy, and chest x-ray.

If other laboratory examinations are indicated by past or family history they are obtained. These, for example, may include determination of fasting blood sugar and a glucose tolerance test if there is a family history of diabetes; cholesterol studies if there is a family history of coronary artery disease; proctoscopy if there is a past history of bowel disturbances; G.I. series, Ba enema, etc. If consultation with other specialists is required, the reasons for such consultation are explained to the patient and necessary arrangements are made. Indicated medical therapy is begun at this time. I have found the medical problems to be of great interest and present perhaps in greater number than I would have anticipated in a supposedly healthy population.

After the family has been seen by the other members of the team, from whom you will hear shortly, we all participate in our staff conference. At this conference we pool all our information and discuss the individual family. Here we discuss all family members, their relationships to each other and to their environment, and of course their health status.

We regard health in both its physical and emotional aspects. Many of you may classify this as organic disease, psychoneurosis, or psychosis. However we have found in our random selection of persons, many problems which do not fit exactly into any of these categories. We have found problems, some common to many families, which have not been recognized as severe enough to warrant the family's seeking psychiatric help. However, they are severe enough to interfere with family function and may become even more severe if illness strikes the family. The popularity of the term "psychosomatic illness" also attests to the fact that organic and functional illness cannot always be separated easily.

With this in mind, we determine at the staff conference just what, if anything, is to be done for the family and its individual members. Of course organic disease per se is handled by the pediatrician or by me. Even in this sphere, however, other team members may participate in handling such problems as obesity, special diets for different family members, or preparing the patients psychologically for surgery. In addition, where emotional problems may well play

an important role in the illness, such as in duodenal ulcer, asthma, and hypertension, all members of the team may cooperate in treatment. However, my own function does not stop here, since I also follow through on other problems, including marital and parent-child difficulties. Such service, when necessary, usually can be handled by any team member. In these matters I frequently consult with our consulting psychiatrist as well as with the social worker as to any problems of management during the course of therapy. We do not attempt to handle psychoses or complex psychiatric illness. These are referred to psychiatrists or other agencies. However, even in these cases, we have a responsibility. If such patients are not ready to accept psychiatric help, we work with them toward this end.

After the staff conference, the adult family members meet with the team—the pediatrician, nurse, social worker and myself. This family conference is informal and takes place at a mutually convenient time. Here we present to the family those findings and recommendations decided upon at our staff conference. At this meeting, most of our patients talk freely and show interest in continuing with our recommendations.

Many of our recommendations are in the field of preventive medicine and the maintenance of good health, as we have defined health. Annual examinations will be performed, and when indicated more frequent examinations will be made. When family problems which may interfere with function are recognized by the team, they may, or may not, be indicated at the time of the family conference. This will depend upon the makeup and attitudes of the individuals involved. Frequently, we will recommend that one, or both, of the parents come back to see one of us in regard to a particular problem or area of difficulty. Later, in certain instances, an attempt may be made to have the person involved recognize his own basic difficulty. Many of our patients feel better simply because we represent an objective third party.

At the family conference, the patients are encouraged to talk, and in this atmosphere even further information may be obtained. Not infrequently we find that husband and wife at these conferences

discuss matters which they were unable to discuss with each other in the past.

Another method we employ is that of group discussions. Last year we had a very successful discussion group on parent-child relations. All the team members participated, as well as the interested parents. In the future we anticipate more such meetings on a variety of subjects. These groups will be led by a team member. There will be groups not only for parents, but for teenagers and children as well. You will hear more about these meetings later from Mr. Shapiro, our health education consultant.

In addition to participating in the before-mentioned functions, I am, of course, "the doctor" to these patients. Rather, I am their personal physician and carry out all the functions and responsibilities inherent in a patient-physician relationship. With all the information and personal contact available, this patient-physician relation is very strong and trusting. It is even further strengthened by the frequent opportunities for informal contacts with the patients when they are visiting other team members. Even when consultants are used I still am able to practice my specialty and remain the patient's personal physician by following through for them and speaking to them frequently during the course of their treatment. Frequently, I am present at the time the consultation is made and, if not, I am in contact with the consultant. In this manner continuity is maintained both in therapy and in our relationship. Often our patients will come to me with problems not related to organic diseases which, I think, indicates their confidence. Although I have had no formal psychiatric training, my contacts with the other members of the team, as well as the consulting psychiatrist, have helped me to the extent where I can more intelligently handle many of these problems.

During the entire discussion I have referred to "the team." This consists of a group of trained individuals, from whom you shall hear, practicing teamwork. This teamwork is dynamic and well-integrated. It appears that in our modern society it is necessary to have such a team in order to know the family and properly maintain its health. Members of the team are well-trained and play

specific parts, although in many areas these parts overlap. In other words, each member is trained in his or her own field, but each fortunately is personally flexible and can adapt to the needs of the patient and the team. Actually this is not a new concept. Most of the recent major contributions and advances in scientific and clinical medicine have been made by teams—teams consisting of internists, surgeons, physiologists, chemists, etc. Our team relations differ from the traditional nurse, social worker, and doctor relation. It is completely democratic and no one person is "the boss." It can be compared to an athletic team. There may be one disadvantage in that there is no captain of this team. However, the advantages of such a set-up, in that it makes for informality and a free exchange of ideas, may well outweigh this disadvantage. This is something to which I personally had to adjust. The adjustment has not been too difficult.

I have also found the matter of academic opportunities most gratifying. There is time for me to participate in other research and clinical medicine. My function as attending physician at the hospital, member of the cardio-vascular research group, and my interest in teaching have not suffered. If anything, I have found that there is more time available for these activities.

As in most new experiences and experiments there have been some grievances and annoyances. But in analyzing some of my own "gripes" I find that they are not inherent to the practical application of our demonstration. Rather they are present because this is, in a way, an experiment, and laborious details and evaluations appear to be necessary so that others as well as ourselves may learn from this experience. Another possible problem which has been brought to me by some of my colleagues is that of "spoiling the patient." As you can well realize our patients receive a great deal of attention from us. In their contact with other facets of the medical care involved, such as laboratory and consultation, our patients show annoyance if there is waiting or if the procedure is rushed. I do not feel that this is "spoiling the patient" but does perhaps indicate some of the short-comings of the other services in regard to the relationships with the patients.

There is still one reservation which I have and should like to mention. Our team is set up to include an internist and a pediatrician. By doing this we no longer have a complete "family doctor." It would perhaps be more advantageous to accomplish our aims if there were but one physician to care for the entire family in most of their illnesses whether pediatric, obstetric, or surgical. There is no doubt in my mind that this would be the ideal situation. In our urban community, however, where the lay public wants and expects specialists and particularly a pediatrician for the children, it would have been quite difficult to interest families in participating in our program without specialists.

Unfortuately, it is much too early to present results. We are in the process of attempting various methods of scoring, statistics, and analysis which you will hear of later. As for myself, the Family Health Maintenance Demonstration has thus far for the most been quite satisfying and educational. It has been satisfying from the point of view of a complete way to practice medicine, to know each patient well, and to participate fully in any help he may need. I have learned a satisfying new approach to medical practice which I had not encountered in my training days. Some of the concepts which I have discovered through working with the team have been incorporated in this discussion. In summary, these include: 1. The recognition of the family unit and the role the individual members play in this unit. 2. The recognition of a broader aspect of health, not strictly limited to organic disease. 3. The advantages of practicing preventive medicine and health maintenance. 4. The need for teamwork and my ability to participate in it in order to accomplish all this.

THE PEDIATRICIAN IN THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

ESTELLE SIKER, M.D.

PREVENTIVE medicine and the understanding of emotional problems are not new areas in pediatrics. However, the Family Health Maintenance Demonstration is a new and challenging experience. Here, the pediatrician is a member of a team consisting of family doctor, social worker, public health nurse, and pediatrician, a team concerned with the physical and emotional welfare of the family as a whole.

Often, my first introduction to the family occurred even before the initial examination of the children. I met the parents and the children when they came in for interviews with other members of the team. This was helpful in allaying apprehension on the part of the children. The pediatrician cared for boys until 12 years of age and girls until 15 years of age because adolescence is an area of great interest to pediatricians.

At the first visit, the children were encouraged to play in our well equipped play area with the social worker or nurse often acting as an interested baby sitter so that I might obtain an extensive history from the mother. Since the fathers were so intimately involved in this program they frequently were present when their children visited the pediatrician. A detailed medical history was taken and records were obtained from other physicians and hospitals. In addition, well integrated with the medical history was what we called the "psychological profile." This consisted of a series of questions, the answers to which point up attitudes toward the practices of child rearing. Together with the routine questions about type of delivery, baby's birth weight were included questions about how the mother felt during pregnancy, whether she was interested in breast feeding, wanted a boy or girl. This information is now obtained by

the social worker. Above all the mother was given ample opportunity to speak freely with the pediatrician.

A complete physical examination followed the history. This included testing by the nurse of vision and hearing, using the audiometer in children over the age of 5 years. Over the age of two, routine blood counts and urinalyses were done once yearly. Chest x-rays were done routinely over the age of 12, otherwise x-rays and laboratory procedures were done as indicated.

If the complete history and physical examination revealed illness or defects or urgent behavior problems, these difficulties were discussed with the parent at the initial evaluation and treatment instituted. For example, a family history of diabetes with a complaint of excessive thirst called for further investigation; or a sore throat found on examination required the immediate institution of antibiotic therapy. The findings of defects called for immediate referral to other specialists.

All types and all degrees of preventive health service were possible in the Family Health Maintenance Demonstration because of the fine cooperation of the families. Infants under one year of age were seen by the pediatrician once a month, examined and advice given the parents concerning feeding, development and behavior. Babies between one and two years of age were routinely examined every three months; children between the ages of two and five were examined every six months and children over the age of five years had routine examinations annually. Where a family history of diabetes was present, a urinalysis was done every six months. Vision and hearing were checked by the nurse annually.

The immunization schedule as well as the time interval for routine examinations followed that recommended by the American Academy of Pediatrics. All the children on our program were immunized against diphtheria, tetanus, pertussis and smallpox and received boosters to supplement the original immunization. On the basis of advice from Drs. Lincoln and Brailey, we instituted routine tuberculin testing starting at six months of age.

I.Q. testing was done where there was a question of retardation or maladjustment in school. In the past year, the consultant psy-

chologist on our program has started to administer the CAT to the children routinely.

The Family Health Maintenance Demonstration offers a wonderful opportunity for a pediatrician to collect longitudinal records of growth and development for all the children in his care. We used the Wetzel Grid upon which to record the progress of our children. This type of recording can show movement, allows for the variability of body build and expresses the range of norm in percentiles.

Sick children were seen either in the office or at home depending upon how incapacitated they were by their illness. An acute illness was handled immediately; a non-pressing problem was handled at a regularly appointed office hour arranged by the nurse.

As in any pediatric practice, telephone consultations were an important form of contact with the parents. Problems were often handled in this manner without seeing the child, in addition the nurse on the program also handled the phone calls for minor matters such as the type of vitamins to administer and advice for colds.

Incidental contact with families is unique to HIP and especially the Family Health Maintenance Demonstration. There were many opportunities to remind parents about immunizations or discuss treatment when we met by chance as they were making appointments or keeping appointments with other members of the staff. In addition there was opportunity to talk with the older children and discuss how they were getting along in school, socially, etc. I also recall the evening when, as one of the mothers on our program and I met as we were purchasing gloves in a local department store, we also discussed how to treat Freddie's mild conjunctivitis.

From the moment the family accepted the Family Health Maintenance Demonstration, the team was in operation. The pediatrician was informed by the nurse about pregnancies; we often had to care for sieges of respiratory infections before the initial evaluation. In one case before the family evaluation was completed, the team with the advice of the psychiatrist, recommended postponement of a tonsillectomy in a two-year-old child and in addition supported the parents in their acceptance of this decision. After initial

examinations, the nurse and I often discussed some of the apparent problems in parent child relationship and formed a plan of action to help the family. For example a mother at the initial evaluation of a child presented a feeding problem as the chief complaint. Preliminary advice was given by the pediatrician at that visit; the pediatrician and nurse then consulted and a plan was established whereby the nurse would continue the discussion of feeding technique with the mother. These illustrations are an attempt to show the close, daily working contacts between team members.

Once the evaluation was completed, the team at a formal meeting time held a conference about a family. At this time, all aspects of the family life, physical, social, emotional, economical, etc. were discussed. We found that very often the parent-child relationship area was one in which parents were uncertain and children troubled. This was an area in which we could offer positive suggestions and guidance. At the team conference we planned the recommendations to be made to the family. These recommendations touched on various aspects of living such as the sleeping arrangements of parents and children, recreation and time spent with the children, family attitudes toward child rearing and discipline, referral to specialists for corrections of defects or early detection of physical problems and corrections of dietary habits of both parents and children. Before we were able to make recommendations, we had to be well acquainted with the family's economic status, so that our suggestions were within the realm of possibility.

Consultants were used freely on our program. For medical consultations the pediatrician used the HIP specialists. For example, if there was any question of impaired visual acuity on our gross testing, the child was referred to the ophthalmologist; a child with a hernia was referred to the surgeon for correction. The pediatrician personally discussed the problems involved with these other specialists.

We discussed with our consultant psychiatrist the techniques in child rearing used by parents in areas such as feeding, sleep, toilet training, and the possible effect of their attitudes on the children. He helped us determine the families who required referral to out-

side agencies for psychiatric help and those whom we might be able to help on our program. Usually, where support, education, or correction of attitudes was necessary, the pediatrician played an important role.

A family conference was then held with the parents, family doctor, pediatrician, public health nurse, and social worker attending. At this meeting, the pediatrician discussed in detail the findings on the physical examination of each child, the results of the laboratory work; discussed the growth and development of the child, the specialist referrals if any and their significance; recommendations for immunization; changes in diet to be worked out with them by the nurse. Here the team tactfully discussed with the parents, the attitudes and anxieties of the parent-child relationship with which the family needed help.

Like the other members of the team, the pediatrician kept a record of type and number of services given to the children on the program. On the initial evaluation sheet, the pediatrician completed the sections on family history, physical condition, nutrition, sleep, and personal adjustment and interfamily relationship wherever it was felt a valid opinion could be given.

Thus far, I have outlined the methods and procedure utilized by the pediatrician on the Family Health Maintenance Demonstration. Now, it is important to consider what advantages, if any, are offered to a pediatrician under such a scheme of team operation. First let me say that in no other situation is a pediatrician able to integrate himself so completely with the family unit. Working with a public health nurse and a social worker increases the helpfulness of the pediatrician to the family. The information furnished to the pediatrician by the investigations of the other team members is indispensable once it has been experienced. The average pediatrician attempts to educate and guide mothers in their attitudes and to handle emotional problems, manifesting themselves in various behavior disturbances. How often does the average pediatrician meet the father? The receptionist may inquire as to the family income, but does the pediatrician really have any idea of the actual day to day living of the family; rushed, on a house call, the pedia-

trician gains little insight into the values and motivations of the average family. Yes, in the exceptional case where a severe behavior problem requires immediate attention, investigation and referral for psychiatric help, the doctor becomes more familiar with the family as a whole.

In Family Health Maintenance, what a wealth of information is furnished to the pediatrician; the actual home conditions; detailed diets of children, including those who don't eat a thing all day long according to mother; the school teacher's report on how the child is doing both in school work and extracurricular activities; the family economic situation; the backgrounds of the parents with their inherent attitudes; the results of the psychological tests of the parents which cast some insight into the problems they may have in relating to their children. The pediatrician finds out how much time families spend together, whether children apparently overprotected in the doctor's office are actually emotionally starved at home. These are but a few of the many advantages offered by team operation in getting to know a family.

The amount of education and guidance generally offered by the pediatrician to a parent is but a drop in the bucket when compared with the possibilities for guidance offered by such a team. The other papers will clarify how the various team members function with the pediatrician in educating and advising parents about child health, development, and in imparting a healthy understanding of child rearing to families. In addition, we feel that we may be able to help children with emotional difficulties whom the average pediatrician would have to refer to almost non-available and inadequate guidance centers. The pediatrician no longer has to throw up his hands in frustrated desperation over problems he feels he can do nothing about; in Family Health Maintenance Demonstration he receives the assistance of the family doctor, the social worker, and the public health nurse.

As can be seen, such a program is a time consuming one for every member of the team. However to reduce the time spent with parent and child means to diminish the amount of insight into the parent child relationship. To properly evaluate a family team conferences

are necessary. The necessary medical care, team conferences, consultant conferences and family conferences call for the services of a full-time pediatrician.

Therefore the problem encountered which stems from the time consuming and expensive nature of such a program is the degree of participation required by the pediatrician. The Family Health Maintenance Demonstration is being conducted in an urban area where families are educated to the use of a pediatrician for their children and demand such care. We realize such is not the case in most semi-rural and rural areas. Thus in an urban center we can follow either of two courses. The first is to use the pediatrician as a consultant just as the other medical consultants with perhaps a weekly meeting with the team. The alternative would entail a full-time pediatrician as an active member of the team.

To use a pediatrician as a consultant is to deny the families the services of a person trained in preventive medicine and the understanding and the ability to help families in the realm of the parent child relationship. Therefore, I feel that in communities where the services of a pediatrician are available, the pediatrician should be an intimate member of the team.

Appendix

Complete physical examination includes height, weight, circumference of head, chest and abdomen, in infants up to 1 year.

Immunization Schedule. DPT (triple vaccine containing diphtheria, tetanus toxoid and killed pertussis bacilli) started at 3 months of age. Booster given one year after completion of original series, then in two years and every three years thereafter until age 10 after which only tetanus toxoid was to be continued.

Smallpox vaccination in the first year of life, to be repeated every five years until graduation from high school.

Mantoux Testing Schedule. Routinely used 1/10 mg. O.T. intracutaneously where there was no previous positive report, or no suspicion of tuberculosis or chronic respiratory disease. The first test was given at 6 months of age, to all new children on the program, and was to be repeated at ages 3 and 12 years. In between, the Vollmer patch test was to be used at ages 1, 2 and 5.

Discussion

Chairman Baehr: The point Dr. Siker made about what the families expect in return for complete prepayment of medical care and with regard to pediatrics is interesting. Families in this City generally expect the services of the pediatrician for young children—certainly during the first year of life when most of the preventive services are required.

In 1949, after the study of the American Academy of Pediatrics had been published, the thirty medical groups in the Health Insurance Plan of Greater New York were required by the Medical Control Board of the Plan to provide routine pediatric care to all children up to school age. It was decided that the influence of the pediatrician was required for growth development and behavior problems of children which otherwise were not being handled adequately by the family doctor of the insured family.

It has not been possible to accomplish this in all thirty medical groups throughout the City because the pattern of medical practice differs in different parts of New York City from a rural pattern in most parts of Staten Island, and even some parts of Queens and Nassau Counties, to a very highly developed urban pattern in Manhattan and Brooklyn. In Manhattan and Brooklyn most of the medical groups have advanced their routine pediatric services even up to puberty, as has the Montefiore group, whereas some of the groups in some parts of other boroughs have been able to include routine pediatric care in addition to the family doctor's services only up to school age (6), and still other groups have not been able to bring it beyond the end of the first or the end of the second year as routine care.

I speak of routine care in distinction to consulting services, which is a totally different kind of pediatric service. A consulting pediatrician sits in his office and has the children brought to him with major disease problems. He rarely enters the home. When the pediatrician is responsible for the routine care of the child, he makes most of the house calls. In fact, house calls constitute about 30 per cent of all the professional services by pediatricians who serve as the family pediatrician. When pediatricians sit in their offices as consultants, the percentage of house calls made by them is very low. Most of the house calls are made by the family doctor, often without consultation with a pediatrician.

THE PUBLIC HEALTH NURSE[1] IN THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

HELENE RINGENBERGER, R.N., B.S.

THE public health nurse in the Family Health Maintenance Demonstration is a member of a professional team concerned with the evaluation and promotion of family health. She coordinates and integrates her functions and services with those of the doctor and psychiatric social worker on the team, confers with consultants and other staff personnel. The nurse visits homes and schools to assess environmental conditions, records, and evaluates these data. She gives health counseling and teaching to families and assists with health examinations. She aids in the determination and evaluation of family environmental and health needs, and in team planning with families to meet these needs.

What I should like to discuss are two questions: How does the public health nurse carry out these functions on the Family Health Maintenance Demonstration? What are some of her problems?

Families invited to participate in the Family Health Maintenance Demonstration are interviewed by the psychiatric social worker or the public health nurse on the team (there are two teams) to which they are assigned. The nurse, or social worker, (1) outlines the background, objectives, and goals of the program; (2) explains the procedures necessary to a total health inventory, estimates the time needed for each, and describes the services offered; (3) encourages the family to give careful consideration to all these factors. To avoid possible misinterpretation, she sees husband and wife together.

The facts must be clearly presented in the interview to gain the family's participation and cooperation. Responses vary: some families are intrigued by the Program's broad concept of health and its research aspects; others are more interested in the services available

[1] Miss Bertha Kahn is the public health nurse on the second team.

to them on the Family Health Maintenance Demonstration; a few families express interest but are unable to participate because of special circumstances, such as plans underway to move out of the district or to terminate HIP contract.

When a family decides to participate in the Family Health Maintenance Demonstration, all members are given appointments for initial health examinations. The public health nurse assists with the medical examinations and gives hearing and visual acuity screening tests. She gives necessary routine immunizations to the children under the direction of the pediatrician and interprets their purpose to the family.

While engaged in these various activities, the public health nurse observes and notes individual reactions and intra-family relationships. She interprets recommendations and laboratory or other service procedures. These contacts give the nurse an opportunity to build up good relationships with the family, and to discuss and plan office and home interviews.

For scientific and statistical evaluation of the health status and needs of families, comparable data on environmental factors and health practices are needed. The public health nurse in her home and office interviews with family members is responsible for assessing and evaluating certain environmental conditions with respect to housing, nutritional habits, sleep, rest, recreational practices, and intra-family relationships.

In the preface to his book HOUSING AND FAMILY LIFE, (1) J. M. Mackintosh states that "The house is the temple of family life and its soundness is closely interlocked with the family health." The public health nurse obtains factual information on housing conditions by means of a written questionnaire. Home management, accidents or health hazards, and that more intangible factor, the soundness and emotional climate of the home, are assessed by means of observation and interviews during home visits.

The fact that the present housing situation limits the number of homes which offer positive advantages in space and facilities for comfortable living is not the whole story. Any degree of crowding requires that adjustments or compromises be made. But how they

are made, and the attitudes of the family members are what count. People, not houses, make a home. For example:

> Family "A" has four small children. They live in a three-room apartment on the fifth floor of a walk-up. Home management is further complicated by a marginal family income, lack of adequate laundry facilities and storage space. Of course, the family would prefer a larger apartment with the advantages of more space and better facilities. In the meantime, they do not allow their present housing conditions to interfere with happy family living. The family makes good use of the space and resources available. Furnishings are kept simple; they are so arranged as to provide maximum play space for the children. The baby takes his airing on the roof. The older child attends a nursery school part of the day. The father watches for "specials" in the super-market on his way home from work. (He jokes with his neighbors while hanging diapers on the roof before leaving for work.) The mother is busy, but plans her daily activities so as to be able to spend that valuable time with her children which is so necessary for good parent-child relationships.
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> Family "B" has similar housing problems. Here, however, there is a vast difference in the family's ability to cope with the situation. The mother does not know how to face her multitudinous duties. The children sense her tension and react by quarreling with each other. The apartment is usually in a state of confusion. The husband sympathizes with his wife but is at a loss as to how he can help her. In this situation, the nurse with her intimate knowledge of the home and community helps the family with planning daily activities so that there is better use of time and effort for more comfortable living.

We have found that not all problems in home management are related to over-crowding. For instance, Family "C" has a spacious apartment but the mother is a compulsive housekeeper. She is torn between her need to keep the home spotless and tidy and her children's demands for more freedom in play activities. She needs help with understanding the play needs of her children and in planning to meet these needs without disrupting the entire household. Such

help will not solve her basic problem but it may reduce some of the tension in the home.

During the home visit, the public health nurse obtains individual diet histories and details about family eating patterns. Usually, the father is not at home and his food habits are discussed with him in an office interview. The nurse uses this information as a basis for helping the family meet the individual nutritional needs of its members within its own cultural pattern. Two common problems we have to deal with in this area are (1) obesity and (2) the fact that many mothers tend to neglect their own nutritional needs while busy caring for those of other members of the family.

We are interested, too, in what happens to the child at mealtime. He is, of course, deeply affected by the way his parents act and feel about the way he eats. Parents are naturally concerned that their child eat, but too frequently we find that their very definite ideas on the amount of food or the way to eat it conflict with the child's needs at that particular stage of his growth and development. A review and evaluation of the child's eating pattern for the past few days or weeks in terms of his nutritional needs is sometimes all that is necessary to reassure the parents. Johnny, for instance, finding the atmosphere at the table more relaxed and his parents less concerned about what he eats, may surprise himself, and them, by developing a hearty appetite.

The nurse discusses the child's behavior at mealtime with his family in order to gain a clue to his needs so that his parents may be helped to understand and meet these needs. A loss of appetite in an otherwise healthy child may indicate some insecurity because of a need to adjust to a new situation. Three-year old Jimmy, confronted by a new sibling, may need to regress to more infantile behavior at mealtime until once again he is assured of his place in the affections of his family. Eight-year old Anne may not be able to eat breakfast because of her need for help in adjusting to a new school. It has been our experience that many eating problems in children stem from the child's reaction to the excessive demands and pressures of his parents in many areas. Much is done by helping parents understand the psychological as well as the physical needs

of their children. In a situation, however, in which a parent is unable to respond to an educational approach until his own deep-seated emotional conflicts are resolved, our close working relationships and the informality of the setting facilitate the participation of the psychiatric social worker in the helping process.

During family interviews, the nurse is responsible for obtaining information on individual rest habits. While it is true that the physiological processes of the body require that a person have a minimum amount of sleep and rest if he is to function at all, the amount of sleep needed to promote and maintain optimum health is as individual as the person himself. Therefore, in addition to the number of hours of sleep, we are interested in its restful quality which may be affected by the person's posture and the type of mattress or bed as well as by the accumulation of nervous tension and frustration.

A common statement made during interviews is, "I get eight hours sleep but I am always tired in the mornings." All of us, I am sure, have experienced mornings when we are loath to get out of bed and face the realities of the day. When this becomes a chronic pattern, investigation into causal factors is indicated if healthful living is to be achieved. Few, indeed, are the individuals not affected by the tensions of modern living with its accent on competitiveness in all areas.

The child's sleep habits, too, are related to what happens to him day by day, his reactions to these experiences, his feelings of security or helplessness, adequacy or inadequacy. His sleep habits may reflect the tensions in his home or school situation, the quality of his relationships with his parents or unfavorable physical environmental conditions such as lack of opportunity for outdoor play.

Simple environmental conditions which affect the child's sleep are often more easily correctible than psychological or emotional factors. Comfortable clothing, better ventilation, changes in routine, more active outdoor play, or less stimulating activities prior to bedtime; one or more of these may be the answer. In some situations the family may need to change its sleeping arrangements. Mary, for example, is a healthy, happy youngster, who at two years

of age began to protest being put to bed. She slept in a crib in her parents' bedroom. Leaving a light on or the door open, or sitting with her had no effect in subduing her screams. The parents in desperation tried reducing her nap periods and awakening her earlier in the mornings. These methods only served to make Mary irritable. The child would play happily all evening and sleep a good twelve hours after everyone was in bed. The fact is, Mary was getting adequate rest. But her parents were finding less and less opportunity to indulge in quiet evenings of relaxation together or with friends. Mary is a delightful child. Both mother and father enjoy her thoroughly and were deeply concerned about their growing resentment of her interference with their few cherished hours together. Mary's mother, in particular, found herself growing tense and irritable, her own sleep disturbed by frequent headaches and insomnia. The solution to this particular problem, based upon psychiatric considerations relating to both the child and her parents, was a change in sleeping arrangements. Following a recommendation to this effect made during a family conference, the parents arranged to sleep in the living room, turning over the bedroom to Mary. Within a short period of time she was once more going to bed cheerfully at a reasonable hour. The parents found that the easing of the tension well repaid them the inconvenience of having the living room serve a dual purpose.

Problems such as this one sometimes appear to be minor at first glance. If they go unresolved, however, their effect on family living can start an insidious cycle of mounting family tensions.

Recreation makes an important contribution to family health. We know that family fun helps to cement good family relationships as well as provide needed relaxation for the individual. What are each individual's needs, and the interests of the family as a whole? How are these needs being met in terms of the family's own resources and the community's facilities? What factors in the family's situation make the fulfillment of these needs more difficult? These are some of the questions the nurse keeps in mind when interviewing a family about its recreational practices.

A realistic factor for many of our families is the father's lack of

opportunity to spend time with his family. We hear much about the forty-hour work week and the growing availability of leisure time. However, our high standards of living, coupled with high costs, drive many men to seek extra jobs. We feel that it is all the more important then that what leisure time is available be spent profitably and economically in terms of physical and mental re-creation and family fun.

The forty-hour work week has little meaning for Mrs. X., a busy housewife and the mother of several small children. Baby-sitters are expensive. Yet, a dinner out may repay itself many times over in lessened fatigue. Both she and her husband may need help to appreciate that she can be a better mother and homemaker if she is a rested and relaxed one. Frequently, the recognition of the relation of recreation to health encourages a family to budget realistically for fun without the need to rationalize guilt feelings about it.

How well are the child's play needs being met? Do his parents realize that he needs to explore, to experiment, and to experience in order to learn about the world, or are they too over-protective? What are the child's relationships with his peers and his siblings? These are some of the questions the nurse considers when making home visits. Frequently she has an opportunity to observe the child at play. Is he hemmed in with too many parental "don'ts"? Has he simple constructive play material that will give full range to his imagination or is he bored with mechanical toys that break easily or frustrate him? What opportunities and resources are there for safe outdoor play with his peers? Are there accident hazards in the home? The growing list of children injured each year throughout the country is a serious public health problem which challenges all of us.

Because the school environment and the child's reactions to it vitally influence his personality development, the public health nurse, with parental permission, visits the child's school and notes the general atmosphere and its physical facilities and equipment. She confers with the child's teacher and school nurse and discusses his adjustment to the classroom situation, his health needs, and his relationships with adults and peers. She shares pertinent information

with school personnel for better mutual understanding of the child's needs and offers cooperation in planning to meet these needs.

When all members of the team have completed their initial contacts with family members and have recorded and evaluated (according to presently accepted standards) the data obtained in these interviews or examinations, they meet to discuss findings. The team arrives at a composite evaluation of the family's health status and the need for change, if any, to promote more positive social, emotional and physical health. All members of the team continue to have contact with the family but depending upon such factors as the family's interest in help, the type of need, the priority of any one need, the quality of rapport established, and the distribution of the workload, one team member may plan to work more intensely with a particular individual. The findings and recommendations of the team are discussed with the adult members of the family in a joint family conference.

The primary purpose of the family conference is the encouragement of a broad concept of positive health. The family is encouraged to discuss and appraise its health needs, to raise questions, and to express how it feels it can use the services offered by the Family Health Maintenance Demonstration. The public health nurse, in conjunction with the other team members, plans with the family the use of her services if these are indicated at the time.

How much service the public health nurse gives to any one family depends on the needs which fall within her competence to meet and the family's ability to make constructive use of her services. The public health nurse in the Family Health Maintenance Demonstration gives "simple" services such as encouragement of continued good health practices, "complex" ones such as family counseling and teaching throughout the maternity cycle, "intangible" ones such as the encouragement of better parent-child relationships, and "concrete" ones such as the demonstration of formula-making, corrective exercises, or aid with planning family budgets. In her article, "The Public Health Nurse as a Family Counselor", Ruth B. Freeman (2) sums up the public health nurse's services in this area in these words: "Family counseling is concerned with understanding

and redirecting emotions and attitudes as well as with the provision of sound health information in a wide range of health situations." The staff consultants offer the public health nurse additional background in theoretical understanding and a view from other disciplines that helps to clarify problems and assists in actual educational work.

The public health nurse in the Family Health Maintenance Demonstration also helps families secure bedside nursing services, if indicated, from other agencies and maintains contact with these agencies for the exchange of pertinent information and joint planning. Only in unusual circumstances does she give direct bedside care. However, families are encouraged to contact us about illness situations and much teaching is done with regard to home nursing.

The amount and kind of service the public health nurse gives is primarily determined by the time available to her. To date there are 100 families participating in the Family Health Maintenance Demonstration. They were not referred nor did they voluntarily seek public health nursing services. These services are offered to them as part of the total program, not simply in response to felt needs at the time of joining the program. How much the families use the nurse's services depends on their relationships with her and the program as a whole. We have had a good response and the multiplicity of services which the public health nurse can give is limited only by the time available. For example:

> There are many families for whom some nutritional teaching is indicated (only forty-five out of the 409 individuals on the program can be considered to have excellent food habits). Approximately 7 per cent of the adults are 20 per cent or more overweight; 25 per cent are between 10–20 per cent overweight. A larger percentage have food habits which if continued over a period of time probably will result in overweight. Mortality and morbidity studies of insurance companies testify to the harmful effects of even moderate obesity on health.
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> There are approximately fifty families in which the home crowding index is 1.0 to 1.5 persons per room and ten families in which it is 1.5 to 2.0 persons per room. Much can be done to help these families make better use of the space and facilities available

to them to lessen the amount of fatigue and frustration which such conditions frequently aggravate.

There are many parents who have the many questions about child care we know so well—when and how to start toilet training; how to prepare and introduce new foods; how to give sex information; what to do about sibling rivalry, etc.

Teaching in the areas of nutrition, home management and child care takes time, and to be effective must be related to the individual's readiness and recognition of need. For example: we have found that in addition to help with planning a well-balanced, low caloric diet, the individual who is overweight needs continued support and encouragement as well as help with meeting his psychological needs in a more mature manner. We have found too that although a large proportion of the parents on the program have good educational backgrounds, many experience difficulty in relating knowledge about child care and child rearing to their own particular situations.

The public health nurse's main problem in the Family Health Maintenance Demonstration, then, is deciding where to concentrate her efforts. The initial home visit to discuss and observe environmental conditions, health practices, and intra-family relationships takes an average of one and one-half hours. The father is seldom home at the time and it is usually necessary to arrange an office interview with him. Teen-agers frequently are seen individually. These interviews are of little value unless time is allowed for the individual to talk about his feelings and his needs as he sees them. School visits average one-half hour per school child. The geographic distribution of the families is such that few families have children attending the same school. Because of the age differential, children in the same family may attend different schools. Travel time for these visits must be considered. The compilation of the data discussed above for statistical analysis, its recording and evaluation are time consuming. In addition, the public health nurse spends one-third of her time in such functions as assisting with initial, annual, or, in the case of young children, more frequent health examinations; administering initial and annual hearing and visual acuity

screening tests; and in giving routine tuberculin tests and immunizing agents to children. Thus the nurse at present has a limited amount of time available for important follow-up work.

Presently, the public health nurse is devoting most of the time available to her for teaching, to those families in which there is an expectant mother, a young infant, or preschool children. She is giving priority to those families in which there is a very definite health or environmental hazard. It is planned that as intake of families is completed, the time now spent for initial interviews can be used for planned group discussions. A number of such groups is visualized; with mothers of small children and with individuals interested in weight control. Time will continue to be needed for annual evaluations of the health practices of all individuals for statistical purposes, and to determine continuing or changing needs.

The public health nurse must decide just what proportion of her time should be given to routine office nursing services, to planned individual health teaching or to group health teaching, in order to utilize her skills most effectively. However, regardless of the particular setting and emphasis, the realization of the nurse's objectives depends to a marked degree upon the support, encouragement and interpretation which she is able to extend to the families in conjunction with the other team members.

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THE PSYCHIATRIC SOCIAL WORKER[1] IN THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

CHARLOTTE STIBER, M.S.S.

IN looking back on the two and one-half years of activity on the the Family Health Maintenance Program, it appears that there have been two distinct and yet related roles which have evolved for the social worker. One has to do with the actual work with the families and the other with the social worker as a member of the team. I have said that these two are interrelated because what the social worker is to do and how she is to do it depends in great part on how clearly all team members are aware of their own roles and how these interlock. I would like first to describe the role of the social worker in relation to the families on the program.

Once the family has accepted, the social worker arranges an appointment to interview individually both the husband and wife. This interview takes place in the office, although I have on occasion seen a mother in her home because of apparent difficulty in coming to the center, but have found the atmosphere of the home more constrictive because of the lack of privacy.

What is the purpose of this initial interview? It has several purposes: To get from the individual his conscious report as to his understanding of himself in relation to his job, his spouse, his children; his areas of tension, dissatisfaction and concern; and his goals, satisfactions, and interests. From our point of view, the interview is a diagnostic tool to help us to differentiate the healthy from the unhealthy; the well functioning from the poorly functioning; to determine where tension, strain and dissatisfaction exist; and how willing, ready and insightful the individual is about himself and his needs. As Allport has recently pointed out in an article in the January, 1953, issue of the *American Journal of Orthopsychiatry,* both

[1] Miss Hanna Bamberger is the Psychiatric Social Worker on the second team.

direct interviewing and project tests must be used in any diagnostic study if we wish to differentiate the healthy from the psychoneurotic.

Since we cannot hope to study in detail every aspect of the personal life, certain areas, such as work history, relationship to wife and children, etc. have been selected. The interview may last from one to three hours and as such differs from a more orthodox intake interview in several ways. First is the fact that these people, by and large, have not specifically sought out us or anyone for help. Of the 100 families on the program to date no more than 10 per cent have consulted a psychiatrist or social agency for help in the past. Indeed, very few of these families, even less than 10 per cent were known to any social or health agency prior to our contact with them. (All cases are cleared for information with the social service exchange although the lack of registration is not necessarily significant since many agencies do not register their cases.) But the fact that they have not sought help means that they bring to the interview heightened concern over what will be uncovered. Much more information is solicited at this interview than is generally attempted in a first interview. The arousal, therefore, of too much anxiety must be avoided, yet the way left open for further study and treatment. The fact that the spouse is also seen has great meaning for many. Some speak of relationships and situations about which they would not ordinarily because they feel that these are matters of concern to the spouse and will be mentioned to the worker. Some attempt to elicit information as to what the spouse has already said about them or a particular situation. Many speak in the past tense of situations and personal relationships implying that difficulties did exist but do so no longer; implying that the interview marked a turning point in their lives—there was to be no reason for us to suggest change, they are already embarked on a different mode of behavior.

There is as I have said, much concern about the worker's appraisal of them. This is accompanied by a corresponding denial of the interview, the worker, of psychological thinking in general. Much hostility is called forth directed primarily against the worker —sometimes veiled, sometimes open, and this may develop and persist after the interview, but is usually confined to the worker and

not directed against the program as a whole. It springs, of course, from anxiety about having revealed too much of the self and therefore having rendered oneself vulnerable. It may be that some of this anxiety and hostility might be avoided by dividing the interview into several sessions, but I feel that since there is no motivation originally, few would return at this initial stage for more than one interview.

Resistance to the interview is frequently met with, but this can sometimes be broken down by encouraging an open expression of hostility towards the worker, or by starting the interview at a point which seems most comfortable for the person and encouraging the discussion of less threatening material until the individual feels more secure.

What of the information desired in this initial interview? Information on the person's own childhood is elicited. What was his relationship to his parents? Did he perceive them as interested, supportive, sympathetic, harsh, remote or preoccupied? Is he able now to see his relationship to parents and siblings with some perspective or do the old wounds rankle and the old ties bind. What is his relationship to his own children in terms of his childhood experiences and how much awareness is there of the parallel between the two. On the whole there would appear to be less clarity, more confusion, less resolution of feelings in this area than in any other.

Education and Work History. What were the goals and interests in securing an education? How did this correspond with interest, help, and encouragement from the family or other key adults? Of the 194 adults about whom we already have this information, seventy-three were graduated from high school and/or had some college training, while sixty-eight were graduated from college and/or had some graduate work. It would seem then that the emphasis on securing an education was strong, particularly among the Jewish and Protestant families, less so among those of Catholic faith. Many of them secured their education with great hardship through part time attendance or night school over a period of years. When, however, we come to an analysis of work history we find that sixty-seven of the ninety-seven men hold civil service jobs. Acknowl-

edging the fact that the total HIP enrollment is largely made up of civil service employees, it is nevertheless a fact of significance and interest in helping us to understand these individuals. What were the influences which led them to choose civil service. For most, security was of the utmost importance. Almost all were profoundly affected by the depression. If they had not personally suffered hardship during this time, they arrived at working age to find the job-market almost non-existent. Civil service seemed the only answer. Not many were aware then or now of those elements in their own personality—fear of aggression, open competition, passivity, and compulsiveness which led them to make the choice. For many, the very search for security seemingly achieved through civil service has been a betrayal, since rising costs have placed the civil service worker at a disadvantage confronted as he is by high prices, diminished income, and the consequent reawakening of anxiety. In spite of the drawbacks, are there satisfactions to be found in the work done? Satisfaction is most easily achieved by those whose original ambitions and goals work-wise were either ill defined or who were able to achieve work somewhere near their original goal.

Of the 100 wives on the program thirty-five work—six of them only part time. Most of the wives work less for monetary gain than for the opportunity it affords to release them from the confines of the home. A few of these, notably where the work is primarily for money, find working and maintaining a home difficult and enervating. Husbands of wives who work seemed genuinely accepting of the situation and little threatened by their wives' ability to earn. Arrangements for the care of children of working mothers are usually well thought out, and, of course, in the case of those teachers or school clerks with school age children, the corresponding hours, holidays, and vacations, made the problem comparatively simple. Almost all wives worked before marriage and many who were now at home expressed the hope and desire of returning to work some time in the future when the children would be in school and not require their whole attention. Comparatively, few women looked upon their functions as homemaker with interest or enjoyment. For most it appeared to be a necessary evil, nevertheless only a few were

immobilized or overwhelmed by the demands of their jobs as homemakers.

Social and Leisure Time Activities. There was perhaps more dissatisfaction, disagreement, and unhappiness in this area of personal and family living than any other. Gregarious men felt their wives to be seclusive, disinterested, and timorous. Gregarious women felt their husbands were uncommunicative, unfriendly, and asocial. Those individuals with their own interests induced in their partners, more often the wife, a feeling of being excluded, thrown upon their own resources where none existed; or a feeling of being surpassed. Another feeling often expressed is that in marriage they have drifted into a rather dull, nonstimulating round of duty with little pleasurable activity and few interests. There was generally a feeling of surprise in talking of this, as if they had not in a long time, if ever, stopped to examine what they were doing or why. There was to be found a considerable poverty in the pleasure-giving activities, particularly among the women, and an accompanying feeling of sterility, lack of pleasure, and resentment. The often expressed hope and the fear that when the children were grown, life in its pleasure giving sense would begin. In order to deny the sterility and emptiness of their lives they surround themselves with a ceaseless round of household chores with much emphasis on "doing for the children."

In the area of interpersonal relationships—that of husband to wife and parent to child several areas were demarcated with a view to seeing how the individual saw himself as functioning in these roles, where his satisfactions and dissatisfactions lay and whether from this material we could begin to formulate some standards for defining the functioning, "normal family."

Information was sought on the sexual relationship. It was felt that where a good sexual relationship existed there was generally a more satisfactory relationship between husband and wife and, conversely, if the sexual relationships were very poor it would be reflected in other areas of living. It is for the most part difficult to secure valid material on the sexual relations. These are usually described as good; however, the concept of a good sexual relationship is so overclouded with misconceptions, status feelings, prudery,

and the living out of unconscious fantasies that they can only begin to be assessed indirectly from information given in relation to other areas where the individual feels less threatened and can speak more freely. For example, the woman who maintains that she enjoys sex, achieves satisfaction and has no complaints will, in speaking of the method of birth control used, reveal a hostile, punishing, or disgusted attitude toward the husband clearly demonstrating that, for her, sexual relations are distasteful and which she participates in only out of a desire to "hold her husband." Husbands also describe sexual relations as satisfactory yet curiously enough many men in this group describe a lack of interest in girls up until their late teens or early twenties—this lack of interest being rationalized on the basis of studiousness, interest in sports, aggravated financial condition, but all indicating a deviation in the so-called normal hetero-sexual development.

Is money a source of conflict between husband and wife? On the whole finances in the sense of management of income is not a matter of concern. Usually, one member, husband or wife, and more often the wife takes over the total income and dispenses it with the apparently unspoken agreement that major expenditures will be undertaken only after joint discussions. In a small fraction of the families money was being used to express dissatisfaction with the spouse whether in terms of management or provision. One is, indeed, struck by the accumulative evidence in these 100 families of good management of income, sound financial status, ability to plan, save and acquire in the so-called American tradition.

Religious Practice. Usually both husband and wife were pretty much in agreement over the degree of religiosity in the home and for the children. Of the Jewish families on the program, (49) only a bare minority, two or three at most were Orthodox in religious observance. For most a desire to identify themselves as Jews appears; to teach the children Jewish history; perhaps some Hebrew; to celebrate holidays and festivals but not to maintain the Orthodox religious observances as expressed in the ritual of eating, observance of the Sabbath, etc. In other words, there was emphasis on the cultural aspects of Judaism rather than the strictly religious. Protestant

families (9) too were much in agreement over the degree and amount of religious observance in the home and with the children. Generally speaking, if one parent attended church, the other did too, but there was little if any disagreement over the place of religion in the home. Catholic families (36), (5 mixed Catholic and Protestant faith), on the whole, also presented a united religious front. It was interesting that where either husband or wife was more devout the other recognized this to be so and went along with the more religious partner particularly where it concerned the children. Approximately 60 per cent of the Catholic families sent their children to parochial schools. Parents who were themselves somewhat lax in their own religious observances, insisted on the children's receiving a most rigid and intensive training in this respect.

The overall picture of relationship between husband and wife reveals much confusion, dissatisfaction, and resignation. Few of the adults appeared to be mature enough to support the demands of such a relationship. Men were on the whole passive, immature, undependable in an emotional sense. Women were more aggressive, immature, unable to accept the feminine role of wife and mother. Disappointment in their expectations of the possibilities of the relationship was common. The resignation comes, I believe, from some awareness which they have that some of the difficulty rests with themselves and that another or different partner would not bring about a different relationship.

Relationship to Children. Although children are very much wanted on a socio-religious level, children in the flesh are often resented, felt to be a burden, a grave responsibility, a hedge against a lonely old age, but too rarely a source of pleasure, fun, or satisfaction. Children call forth too many opposing feelings and loyalties and because their own identifications are not well founded they cannot tolerate or tolerate uneasily the triple strain of being individual, spouse and parent.

There is little meaningful communication with the children. They understand their role of teacher best, but are confused over what it is that should be taught. There is much lip service to certain ideals of child-rearing about which there has been wide dissemination of

information such as demand feeding, toilet training, etc. but much of what they understand they understand at best only intellectually. They are inclined to be rather protective of themselves as parents and in an effort to escape the possibility that they have failed as parents they will mitigate the meaning of certain behavior or symptomatology in their children. Nevertheless they are most easily approachable through the children. For the most part they want their children to be happy, constructive individuals. The social worker secures from the mother a detailed developmental history on each child. Again the emphasis is not so much on the actual details of the development but how the child and the mother reacted to the dependency needs and to each stage of increasing independence.

The social worker as does the nurse makes visits to some schools in order to get from the teacher a picture of the child in the school setting. The school visit which is made with the consent of the parents is often an indication of the parent's concerns and feelings about the child. Some of the parents who are excessively protective about the child, particularly where the child is having difficulty in school, are apprehensive about the visit. Others who lack confidence in themselves and their children welcome the visit as unprejudiced proof that their children are really doing well in school and by the same token that they are doing well as parents. Few of our children experience difficulty in school in an academic sense. No more than three are academically retarded. Some of the children, and even here the percentage is small, have difficulty in school, rarely behavioral but more often related to an inability to relate to the other children, to work up to capacity, to use their potentialities, but these children generally are experiencing difficulty at home and in other areas also.

So much for the initial interview. What then does the social worker do for those who need help? Certainly it would seem from the brief description of the material gathered in the first interview that many are in need of help. We come now to the second role of the social worker—her part as a team member. Several conflicting, not clearly defined principles are at work here. On the one hand the work of the program has been defined as preventive, but it would

seem important to clarify that we cannot mean preventive in a primary sense, as in public health epidemiology, but preventive in the sense of ameliorating function inhibiting anxieties, freeing energies, circumventing more serious disturbance.

Who then is to be treated, how, and by whom? The social worker having seen both parents, having observed the children on their visits to the center; having observed the interaction of parent and child on such visits, having in some instances had the opportunity to do some play or interview therapy with the children; prepares a diagnostic statement with regard to the family as a whole and the individuals who go to make up that family. A diagnostic statement consists of the worker's formulation of the personalities of the family members on two levels—one with regard to what the patient consciously know about himself and his functioning—how aware he is of the stresses and strains in his own make-up and secondly the worker's analysis of those unconscious factors in the individuals and family's personality which influence behavior. It includes also an analysis of how the family functions, where the difficulties exist, who is in need of help, and some statement as to the readiness of the individual to respond to an offer of help. Very often the initial interview itself is therapeutic since in talking about their feelings they experience some ventilation and occasionally achieve an insight about themselves in relation to a family member or a situation.

At the time of the staff conference on the family, the social worker presents her diagnostic statement—all members of the team having previously read the total family record. It is then decided which member of the team shall work with which member of the family, providing a need for treatment is seen. If the decision is that the social worker is the one to treat either parent or child, this is discussed with the parents at the time of the family conference. If at this conference, the parents object to or deny the need for help either for themselves or the children, no further attempt is made at that time to involve them, but the way is left open for them to reconsider their decision.

Actually the whole concept of the family conference is a very interesting one and deserves a special study in itself. To my mind

what is most interesting is the subsequent reaction of those to whom recommendations have been made. During the conference, there may be a denial on the part of one or both parents as to the validity of certain recommendations and observations being made—as for example the man who denied that there was a need for him to be less driven both on the job and with his family and particularly with his family since we did not hope to ever change his basic personality structure. The need for him to be more relaxed and pleasure minded with the family was pointed out. Following the conference he proceeded to buy a car which resulted in great pleasure for the family as a whole. Our recommendation had certainly not been that he buy a car, but he had as certainly acted upon our observation of him in relation to his family and he had attempted to bring about a change in his behavior in a way which was most satisfactory to him.

The number of families in whom we have seen a need for help has been rather high—originally we had thought to refer to existing community agencies and private psychiatrists those who were in need of more extended help. Our experience has been, however, that such referrals are not entirely satisfactory first because we lose that close contact with the family which characterizes the program and second because referrals to other agencies or private psychiatrists has an ominous note. As one mother put it, "Are we so sick that you cannot take care of us?"

I have worked intensively with several of the adults and several of the children. My feeling is that in terms of what can be accomplished, in the light of the needs of those on the program and with our goals, work with the children is more hopeful. In the coming year plans are underway for a play-therapy group for selected children.

Because up to now we have been busy with the collection of data about our families, we have not had the opportunity to clarify how we hope to work or what we hope to do in the next or treatment stage of our program. One of the basic assumptions of the program all along has been that treatment is not necessarily the sole province of the social worker.

While in principle I have no quarrel with the attempt to widen

the base of those available to do therapeutic work of however superficial or "deep" a nature, I do believe that certain safeguards or opportunities for growth and learning must also exist. In order to be able to help others, it is necessary to have theoretical knowledge and practical experience under supervision in the actual art of helping. Each team member has a particular contribution to make to the total effort—the doctor in the area of medical treatment, the public health nurse in education, the social worker in the understanding and treatment of interpersonal relationships. Since this is so, I feel that the best interests of the program would be served if the supervision of other team members engaged in therapy were the responsibility of the social worker. This does not supplant the psychiatric consultant who is responsible for the establishment of the diagnostic categories and the development of the educational program. It also permits more effective use to be made of his time and skills on a consultive level.

To sum up, the social worker as a team member has been securing information with regard to our families; as a treatment person has been working with some of the adults and children; as the representative of a particular discipline has been assisting in the development of the research aspects of the program. As a person she has enjoyed the opportunity to participate in such a stimulating association.

Discussion

Dr. Grant: I would like to know what the last speaker (Mrs. Stiber) meant by "supervision," what the word "supervision" of treatment means.

Mrs. Stiber: It is an educative process whereby those who are new in a certain way of working can discuss the patient with the colleagues that they are working with, with those who have had more experience, and in whose experience they can share.

Dr. Berle: I am having difficulty in separating the roles of doctor, nurse, and social worker. When you are working with a family as a team and are in constant contact with them, I do not see how an indi-

vidual can be told that he must discuss one particular problem with the nurse and a different one with the social worker. I believe that the willingness of an individual to discuss his personal problems in such a setting depends upon the rapport which he may establish with nurse, doctor, or social worker and that differences in personality outweigh differences in professional training. Therefore I believe that all members of the team should participate in psychotherapy and that the team member with whom the emotional problem is first brought up should assume this therapeutic responsibility.

DR. AARON: The team is well integrated and our functions do overlap. We do not have the formal supervision that Mrs. Stiber spoke of. However, emotional problems are not channeled directly to the social worker on all occasions. On many occasions the so-called supervision or education is held on an informal basis. Frequently without arranging an appointment with Mrs. Stiber, I will inform her of what I am doing with a patient or a problem I have, and how to handle it. The same thing is true of Miss Ringenberger and Miss Kahn. Miss Bamberger is the other social worker on the program. Our functions do overlap to a great extent.

There may be certain problems with which I am faced which I feel I cannot adequately handle. In those circumstances, I specifically refer the individual patient to Miss Bamberger or Mrs. Stiber.

DR. DEAN A. CLARK: I judge, though, that in the long contact you have and will have with these families, most of the problems are important. Do you find that in general a given family, either by accident or design, will drift toward one member of the team as the main person that they have confidence in and will talk things over with? I should think if you scattered such a family among all four team members, you might get into a little bit of trouble.

DR. AARON: Actually, we frequently find the patients will present their problems to one in particular, possibly particularly to the physician if there is also some associated organic complaint, and occasionally to the social worker directly because they expect this may be the role of the social worker. In our original manner of selecting the patients to be worked with, we have no definite criteria that a certain problem would be handled by the physician. This has been educational from the point of view of the team members as well. At least from my own

personal standpoint, I think I have learned a lot from both Mrs. Stiber and Miss Bamberger.

The patients are not particularly channeled, except that one of us may be overcrowded or one of us may not feel capable of handling the particular problem that comes up.

Many of these persons are seen in so-called treatment or therapy by more than one member of the team. If you take a disease which is fairly well recognized as having some emotional components, such as ulcer, for instance, that person is naturally going to be seen by the physician and possibly also by one of the social workers involved. The patient doesn't understand or it is not pointed out that he is coming to me for medical management and that he is coming to the social worker for emotional management, because this is not the case, but both are handled at the same time and not as independently as it may sound.

Dr. Downing: How quickly does the family accept this type of care? It is quite dissimilar from any pattern with which they are acquainted. Doesn't it take them some time to get oriented to having various people all directly concerned with them?

Dr. Cherkasky: I don't think it is true that families are not prepared for this kind of care. As a matter of fact, modern American families have wholeheartedly accepted medical specialization, and when they have complicated problems they are well prepared to have these problems dealt with by different professional people. Once the families have understood what the project is about, they have been willing, nay anxious, to participate and the multiple interviews have created no problem. This is particularly true because the families themselves have a pretty good understanding that they are not fully realizing their own potential or the potential of their children.

Dr. Aaron: I would like to point out again that these people who come in spend a great deal of time with us. The physical examination for adults, for instance, may run an hour and fifteen minutes, give or take a few minutes either way; the same with the children. There is the conference with the social worker, the conference with the nurse, repeat visits, laboratory examinations, and dental examinations. I think if the people were not interested in what we are trying to do and what they want to get from us, they would drop out of the program

once they saw the tremendous amount of time they have to spend at our center. Many of them almost call it a second home.

We have not lost anyone because of this. In fact, I think I am correct that the only families we have lost are those very few who moved out of the area and are no longer under our supervision.

DR. MACMILLAN: I note that there are two important "supportive" aspects of this Demonstration, so far as the participating families are concerned. These are (1) economic—in that these families have extraordinary "value" for the actual cost of the health service to them, and (2) social, because of the very unusual opportunities for certain types of supportive human interactions with specialists—such as are rarely available to the average urban family. It is in connection with the latter aspect, particularly, that I ask myself, "What are the implications, in terms of social effects, of this type of program on the normal neighborhood or other interpersonal relationships of the family members?" As I view it, here is an essentially new "supportive" device built into their social-relationship environment, quite apart from the implications of the economic support. What are the implications of this extraordinary social support within all the other social relationships in terms of friends, work associates, schoolmates, etc.? Is an important segment of their "usual" social support and interaction now being underwritten by this health program—a segment that was formerly supported by other people in their earlier social environment? This may seem rather a naive query, but I am wondering if the possibility had been anticipated. One hypothetical "result" we could propose would be that there might be the danger that such a service could create a need which might be most difficult to satisfy.

DR. SILVER: If your question is directed at whether this is a replacement of an existing situation, it is subject to study. There will be information obtained as to whether these people got this kind of care or got this kind of help, and from what other sources.

I would say, without having access to data of that kind, that these people are having their first opportunity to discuss problems of this kind and to get information that they consider useful information, and not simply rationalizations that they work with from day to day, like "What shall I do with this child? He is driving me crazy," and then the neighbor tells them what to do and they do it. This is the first

opportunity that many of the people have had to discuss organic problems of their relationships with the spouse and with the children, with someone that they feel they have confidence in and can trust.

DR. MACMILLAN: I wasn't questioning the value of it at all. I was wondering what other interrelationships might be neglected, what other sociological implications it might have.

DR. DEAN A. CLARK: It might be the minister, the school teacher, all kinds of other people. Most of the families seem to be, at least in the formal sense, a fairly religious group. Had they had any relationships comparable to these with their various pastors?

DR. SILVER: I would doubt that very seriously. You will see this illustrated in the group discussions that are held with these families where a number of them came together over a period of eight months and discussed problems of child rearing with various members of the team and with a discussion leader in attendance. In this discussion the problem was not that there was a conflict of information from other sources, but the problem was one of complete lack of information and a lack of knowledge as to where in the community such information could be obtained. So a frequent comment at these discussions will be, "This is the first time we have ever had a chance to talk about something like that."

MISS FREEMAN: I believe the impression that we are getting is that this is something brand new. I think the organization is new and the integration is new and wonderful and very productive, but family health guidance has been given and most of the things we are describing in relation to the nursing part of the team are being done every day in a great many nursing agencies.

In Iowa over ten years ago there were family discussions with the pediatrician, parents, and nurse, making plans for the family. But the new thing here is that you have it all wrapped up in a package and focused on the family in sufficient intensity and over a long enough period of time so that it really produces results, and I would say with a higher degree of expertness than we have ordinarily been able to marshal. So I don't think this is something that is going to disrupt the pattern of people seeking care nearly as much as it is going to give them the satisfaction and feeling that for once they can carry their

problems to one spot and not have to go to several agencies, and they can also give them the satisfaction of services rendered at a more expert level.

DR. DOWNING: I am struck with the readiness with which the program is accepted. The consideration of emotional problems in the whole family structure, in the first place, I thought was being sort of pushed on these people, but apparently they had a need which was unsatisfied which this step met. Is that true?

DR. CHERKASKY: If we think about ourselves for a moment, we will recognize, that we have much the same problems as do the families in the Family Health Maintenance Demonstration. We all have emotional and interpersonal problems and frankly, we do not have easy access to places where we can get help with these problems.

DR. CLAUSEN: I think it was pointed out that there was a certain amount of hostility directed toward the social worker and perhaps toward other members of the team. I wonder if we could have some indication of how often there are areas where there is real resistance to your going in.

MRS. STIBER: I say that actually in the initial interview they are not too interested in giving information. When it comes to actually doing something about the problems that they have outlined, that is a different matter. They are not so readily accepting of the idea that they should come in and talk with us, thinking that everything will be all right. What we have found is that, given time, they will come. Sometimes it takes a year for someone on the program to finally accept the fact that what we have seen in the beginning and pointed out to them as a problem is really a problem. They now want to come and can get some help with it. It is not that they are so happily accepting the offer of help. They are not.

DR. EVANS: I don't know whether this question is in order or not, but I would like to back up a moment.

We have heard a great deal this morning about the team from the members of the team. I would like to know something about the original plan of the program, and why the team was designed as it is, how the membership was determined, and what its functions are con-

sidered to be. To what extent was it considered possible to start with a "minimum" team, letting experience dictate the composition, the growth, the elaboration of the team, and thereby clarifying somewhat the function of the various members and skills, by adding individuals as they were required to meet a demonstrated need which had evolved as a part of the data of the experiment.

I have the feeling that the composition was determined prior to the experiment, and now the tendency is possibly to fit the observations into the prior concept of the function of the team, rather than letting the concept of the functions of the team evolve as a part of the experiment.

DR. CHERKASKY: The kind of team which we determined upon at the outset of the program was, of course, dictated by the objectives of this experiment, which were to attempt prevention in the medical and social areas. In the Community Service Society, the public health nurse and the social worker were already working with families, and in the Health Insurance Plan, of course, we had as the prime individual, the physician. It seemed to us, that the major problems we would face in bringing positive health to our families, were such as fell within the professional competence of the doctor, the nurse, and the social worker and that in fact these professional workers were now working with families, though primarily on a curative rather than on a preventive basis. In addition we had already demonstrated in our Home Care Program, the practicability of welding together a team consisting of the doctor, the nurse, and the social worker. For all these reasons we decided upon this particular team. This, of course, does not mean that other teams composed of different kinds of people or arranged in some different kind of way, might not be used. However, I seriously doubt that in view of the problems and the availability of health personnel there is any other grouping better able to do the job. With regard to the question—one family physician or a pediatrician and an internist? This was decided more on the basis of what the families wanted and expected rather than on what was ideal. In this area, our experience may dictate the need for a change.

DR. DEAN A. CLARK: You have two teams, that is, you have two public health nurses and two social workers. Did you start out with two social workers and two public health nurses, or were these additional ones added because of the need?

DR. SILVER: They were added. It was contemplated that they would be added at a certain point. We were operating in a new area with regard to the volume of work that could reasonably be expected of a given professional person. In this field it just wasn't known. We started with one of each, one social worker and one public health nurse. When we had taken on fifty or sixty families it became perfectly obvious that we were backlogged to the point of three or four months of examinations and study ahead of us to get these families on, and then to carry on what treatment, conference, study, and evaluation had to be done for those already on, we had to have another team. Of course, the numbers are out of all proportion to the kind of service that you could expect in an on-going or operating program because of the necessity of doing this tremendous evaluating job in the beginning as well as carrying on.

It is quite conceivable that the whole load could be carried by one team of a social worker and a public health nurse. This is something we will have to learn.

The concept was a five-year study. When this was written down, I presume the people who set it meant that the families were to be under study for five years, but there are certain reality situations you have to face. It takes almost a year to get on one hundred families, so if the study lasts exactly five years there will be no family that will have five years of study, but there will be a certain number that will have four years of study. It is conceivable that we may set four years as the study period for a family and continue the program over a period of time so that every family will be cut off at the end of four years after it has come on.

DR. DEAN A. CLARK: You have listed in your table some control families. What are you doing with them, if anything?

DR. SILVER: We are not doing anything with them. They were selected according to a technique that we arrived at after considerable discussion. For example, one hundred families were selected at random by the Machine Records Unit at the Health Insurance Plan of Greater New York. These one hundred names were sent to us, and then we bracketed them in groups of two as they appeared on the list. For each two, each couple, a coin was tossed, and when the coin came up heads, then that first family was the study group. If the coin came up tails,

the first family of that couple was the control group. In each case the study and the control were bracketed in that way. The control families are merely listings in our files. We don't notify them that they are controls. We don't give them an initial evaluation or examination, but at the end of the study they will be evaluated by the same technique that the study families are being evaluated. So we will have then a group of controls presumably identical with the study group because they have been selected in this duplicate manner, to whom nothing has been done deliberately.

DR. BERLE: What will be your criteria for determining differences between the people for whom you have been caring; those who have a lesser incidence of illness, and whose problems appear to be solved?

DR. SILVER: We have a rather complicated evaluation form in which we have set up ratings in a dozen categories, and the ratings are on a scale of four. These ratings are defined. The categories are things like physical health, emotional personality characteristics, relationship to the children, adaptation to work, and so on. The scale of four represents from the top to the bottom and the people are graded on this scale.

There is a series of questions in each of the categories that corresponds to a definitive pattern of a person's behavior within that. In the process of establishing the evaluation, the various people on the team are going to put down their opinions, and then there are going to be these evaluations in terms of numbers. The people who make the evaluation in each category will be compared with one another so there will be an effort to arrive at some objective conclusion as to whether there is any real difference between these people before and after, and between these people and the control group.

In addition to this evaluation summary material, there will be also the problems of illness in the various categories and the conditions for which they consulted a physician. So there will be, from the HIP record, information available as to whether these people were sick during that time, what kind of sicknesses they had, and how frequently they consulted a physician. These data will be available on the controls, as well.

Then there will be some additional information, for example, which we could very easily obtain from the schools' attendance records and

report cards. So there could be some comparison of achievement in that direction.

The main body of information with regard to progress will be derived from the evaluation summary sheets.

MISS HUBBARD: I have a question about procedure. Dr. Aaron and Dr. Siker, the actual physician, go to families when they have illness in their fields, but I understand that is not true in the nursing service because another service will give the nursing care.

DR. SILVER: If there is home nursing care to be given, it will be given by the Visiting Nurse Service of New York through the regular HIP channels. If the children need penicillin injection for treatment, we use the VNS of New York as for our regular HIP patients. We are going to use our own nurses for the teaching, the prenatal service, the classes with the mothers, and so on. But for what we would customarily call the VNS, we will continue that.

MR. COCHRAN: I would like to hear some comments from team members on this question of volume of work. When the initial examination is over, the team confers to discuss what kind of help the family or the individual needs. At that time does the team feel it is going to be able to tackle—I don't mean necessarily tackle successfully, but at least do some work on all the principal problems that they have outlined, or does it find that there are too many problems? If the latter is the case, what kind of order of priority does the team give? Miss Ringenberger gave me the idea that the toughest problems would be tackled first.

It would also help to have some picture of the distribution of effort among the families. Are there some families that receive relatively little attention while others receive a large amount of attention?

MRS. STIBER: I think it is true that there are many families that will get little help, either because they are not ready for it, they don't wish it, or they haven't any problems that are too pressing. So we concentrate on those who have the most problems and the most pressing problems. In relation to which problems should be tackled, again we try to find out where that family is, which problem they consider the most pressing, and on which they are most ready for help.

It does very little good for us to say, "This is your main problem and

this is what we want to work with you on," when the mother is busy thinking about how the children don't eat and she wants help with that. We like to start with where they are and where they consider the problem most pressing.

MR. COCHRAN: Does the team feel on top of the job, in the sense of having time to think about things, having a little leisure to be able to tackle the most worthwhile problems, or does the team feel that it is going to be very rushed and must just do the best it can in the different situations? I am thinking of this in relation to the previous question: what does the family health demonstration consist of? We are trying to measure its effects, but we also ought to know what it is. Is there going to be some kind of systematic recording of what the treatment consisted of?

DR. CHERKASKY: I might say, Mr. Cochran, that your question is one of the questions which we asked ourselves at the outset of the program. While it is true that nobody can do a job if rushed, on the other hand, we wanted this program to be on so reasonable a basis that it could be reproduced elsewhere. You could well conceive that a group practice unit would add to its staff, several social workers and several public health nurses to broaden their preventive services to families. It is possible that so limited a staff would not be able to do all the job that needs to be done, but we are hopeful that so reasonable an increase in staff can do a significant job if it confines its activities to specific areas.

DR. REGENSBURG: Do we have to deal with something that hasn't been mentioned specifically? There is a different quality to the kind of problem that the social worker discusses in her first interview which isn't so readily accepted by persons in our present society. There is something more one's own and more intimate, something one keeps to oneself much more than a defect or physical disability which seems less a part of oneself in the sense that one does not have a responsibility for it in the same way.

Added to that is the very particular situation here, with the parents of young children, and that is the absolutely normal and inevitable self-protection that a parent will erect at any hint that he is not being as successful as he might, since it is his job in society to maintain a home for his children. Therefore, one should not be discouraged or

expect too much in the way of an immediate responsiveness to certain kinds of help that a Demonstration of this kind would offer.

MISS BAMBERGER: There is one important aspect of our work which is not as easily recognized as are some of the others, but which can be of great importance in the helping process. I am referring to the extensive informal contact we have with the families on our program. With many of these it takes a long time to develop a relationship, and this can be done only by our being available when the parents come in for their own and their children's medical examinations and other appointments.

In this way we have a chance to show that our interest reaches beyond the office interviews, we get to know the families better, and they more easily get to know and trust us. We could cite numerous examples of individuals who, when they first joined the program, were very reluctant to discuss their problems and who gradually gained sufficient confidence in us to freely discuss and get help with their difficulties.

MRS. ALT: I am interested in the point Mrs. Stiber has brought out, that whereas at the beginning the general plan provided for referral of social and emotional problems when found, the group has now learned that they prefer to provide more of these services directly since much more can be done for the people. Because of the types of problems that are coming out in the early contact, and the circumstances, I presume the group does not feel that it can refer as many people for service.

I wonder if this is not also a factor in the time schedule, in that the amount of time now occupied in treatment is beyond that planned in the original design.

THE CONSULTANTS TO THE WORKING TEAM

INTRODUCTION

DEAN A. CLARK, M.D., *Acting Chairman*

HAVING heard the working team, we are now going to hear the consultants to the working team. I don't know just what their point of view is going to be, but I am sure it will be of great interest to us all, inasmuch as this working team has available to it the social sciences, and that, of course, is what we are going to talk about this afternoon.

This is something that I think a lot of us have been talking about, that is, having social science and medical science linked somehow in research projects, but actually there are very few places, at least that I know of, where something has been done about it. This is one of those places. I think also of North Carolina, Nova Scotia, Syracuse, and perhaps Baltimore. But it is still a rarity and still something from which we have a lot to learn. I think we all look forward to hearing from the consultants to the working team.

PSYCHIATRY AND THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

HOWARD H. SCHLOSSMAN, M.D.

AS THE pilot study progressed, the team of general practitioner, pediatrician, public health nurse and social worker came to meet the broad aspects of the problem of individual psychopathology and the problem of social functions within the families studied. This had been anticipated and a group of consulting specialists in the psychological and social sciences were brought in to help the teams.

Approximately eighteen months ago, I joined the project in the role of consulting psychiatrist. My function was loosely put at helping the team achieve its goal of raising the level of health in families through a team approach. How this would be implemented was up to the team and myself to work out. We had to find out whether I could help and how.

There is a growing body of knowledge referring to the influences of emotions, attitudes, and behavior in somatic function and dysfunction. This is readily demonstrable in the embarrassed young lady who blushes. We set out with the premise—if we lower tension states, alter attitudes and behavior which seem to predispose to psychopathological conditions; this should lower the level of morbidity within the group. However, we had to accomplish this without doing psychotherapy in the usual sense as a patient would encounter in a psychotherapist's office. The families under study were not psychiatric patients aware of inner conflict and asking for help, and to attempt to treat such a large body through the team would be impossible even if they were all trained psychotherapists.

We began by looking at the records. The team has made a study of each family. In addition to the physical history and status on each member, we had a record of their behavior, attitudes, frus-

trations, and goals as they consciously express them and as they are apparent to the examiner.

The entire spectrum of psychiatric disease became evident. There were a number of cases of neuroses, psychoses, and severe character disorders. However, these were in the minority. Mainly we have to deal with elements of psychopathology—trends which may lead to major disorders—neurotic traits.

Following the record study, group conferences are held to develop a plan of treatment for an individual family. Where indicated, cases have been referred outside the project for psychotherapy or psychoanalysis. In most cases, one or more members of the team may see members of the family in regular session to explore problems, help them become aware of behavior and attitudes which may be damaging to themselves or other members of the family. At the conferences, we try to point up what can be done, what should be approached in an exploratory manner and what can't be done.

At the conferences, we may also turn up areas where there is a significant lack of information—"significant" in the sense that it points to problems the family is avoiding bringing to the team.

In one family the mother had been pressing the pediatrician for a tonsillectomy for her son. There were some medical indications—the child had had many sore throats—the tonsils showed some chronic infection.

However, the child was young—age 2½—and in a continual mild state of anxiety. The mother was an overly aggressive woman who seemed to act out her hostility in her handling of her son.

In light of the character of the mother and the understandable anxious state of her son, it appeared that a tonsillectomy would be a severe psychological trauma, in this child.

A further consultation with the pediatrician brought out that the operation wasn't immediately necessary. Antibiotics would probably control the infection. Also the mother had been pressuring him to do the operation.

When the team explained to the mother that there were no immediate indications for surgery and that psychologically an opera-

tion would be less traumatic when the child is older, she agreed to a delay.

This child may yet get his tonsils cut out but the longer this can be delayed the more mature he will be and better able to integrate the situation.

In addition to the group conference, there are scheduled weekly meetings with each team member. Here we discuss the problems they meet in working with the members of the family—their understanding of the material gathered and plan further steps in therapy. In this manner the work is controlled so that we avoid any emotional crisis beyond the ability of the team member to handle it.

Also in these individual weekly conferences I can coordinate the effort of the entire team upon a family.

In another family, the mother showed many of the signs of early schizophrenia. She refused treatment and her behavior was not such that she had to be committed. However she had formed a positive relationship to a few members of the team and came in frequently to discuss her problems. Her functioning was constantly being studied for any malignant signs of a breakdown. So far she continues as the mother of a family.

Her husband had treated her behavior as perverseness and reacted with anger and despair. However, when her mental state was explained to him he became more kindly and sympathetic to her. This probably contributes to her continued functioning.

In a few situations, one or more members of the family were referred to psychiatrists outside the project for psychotherapy. Here the team members helped the person become aware of emotional problems within themselves so that the treatment was actively sought by the patient.

Early in the project we all became aware of a difficult problem. How can we measure what we were doing?—How can we measure our effect on these families? This took on the proportion of a much older question in psychoanalysis. How can you measure libido? To measure a psychological energy by physical means is probably impossible. However can we measure changes in mental and physical health indirectly—by their effects? This what we set about

doing. We all contributed what we thought were levels of function in many areas of endeavor. Then these were narrowed down to areas of practical determination.

As the psychiatric consultant, I was interested in the waxing or waning of inhibitions, phobic conditions, compulsive behavior, and levels of satisfaction in their family, social, and work life.

These have been incorporated as far as determinable in the movement scale that has evolved—in the work history—frequency of job changes—time spent with the family and how—recreational activity—divorces and separations—to state a few.

As the project continues, new data calls for conferences among the consultants. We try for an interdisciplinary approach and gradually educate each other in the concepts we practice. From our confluence and differences we learn more of the family—its functions, goals and cohesiveness.

In summary, as psychiatric consultant I assist the team in understanding and treatment of the emotional problems they meet in the care of the families.

This is done by a study of the records of the family, explored in a group conference and supervised in weekly individual meetings.

All the specialties worked together to evolve a scale upon which to measure the movement in the direction of health or illness by the individual members of the family.

THE PSYCHOLOGICAL CONSULTANT IN THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

CHARLES E. ORBACH, PH.D.

THE psychological consultant has contributed to two important aspects of the Demonstration, research planning and diagnostic service to patients. Initially there was an emphasis upon the formulation of the research problem and the development of methods for evaluating the outcomes of the educational and therapeutic services provided by the working team. Later this emphasis shifted to diagnostic psychological testing whose purpose was to supplement other sources of information utilized in the family conference.

My appointment as consultant to the Demonstration was made in February, 1952, when a pilot study of twenty families had been in progress for approximately nine months. Enough data had already been gathered to permit an analysis of findings and the establishment of tentative conclusions. My first step, therefore, was to review the interview records thoroughly and to arrange conferences with the entire group of investigators conducting the pilot study to acquaint myself with their observations and unreported interpretations.

A number of important trends emerged from these two sources of information, some of which had already been apparent to the working team before an analysis of the data was attempted. All members of the working team stressed the ubiquitous presence of anxiety and tension as sources of unhappiness and harrassment in the daily lives of both the adults and children in the pilot study. The large number of manifest disturbances in significant aspects of life function such as work, sexuality and social relationships was a second important trend. Still another was the inability of many married adults in the group to emancipate themselves from the direct control which their parents still exercised over their lives.

The pervasiveness of the manifest anxiety made evident that the development of criteria for evaluating its presence and severity would be a necessary objective before undertaking the projected five year study of 150 families. Strong interest was expressed during conferences with team members about the possibility of utilizing a published scale for the measurement of anxiety or in constructing one specifically for the Demonstration. The primary value of such an anxiety scale was its potential use in establishing a baseline for each subject at the beginning of the project from which movement could be determined when compared with his status at its termination.

My role at this point consisted in helping to clarify the limitations of any theoretical approach which considered anxiety as a directly measurable, static property and in presenting a more dynamic conceptualization of anxiety. The function of anxiety in the adaptation of humans to the demands and dangers in their social and physical environment was stressed. Anxiety was conceptualized as a signal of expected injury and it was clarified that its warning had considerable utility in alerting a person to overcome or escape from actual environmental dangers. It was also pointed out, however, that anxiety could seriously interfere with effective functioning and happiness when based upon irrational expectancies (1).

Considerable time was devoted in conference discussions to the integration of this concept of anxiety into a more comprehensive theory of human adaptation. An adaptational viewpoint was implicit in the focus of the pilot study interviews but was never explicitly formulated. Defensive maneuvers were interpreted as preparatory steps undertaken by a person with the purpose of increasing his sense of mastery in coping with perceived threat. In contrast, partial or total inhibitions in specific areas of function were interpreted as withdrawals from action by a person who believes that he is powerless to defend himself against or escape from expected injury. The relationship of anxiety to performance was repeatedly emphasized to establish the principle that inhibition often constitutes evidence of more serious maladaptation than the presence of manifest anxiety. This viewpoint has been succinctly stated

by Angyal (2): "Anxiety is not a mental phenomenon but a state of limitation of life. When we have sufficient information about a person's mode of living, we can determine whether his life is a narrowed one or not; that is, we can determine the presence and degree of the condition of anxiety, independently of the presence and degree of anxious feelings." The anxiety frequently masked by an inhibition is revealed by the occurrence of acute anxiety attacks or psychosomatic symptoms when life circumstances force an individual to take action in an area of function formerly interdicted by an expectation of injury.

Although the role of rage in human adaptation was not stressed as much as that of anxiety, the relationship between these two fundamental affective reactions was formulated. It was stated that rage is precipitated by anxiety and has two major functions. The first is to press an urgent claim on a person of great emotional significance who is realistically denying affection or who is perceived, because of earlier disappointments by others, as failing to understand deep needs for nurturance and protection. In this context rage is an appeal to prevent feared isolation and a coercive attempt to restore a love relationship. The second function of rage is to attack or eliminate a person who realistically blocks access to valued goals or who has been symbolized as a barrier to the achievement of important ends. In this context the expression of rage, however, is predicated upon a sense of considerable adequacy in handling whatever consequences follow. When expectancies of certain and severe retaliation are associated with the expression of rage, then its arousal is attended by anxiety (3).

This theoretical orientation was formulated so explicitly because of the intimate relationship which exists between theory and the direction of observation in scientific investigation. The final objective in theory construction was to postulate the complex learning process by which childhood experience is translated into the expectations of injury that disturb or inhibit function. Direct teaching by parents and other important adults results in the child attributing specific significances to events, the actions and feelings of others, and aspects of his own functioning. The child also makes inferences

from their behavior and feelings toward him and others and their actions in a variety of other contexts.

The significances attributed to experience are loosely organized initially but gradually become formed into convictions which provide a frame of reference for interpreting transactions with the physical and social environment, intended actions and self-value. Convictions are assumptions made by a person about himself, others, and events which govern action as if factually based (4) (5). The organization of convictions in response to childhood experiences of injury, deprivation, and disappointment has been emphasized by psychoanalysts because of their strong interest in the related security operations. It is important, however, to recognize that positive experiences with nurturant, protective, and affectionate parents result in the fundamental convictions of lovableness, self-value, uncontingent acceptability and trust in others. When a belief exists that an intended action is evil or injurious to others, expectations of injury are aroused. Expectations, therefore, refer to the projected consequences of action. Because of their function in organizing experience, convictions and expectancies may continue indefinitely and have a profound influence on adaptation in every aspect of adult living.

A comprehensive assessment of an individual's convictions, expectancies, and adaptational patterns would have provided an ideal baseline for evaluating the educational and therapeutic efforts of the working team. Intensive information of this type can usually only be obtained through a long series of life-history or psychotherapeutic interviews. The practicality of conducting unstructured life-history interviews with 300 adults was seriously questioned. In addition, it was doubted that the cooperation of a majority of study subjects could be obtained for repeated intensive interviewing even if sufficient staff time had been available. It is possible, however, to establish a baseline of considerable value by identifying the major areas of function in which long-term adaptations are manifested. Then focused interviews can be conducted to determine whether action patterns in these areas of function (1) are free of anxiety, (2) are accompanied by manifest anxiety, (3) can only be

carried out in conjunction with preparatory defensive maneuvers, or (4) are inhibited in execution or devoid of satisfaction after execution. It is also possible to determine or infer from the interview data some of the beliefs, values, and expectancies that underlie patterns of behavior.

Several areas of life function were selected for inclusion in the focused interview: interpersonal relations within the family, social participation in the community, work, housework, sexuality, recreation, child rearing, and emancipation from parental control. Their choice was based upon the findings of the pilot study and studies at Memorial Center concerned with restoration of function following radical surgery.

The construction of a schedule to serve as a guide in conducting the focused interview constituted the next step. The interview schedule which had been constructed for the pilot study provided an excellent basis for the development of a more extensive one. Members of the working team suggested revisions and supplements to the original schedule which they regarded as essential to an evaluation of function in the areas of life activity with which they were most familiar. Conferences were held to discuss the importance and relevance of the revisions and additions, and also to obtain criticism of my own suggestions for the schedule. The final draft was completed after an intensive discussion of each area of function with the psychiatric social worker who had planned the interview guide used in the pilot study.

Since the interviewer must rely largely on the interviewee's report of his self-observation and subjective experiences, the rapport established in the relationship is of critical importance. The knowledge on the part of interviewees that the information obtained would be used to promote the health and happiness of their families proved to be strong motivation for frank communication. In order to further foster the rapport created by this knowledge it was decided to have individual team members cover those aspects of the focused interview most closely related to the services which they rendered the study families.

Before the large-scale study was undertaken, it was first neces-

sary to determine how useful projective psychological tests would be in supplementing interview information primarily concerned with adaptation. Since many of the beliefs, values, and expectancies which govern behavior are not in awareness, the Thematic Apperception Test was selected as the projective test most likely to permit their indirect expression. This hunch was supported by the type of story fantasies created by the adults in the pilot study. In contrast to many college students who tend to intellectualize and symbolize their underlying conflicts and convictions, the majority of these adults directly expressed formative life experiences and current pressures in the content of their stories. This tendency was fostered by careful inquiry which encouraged the storyteller to develop the feelings and thoughts of his characters as well as their behavior. Rorschach tests were also administered to part of the pilot sample. The evidence of psychopathology, in terms of Rorschach interpretive criteria, was so striking in the protocols that I seriously questioned the applicability of these criteria to an unselected nonpsychiatric sample. For this reason and also because it provides little information about long-term adaptive patterns, the Rorschach test was not adopted for use in the larger study.

When the study of 150 families was undertaken, Miss Tanzer joined the Demonstration as clinical psychologist and I withdrew entirely from testing. She is at present completing the administration of the Thematic Apperception Test to the 300 adults in the study and has prepared interpretive summaries for the family conference. She is also testing all children between 6 and 10 years of age with the Bellak Children's Apperception Test and all children between 10 and 16 years with the Symonds Picture Fantasy Test. In addition, she is doing more intensive diagnostic testing of special problems referred to her by the working team, such as reading and speech difficulties in children and chronic psychosomatic disorders in adults.

Although the projective psychological tests have not yet been systematically analyzed, the clinical psychologist's impressions of some outstanding trends will be reported. Many adult subjects portrayed parental figures in their stories as opposed to the emancipation of

their children from parental control and to the achievement of adult heterosexuality. In addition, parents were often portrayed as punitive, untrustworthy, and failing to provide needed interest, recognition, and affection. Many adults also told stories in which inhibited competitiveness, envy, and jealousy were attributed to the figure of identification. Although these feelings were sometimes expressed in the context of sexual adaptations involving rivalry, more often they appeared to be responses to deprivation of affection. Stories involving the expression of sexual impulses, even in a symbolic form, occurred infrequently. Picture 13 MF which has sexual connotations was interpreted by a high proportion of men as well as women as a scene of an ill or dying woman who is in this predicament because her husband has failed to protect her from want or illness.

Perhaps the most important impression which can be reported about the children's test records is that having tested the parents first the clinical psychologist was rarely surprised by the content of their children's stories. The beliefs, values, fears, and feelings of injury expressed in the children's fantasies took many forms but were not inconsistent with the emotional problems of the parents and their difficulties in relating constructively to their children.

When the service aspect of the psychologist's role was assumed by the clinical psychologist, I began to participate with the working team and psychiatric consultant in constructing a scaling procedure by which changes in adaptation could be assessed Originally it was intended that the evaluation of movement would be limited to descriptions of change in the direction of expansion or curtailment of activity, increase or decrease in defensive maneuvers, and increase or decrease in anxiety associated with activity, all in specific areas of function. While this approach has the advantage of emphasizing adaptive processes rather than character traits or needs, it does not lend itself to quantification. In order to permit even crude quantification, it is first necessary to reduce descriptions of complex processes to a more static framework. This was accomplished by posing several questions about action patterns and feelings in specific areas of function which could be answered by *YES* or *NO* judgments.

These questions include aspects of behavior and feeling which the team members and psychiatric consultant considered important in arriving at ratings of the "goodness" of adaptation. The rating scales constructed consisted of four steps, each of which explicitly states the criteria for assigning a particular rating. Although the ratings are frankly evaluative, they are supported by extensive psychiatric experience in what constitutes positive mental health as well as maladaptation. In addition to freedom from disabling symptoms such as phobias, compulsions and depressive moods, mental health consists of the ability to relate constructively to others and to take action towards the fulfillment of meaningful goals.

At present the clinical psychologist and I are collaborating on the construction of a scoring method for the T.A.T. which will attempt to code not only the behavior and feeling of the characters in the stories but also the context in which they occur. As soon as this method of scoring is completed, it will be utilized in a projected study of the interrelationship of parent-child tensions. Other studies have been proposed but will not be planned until the completion of the projective testing.

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THE CONSULTANT SOCIAL SCIENTIST IN THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

CAROL F. CREEDON, PH.D.

IN JULY of 1952, I joined the Family Health Maintenance Demonstration as consultant social scientist on a two-year grant from the Russell Sage Foundation. As many of you know, the Russell Sage Foundation is currently providing a number of sociologists, social psychologists, and cultural anthropologists with the opportunity of working in close collaboration with practitioners in the medical, nursing, and social work professions. In this way social scientists become acquainted at first hand with the problems, particularly those in human relations, which practitioners face in carrying out their professional roles and, at the same time, social scientists make available to members of these professions such specialized skills and knowledge as they possess which are relevant to the solution of these problems.

My activities in connection with the Family Health Maintenance Demonstration illustrate one type of contribution which a social scientist may make to the medical and allied professions.

One of the primary responsibilities of the social scientist in a project such as this is to point up social and cultural factors wherever they might contribute to a more complete understanding of the family.

I am particularly concerned about the influence which socio-economic and ethnic group factors may have upon both individual and family adjustment and functioning. For example, among the non-civil service employees on the project, we have encountered a number of families in which the usual social and economic status-strivings that characterize the middle-class in our culture appear to be somewhat exaggerated and, in some cases, these strivings are accompanied by symptoms of physical and emotional stress. In certain instances such strivings may represent attempts on the pa-

tient's part to compensate by means of economic or professional achievement for real or imagined inadequacies in quite different areas of personal adjustment. In other instances, these status-strivings may represent a response to strong cultural pressures, an attempt to live up to the culturally-determined demands and expectations of parents, spouse, or one's own social group. In most cases, of course, both uniquely individual and cultural forces operate together to produce this strong upward thrust which may be disrupting to both the individual and his family. During the team conference, or in informal discussion, the social scientist may help to place such patients in their social and cultural contexts, in terms of which their behavior may become more understandable.

Another example illustrating the influence of cultural conditioning on family relationships has been encountered among some of our adolescents. Given a certain ethnic, religious, and class background, social activity for adolescent girls, especially that which involves contact with boys, is sharply restricted by the parents. This may become a source of considerable family tension and conflict as well as interfere with the normal social growth of the child. This is particularly true when much greater freedom and independence is the norm for other adolescents in the community. An understanding of this situation in terms of culture-conflict as well as in terms of individual personality dynamics may aid the team members in interpreting the problem to both parents and children.

A final example, and one which well illustrates the differences in values which are associated with differences in cultural background, is the tendency noted in some of our families to place a great deal of emphasis on the intellectual development and academic achievement of their children (especially male children) along with a devaluation of other aspects of growth and development. Such pressure from the parent frequently forces a child to perform at a more mature level than he can manage without undue tension and anxiety. Recognition by the team members of the cultural origins and supports for such values may help them to understand the source and strength of parental expectations and pressures and to define preventive and treatment goals which are appropriate

to the particular cultural context within which such families function.

In such instances as I have cited we see evidence for the fact that personality needs and cultural background together with other individual and environmental factors interact in a highly complicated way to produce a total pattern of adjustment or maladjustment. Neglect of one or the other set of factors would provide us with, at best, an incomplete picture of the patient and his family.

During the team conferences, it has seemed appropriate that leadership functions be concentrated in the team members, with the consultants participating, for the most part, only at those points where their specialized knowledge may be of some help. This arrangement has encouraged the development of a working relationship in which the team members have not become unnecessarily dependent upon their consultants, nor have the latter tended, as sometimes happens, to assume a practitioner's role for which they are not properly qualified nor are they expected to play.

In addition to the family evaluation and planning of follow-up care, the team conference is also used as an occasion to raise administrative problems, to debate (but not always to settle) questions of policy, and to devise ways of improving existing procedures and practices. Here the consultant, being somewhat less personally and emotionally committed to a particular practice or point-of-view than the practitioner, may help to identify and clarify the problems facing the team and to share in their solution.

Many of our meetings have been devoted to revising the rating scales by means of which each family member is evaluated at the time of intake, and again at the end of the project in order to determine movement in ten areas of physical and emotional health. The development of these scales proved to be a most difficult task. Both the consulting clinical psychologist and I had previous experience in designing rating scales which we were able to contribute to the team members. However, in common with the general experience of others who have worked on such scales, none of us is completely satisfied with their final form. This is primarily because applying the scales as they now stand is very time-consuming, thereby reduc-

ing the amount of time available for direct services to the families, and because, inevitably, a certain amount of ambiguity and subjectivity remain in the instruments.

In addition to the team conferences, I also attend the weekly meetings between the team members and the pediatrician which provide for an exchange of information regarding the physical and emotional status of the children on the project, and the treatment in progress. I also attend the general monthly meetings at which the project Director and the entire staff are present. These meetings are devoted primarily to administrative and policy matters. I was also present, in the capacity of a non-participant observer, at the parent group discussion meetings on child-rearing held last year under the direction of our educational consultant. This has constituted my only direct contact with the families, excluding those informal exchanges which occur occasionally in the waiting room outside my office. I also attended a family conference, at which the team explained their findings and recommendations to the family concerned. Finally, for the past several months, I have been meeting with the Director of the project at regular intervals for a discussion of my research and other matters relating to the Demonstration, particularly to problems which might affect staff or patient morale.

In addition to the "official" contexts described above, I am in continuous and fairly close informal contact with the team members and consultants. Such contacts have perhaps been even more valuable than our regularly scheduled meetings in affording opportunities for an exchange of information, ideas and viewpoints, in providing me with a much-needed orientation to the medical and social work professions, and to the many problems inherent in the practice of team medicine. Most of the problems which I have been observing and analyzing in terms of social science concepts, are common to all small face-to-face work groups, especially those in which each member represents a different discipline. Particularly during the early period of the project, we were confronted with problems in communication due to the specialized terms, concepts, and assumptions peculiar to each profession, differences in value-

systems for each profession, problems relating to the need which we all experience to maintain and enhance status and prestige, and problems having to do with the distribution and exercise of responsibility and authority. Such problems as the last often arise over differences between how one defines one's own professional role and the value one places upon it, and how others with whom one works define and evaluate that role. Also encountered were the problems which tend to arise with the addition and integration of new personnel. "New" staff members often raised provocative questions and offered viewpoints which precipitated a reexamination of our basic assumptions and procedures. On the whole, this was constructive and stimulating, although at times somewhat disconcerting for the "older" staff members. In addition, most of us have experienced some conflict between our need to function in new ways (in keeping with the plan of the Demonstration which involves a new type of interdependence between staff members), and our tendency to maintain traditional patterns and relationships. How to arrive at group decisions involving the fullest participation of all staff members without an undue expenditure of time and energy, and without creating feelings and attitudes which later interfere with the carrying out of these decisions, and, finally, how the team members can best use such skills and specialized knowledge as the consultants may possess constitute problems on which we are still working. Social scientists, particularly those such as myself who have a special interest in the social psychology of small groups, are often able to clarify problems of the kind I have described, and aid in their solution.

I am happy to report that from the outset the team members were most "permissive" and "acceptant" so far as having a social scientist poking about in their midst, despite the fact that such an arrangement was quite new to all of us. Good interpersonal relationships, for the most part, a generally high level of competence, and the very real interest which the staff has in our families constitute our strongest assets in working towards a solution of the problems which I have mentioned. Since no group is entirely free of such problems, our experience, when thoroughly analyzed

and digested, may be of value to similar medical care and research programs in the future.

Now I should like to describe my research activities on the project. These have been in two main areas: First, with the assistance of our consulting statistician, I have undertaken the analysis of our medical records and interviews for the purpose of determining the sociological characteristics of our families. A summary of the material analyzed thus far has been made available to you today in a separate appendix. These data will help us answer a number of questions concerning relationships between social and cultural factors, and the physical and emotional health of our families. For example, I am investigating differences in child-rearing attitudes and practices as they may be related to socio-economic class, ethnic group, and the age, sex, and birth order of the child. I am also interested in determining the extent to which cultural factors may be associated with male or female dominance in the marital relationship, and in marital adjustment or maladjustment as a function of similarities and differences in ethnic and class background of marital partners. Another study concerns the role of situational stress (e.g., differences between status-aspiration and achievement) in psychosomatic disease. A final illustration of the type of research in which I am involved is the investigation of cultural correlates of eating problems and overweight in both children and adults.

My second major area of research is focused upon an investigation of the attitudes of our families toward the project itself, including the staff and its services, and how these attitudes determine, at least in part, the effectiveness of the Family Health program. In this connection, I have prepared an interview schedule which I shall use with those of our families who have been on the program for one year or more. I shall also use this opportunity to discover something about their motives for joining the Demonstration, their knowledge and beliefs regarding Demonstration goals, their attitudes toward the team's recommendations, what expectations our families have regarding the services which the team members can and cannot render, the nature of their concepts of health and illness, and their conception of what constitutes adequate medical

care. These are all questions which the team members selected as having practical importance to them in their work with the families. In addition, research along these lines may increase our understanding of doctor-patient relationships as they have existed in the past for our families, and as they are now experienced (more favorably, we believe) on the Family Health Maintenance Demonstration.

In addition to the two main areas of research I have described, I have served from time to time in an advisory capacity to the educational consultant, the consultant psychiatrist, and our public health nurses in connection with certain aspects of their own research projects.

To summarize: First, I participate with the team in the diagnosis and evaluation of our families through communicating social science concepts, techniques, and findings where I believe these to be relevant. Secondly, I conduct research based upon Demonstration data in order to expand our knowledge of the role of social and cultural factors in individual and family adjustment and functioning, and to evaluate the attitudes of our families toward the project.

My year and a half on the Family Health Maintenance Demonstration has afforded me, as a heretofore strictly academic social scientist, a unique opportunity to learn, at first hand, to what extent the professional roles of doctor, nurse, and social worker as traditionally conceived need to be redefined if the goal of family health in the broadest sense is to be fully realized.

The question which I should like to leave with you is whether or not the average practitioner in each of these professions can, in the future, be expected to assume comfortably and successfully all of the new responsibilities and functions described in the previous papers in addition to fulfilling his role as customarily defined. Not only do we need a new conception of medical care; it also appears that a new type of medical practitioner may be required to provide such care. Whether on-the-job training programs will suffice, or whether in addition, more or less extensive changes in the curricula of the various professional schools will be necessary, is a

question which must be determined in the light of the total Family Health Maintenance Demonstration experience.

Discussion

Dr. Clausen: May I ask one question of Dr. Creedon? With reference to your second area of research, in trying to assess the attitudes of families toward the project itself, I wondered what sort of definition of your own role you give to these families.

Dr. Creedon: I have given considerable thought to this. I haven't arrived at any final decision, and I would like your help in defining my role to them.

It would seem desirable to stress my independence of the project; for example, to emphasize my association with the Russell Sage Foundation, which I would hope would give our families greater assurance that their responses would be treated confidentially; and not to be reported back to the team members except in terms of group trends.

Dr. Clausen: I would think that would be precisely the most fruitful role definition.

One related aspect: I would tend to think that interviewing in the home might be more feasible for achieving your objective than having people come in to the place where the service is given.

Dr. Creedon: Yes, especially since my office is adjacent to the team members' offices and in full view of the waiting room. However, I may encounter some practical difficulties in making home interviews. Our families are very widely scattered in the Bronx, Yonkers, and Mount Vernon. In addition, the nurses and social workers who have gone into the homes report many interruptions from children, neighbors, and relatives. However, I do plan to try a number of home visits, to see how it will work out.

Dr. Zubin: May I ask, in connection with that last comment: These special researches you have in mind, say, on child rearing, attitudes, and on the relation between the marital partners and so on—just how do you intend to get that information?

Dr. Creedon: The data for these different investigations are available to me in the extensive records which we have on every family

member based upon the interviews by the doctor, nurse, and social worker. I have formulated research questions for which I will not need additional data or for which the amount of additional data needed has been kept down to a minimum. In case additional data are required to answer a particular research question, I am hoping to obtain it at the same time I interview our families regarding their attitudes toward the project, or else by means of a mailed questionnaire.

DR. ZUBIN: Has the original source of intake been apprised of your intention to study the records from this point of view?

DR. CREEDON: My research problems were formulated after the interview schedules employed by the team members had already been designed, so I am limited to those research questions which can be answered in terms of the data that have already been obtained. Because these interviews are so thorough—the total interviewing requires about six hours—I do have a good body of material to work with, much more so than would ordinarily be the case in most investigations focused on similar research problems.

DR. MACMILLAN: I am wondering if Dr. Creedon has considered the possibility or the feasibility of gathering this sort of attitudinal information from the people who are not active participants, neighbors, etc.

DR. CREEDON: This method would not seem to be appropriate for an urban population, such as ours, where contact with neighbors is fairly limited. Also, I think we would have to forego this for the same reasons that the team decided at the outset not to investigate the job situation at first hand but rather to rely on the report of the family member concerned. The teams feel that they are already demanding a great deal of these individuals, and they have been reluctant to subject them to any further pressures, such as interviewing their neighbors or work-associates might constitute for some of them. I imagine it would make many of them feel quite uneasy if they knew that we were discussing them with others.

We have to bear in mind that we are looking forward to a five-year relationship with these families, and we are anxious not to alienate any of them. These are some of the practical limitations we face.

MR. COCHRAN: If Dr. Creedon needs any moral support in studying the attitudes of the participants, I should like to give it. This kind of study is important from at least one point of view. One of the difficulties with a research program of this kind is that part of the measurement of success is being done by people who are trying to bring about that success. Therefore, anything that provides an independent check on the success is valuable. If good data can be obtained from the participants and can be kept free from distortion of their true opinions through politeness, etc., it would be well worthwhile.

EDUCATION IN THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

IRVING S. SHAPIRO, M.S.

IN A statement of January 3, 1950, relating to the FHMD, Bailey Burritt wrote of adding to the improvement and success of family life. He described the "successful social case worker" as a "successful teacher of the art of human and social relations," "the successful public health nurse" as a "successful teacher in securing the adoption of known and tested health facts in the daily habits of individuals and families." He added that physicians "who are successful in preventing physical and mental illness and in developing and maintaining positive health accomplish this largely through the teaching process." (1)

Dr. George Baehr in a similar statement of the same date wrote, "Prime stress will be laid upon preventive psychiatry and what might be better termed preventive sociology, through an unobtrusive progressive education of the family." (2)

Three months later an overall description of the proposed Demonstration was prepared by the Health Maintenance Committee of the Community Service Society. (3) It contained this sentence: "Health maintenance is therefore influenced greatly by self-education supplemented by the aid of the physician, the public health nurse, the case worker, and others. It is chiefly an educational process."

At the 1951 Annual Conference of the Milbank Memorial Fund, Dr. Martin Cherkasky, describing the FHMD, stated, "We have considerable hope that by services which will be primarily educational in nature, we can help families use their own resources and strengths to reach or maintain a level where they may function effectively and comfortably, within the framework of this society." (4)

Dr. George Silver, describing the goals and future hopes of the

FHMD a year and a half ago, wrote about helping to resolve an educational problem which he summed up as "How do we get people to do what we know is right for them to do?" (5)

These quotations indicate clearly that those most intimately concerned with the development and functioning of the FHMD have accorded the educational aspect of the Demonstration's services an importance beyond the traditional. The emphatic recognition of the role of physician, nurse, and social worker as teacher poses a nice question: Is there a place for a professional educator in the program?

Non-professional teachers understandably avoid describing too specifically the kinds of educators (if any) with whom they would like to work, perhaps because there seems to be too rich a variety. Certainly there are different philosophies of education, an assortment of theories of learning, and numerous schools of education and settings in which educators work. Definitions of education, teaching, and learning vary accordingly. However, I understand this state of affairs exists in other professions, and can be considered a sign of health.

What then could an educator contribute to the FHMD? It was agreed that the functions of an educational consultant might be:

> To stimulate the interest and involvement of the team members in educational efforts to the end that their stated responsibility for functioning as educators for the FHMD families is most effectively discharged.
>
> To suggest or demonstrate appropriate educational methods, techniques, and materials as their use is indicated.
>
> To present for consideration the basic goals and current assumptions of health education, parent education, education for family living, adult education, and maybe just plain education.

Now right here is the exciting challenge of the FHMD to education, and of education to the FHMD. For many of the fundamental propositions in education not only lend themselves uniquely to helping achieve the service goals of the Demonstration, they actually are the same as these goals. Thus the FHMD aims at helping parents to be "resourceful," "effective," and "comfortable,"

and their children, "well-adjusted," and eventually "mature." (6) Many definitions of education would use the same words. Professional teacher organizations describe their purposes similarly. The Society of Public Health Educators, as stated in its constitution, exists "to promote, encourage, and contribute to the advancement of the health of all people." (7)

In greater detail, the objectives of the Demonstration in that area of family living which focuses on parent-child relationships are identical with those of parent educators. Would not the team members and parent educators today agree that the child, though still important, is no longer the central figure he used to be in family education? That there should be recognition of the individual rights and privileges of both parent and child, as well as of their interdependence and collective responsibilities as a family unit? Further than that, do we not agree that "the best parents are not necessarily those who know the most about the physical, mental, and emotional growth of children, but those who are best integrated adults"? (8)

The dual challenge is exciting in more than the equivalence of long range goals. Some of the most effective educational methods are the very ones preferred and even necessary in the Demonstration.

Thus adult education is giving increasing attention to groups. (9) Learning in groups and in relation to organized activities in the community are considered of "pre-eminent importance" as against learning through independent individual activity or the use of the media of mass communication. (10)

Dr. Jerome Frank recently offered one summary of the elements of an effective learning situation which when used as a yardstick against the available educational approaches to the families on the Demonstration reveals a superiority in the group method. He writes: "For a learning situation to be effective in changing attitudes, . . . it should be perceived by the learner as relevant to his purposes so that he becomes involved in it. It should challenge his old ideas but support him emotionally while doing so. It should supply incentives to apply what he learns by giving him opportunities to test out his old and new attitudes and ingrain the better ones through practice, and the more it resembles the rest of his life the

better. Finally, perhaps it should include possibilities for group decision as a means of strengthening the resolution of the members." (11)

Other descriptions of the necessary elements in effective learning, or of basic assumptions in educational practice contain essentially the same points. (12)

There is no time here to contrast educational approaches as they measure up to these criteria, nor to spell out the unique advantages of the free discussion group. The objective of most educational effort is to approximate the ideal within the limits set by the conditions of work.

The FHMD functions through its service teams—the doctor, the nurse, the social worker. Each is active in his professional role independently with family members, and jointly at family conferences. Each, as has been pointed out, is educating and teaching in face-to-face contacts with single members and family groups. An extension of the teaching efforts of team members leads most logically and efficiently toward the group approach, and, if it is to be most effective, toward the "free discussion group." Thus the Demonstration welcomes and needs group education activity for its families.

But group discussion is not simply a quantitative change, where the expert speaks less, encourages more questions, and gives the answers. There is a qualitative difference between the setting in which it is expected that authority will tell "the latest" and provide "the right answer," and the setting in which, given leadership, people will explore their problems, use specialists and other resources for guidance and suggestion, weigh possible answers and approaches in light of their own living, and try new attitudes or begin to build new habits with support and comfort—not anxiety.

As an aside, this morning when the discussion arose about possible hostility toward the team members on the part of some families and the whole question of acceptance of services came up, it brought to my mind a common pattern that parents exhibit during the early meetings of a series of group discussions focused on family relations or parent-child relationships. There is often a clearly expressed

ambivalence toward experts. I think we can see why this occurs. Initially, the parents will say, "We don't want to have any experts thrown at us. We don't want quotations from Gesell and Spock and all the rest of them. We have had those by the dozens." They feel that they have been given conflicting advice, and that they would like to have something more "down to earth," as they put it.

At the same time, as the discussion goes on, it is quite evident that they *do* want expert knowledge or would like to have access to it, but at their own rate of speed and in relation to the problems that they themselves feel. I think perhaps it isn't so much that people today are so commonly acquainted with experts that they may tend to discount them, but that perhaps it is the *way* in which the expert knowledge has been offered, with a degree of rigidity and implied blame that has brought about this feeling of antipathy. Recognition of this feeling may perhaps have been behind the questions and the remarks made earlier this morning.

It seems to me that this ambivalence toward "experts" is essentially a reaction to an authoritarian pattern that was laid down early in life for most of us by parental discipline and the kind of schooling we have had.

Again there is no time to describe in detail the essentials of this latter approach. A proposed educational program for the FHMD was prepared by the educational consultant for discussion by the staff. It described the basic goal, techniques, content, and the role of the leader in such group discussion. (13)

The staff agreed to try the program outlined. It was decided to start with the organization of a parent discussion group in which the team members would participate. Invitations to join a discussion group on parent-child relationships were sent to the parents on the program. Twenty-five parents attended one or more of the twelve meetings, held every three weeks. They discussed a range of concerns including discipline, jealousy, sex, social and psychological pressures, individual and family goals, norms, and the changing needs of children. The meetings were fully recorded on a tape machine.

Following each meeting the team members and the educational

consultant met for analysis and discussion of the strong and weak points, the growth of group feeling, the nature and extent of individual participation, the leadership, measures of effectiveness, the content, and other elements of the meeting. The tape recordings were of considerable usefulness, for often the necessary evaluations could not be made without their reproduction of detailed content and group processes.

In addition, the parents rated each meeting at its close on special forms, and at the last meeting discussed the series and its meaning for them. Comments by the parents approximated those made by parents attending similar group discussions throughout the country. The following are brief excerpts from the remarks of nine of the parents: "The meetings have helped to develop an attitude which may reflect itself in our actions to the children without our directly realizing," "I realize I have a normal child," "I appreciate learning that there is no perfect parent, that I'm not alone," "We have been talking about our problems as individuals as well," "I've come to regard these meetings as a place where I can gain some sort of overall perspective as a parent," "We've learned to be a little more relaxed with our children," "I'm getting a better look at my daughter," "I've discovered my husband—there were times when he sat here and gave forth with such great feeling," "I learned not to get overexcited." Often the parents described specific behavior and situations at home as examples of what they meant.

Incidentally, I think it is important to keep in mind that what was discovered here and what is felt by other educators throughout the country working with parent groups is that, despite the problems with which parents seem to be burdened and despite the strains in interpersonal relations that may seem to exist, essentially people *do* manage to lead fairly successful family lives even in times of stress, and given half a chance, they do have the strength and the ability to change if and when they themselves decide that they want to change.

The task is that of building a climate for learning within which parents have access to information which they can weigh in the light of their own needs and problems, and be encouraged to use.

You may have gained the impression that this is an abnormal group of family members with all kinds of serious problems which would require years of treatment or professional attention. I would like to emphasize the positive side of the picture. While of course I cannot speak for the team members, on the basis of my contacts with the parents, I believe that at least those who came to the discussion group were largely happy and healthy despite the problems they were facing.

It is, of course, the professional obligation of an educational consultant to build into his work whatever appropriate measures of evaluation are feasible. A questionnaire measuring certain dimensions of parent-child relationships was given to those who attended the meetings and to a control group, before and after the series of discussions. Among these dimensions of parent-child relationships were authoritarianism, permissiveness, rigidity, and good judgment which were measured not in relation to the specific content of the meetings but rather in quite general terms of family relationships. In addition, the nurse and social worker rated the parents in both groups according to a scale for the same dimensions, again before and after the series of meetings. The results are in the process of completion, but it is heartening to report that statistically significant results were obtained, testifying to movement by parents in the discussion group in the desired direction. (14)

This first parent group met until the summer of this year. During the coming year the staff plans to lead a variety of groups in discussion. Thus it is hoped that with the increase of the numbers of families in the Demonstration, several groups will form for discussions of parent-child relations, that another group will meet to focus on weight reduction, that still another can be formed with young teen-agers, and also one with much younger children.

Now that you have met the team members, I would like to identify which team member will lead which group. The groups that will deal with parent-child relationships will be led by Miss Bertha Kahn, a public health nurse, and Miss Hannah Bamberger, a psychiatric social worker. The teen-age group will be led by Dr. Robert Aaron; the weight-control group by Miss Helen Ringenberger; and

Mrs. Charlotte Stiber will lead a special play-therapy group for selected children.

There are many resources and educational techniques which the team member discussion leaders or moderators can call upon to make group discussion productive. There are personal teaching skills to be acquired and sharpened. This may be true also for the one-to-one contacts the staff has with members on the program. (15) The educational consultant's job with the FHMD is a rewarding one however, not solely because the team members themselves have the abilities and personal characteristics which enable them to function as effective educators, but more basically, because those directing the FHMD as well as the team members have recognized that in teaching too, there is no one "right way." With an appreciation of some of the fundamental teaching and learning propositions, and given time and access to necessary materials, education through group discussions as well as most effective one-to-one teaching can grow in the FHMD.

For a long time now there has been talk of the team approach in public health. Often the description of these teams omitted the educator completely or mentioned him casually. In actual programs, the educator, the health educator in this instance, played a variety of roles, many of which were incidental. Perhaps this has been so because medicine has not yet been able really to focus on prevention and positive health. Whatever the reason, many schools of medicine, social work, and nursing have not sought to transmit to their students the understanding and skills of educators. Reports of first steps in the direction of group education in public health work have only recently begun to appear, (16) and a leading nurse educator has written: "Whatever relative value of group methods may finally be assigned in health counseling, it is certain that they are sufficiently proved to receive serious consideration in planning programs, and that public health nurses should be equipped to provide group leadership." (17)

Educators for health, for family living owe a special tribute to the FHMD. Surely, in its recognition and demonstration of the place of professional educational services in its program the FHMD

will encourage the kind of cooperation between educators and all others working for happier health which can result in better services to people.

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Discussion

Dr. Zubin: First of all, I am a little concerned about the use of the term "patient." It looks as if in this very beautiful interaction between the members of the team, somebody got there first with the term "patient," and the name stuck. I don't see how the educator can use this term or how the social worker can use it. The nurse and doctors perhaps should. I wonder whether that is a fortunate term for general use.

I am also confused about the term "consultants." Apparently the consultants don't see the patient. That is their distinction. All they do is deal with secondary data. I wonder, too, whether that is an advisable or a realisic situation, when the bulk of the analysis and the results of the study are obtained from people who never see the original patient on whom the data are collected.

These two are only incidental points.

I am a little more concerned about something else, and that is the entire attempt that we have seen here, especially on the part of the first two papers, and also the third and fourth papers, to apply numbers to the data that have been collected. I am all for the application of numbers. I think the only way to understand is to measure. Until you can measure something you really don't know it. But I am puzzled sometimes by the premature application of numbers.

If I am allowed a moment or two to digress, I think the whole notion of measurement or quantification is merely hypothesis. We don't know whether quantification will ever get us anywhere in the measurement of personality or not, but it is a good hypothesis. I like it because I think we have gotten places with it, but whether or not we are ready for the kind of quantification which we like to see applied to these data remains questionable for the following reasons:

It is true that even physics began originally subjectively. The first measurements of heat or of weight or of light were subjective. There was no thermometer, so warmth was measured in terms of whether it *felt* warm or not. But gradually physics transcended self-reference in its measurement, and we have yardsticks today, of length and width, mass, temperature, which somehow or other have external criteria,

external to the individual who applies the measure. It is true, he has to have eyes to see the gadgets with, and so on, but they are independent of the actual modality being measured.

In psychology and in psychiatry, we have only a few dimensions which we can call measures that have transcended self-reference. If you look into books of about 1900 or so, you will find that intelligence was then measured with the terms "intelligent" and "unintelligent"; intelligent—like the examiner; unintelligent—different from the examiner. The self-reference there was quite clear, until Binet applied some external criteria. He was able to develop a mental age scale, a school progress scale against which the intelligence of children could be more or less evaluated, and it became external to the examiner. Anybody could get that measure now, provided he had enough training to apply the test. It doesn't depend upon his feeling, his subjective point of view, or his own intelligence.

All the data that you have presented today, interesting as they are and challenging as they are, are still back there in the self-reference stage. I don't know how you can objectively determine whether a person is well-adjusted or not so well-adjusted in these four steps, except by some kind of subjective self-reference, gained either from your own personal experience or from the experience you have observed in patients or in other people that you have investigated. This is the best we have now.

I am not complaining about the use of self-reference, but I wonder whether this wonderful opportunity that is being afforded by this research cannot yield more objective data of the following sort:

For example, I question whether it is necessary to concentrate on aspects of adjustment that are based upon theories derived from psychoanalysis, or psychology, which are interesting theories, but are essentially hypotheses that have never been demonstrated. In addition to worrying about whether children who are deprived in early childhood are the ones who later develop problems, or whether rage is based upon inhibition or regression—couldn't we have a simple count of the number of episodes of anxiety that the members of the family under scrutiny had during the month? Could we have a count of the number of family squabbles among the children of actual overt episode or conflict? Instead of getting a rating on sibling rivalry, could we have a count of how many times Johnny hit Mary last week. I don't know whether it is possible or not to get objective enumerated aspects of

family life. How many times did the patient feel blue last month? How many colds did he have? How often did he break a date with his spouse because of emotional problems, and so on? How often did he fail to go out for social reasons when he had planned to go out?

Such objective nose-counting would constitute, if you will, a Kinsey-like approach to the every-day problems of the individual in terms of his anxieties, depressions, family fights, and so on. Is it possible to utilize, at least on a sampling basis, the kind of information you are getting to obtain such objective information.

DR. SILVER: Dr. Zubin and I have discussed this problem before. This is not the first time that we have come up against what is essentially the key problem of emotional measurement and how it is going to be approached in a demonstration of this kind or any other kind which has to take emotional factors into consideration.

I think that everything that Dr. Zubin says with regard to objective measurements of families can be done. I don't think there is much doubt about it. I would say, myself, that after it was done I don't know whether any more would be accomplished than what is being accomplished now.

In the first place, the problem is one of definition. The definition of what one counts as an event in your category would raise similar problems to the events that we are counting. In other words, you are asking what it is that gives us the right to set up these events to count, and you would prefer that we counted other events, like a family squabble. Then I would have to ask you, "What constitutes a family squabble?" I would have to ask you, for example, "What constitutes feeling blue?" I would have to ask you with regard to anxiety itself, with which you have had so much experience and about which you wrote a book, in terms of your schedule of events, when is a person anxious?

You developed a schedule which you told me yourself wasn't a satisfactory schedule with regard to this measurement. How would I be able to count episodes of anxiety?

Let's take up the arguments one by one: first, that the application of numbers is premature and perhaps dangerous in an experiment of this kind. Number 1 in the list of Bentham's logical fallacies is, "Not now; now is not the time." In other words, when you want to give a good public reason for not doing something, you always say it should be done at some future date. I think this has hindered some of the

development of the exact facts that we want, that people have hesitated to develop some of the broader generalizations with regard to these facts and come out perhaps a little bloody and black-eyed but still with some additional information on the development of the family.

It may be that the things that go on in childhood have no appreciable significance with regard to adult behavior. Dr. Linton spoke here a couple of weeks ago. He said he doubted very seriously whether anything that happened to a child before the age of three had any significant effect. Of course, the Freudian audience in front of him was ready to eat him. I think that is what they do with their enemies, don't they?

The point is, I think, that we don't know any of these things, Dr. Zubin, and when we came to talk about it once before you said, "You will be doing the greatest service to mankind if you can develop a schedule that people could follow." I think what we had to do was to start with a hypothesis and to say, "We don't know whether this is true or not." We are assuming for the sake of argument and for the sake of our demonstration that there is something different about people who have had a gracious childhood with permissive parents, compared with those people who have had an ungracious childhood with very rigid and restrictive parents. We may be dead wrong in this concept. If we are, this has no validity, and whatever results come out of the study are absolutely pointless. But this is what we started with.

I think we need to explain exactly how we have applied numbers rather than to leave it to the audience to interpret from their own experience what we might be doing. We have not, at least during this day, explained exactly how we score or what goes into the scoring or what we are going to do with the numbers after they come out of the scores.

We are scoring people, and then we are going to measure the scorers against each other, and we are going to measure some material from outside against the score, and then we are going to create a schedule for measuring a test that is going to be applied against the score. So we will have two, three or four different approaches to the person's personality, and we are going to weigh these things against each other before we say that this is a good or a bad way of deciding whether rage, anxiety, and other things can be measured.

DR. ZUBIN: You have answered my question very well, and I think

I have nothing else to say, except to ask for a compromise. If you ask me today how I am going to find out about the number of blue funk periods that somebody had during the past month, I would have to plead ignorance; but I would be willing to try on a small sampling of a group of people to talk to them and focus the interview on these very topics which we are talking about. What do we mean by emotional health and adjustment. We mean people who are relatively free of these particular disabling moments which I have enumerated. A person who has them all the time is psychotic. A person who has them only once a month or so is perhaps quite normal. If he doesn't have them at all, perhaps he is a psychopath.

All these things get to be very important in determining the value of the kind of data you collect. I would be so happy to be able to say when this is all finished that we have a distribution of the expected abnormalities of the general population. How often do they occur, as defined any way that we can finally define them. How many times do children really fight with each other during the week, and so on?

It may be a totally different kind of thing from what you have in mind. But it seems to me that this is a grand opportunity to consider this problem and see whether we can get even a small bit of basic data, on these questions.

DR. SCHLOSSMAN: First of all, emotional health can not be measured in quantities of a person's emotions. In many cases we must consider states of anxiety; and anxiety equivalents, which are not manifest as anxiety but rather in the avoidance of situations or thoughts that some people show in their general behavior.

I think that emotional health can perhaps be measured more accurately in terms of the behavior of persons, how realistic their behavior is, how they meet the problems of every-day life and the problems in fulfilling their goals, rather than when they experience emotion.

Just one final point, I would like to bring out on your question "How many times do you feel blue?" First of all, you may ask, "How many times do you feel blue?" but most of the episodes of depression have been repressed and are not recalled. On the other hand, if you are dealing with a compulsive, he hasn't been blue or had any emotion since he suffered toilet training. Actually, in such a case his beginning to feel blue or to feel other emotions would be indicative of his getting better rather than his getting worse.

DR. ORBACH: I think that the point Dr. Schlossman has just made is an extension of Dr. Silver's comments in answer to the questions raised by Dr. Zubin in his original discussion. Dr. Zubin has proposed an alternative definition of mental health and has adopted as his definition an absence of overt symptomatology or disturbing feelings. While these aspects of emotional disruption have not been excluded from the definition adopted by the Demonstration, we have suggested that inhibitions of function which involve avoidance of important areas of life activity or distortions of interpersonal relationships may be more significant evidences of lack of mental health.

This is part of the formulation of the research problem itself and I for one would take issue with Dr. Zubin's definition just as he has taken issue with the one which has been presented today.

DR. CLAUSEN: I would like to comment on what I understand to be Dr. Zubin's orientation toward getting data on certain observable behaviors that can be related to other measures of health and to try to relate this to some of the original objectives of the Demonstration. I am not sure that I understand clearly enough what your objectives are when you talk of improving health. It seems to me that perhaps you need a more explicit statement of the general hunches you have that lead you to undertake your program. For example, you feel that if you can help these parents to create a more permissive atmosphere, some changes will take place in the health picture of the family. What are these changes? Do you have other theoretical orientations as to how changes in health are to be brought about?

Also mentioned was the desire to spot problem situations where you could intervene, problem situations which normally would have certain pathological consequences if they developed. You would intervene to prevent these consequences. What are some of the hunches you now have as to the kinds of situations in which you can intervene, the kinds of things you want to prevent?

There may be a lot of health problems in the group that you don't really think you are going to affect very much. There may be some others that you do expect to change, and for which you feel confident you can specify the kinds of changes you can bring about. Can you then, in these areas, try to develop some of the types of variables that Dr. Zubin has mentioned, and establish how these are influenced by your program?

DR. COTTRELL: I am not sure that I disagree or agree with Dr. Zubin, but following Dr. Clausen's remarks and tying up with Dr. Shapiro's, it seems to me that in this development of specific criteria of what you are trying to do, you might start at the point where you are talking about education of people to handle their problems of health. You might ask the question: If we could prescribe the qualities and capacities to cope with problems, what would they be? This would mean that we might not be concerned with the content, let us say, of good or ill health so much as the kinds of skills or qualities or abilities that we would like people to develop, which, if they did develop, we would feel they could handle their problems of health, or at least handle them with appropriate help from experts on occasion.

I think I got a little of this contrast from the social worker's report this morning. You seemed to develop a concept here in which you think of the people as patients loaded down with a lot of problems, and then you ride to the rescue, so to speak. If you aren't there to help them, they are not going to the doctor, and you are very necessary people. We hate to give up this concept of ourselves sometimes.

On the other hand, you can conceive of the job here as one of developing those competencies which will minimize the amount of help they have to have. I am not sure just what the orientation of this project is. I rather get the feeling that at one time you were oriented to what you might call the therapeutic, the picking up of the pieces of a rather problem-ridden world in which people depend on experts for salvation, and at other times you conceive of your task as being the generation of capacities and abilities of people to handle their affairs in such a manner that they will meet some criterion of health.

I am afraid I haven't given you a very clear distinction between the two orientations, but there is a very definite difference that I have observed among social workers, psychiatrists, and people who deal with problems, on the one hand looking at the world and seeing nothing but problems which need our help, and on the other hand the orientation that people, once you can help them develop certain basic skills in handling their affairs, will achieve health. I think some clarification of that orientation is necessary in this team.

MR. SHAPIRO: In reference to Dr. Cottrell's point, I wonder if he was asking whether or not we start with the assumption that health appears in everyone and that what we are trying to do is to improve

whatever health there is, or do we assume that everyone has a dark spot on his health escutcheon and that we are there to erase it?

DR. COTTRELL: That is a little bit too Rousseauian. I started with the kind of problem we had in a different arena of activities which I have been working on with Mr. Nelson Foote, who is Director of the Family Study Center at the University of Chicago, in which we were asked to point out some needed new directions for research in the field of families. We first wrote a memorandum with the conventional review of the literature, and pointed to some interesting problems that research people might engage in, whereupon we discussed it, threw it away, and started afresh with this kind of question. Assuming the family to be a major factor or matrix in which we generate the personal qualities that are necessary in the carrying on of our culture and value system, what are those qualities that we would like to see generated in the family matrix?

We were confronted at that point with the alternative of going along the line of the conventional concept of adjustment, which is a very vague sort of concept. Your client-patient-citizen can always ask, "adjustment to what?" and in a changing world, you are really up against it to answer him; or you can go in the direction of the capacity to cope with whatever comes. We use the word "competence" as an alternative term as over against the passive adaptation-adjustment concept.

DR. MCCREARY: If I may follow up Dr. Cottrell's remarks concerning whether to develop basic skills in meeting life's problems or whether you are bringing in therapeutic experts, I think that this project would have quite an ethical problem if they do not go in the direction of basic skills. At the time when the project is finished, there will be a cutoff point, and then the subjects will be without all this care.

In connection with this, a statement was made that the controls were not measured initially, because then you would have to do therapeutic work on them. If they are measured at the final stage, I think you are also in the same position i.e. that you will have to do therapeutic work on them at that time.

There is probably an instrument effect, also, which may be partially within the assessment itself that was done on the experimental group, so the experimental group had an instrument effect, plus the therapeutic effect if it exists.

The other point that I wanted to mention was in connection with Dr. Zubin's point, that is, of measurement. As I conceive it, there is no simple answer to the problems of measurement in the social sciences but, as he points out, some sort of experimental work has to be done with various systems of measurement that one can develop; in other words various assumptions are made and a test done to see if the results coincide with the mathematical or statistical model.

We are at much the same point as the Egyptians or some of the earlier people were when they observed that the square of the hypotenuse of a right-angle triangle was equal to the sum of the squares of the other two sides. This was probably determined experimentally before it was ever deduced logically. We are in a position where we have to keep experimenting; e.g. if we add things together, does that come out with a result that is meaningful in terms of some real phenomena.

Dr. Silver: I would like to answer the point that Dr. Clausen and Dr. Cottrell brought up before, about a more precise formulation. There are rather more precise formulations, in that we do have specific criteria for what you might call the warning situation. How do we know that something needs to be done to prevent a catastrophic breakdown? By dividing our areas of interest with regard to the four situations—work, play, sex, and family life—we find there are again certain generally accepted patterns of behavior among those four areas that we can accept as significant for us to try to do something about.

I cannot be more precise than that without picking up specific situations, because to generalize in the area of when you are going to do something means that you might interfere when somebody is doing something for himself already, or you might interfere in the sense of producing a family catastrophe. The kind of interference that is done has to be judged in an individual case by the sum of the events that are entering into the consideration.

I have been looking through my papers here for an appropriate quotation, because I always feel safer when I can say that somebody else said it, too. I just want you to know that an internationally famous physicist, in a discussion of an important physical problem, for which I understand they have much better methods of measurement than we have in the emotional area, says, "It may not be universally true that the concepts produced by the human mind when formulated in a slightly vague form are roughly valid for reality but when extreme

precision is aimed at they become ideal forms whose real content tends to vanish away." I think maybe in our particular case this would probably be particularly true.

The problem of normality that arises is again one that we ought to emphasize. It was emphasized at one of these meetings at another time. We are talking about normal for us and normal for our little cultural enclave here in 1953, in New York City, and with the kind of people that we are working with, because otherwise we would have to start defining what we mean by "normal" over a long period of time, which would be very difficult.

As far as whether we are oriented for therapy or for mobilizing resources, we are oriented for both. Where we find a situation that requires our help and assistance, as an agency to provide service we are supposed to do something about it if we can. Where we find that with the tools at our disposal for giving these people information about their interpersonal relationships and about their child-rearing practices, we can help them to mobilize their own resources.

DR. CLAUSEN: I would wonder about some of the implicit assumptions that you may be making with respect to the proposed measures. Granted, it may be very difficult to come up with adequate indices. I was puzzled, though, by the reference to the Rorschach test. Initially, you thought you might get a useful assessment there, but your sample showed so much pathology that you decided the Rorschach wasn't suitable. This suggests either that the Rorschach's standardization is so inadequate, and the test is so poorly validated, that this tool is not worth trying out, or that the particular pathological problems revealed by the test are not the kinds of problems you want to deal with.

I should have thought, otherwise, that if a lot of problems showed up, you might be very much interested in learning whether these problems might be modified by your program.

DR. ORBACH: The reason the Rorschach test was rejected is that there are no adequate normative data against which to evaluate these problems. In accordance with the standard manuals of interpretation, it appeared as if there was a lot of psychopathology, but actually these people are functioning quite differently than, let us say, State hospital patients or patients in psychotherapy who have similar kinds of records.

Not so long ago I received an informal communication about a large

number of Rorschach tests which had been administered to psychiatric out-patients who also had received a good psychiatric evaluation. There was little or no correspondence between evidences of schizophrenic symptomatology in the test protocols and in the diagnostic interview. In many instances overt symptoms of schizophrenia in the interview were not paralleled by signs of disorganization or of a thinking disorder on the Rorschach test. In addition, evidences of schizophrenia did appear in test records when none was present in the interview. It is my opinion that it would be much more difficult to relate test findings to the interview data in the population from which the study sample has been selected. I wouldn't know how to do it.

I thought this would create a research problem within the project rather than add to an understanding of the processes we are dealing with.

Dr. Silver: We apply preventive services and guidance and educational services in this preventive area to this group which is not generally available to the control group. That doesn't mean that they may not get it somehow, because as Miss Freeman pointed out this morning, preventive and educational services are available in the community, but in the general pattern of care these people don't get that kind of treatment.

We have found from experience that when people come in and talk to you about things, for instance, if you would do a psychiatric examination or even a social work interview and people would discuss the problems that are disturbing them, the mere act of discussion sometimes brings to the forefront of their minds the fact that they have to make a decision, and they do something about it.

Dr. Orbach: There is implicit in the scales developed for the different areas of life activity a dimension consisting of decreasing limitations of function. For instance, in the sixth one which is concerned with family relationships scale point four which is the poorest rating refers to a lack of emotional contact or participation in the family situation. This would be the extreme of isolation when living in a family unit. Scale point one which is the most positive rating refers to a great deal of interaction of a constructive nature. There is, therefore, a dimension of emotional interaction which is an integral part of this scale and any decrease in the fears which result in isolation will

be reflected in a rating of increased interaction. One of the very important assumptions that we have made is that coping ability or mastery is related to the kinds of irrational fears that lead people to avoid expanded function in a number of areas.

I think this picks up one of the points that you were making, Dr. Cottrell, and that is, we believe if patients or clients in the study have therapeutic intervention, coping ability or mastery will be increased by dealing with sources of anxiety in their lives; that the two are not separate kinds of processes.

DR. COTTRELL: I would like to put into the record that it is my impression of this project that you haven't stopped merely on the therapeutic level, but have already advanced into what I call the "coping" area, and this represents quite an advance in the total cycle of development in social and welfare agencies in general. This development could be thought of as falling into stages that might be called: (1) charity; (2) rehabilitation, e.g. putting a broken family on its feet; (3) therapeutic; (4) preventive; and (5) developing positive competence. A history of welfare activities might fall into some such series of stages of development; and also at any one time an agency may represent efforts in any or all of these stages.

DR. REGENSBURG: I would not myself be able to see the concept of coping without having integral to it the concept of better mastery. That is what Dr. Cottrell, meant. I confuse myself. I can't see therapy of any kind which does not result in that same increase in mastery or functioning. So the distinction I would be more inclined to make, from my standpoint as a social worker, would be that you would be using different methods with different people as they were able to respond immediately to something as direct as teaching, or needed first to go through a therapeutic experience of some kind before they could increase mastery.

I wouldn't in either case see anything except an increase in the competency or mastery as one's objective. It was your difference in method that interested me, rather than the distinction I thought you were making.

DR. COTTRELL: I would draw this distinction: Certainly in the field of research, you have a different orientation, and I think in social work and other welfare fields also you would get some difference in programs

and in attack on problems if you started out with the assumption that our examination of the family is in terms of seeing it as a series of problems or pathologies to be cured on the one hand; or if on the other you started out with the question of what will maximize the capacities to "cope with life."

DR. DOWNING: I think symptom complex has a different meaning to a person who is coping with life than to a person who is not coping with the realistic problems of life. Because we have no other term, we apply pathological terms, like neurosis and character disorder, to symptom complexes which are essentially healthy and coping adequately with life. It has a different meaning. The working team seems essentially optimistic about these people. They are changing and getting something out of this program despite the fact that at first glance there seems to be a great deal of major psychopathology.

DR. SCHLOSSMAN: On the question of psychopathology again, if you just try to add up the psychopathology that you find in this one family or in all the families, of course you come across a big mass of so-called psychopathology. It is really not a criterion for judging what the level of the families is. Their functioning is a much better level, because I am sure that in every single person in this room you can find some neurotic trait or another, and it is based on psychopathology, but that is not neurosis or psychosis.

DR. COTTRELL: I think Dr. Schlossman has put his finger on it. We are concerned with maximizing competence in coping, rather than approaching everything as a disease which must be cured or as some mythical equilibrium or previously existing state of health. What we are concerned with is an increasing capacity to cope with what comes. His criterion, it seems to me, if I understand it, is that, rather than symptomatology of pathological conditions.

I am a little concerned over the change in role of the social worker as I used to know that role when I used to work in clinics, and the role I get from your description. There may be all kinds of reality conditions which make for this. How does it happen that you are supposed to describe the social processes going on in the family, the conditions under which they operate, from an interview in the office? It seems to me that you need to go out and see this family in its natural habitat.

I have every respect for Miss Ringenberger and her capacity to

bring that information back, and maybe the team has to depend on her contact, but I am a little surprised that the social workers are not out in the social context seeing it for themselves.

MRS. STIBER: I think the social workers more and more have gotten away from visiting patients in their homes. The situations that we are dealing with are not so much reality in the home setting. They are describing the feelings and attitudes, which they can describe just as well and in fact a great deal more freely in an office where the children are not around, and there is no chance of the neighbors coming in. I think they have much more freedom in an office setting than they have in their homes.

I have the impression from the few occasions I have made a home visit that the patients have the feeling that the very walls are taking in the things they are saying and will repeat them at an inopportune moment.

DR. COTTRELL: Let me agree with that, but say that in addition to what is learned in the freedom of the office contact, I still think you need also to see the person you are studying in the interactive situations outside the office. To some extent possibly the public health nurse supplies this set of eyes.

I remember when I used to study delinquency with Mr. Shaw in Chicago, one of the most revealing things that I would do would be to go around and interview a family about the situation of the boy and see the various members put in their two cents worth, and the way they did it. After that, the record made much more sense to me as I saw these people operating, even with a recognition that my presence did make a difference.

I am not prescribing what you do on the team. I am just voicing some question mark there as to whether there is too much based on the examination of the family relationships through office interviews and reports of one person, who necessarily has to be concerned with the things that the public health nurse has to look into.

DR. ORBACH: I want to comment on one of the issues that Dr. Cottrell raised. I think it is a basic one in this kind of research.

By what kind of method are you going to obtain the data which goes into your final evaluation? There has been, I think, in this study a somewhat heavier emphasis upon the interview technique as over

against direct observation. I think that has been based upon the assumption that you can get at more significant kinds of material through the interview than by spending a comparable amount of time observing these people in the home situation. The social worker obtains life-long patterns of adaptation from these people that I don't think would be available in direct observation.

DR. COTTRELL: From other studies in which I have had occasion to discuss this matter of keeping close to the realities of the situation, it is my impression that there has been a very strong change in the professional training and orientation of the social worker in the general direction of minimizing what might be called the description of the reality situation and a maximizing of the perceptions of the situation as revealed through the interviewing technique. I am of course very strongly in favor of using all the skill we can in getting the person's own definition of the situation. But I also think the burden of some of these questions here this afternoon also indicates the necessity for being sure—and this is with full respect to the work of the public health nurse—that the reality situations are seen in something approaching their natural conditions and circumstances.

I have one point in mind which grew out of another study which involved the same issue, in which great skill was being utilized in the interviewing technique. The perceptions of the person were cast in the classic Oedipus and other psychiatric formulations, with complete disregard of what was actually going on in the reality situation, to the detriment of diagnosis and treatment. I insist that this is something that needs to be constantly watched.

DR. REGENSBURG: May I support Dr. Cottrell strongly on that. Also, I do believe that among social work educators and practitioners at the moment, there is a very decided effort at this point to put both aspects together so that we have, I hope, some chance of achieving a balance, discarding neither one nor the other; but we certainly have discarded the one very badly, I think, for a long time.

DR. ZUBIN: There is one anomaly at this conference I would like to call attention to, and that is that all the psychologists, as one, discount the objective test and prefer the interview. That is kind of a victory, I think, in a sense, for social work, because for a long time they had been promulgating this idea that testing is only ancillary to evaluation of

personality, and I think all right-minded psychologists agree with that.

I would like to call attention to one particular aspect of this which I think is important for further research, and that is, why is the interview so much better than test? It is so much better than test because the interview, when it is focused on emotional problems, doesn't concern itself with facts or abilities or capacities as such. It tries to elicit from the patient, from the client, his attitudes towards those events, his feelings towards those events. I am not saying anything new. All social workers have said this for years.

There is one more thing to be concerned about, and that is, what is the technique with which an attitude is elicited? Granted that the interview is to elicit attitudes and feeling, what does the interviewer have with which to elicit those attitudes? All he has are his *own* attitudes. He has to play on the strings of his own attitudes so as to elicit reverberating attitudes, from the client.

For the purpose of determining the particular techniques that are most suitable for eliciting such information, we have to have recorded interviews. Without recordings we are dependent entirely on the final intuitive distillation of the social worker's mind. No matter how good he or she is—and I have no hesitancy to accept the goodness of their work—without the actual recorded process we are at the mercy of the intuitive evaluation beyond which we can't go any further. We can never get back to the actual process.

So again, may I bargain with you to do a sampling study in which the interviews are recorded, to see whether you can't first of all, find out what the process was, what was done that really elicited the attitudinal information; and, secondly, what could be done to improve it. Because without having the process before you, you can never improve it.

CRITICAL APPRAISAL
OF THE DEMONSTRATION IN TERMS OF:

PUBLIC HEALTH

DUNCAN W. CLARK, M.D.

THE first and rather obvious point is that the Demonstration, and the experiment that it connotes, is an important example of public health activity. We have here an effective partnership of community agencies representing a family agency, a university, a foundation, a hospital, and a medical care insurance group practice unit, among others, co-sponsoring and in different ways active in a research and service project.

Within the experimental demonstration itself there is the representation of a wide range of skills and disciplines, some of them just moving into the health fields. Incidentally, Dr. Leo Simmons of Yale reported at least a year ago that he knew of more than fifty social scientists directly active in medical care and public health programs.

In an appraisal of what meaning this demonstration may have in public health terms, one might begin with reference to the objects of attention of public health. These include society generally, the local community, groups whose health is at risk by reason of age, sex, occupation, and so forth, the well individual, the sick person, particularly one with a communicable disease, and the family.

Much of official public health practice so far as the personal services are concerned, is directed through control programs to those whose health is at risk; for example, the programs of maternal and child health. It has been through attention to maternal and child health that the public health nurse particularly has become involved in at least one phase of family health care. Nursing, in some instances, has set up its records "family style," which is more than most physician agencies or groups have done.

There is rather general agreement that the family itself is the optimal unit toward which medical and social care should be directed. This has received much emphasis of late because of national

concern with the forces that disrupt family life. We have reached a degree of specialization in this country—and it will get worse—which makes the delivery of such attention almost hazardous to the family. To the extent that we successively multiply social, medical and health agencies and services, each with a portal of entry to the family, and when we deliver these services in an uncoordinated way, to this degree does the weight of combination of these several services make for an additional disintegrative force in family life.

As a consequence, it makes sense to seek in the design of a professional service a coordinated approach, wherein there is awareness on the part of the professional staff of the sum of the family problems, of their relative importance and relationship, and where the idea of preservation of the family as a unit is both the standard and an objective.

The Family Health Maintenance Demonstration, functioning as it does in a setting of group practice on a comprehensive prepaid insurance basis, has a most fortunate professional environment. At least, some of its unique features appear to be the following:

An attempt to test whether the addition of preventive services, guidance, and health education to an experimental group of families will result in significant improvement of their health situation. These are middle-class, self-supporting families. The professional services have been reorganized in a manner and form not previously tried. There is a basic medical care team thought suitable to an urban environment wherein the functions of the doctor have been reduced and some of his ordinary functions assigned the nurse and social worker or the corporate unit itself, the team.

There are consultants from a range of the behavioral sciences, particularly for the interpretation of research, and presumably advisory when they may be of assistance in the interpretation of therapy. Health care is offered families not volunteering for it. The main theme of guidance is that of direction, presumably in interpersonal relations between parents and children.

It seems almost premature for any of us to pass judgment on the Demonstration as research. There are too few data at this point. Many of the questions that concern evaluation are due for a hear-

ing tomorrow. Some of the questions raised yesterday with respect to methodology can stand re-emphasis.

Dr. Evans asked about the basic medical care team, whether too large a team had been formed initially even before examination of the functions required of this form of medical and health care had been determined. It seemed implicit in his question that a more economic use of patient time and professional time might have been arrived at. That a smaller basic unit would be more economic financially seems quite possible. That more valid information necessarily comes as you increase observers is also a question, although this was not claimed.

Parenthetically, the experience of rural medical care in Sweden might be mentioned as an interesting example of the economic delivery of public health and medical care in a compact package, namely, that of the long established working association of rural district general practitioners and public health nurses. Appointment to the position of district general practitioner is much sought after. He receives a part-time salary from the state and has a home and office provided by the local commune which must meet the minimum conditions of the Swedish Medical Association. The appointment to the post is presumably to the physician with the best credentials, which usually means long-term training, frequently of three, five, or seven years of house-office training. He is sufficiently remunerated during such assistantship that he can support a family while taking this extended training.

Currently, aspirants for such a post also tend to take a graduate course in public health of at least six to eight weeks' duration. Consequently, rather well-qualified persons are likely to receive such an appointment. Assisting the doctor are two or three public health nurses, and a midwife who does normal deliveries. The doctor is also paid by the public health authority and makes no charge for preventive services and small charges for curative services. He maintains records of communicable disease within his district.

With all this, the Swedes are not satisfied with the system and are now trying to change to more comprehensive health care which has as one objective the association of one doctor with another (not

now possible in certain of these districts). They want health centers. This is of interest as a general trend seen in this country as well.

Another question raised yesterday was whether the multiple objectives of the Demonstration compete with one another to the extent that they may be interfering. At least this was implied. For example, it was stated that the most pressing family problems receive the most clinical attention, and that families having few problems receive rather a minimal degree of attention.

It is worth noting that the latter may be by far the more suitable for the intensive kind of study of who is healthy, assuming that this group may be the so-called healthiest. At least some extra examination of this group seems in order. It might even be found that among several of them the parents have had a childhood not classifiable as "gracious" and their parents were anything but "permissive."

It is also true that very much attention to the presumably healthiest could be pursued only at the risk of losing the race with the controls.

In yesterday's discussion several subsidiary experiments were suggested. More emphasis on the observation of the phenomena of healthy living was urged. If interviewing is to be the principal technique, then such interviews preferably should be recorded and interpreted by more than one observer. When so many standards of judgment are subjective, the imposition of personal norms is, of course, inescapable and some added control of this particular feature seems warranted.

Let us now consider the usefulness of this as a form of public health and medical care practice. It is conceivable that at the end of the experiment it may be decided that it is not a useful form of practice, although that seems unlikely. Even if this were to prove to be the case, quite obviously this Demonstration has already become the focal point of considerable interest and attention in efforts defining the methodology for an approach to the study of health.

So let us assume, on the other hand, for the sake of discussion that the Family Health Maintenance Demonstration is ultimately proved to represent a highly useful form of public health and med-

ical care practice. What implications has this to public health? The recommendation might come that this is a desirable practice and a prototype for emulation in a variety of settings—in group practice, in medical care programs of welfare departments, as extensions of existing home care programs of hospitals, and in district health centers of the city health departments, possibly of association with the activities of other official agencies. Some of the examples mentioned may even be disturbing!

Let us recognize what is already in existence.

Public health nursing, alone or in combination with social workers, in family agencies, is offering health education, guidance, and preventive services. In this Demonstration we see transported this going activity to the realm of the hospital and the setting of a group medical practice unit. The hospital and the group practice unit appear to be in the role to some extent of validating the basis on which social work and public health nursing proceed with their guidance, and I make this as a deliberately oversimplified statement. The converse situation may also develop. Just as psychiatrists already advise social workers in family agencies, so may the internist or pediatrician possibly find an advisory role in recommendations concerning the care of the clientele of the family agency.

The question also arises as to whether family care á la Family Health Maintenance Demonstration style, in the sense of preventive services, guidance, and health education, might seem a proper function of a health department. I wish to comment on this also from a personal experience in medical education, because there are developing certain projects which have some resemblance to the one under discussion.

In New York City, for instance, the Health Department makes available the facilities of district health centers. We have such an association in our own school in Brooklyn. It is because of the very fact that the personal health services of the Health Department are so fractionated into multiple control programs that we developed the theme of family study four years ago. Each student in the course is assigned a complete family for complete medical and social study for the purpose of initiating recommendations with respect to med-

ical and health care. He is not there as a doctor, but as a fourth-year student. He is supervised by internists, by social workers, sociologists, psychiatrists, and other representatives from the departmental staff. The purpose, among other things, is to bring him in contact with a wide variety of agencies that have had some past or present contact with the family, so that he is the better motivated in acquiring an understanding of certain of the resources of the community when he does these things on behalf of a patient. So here we have set up within a district health center, for the purpose of meeting a teaching need, a rather full-scale family program. It is not family health maintenance; it is a diagnostic and evaluation service with continuing treatment administered by other community resources. The possibility of continuity of observation for the student is obviously sharply restricted.

While still on the subject of medical education, it is rather common practice to advise medical students that the collection of social information should be as an integral part of the medical history and that such information is best obtained whenever the patient offers a clue or opening at any point of the medical history. Quite obviously, over and above this there are certain areas that must be routinely inquired into, but by and large we would not be disposed to look with favor, at this stage of the student's education, on the demonstration of a practice where the doctor appears to be placed in the role of collecting too little of the social information. That was an inference I gathered from the present Demonstration. Maybe it is incorrect.

This raises another point, that in my opinion there should be a captain of the medical care team; and that person, it seems to me, morally and legally, as the one most responsible, as the dispenser of important services, should be the doctor. The point could be made that at least he is the pivotal person, if not always the one most centrally and directly involved.

Finally, what of the costs of such a service if proved suitable for widespread use in public health and medical care practice? The chief costs might be less in money than they would be in manpower. We have shortages in teaching, nursing, and social work.

There are said to be about 75,000 social workers. The great majority, however, have not had one or more years of professional training. They are for the most part in public assistance programs. With respect to public health nursing, we see in the program eighty families and two nurses. The nurses are obviously quite busy. All of the problems cannot be met. Yet here the ratio of public health nurse to the population in the demonstration is one to one hundred sixty. We would be happy throughout the country if we could get one public health nurse to five thousand. This isn't exactly a fair comparison in view of the very extra efforts that go into a research operation.

Just some comments about the family study itself. I think, when we collect a huge amount of information about a family, their past and present illness and the many problems that they have, and since we all naturally tend to approach this from the point of view of specialists in pathology, we are apt to get the impression that there is an over-serious degree of illness or malfunction within the family unit. I think this has to do with the orientation that we all bring to a clinical study.

PUBLIC HEALTH

DEAN A. CLARK, M.D.

I HAVE very little to add to what Dr. Duncan Clark has said. I think my assignment, which is to discuss the Family Health Maintenance program in terms of public health, is an interesting one because in terms of traditional public health, the Family Health Maintenance Demonstration is pretty unusual, to put it mildly. Assuming, as Dr. Duncan Clark has said, that its worth is demonstrated after the five-year period, it is pretty doubtful, I should guess, that official public health agencies are likely to go in for this kind of thing right away.

On the other hand, if you take the term "public health" in the broader sense in which I much prefer to use it, the discussion is not limited specifically to public health agencies, but includes all agencies, official and non-official, working for the health of the people. Taking the term "public health" in that broad sense, obviously the Family Health Maintenance Demonstration has tremendous implications if it proves to be successful.

The question, to my mind, is: What really is going to be demonstrated? I haven't the slightest doubt that families are benefiting from these services and skills that they are given an opportunity to take advantage of, and yet I am still in some doubt as to how conclusive a proof of benefit will come out of the study, or can come out of the study. This is not a criticism of the people doing the study or of the method itself, really. It is just an awfully difficult field to prove something in on such a broad scale.

I am still bothered about the control families. I understand the difficulties, and yet I do wish some way could be found to obtain some information about control families, perhaps without their realizing it. I don't know how this could be done, and yet it bothers me that we are going to wait five years before we find out anything about these controls. So many things can happen in that period of

time that you don't know about, and you can't really find out about retrospectively. Yet I realize if you took them in for evaluation as you have your experimental group, unquestionably what the staff has said will be true, namely, they would cease to be controls, at least in the sense in which they now are, because the very fact that they were interviewed would alter the situation.

I wonder if there isn't some way of sneaking up on them without their knowing it; not by the same team that is managing this study group, I suppose. If the control families get involved with this team, they certainly will be aware of the fact that they are in a special status compared with other subscribers to the Montefiore group.

I was encouraged to learn that Dr. Creedon is examining the composition of the control group as to age, sex, race, and economic status. I would hope that somebody is beginning to look at their medical records, which are of course on file in the Montefiore group, too. I mean somebody like Dr. Creedon, who is associated with the study but is not herself giving direct service to either the study families or the control families. The earlier in the study such medical information is gathered, it seems to me, the more chance you have of coming up with some meaningful controls later on.

I could even perhaps stretch it a bit further. I say this is sort of off the cuff in a way, but yet I would wonder whether in the course of the period some few people might not be informed as to who the control families are, so that if they do have occasion for a home visit, for example, from the physician or from the Visiting Nurse Association, that some information might begin to be collected about their social and economic situation as well as their medical situation. This may not be possible, but I still wonder, when you get through and go back over five years of the control families, whether you are going to have a body of information that can be compared in any meaningful sense with what you are getting on the experimental group.

There are a couple of other things that occurred to me because we have been thinking about them in Boston in connection with the hoped-for establishment of a family health service by the Harvard

Medical School and the Massachusetts General Hospital, in collaboration. This family health service has already been started for children, and Dr. Stokes, who was here yesterday, will be taking charge of it for adults beginning next July 1. We do not have, of course, the base that you have here with the group practice unit and prepaid comprehensive medical care, which obviously makes an ideal base to start from. We will not have that and we will of necessity, at least at the beginning, be limited to low-income families so as not to get in trouble with the Medical Society, to put it bluntly. Nevertheless, we are thinking about several points which were not discussed as such yesterday.

One of these things is the same question that Dr. Evans and others raised yesterday, of how large a team and how complex a team is necessary or desirable or, for that matter, is economically feasible in anything except a research demonstration, which, granted, is a special case. For example, take the fact that you have both an internist and a pediatrician. Our plan calls for an internist and pediatrician, too, with consultants in other fields. We are toying with the idea—we don't know how it will work yet—that the internist and the pediatrician might get mixed up a little bit. We would like to see that. We think the pediatrician is simply an internist for a small-sized person, and not, as such, distinguishable from an internist, scientifically speaking. So we rather hope that our internists will begin to take care of children in some families, and pediatricians may very well begin to take care of adults in other families. Both would be thought of as "family doctors" and we would call on the particular functions of the internist and the pediatrician as specialists, only in situations that involve some complexity. We haven't exactly started it yet, except that the pediatricians now working with the children in our neighborhood are already finding that they are taking care of adults, too, at home because they are the only doctors around. If the patient's condition involves something complicated, they bring this adult in to the clinic, or, if necessary, take another physician out to the home.

Secondly, we are interested in mixing up the functions of medical social workers, public health nurses, physical therapists, health edu-

cators, and so on, toward the end—which may seem rather strange, yet we are very conscious of it as a possible goal—of having a "home visitor" who functions in all these capacities, except, again, where special circumstances demand the particular knowledge of the specialist. In other words, we would hope to see a public health nurse acting as the home visitor not only on nursing problems, nutrition problems, and health education problems, but on social problems as well, and perhaps under certain circumstances giving physical therapy.

The home visitor would then call on the medical social worker or the expert physical therapist when the circumstances require more specialized knowledge.

How far we can go in this direction remains to be seen. I know that both our nursing service and our medical social service are very much interested in the possibility of merging these functions in one person in the field. This might, to our minds, be more economical in the long run than our present division of labor which has no real logical base at all, but merely a historical one which doesn't necessarily justify it for all future history.

As Dr. Grant knows full well, the Rockefeller Foundation is interested in and is supporting some experiments along this line in England and in France, where some attempt is being made—I don't know the details of it and Dr. Grant may tell us some more later—to study and experiment with merging the functions of medical social service and public health nursing, or at least with bringing them closer together than we are accustomed to seeing.

Of course, here in this demonstration they obviously function close together. It is only a question of how many people, as Dr. Duncan Clark said, you really can afford to have in anything except a research demonstration. This brings me to the next point, which is, how many families could such a team take care of if it were not a research demonstration? It isn't fair perhaps to make a comparison, because right now you are still involved in the intake procedure, which is long and difficult. In the long run this sort of thing can become at all widespread only if it can be shown to pay for itself, or nearly so.

On what terms would that be? If families are made sufficiently much more healthy as a result of this type of service, many of them would perhaps be willing to pay what it costs, but I dare say the cost would have to be less per family than that of the present demonstration. There are, of course, some potentialities for economies in the program. For example, if the home visitor could carry out many of the functions now carried out by the physician, that would reduce the amount of physician-time required; since physician-time, as everybody knows, is very expensive time, one would expect to realize economies by this type of substitution.

I should hope that the demonstration will keep this type of possibility in mind as it goes along, so that in the outcome it will demonstrate not only perhaps that some of these services have made the families healthier, but also will show something about the best techniques for providing such service and about the organizational and administrative problems involved in carrying out this type of service in other situations. There are other situations where this is a possible type of service. I am referring particularly to other comprehensive prepayment group practice plans, of which there now are quite a number around the country, with increasing enrollment. It is true that there are not many new plans of this kind, but there has been a good deal of increase in enrollment in those that do exist.

HIP would be, of course, an obvious example. Other centers than Montefiore now associated with HIP ought to be able to make this type of service available, if it can be demonstrated that it is useful and if it can be demonstrated that it can be done in reasonably economical fashion. Of course, that is true in other such prepayment plans, too.

My final point has to do with education. I mean not only the education of medical students but also of student nurses, social workers, and others in the health field. I should very much like to see this used as a laboratory and a classroom for students of medicine and students of other associated professions. We intend in Boston to use our Family Health Service for that purpose from the very start. In fact, our scheme is a little different from some of the others that Dr. Duncan Clark referred to, in that we intend to have

medical students, as an elective course in the curriculum, start out in their first year accompanying the physicians in the Family Health Service through their rounds at home or in the clinic or in the hospital. Each student will have as his personal responsibility one or two families whom he will follow throughout his four years at medical school. The student gradually will take more responsibility as he gets along in his medical education.

The difference between our scheme and those in most other places is that our Family Health Service will be doing what the Montefiore scheme is doing, namely, providing medical care as well as teaching. It is my firm conviction that medical students—and I dare say it is true for students in other health professions also—learn best when they have to take responsibility not simply for examining patients and observing their instructors, but for taking care of people.

These students, we hope, will be seeing through their four years at medical school a family health service almost as complete as this one. It will be on a smaller scale, perhaps, but the students will be seeing their families clear through from the beginning to end of their medical school experience, so they will get to know what happens to a family during a four-year period.

It seems a shame, to me, that at the moment the Montefiore Demonstration is not being used in this way. I would hope that those of you who are in medical education in New York would try to make arrangements whereby students from the various medical schools, at least from those nearer at hand, like Cornell and Physicians and Surgeons, at least as an elective, could take part in this Demonstration. It is, as Dr. Duncan Clark said, the kind of thing that all medical schools are talking about but very few have done much about. None that I know of has had as good an opportunity as this Demonstration offers.

There is one other question, too, and that is, how long this should go on for purposes of really proving something. I am inclined to think that five years is going to be too short, and that if the Demonstration appears to be proving anything by that time, it probably should go on another five years, perhaps with the same families. Many questions were brought out yesterday about the relationship

of child-rearing to adult maturity, which you won't get the answers to in five years because the kids are still going to be only ten years old when you get through. Who is going to find out what they are like fifteen or twenty-five years from now, and make some comparison between what they are then and what you observe today in their family child-rearing habits or practices? That would be something worth while, it seems to me, and I think there are a whole lot of other things that we don't need to go into now, that, if the demonstration by the end of five years is proving anything, ought to be studied for a longer time if we are going to get conclusive answers on many of the questions that have been raised by this demonstration.

Discussion

Chairman Baehr: The two Clarks have opened up so many opportunities for discussion that I will have to ask you to chain yourselves to the seats until each of you can be given a chance to discuss. In opening the discussion I would like to orient you on a few points.

This demonstration was intended by its promoters as a research project. It was not intended to be a permanent agency which is to be duplicated by others. Obviously, the criticism is correct that this is too large and complex a team to add to a group practice organization that is providing comprehensive medical care to insured families of moderate income. It is a large team, even though it consists of four working members and four major consultants. But in doing a piece of research, it is necessary to bring together all the skills required to carry on the investigation. That means a variety of skills which each individual member of the research team may not possess. I think it is much too early even to attempt to project the end results of the five-year study or to predict what lessons can be learned that can be applied on a practical and reasonably economic basis.

Certainly Dr. Duncan Clark has pointed out the great variety of health resources, voluntary and governmental, that are available in this community, perhaps in many other communities. I would like to point out to you just a few of the resources that could be drawn into a program such as this which might take over some of the functions that are revealed as important by this demonstration.

For example, the comprehensive medical care to which these enrol-

lees are entitled in return for what they and their employers contribute includes visiting nurse service in the home. These services are provided by the Visiting Nurse Services of New York, Brooklyn, Staten Island, and other places. They are paid for by a per capita method of remuneration just as the medical group is paid by HIP on a per capita basis. The doctors responsible for the routine medical care are at liberty to call upon the Visiting Nurse Services. In their ignorance some have not made adequate use of the visiting nurses, for most doctors are ignorant of how to use a visiting nurse, what her public health functions are, and what her health education responsibilities may be. Very few physicians know how to use them. It is possible to have the visiting nurse services take on some of the functions which the public health nurse in this demonstration is exercising, provided the doctors can be taught to use the services of the public health nurse more adquately.

Then the question of the social worker. There is no doubt that social work is an essential ingredient of good medical care. In the hospitals we cannot do without the social worker. Yet she can be used even more effectively in prepaid group practice of medicine because the doctors go into the homes of the people. They are therefore more familiar with the everyday lives of the people for whom they are caring than are the doctors in a hospital, who are for the most part cut off from the homes and never get into them.

As the money available to pay for medical care is better distributed through prepayment, some may be available for the employment of social workers and public health nurses.

Each HIP medical group has a psychiatrist who serves as adviser and guide to the family doctors, the pediatricians, and the other specialists. It may be possible to add a psychiatric case worker to assist him. It is impossible as yet to predict in advance how this can be done with the funds available to carry on a prepaid medical care program, but I believe it may be possible—if not directly, then with the aid of social agencies like the Community Service Society.

Mention has been made of the health department. Now that health departments have cleaned up many of their earlier responsibilities for the control of the communicable diseases, they are looking for new opportunities in the field of chronic illness and psychiatry and in keeping families well, mentally and psysically. The district health centers in New York and other cities were built for a variety of reasons, among

others to establish and maintain clinics for the control of communicable illness, such as the venereal diseases, for which there is now very little need. The need for tuberculosis clinics is also rapidly diminishing. A new use will be found for these facilities and services of health departments for families, not alone the indigents but rather for people who make up the bulk of the citizenry of the community.

DR. BOUDREAU: Dr. Baehr, this should not govern your deliberations, but it seems to me that the question of what to do about the controls never downs. We come to it again and again. I believe that was true, too, when we were discussing the project in its early infancy.

I think this may be an opportunity to get some light on what might be done with the control families, to gather information concerning them before the end of the demonstration. I know this idea will be abhorrent to Dr. Silver, but he enjoys controversy. Dr. Macmillan, who is working on another project in Stirling County, Nova Scotia, might have something to say on the subject.

The other point which is tremendously important, is the possibility of using this demonstration as an instrument of medical education. The project is associated with the College of Physicians and Surgeons of Columbia University which will no doubt take advantage of the possibilities it offers. Such a fine pioneering research effort would appeal to senior medical students, and no doubt some way could be found to use its material without undue interference with its current operations.

DR. MACMILLAN: Controls apparently are controversial. I would like to try to get some sort of base-line of information on the controls, even if it is minimal. I would like to suggest one way would be perhaps through the present public health services, the visiting health nurse or one who could be especially designated for this particular task. The nurse could do it in two ways. First, a dry run with people who are actually not in the control sample. She could present herself as getting certain kinds of medical information from a sampling of people in this area. She could there get a minimal medical history of the individual members of the family, and possibly give at least a Cornell index of the thing. She could also get some basic socio-economic type of data. Then if she could get that sort of information among people who are not in your control, that would sort of give her a training period in

finding out what information she could get, and what is the best way of getting this information without disturbing these people; and, if that is feasible, then go on and do your control families in the same way. There would be no connection with the project, on the face of it, and it would be purely a community thing. That is the way I would suggest getting a minimal base-line of information.

DR. CLAUSEN: I would like to make another remark about the control group, if I may. I like Dr. Macmillan's approach to this. I wonder about the possibility, however, of designating another control group as well. This group would receive an initial assessment, perhaps not as full as the assessment of the group receiving service, but enough to give a base-line. This group would be carried through, getting intervening observations, largely derived from the standard HIP service program, and fuller assessment at the end of the program. This would be in addition to the control group already designated which would be studied only at the end of the program.

DR. SEVERINGHAUS: I would like to speak briefly on this matter of controls, especially from the standpoint of a member of the Board which made the study before the demonstration went into effect. There are a great many of us here today.

The thing that it seems to me important for us to keep in mind is that we do have a considerable amount of control data in the HIP records. I think that probably ought to be brought out by those who can do it best.

The second thing is that although this material may be evaluated at the end of the study, the data are current with the beginning of the study. They are not 1955 data. The data are there for instance for 1952. They can be evaluated in 1955 just as well as in 1952. I think some of us may be under the false impression that if we evaluate the data in 1955, they must be considered as 1955 data. I just want to point out that they are 1952 data.

It seems to me it would be helpful, though, in this discussion to know what data are available in the HIP records which actually are the data of our control group. This is a problem which worried the Board of Directors, and I think consumed more of their time than any other single issue, and since there are about eight or nine Directors here today I believe it ought to be clarified, especially as to what went on before we organized the control group.

DR. FERTIG: The use of two control groups was considered by the Operating Board. It was finally decided that with the resources available, it would not be feasible to operate an experimental group as well as two control groups. It was realized that there are two effects going into the experimental group, the initial evaluation *per se* and superimposed on that the extra services rendered. Unfortunately with the present arrangement we cannot assess those two effects separately. It may be that the initial evaluation itself encourages the families to look into their problems and to do something about them and this may have as great (or greater) an effect than the additional services given. The final decision was to see if we can do anything first of all, and then if we can do something to see if we can break it down into the relative weight of the various factors.

As Dr. Severinghaus mentions there are a lot of data on these controls. They have various physical examinations, and so on. We are not completely in the dark on them.

DR. CHERKASKY: At the outset when we studied the problem of controls, there were two major considerations which led us to pick the control families but do no initial evaluation on them. One consideration was the thought that the kind of thorough evaluation which we do on our experimental families, if applied to our control families, would have a marked effect upon their health status and thus alter their suitability as controls.

The second and more important consideration was based upon the assurance that if we picked 150–200 control families at the same time and in the same manner as we picked the experimental families, the two groups, experimental and control, would be of sufficient size to insure that the same range, variety and kinds of problems which we discover in the experimental group by our thorough evaluation, could be assumed to be present in the control group. In other words, though we evaluate only the experimental group, we could assume that both the experimental and control groups started from the same level of health. If this were the case, it would be unnecessary for us to tamper with the control families until the conclusion of the experimental period.

At the end of the program we planned to evaluate 100 per cent (hopefully) of the control families and all of the experimental families and if we find a measurable difference in the health level of the ex-

perimental families as compared to the control families, our experiment would then have the objective significance we hope to achieve.

The discussion here seems to indicate some uneasiness as to this approach which, I guess, can be best stated in this way—"While it should be true that the control families will start at the same level of health as the experimental families, the participants in this Conference would be much happier if there were some specific evaluation done on the controls which would support this thesis." This is an important consideration and if it is generally agreed to be desirable to evaluate the controls, we will do so.

DR. FERTIG: I would just like to amplify what Dr. Cherkasky said. There is an "if" in what Dr. Cherkasky says—if we can get 100 per cent of these control families in for final evaluation and if we can get participation of 100 per cent of the families chosen for the experimental group. To the extent that that is not true, of course we lose out in the comparison. One point he made may be emphasized, namely, if they start off at the same place, then the difference between the change that goes on in the experimental group and the change that goes on in the control group, is the same as the difference in the final statuses of the two groups. That was the basis on which I think we finally agreed as to how we would proceed.

MR. COCHRAN: My plea will be along the general line of giving reconsideration to the question of controls, although there are arguments on both sides. The problem is harder than has been brought out in the discussion thus far.

The way in which the controls were selected should give a reasonable guarantee of a good control group at the end of, say five years, except for the effect of losses in both groups. The losses may be quite large. Thirty-five per cent for the control group may be an optimistic figure: it should be smaller for the experimental group. The effect of losses is not merely or even principally in reduction of numbers: there may be a selective loss which differs in the two groups and introduces an element of bias.

Thus the present approach may produce results at the end that are confusing and difficult to interpret. If it happens that the controls at the end are at about the same level of medical and emotional health as the study group was at the beginning, or are a little better but are

distinctly inferior to the study group at the end, then all appears well. We might regard this result as good evidence that the study group has moved forward at a faster rate than the control group.

But if it should turn out that the control group at the end is as good as the study group is at the end, then we begin to wonder, were they, owing to losses, not a good control or do we face the conclusion that the control group is telling us that this Demonstration had no beneficial effects? This is a confusing issue to settle. Another difficulty would arise should the control group at the end turn out to be markedly worse than the study group was at the beginning.

Facing these possibilities, the advantage in having a control group that is measured early is that it may give a warning sign. It is to be hoped that the control group would agree well with the study group at that time, because treatments have not had time to produce a major effect. But if, to our surprise, the control group is seriously different from the study group at the beginning, there is still time to do something about finding a sounder control. This is the argument for going to some trouble in order to secure early information on the controls.

We would have to examine very carefully what is the most important information to secure. Since this will almost certainly include information on emotional health, some method of obtaining information on emotional health from the control group must be devised. If an outside team of interviewers is used with the control group, in order to conceal the study from this group, there is the major difficulty of ensuring that the outside team can obtain data that will be comparable to that obtained by the present team for the study group.

To summarize, if reconsideration is being given to early measurement of controls, the first step is to decide what are the most important items that must be obtained from the controls, keeping this list at a minimum. We must consider how long it will take to obtain these items, following Dr. Clausen's remarks. If an outside team is to be used, we must also consider whether they can manage to obtain data comparable to that available for the study group.

As regards one versus two controls, the use of two controls may be out of the question as being prohibitively expensive. If there are no public relations difficulties, I would be inclined to take the chance that one initial evaluation will not have so much effect as to ruin the study. If the initial evaluation plus the whole five-year demonstration is compared with just an initial evaluation and such further efforts

by the families as are stimulated by that, and the Demonstration can't show any additional effects against this competition, then the Demonstration has effectively failed.

There is perhaps a public relations difficulty, in that the controls might learn that other groups are getting favored treatment. I am not able to assess how much trouble that might cause: perhaps Dr. Silver will comment.

Dr. Silver: Most of what Mr. Cochran said was not in the form of a question. It was a matter of an incontrovertible statement. I can't take issue with the points that you make because I think they are so true, especially your point which never entered our minds so far as I can recall. Nobody pointed out to us before that the initial examination might be so damaging comparatively that maybe the rest of the demonstration couldn't possibly be so effective. That might have weighed heavily in a consideration of whether we were going to examine the controls initially if we had thought of that particular point.

As far as the public relations effect of the examination without any follow-up, I think the results might be serious. I think that we would have to do a good many things for the people that we are not doing now as a result of an initial examination by the team and if it covered as much ground as the examination of the study people.

Dr. Dean A. Clark: On this matter of controls, maybe this already has begun, but I am a little hazy about what actually has been done with the control group. I know Dr. Creedon did say something was being done. I wonder whether it isn't possible to begin by taking the data that are already available in the enrollment records and in the medical clinic records and doing some tables on the controls comparable to those on the study group and see how they stack up. Then if you find that they stack up pretty well—and there is every reason to think they will—you have your clinical information on a good many of them, namely, those who have had something or other done as members of the Montefiore group. You can determine at that point how much further it will be necessary to go to get this base-line that we have been talking about.

Dr. Berle: In reference to what Mr. Cochrane and Dr. Dean Clark have said, it would seem to me that the essential difference between the control group and the rest of the population at Montefiore is that

in the demonstration group the team has a comprehensive picture of the individual, and that they treat the individual on the basis of this comprehensive picture. For instance a feeding or a nail-biting problem, which is not considered serious in the sense that it is not the ostensible reason for visiting the physician, is recognized and thought to result from differences in religious background and other tensions in the home. Thereafter these factors are in back of everyone's mind every time the woman or the man or the child comes in to see the doctor for a respiratory infection or any other reason, so in some way the treatment, the advice given, are oriented toward helping the feeding problem.

If the control group were studied and the data suggested by Dr. Clark were obtained, still the family's background would not be known. If one or two additional interviews were held with a view to obtaining background information and this information were stored away and not used, it seems to me that at the end of five years one might have some idea as to whether medical treatment of the whole family with the knowledge of their background was more or less effective than the treatment of individuals without a knowledge of their personal problems. Is the individual with an untreated feeding problem just as well off ten years later as the one who has been treated in a comprehensive way?

These are questions which we cannot answer, because we always say, "If somebody had understood the dynamics in childhood, we would not have a problem now."

I would favor, if it were possible, evaluating the material already existing in the HIP record, getting a picture of the background; storing this away and not making it available to the members of the HIP group who are treating the control families.

Dr. Aaron: There is one paradoxical point that occurs to me in this discussion. If we were doing anything about the controls we should realize that the program has now been in effect for two years, and in order to reach an equal number of controls would require about a year. So anyway between two and three years would have elapsed since we took on the experimental group when we are evaluating the control group. The program is planned for five years. Would it be valid to take what we find at the end of a two or three years' period and say this is what the control group was at the beginning of the study? It

seems to me if we do that, then either we have to throw away our former thinking about the evaluation at the end of five years, or if we didn't throw it away, it would make no difference if we evaluated at the end of two, three, or five years.

MISS HUBBARD: I am ignorant about this, but it looks to me as if the families involved are largely in what you have spoken of as the civil service group. In New York are those persons having annual physical examinations as part of their job personnel policies, the people in the Fire Department and Police Department?

I wondered whether the information that might be forthcoming from examinations of that type, school examinations, and Health Department examinations of pre-schools, would give you anything. It would certainly not be what you are doing in the initial examination, but it would be what anybody else in the public citizenry gets at the hands of either his employer or the Health Department, and might give you something of a base-line.

DR. GRUENBERG: It seems to me that the big questions are: What are you trying to measure in getting a control? and, Is what you are trying to do in the demonstration project a measurable thing?

As I read over the reports, which I was sorry not to hear yesterday, it seems to me there are two kinds of things going on. One is to put to work the knowledge that we think we have as to how to help people prevent disease, get medical care when they are sick, and to promote their health. We think we know what they ought to do and how they ought to behave and how they ought to feel about it, and we want to help them do it. The Demonstration is seeking to help the families do these things. The second thing we are trying to find out, as I think of the problem, is: Does all this make a difference in the incidence of pathology in these families?

With respect to the first, making available to families what we know about health practices in a way they can use it, it would seem to me that controls will not help you to decide whether you are successful or not. I think the team has to decide whether the treated group do what the team thinks they ought to do, and the treated group has to tell you whether they like it or not and whether it meets their perceptions of their health needs. The control group can't tell you whether they are missing what this group got because they don't know what

this group got. You are trying to arouse the consciousness of the treatment group to the availability of knowledge that they are ignorant of, presumably. I don't see how a control can help you on that.

I presume all the talk about control is as a measurement of pathology, and if the measurement of pathology is the big problem, then it would seem to me that the least feasible thing is to measure the effect on the incidence of psychological pathology, since we have fewer reliable indices of psychological pathology than of any other kind of pathology. If you want to evaluate the effect in terms of preventing pathology in the group, I would urge concentration on physical pathology.

It would seem to me under those conditions that the ordinary entrance examination by HIP of its ordinary groups would be probably about as good a screener of physical pathology as the initial workup that has been done in the treatment group. Certainly Mr. Cochran's suggestion and Dr. Clark's suggestion of going over the HIP clinical records of the control group ought to be able to answer that question.

If you think you pick up more minor pathology in the treatment group, you ought to find that out in the beginning, because otherwise you don't have any control.

One of the problems that has been mentioned is the possible effect of entering the treatment program—just the initial evaluation—on the future health of the people examined. I would like to endorse what I understood Mr. Cochran to say: if the evaluation is such a powerful force that it obscures the effect of treatment, then the effect of treatment is much less than the effect of evaluation. If you are really trying to evaluate treatment you have to assume the examination has a null effect in itself, and you have to set up something like Dr. Clausen suggests in the evaluation of the examination as a force in promoting health.

However, there is another factor involved that hasn't been brought out, it seems to me. What is the nature of the conditions under which you are getting knowledge about health and the treatment of the control group? If the relationship of the examiners and the perceptual brainwork of the examiners in the treatment group are different from the standards of examination that are being used in the control group, this again might introduce a bias that would completely obscure the effect of your program.

It would seem to me you have either to get your treating team to examine your control group at some point in the same framework or,

which would seem to me much easier to do, get the HIP clinicians who are treating the controls to examine your treatment group in the same way that they examined the controls. I should think your treatment group was cooperative enough for you to say, "We want an independent evaluation of your health to find out what difference it makes for us to provide these extra services. Will you go down to the HIP center and get the initial work-up that is given to other HIP participants?" Then you would have the same group of examiners examining both groups and the same conditions. That could be done even serially during the course of the treatment.

DR. GALDSTON: I should like to partake in the discussion at this point and to develop further, the matter touched on by Dr. Gruenberg. Most of the preceding discussion centered around the issue of how best to assess the effects of the services upon its participants. The assumption seems to be that we know *what* we are to assess; we are only troubled by the problem how best to weigh and measure these items.

To my way of thinking, however, the greater problem is not *how,* but rather *what* we are to assess. When progress is gauged in simple criteria such as the incidence of dental caries, we can count the cavities and count the teeth. If it is a matter of overweight, we can judge by poundage gained or lost. But in our particular instance, we are confronted with a highly complicated, multifactor situation, and I cannot conceive how one is to gauge the overall effect, particularly since in assessing the group, we must bear in mind the interplay of numerous factors some of which are supportive and some of which would tend to cancel each other out.

I recall discussing a similar problem with Sir James Spence of Newcastle-on-the-Tyne, in relation to his study of five hundred families. But then his situation was somewhat different since he was really making an all-inclusive vertical study of his families. He had records of practically every event of any significance that was experienced by each family; whether it was a visiting Lothario who upset "conjugal equilibrium," or a grandma who brought with her a septic sorethroat that was promptly passed on among the rest of the family.

The HIP study, however, is neither vertical nor all-inclusive. Yet to establish a truly valid index of "progress" it would be necessary to have a "going on" record of the full spectrum of the individual's activities and experiences, and also that of the collective group.

Let us assume that an individual is not doing as well at the end of three months of service as he did when the service began. Who knows how much worse he might have done without the service? Since we aim to gauge the total effect on the total group, how are we to establish and to take into account the differential movements of different segments in the group? A small number might appreciably decline in well being, even while another makes great headway. In the last analysis, unless we know many other factors beside the crude data reflected in the health record, we cannot competently assess the effects of a "health service." An increment in salary, or the promotion to a job with greater rewards and greater responsibilities, may have a variety of effects upon an individual and produce a variety of results completely unrelated to the medical care he might *have* received.

I suspect that one of the reasons why the discussion on the assessment of results has been so long drawn out, and to my mind not too satisfactorily, is precisely because there lurks in the back of our minds, or whatever it is we think with, an awareness of the intricacy of the task and the suspicion that in this case a something quite different from the ordinary statistical procedure is required.

I believe, therefore, it would profit us enormously to first establish *what* it is that we are trying to gauge, that in pretty concrete terms, before trying to establish whether we require one, three, or five groups for control.

Dr. Evans: It would help the discussion, I think, if we did not use the word "evaluation" or "measurability" or "value judgments" or terms which seem to prejudge what it is we are going to get or how we are going to get it. We should try to identify and record those things about which five years from now there will be no disagreement as to their identity or the fact that they were recorded accurately. Evaluation or interpretation will come later.

Dr. Mayo: I think the long tortuous experience of the Community Service Society in measuring what they call the movement of families toward something generally agreed to be desirable is most pertinent and germane to this portion of the discussion.

Mr. Davies: I don't believe we should attempt to get into the whole question of the movement scale at this point. I think it may suffice to say that those participating in the Demonstration are familiar with

this scale—Dr. Silver, Dr. Cherkasky, and members of the Operating Board. In fact, Dr. Hunt, who was primarily responsible for developing the movement scale with us, was in touch with this Demonstration from its beginnings, as well as Dr. Kogan, who was Dr. Hunt's assistant and now his successor as our Director of Research in the Community Service Society. So whatever there is of value in the hard work and good work that was done on this movement scale as a pioneering attempt in the measurement of movement in social casework is already at the disposal of this Demonstration.

DR. GRUENBERG: I would like to put a footnote on my remarks, since I am afraid I didn't express myself too well. I would like to emphasize that I was suggesting not that there be no evaluation, but that there are two kinds of evaluation possible, in my opinion, depending upon which things you are trying to evaluate. I don't know this movement scale very well. I have heard of it before. But there is a way, it seems to me, of finding out whether within the perceptions of the treating team and within the perceptions of the people being treated there had been any gain for them in terms of the use of available present technical knowledge that improved the health of the treated group.

I don't see how the control can help you in determining the answer to that question, because by the very nature of the questions you are asking they have no meaning when applied to the control group. The control group wasn't given this opportunity at all. You are something like an educator, it seems to me, in the broadest sense of the term. You are trying to transmit what you think you know to people who you think don't know it, and to get them to use it constructively. Education in this sense has never been systematically evaluated in the framework of matched controls. I think this form of education, or transmission of knowledge and techniques, is terribly difficult to evaluate except in terms of the perceptions of the educators themselves as to whether the people have moved or not.

If you are trying to measure the pathology, if you think your services lower the frequency with which certain disease processes occur, then I would urge that you get the people who are responsible for the health of the control group to evaluate the frequency of the pathology in the treated group. I certainly did not mean to imply that I thought this was not an evaluatable process, but I was suggesting two specific ways of evaluating.

MEDICINE

RUSTIN MCINTOSH, M.D.

I THINK this is a very difficult assignment, one which I approach with great diffidence and humility. In spite of all the care and trouble that have been taken to give us factual information about the Family Health Maintenance Demonstration, those of us who haven't actually participated are in the position of a person who has been briefed, and there is a big difference between being briefed and going on a sortie yourself. So the comments I shall make will, I am afraid, be platitudinous and repetitious, because I shall necessarily have to go over some of the material that has already been covered.

It seems to me that in a health maintenance program of this kind we as physicians have to keep in mind always the objectives of therapy or at least of our therapeutic efforts. We can be successful at three different levels: The lowest is the relief of symptoms, of anything from petty annoyance to actual pain. The next higher level is the cure of disease. We see actual cure in many examples of successful therapy today. Finally, the highest goal, that which we should always strive for, is the prevention of disease.

I stress in my thoughts on this program the fact that it is a family project. The physician takes the family more or less for granted as the unit of operation. When he first approaches a clinical problem he takes a family history, having in mind the various general forces by which the family can influence the patient's health.

Although this can be only a partial analysis, I would like to talk about three general areas in which family life is pertinent to clinical problems. One is the area of genetic mechanisms, which of course operate through the family tree. The second is the transmission of illness by proximity or actual contact, of which infection is the obvious example, but also I would include trauma, rolling pin wounds, frying pan wounds, and home accidents. Then finally,

the establishment of philosophical attitudes, social and emotional attitudes.

First a comment about genetics. It seems to me that with a study of this kind focused intensively on families, there is a wonderful opportunity for a contribution to human genetics. We recognize that in human genetics the experimental method is denied to us, with the result that we know a lot more about the genetics of the fruit fly than we do about the genetics of homo sapiens. We are limited to observational techniques, and yet there is a great deal that can be learned.

The importance of the science of genetics for the physician lies in its predictive value. The genetics of the blood groups, for instance, have been worked out so successfully that the experience of blood group transmission is entirely consistent with the genetic hypothesis. We use blood group information in determining parentage, and so forth. A good deal has been learned about the genetics of various blood diseases, such as sickle-cell anemia, Mediterranean anemia. A great deal more can be done in various areas of human genetics. It is a trial well worth making where you have the conditions for careful observation, where you know the right kind of questions to ask and the kind of search to make.

So although a good deal of the previous discussion emphasizes the tremendous workload already carried and the difficulty of adding anything more to this Demonstration, I wonder if due consideration has been given to the contribution that can be made by careful genetic observations in the populations that are to be studied.

I am not going to say anything about the element of infection as covered by this study except that here again there exists a wonderful opportunity, it seems to me, to determine morbidity in a well defined and carefully observed set of families in our area and in our time. Those of us who have any knowledge of medical history realize how little we actually know of clinical morbidity in different circumstances and at different times. Where careful observations are already being made, as is the case in this Family Health Maintenance Demonstration, their incorporation in appropriate record form, suitable for subsequent analysis, may represent a great

contribution. In ideal form such a study of morbidity would call for the application of additional special techniques in the search for parasitic infections which have at the time no clinical importance. A search of that kind would obviously greatly enlarge the nature of the study and again may be entirely out of the question, because to be properly carried out it should not depend solely on the existence of recognizable illness, nor even on the presence of a complaint sufficiently prominent to cause the patient to seek medical help.

I may point out that, as many of you know, valuable studies of this kind have been carried out in recent years in Cleveland, where families have been closely watched by home visits and studied by cultural methods for bacteriological and viral agents determining morbidity.

In the same general group, too, I would like to make a plea for a good study of the home accident problem or, rather, the non-industrial accident problem. Mortality statistics show how important accidents are, and yet as we go farther into that question we realize that we don't really know the nature and scope of the problem. Industry has made pretty good surveys of the accident problem, but the surveys of home accidents are, I think, astonishingly limited. Many of the statistics available are dependent upon a patient's being brought to a hospital, to the accident ward, ambulance service, and so forth. Of course, that covers only a small fraction of the actual accidents, and the difference between a fatal accident and a non-fatal accident may literally be measured by a hair's breadth. The accident problem is so important to us that I would hope that it could be studied, and obviously home accidents can only be studied in the home by people familiar with the local setting.

I have pointed this out previously and have tried to enlist the participation of practitioners, especially of pediatric practitioners. Actually there are very limited data on accidents in childhood based on systematic observation and recording. The best studies I know were made in a nursery school in Minnesota where, because of close supervision, every accident could be recorded, and the data which emerged were extremely interesting. That study showed what a great

boon it would be to our approach to the whole accident problem if this fundamental information about the nature of the problem could be evaluated and perhaps put on a quantitative basis. Again I raise it as a question or express the hope.

In relation to the family's contribution in the line of attitudes toward religion, toward ethics, toward humor, the family's attitude toward its own self—what is the family's concept of family life? When we look at a Currier and Ives print of a Thanksgiving dinner in the good old days, we realize how far away we have traveled from that family goal of former times.

I would second the suggestion that was made yesterday that it would be highly desirable if some scoring method could be introduced in this study to make at least a notation of emotional problems as they arise. Dr. Berle spoke of that today and gave an excellent illustration. Although it was pointed out yesterday that the difficulty of evaluating any emotional problem imposes a real problem of scoring, still it could be attempted, I believe, on the basis of simple symptomatology. Nail-biting is one such symptom worth listing; enuresis is another. There is no example of enuresis that is either black or white, either totally of organic origin or totally of psychological origin. All cases represent the interplay of both forces in pathogenesis. So while it would be difficult to evaluate the material, mere enumeration and scoring would I think be a great contribution which this study is uniquely adapted to make.

Recognizing the elusive nature of some of the problems of adolescence, I had hoped at one time that in a preparatory school or in a group of preparatory schools it might be possible to set up an observational study of this kind to determine the natural history of some of these symptoms, to learn whether they were important in later life and what their consequences were. As Dr. Berle hinted, nail-biting may be an index of deep-seated trouble, or it may be a superficial thing which will cure itself. When we first encounter such a sign or symptom in a child, we should at least like to know what are the numerical chances of its being significant or insignificant. With the design of a study of plain symptomatology on their agenda, a group of psychiatrists and school doctors did get together

at one time and had a very interesting and lively discussion; but the upshot of it was that nobody could or would plan an observational program which would enable us to get these data which I myself consider so important.

I am afraid my gloomy conclusion was that none of the psychiatrists was willing to watch the boat drift without putting an oar in, which would presumably so change the outcome that in the end one could not tell what the natural history of these problems was. I think there is still an important assignment waiting to be worked out in this area, and perhaps this study can make a contribution to it.

In listening to the discussion of evaluation, I couldn't help wondering how actively hypotheses, especially hypotheses of psychodynamics, are applied in our attempts to evaluate the patient, without our being sure of their validity. The initial interviews give me some concern on that score. It was implied yesterday, for instance, by someone—I have forgotten by whom—that permissiveness in the family was a good thing in the parent-child relationship, and it was almost inferred that the more permissive the setting, the better the situation was. That represents a hypothesis which I think is somewhat open to challenge. At least, if any of you have read Hilde Bruch's book, DON'T BE AFRAID OF YOUR CHILD, you will recall her account of some of the difficulties that are experienced by parents who have been led to believe that you can't go too far in permissiveness. That way I am sure lies trouble, just as at the other extreme lies trouble.

I think perhaps it is not out of place to remind ourselves of the difficulty of proving certain of our hypotheses, especially in the area of psychodynamics.

I would like to commend the type of pediatric practice which Dr. Siker described yesterday, which I am sure Dr. Beesley also practises, which combines office work with home visits. It seems to me that one of the questions that bothers pediatricians of our times is: Can you really practise pediatrics in the proper sense and in all its implications without being familiar at first hand with the home environment? I even question whether we can rely entirely

on the services of the public health nurse or the social worker to give us the flavor of the home, the aroma of the home. There is no substitute for the pediatrician's personally experiencing it. Consciously or unconsciously, that must play a big part in diagnostic evaluation and in therapeutic recommendations.

We know very well that in the Middle West there are a great many highly successful pediatricians who practise almost entirely by office visits. One colleague from a small town in Illinois told me that he hadn't made a home call for two years. I didn't ask him the question, but I asked myself the question: Is this practising pediatrics?

So I would come back to that: For family care or proper pediatric care, I don't think there is any possible substitute for this gathering of information on the spot, knowing the forces that play a part in determining symptoms and knowing what you can attempt and what you can accomplish in therapy.

Discussion

Chairman Baehr: Dr. McIntosh has offered us a great many challenging ideas. I think most of us who have been watching the comprehensive medical care program are in full agreement with his statement that pediatrics cannot be practised properly when confined to an office. That is also true of family practice in general. The pattern of home visiting in the City of New York differs somewhat from the pattern in the Middle West and the West Coast. In those parts I am informed that not more than five per cent of all professional services are rendered to people in their homes. In New York City the population expects much more home visiting than in most other urban areas.

In our own experience with the Health Insurance Plan over these last six and a half years, about twelve per cent of all services are rendered in the homes. In our pediatric practice, about thirty per cent of all the services are for home care. That is true, however, only of pediatricians who provide all the routine care of children and do not share it significantly with the family doctors. When the home visiting is done entirely by the family doctor, the pediatrician does not learn the home conditions from him any better than he would from a public health nurse.

MRS. GINSBURG: Dr. McIntosh has said suberbly many of the things that have concerned me. May I add a question having to do with Dr. Boudreau's point about using a demonstration of this kind for student training. Specifically, I wonder about the division of responsibility in history-taking. So far as I can gather, the pediatrician takes the medical history of the child, but the "psychological profile" is taken by the social worker.

That reminds me of Dr. Spock's favorite story of history-taking in his student days. When in the pediatric clinic he was busy taking a developmental history and a mother attempted to interject into the question and answer session some comment that had emotional implications, he would shut her up because feelings had no place in pediatrics. But came the afternoon when he was assigned to another clinic and the same mother appeared to discuss an emotional problem he welcomed her because he was wearing a psychiatric hat in this clinic. As a pediatrician, as a doctor who served children he was not expected to be concerned with emotional considerations. I may have misunderstood the preliminary presentations and I have obviously exaggerated the example but I am concerned lest the doctor's role be weakened rather than strengthened by the addition of other experts to the team.

It has been mentioned that the pediatrician needs these ancillary professions to provide him with information. I maintain that the very act of acquiring this information strengthens and is an integral part of the physician's relationship to the family. The kind of physician that Dr. McIntosh was talking about must know these things if he is to know the patient and the family and he can be trained to practice this kind of medicine.

In an experiment, a demonstration, many innovations and departures from tradition are to be expected and hoped for but I would question the introduction of students at this point. In a highly structured team of this kind it is unlikely that a pediatric resident would learn the scope of his role in actual practice or how to use the services of related professional groups while maintaining full medical responsibility for the patient and family.

Another point in this connection has to do with the respective roles of the pediatrician and the internist in this demonstration. It is true in New York that the use of pediatricians as such plus a family doctor on a continuing basis is fairly common, but if you are thinking of this Demonstration in its nation-wide implications, it might be well to con-

sider the fact that in most communities the family doctor treats all members of the family including the children and is responsible for such health maintenance as there is. Have you thought of the pediatrician as a consultant to the internist, just as other specialists are consulted, thus increasing the family's use of the family doctor?

DR. EVANS: I think Dr. McIntosh did us all a very good deed by pointing out so clearly that to study certain problems which medicine is concerned with we have to create new patterns of study. One of the interesting aspects of this demonstration or experiment is that it has provided a situation in which some of the things we have long been aware of can be looked at within a different frame of reference.

Dr. McIntosh mentioned specifically genetics, infection, home accidents, family attitudes toward health, and study of adolescents, all of which I think one would like to say should be a part of normal research in pediatrics and medicine in the traditional setting. Dr. McIntosh said some of those things aren't done and possibly can't be done in the traditional setting.

He mentioned further that medicine has always recognized the family, and that is perfectly true. There is a family history in most medical cases. Medicine's concept of the family is apt to be different from the sociologist's concept of the family or the anthropologist's concept of the family. The doctor is apt to think of the family as something you get by adding up obstetrics, pediatrics, certain aspects of internal medicine, and certain aspects of aging. That is most likely, I believe, to be the doctor's concept of the family. If there is something more that we must learn in medicine about the family, I think that justifies just such experiments as this which deal with the family as a social entity.

This experiment is representative of a kind of activity which indicates that medicine is undoubtedly astir now in a way that it has not been for thirty or forty years. It is particularly astir since the World War. Medicine is astir not because what has happened in medicine is not good or bad at all, but rather because the significance of medicine to society is being felt more widely.

We are inclined to think of medicine as I think most doctors would talk about it. Yet, medicine is something much more than what doctors might think medicine is. I think the structure of this program and the composition of the staff of this Demonstration indicates that this is so.

As was pointed out yesterday, we are now trying to bring together a group of skills, knowledges, information, and so on, in an attempt to redefine, to construct for future use the thing which we call medicine and health. Whatever develops will grow from the excellent foundation which has come to be known as scientific medicine. But in the development of scientific medicine we more or less moved medicine out of the community and put it in the university hospital, and thus were able to study the individual somewhat to exclusion of the environmental component of organism-environment relationships.

Now I think, having proceeded far enough in the study of the individual to recognize a lack in the study of the broad biological problem of organism-environment relationships, we are now seeking ways of studying equally accurately and with equal scientific skill the environmental component of organism-environment relationships. That is possibly a short way of saying it is necessary that the social and behavioral sciences actively engage now in exploration along with medicine of this thing which society has accepted so readily and which society is demanding much more in the name of medicine.

I would like to come back again, because George Silver said this morning when I came in—I don't know what I said yesterday that stirred him up, but anyway George said, "Are you going to use both barrels today?" I would like to come back again to the professional staff structure of this Demonstration because I think it possesses a great opportunity for exploration of some questions which we don't ask each other often enough. Ethel Ginsburg just referred to the doctor in relation to these other persons.

I wrote down yesterday as the discussion went on in the morning: "How far can we go now in saying what the specific job of each member of the team is? What is that member equipped to do? How can he do it and why? Is it possible to maintain a flexible setup where we might look at the reassignment of duties, responsibilities, and so on?"

I should think that one of the objectives of this Demonstration—although it may not have been stated in the beginning, it seems to me it is becoming quite clear now—is that there is an excellent setting here in which to study the professional roles. That was discussed yesterday. That requires a great objectivity on the part of all persons participating, all of us who are observing, and all of us who may be consulting in one way or another.

I think Dr. McIntosh is asking for that in a way, because he says that possibly here is something which will help pediatrics or the pediatrician further understand what the pediatrician, now being trained in the traditional way, should be prepared for in the future, how he will function with other people.

As we listened to Dr. Aaron talk yesterday, Dr. Aaron was not talking at all like the traditional internist. He simply has the name internist because that was the basis of his training. He was talking about another kind of doctor, and a great many internists would not recognize what Dr. Aaron is doing as being internal medicine. I am using that just as an illustration to point up some of the opportunities that we have of examining ourselves, our activities, our professional groupings and regroupings, in order that we adequately anticipate the future in terms of better study of the patient's needs.

I would like to make a plea, therefore, that this Demonstration be looked on not only as an opportunity to learn more of the psychosocio-biological behavior of the individual but also to learn more of the role of the several professional groups involved in health and medical research and service.

MR. DAVIES: On the points that Dr. Evans has so well made and the concern that Mrs. Ginsburg expressed and the whole question of professional roles and the make-up of the staff team here in this Demonstration, I do think that it is important for us to keep constantly in mind that this Demonstration is not or was not intended to be a demonstration in treatment or in the ordinary kind of practice. It is a demonstration in health maintenance. That may be a different kind of thing. It may call for a different kind of team setup. It may call for a different situation in professional roles.

Remember, we took the original inspiration for this Demonstration from the Peckham experiment. As I recall the things that Dr. Pearse and Dr. Williamson of Peckham said to us when they were over here, they developed the philosophy and the conclusion that if the thing we were seeking was abundant health and the good life rather than mere absence of disease and distress, somehow in the last analysis that had to come from the spirit of a person, his own adjustment to life and his outlook on life.

Then we think of the Bowlby material and the scientific support from data gathered from researches all over the world for a renewed

emphasis on the parent-child and especially the mother-child relationship, and particularly in the early years, and of the emotional and human relationship factors that enter in there.

It raises some deep questions for us as to whether we are going to be able here really to demonstrate the things that are basic equally to the maintenance of physical health, social health, and emotional health. That I dare say may call for a different kind of teamwork than we would visualize in practice. Is our focus here on health maintenance? If it is, it is something new we are trying. We don't have any of the answers.

For that reason I think it would be a mistake to assume that this Demonstration as now set up is necessarily as yet, until we get some answers, a model for teaching particular methods to medical students or social work students or anybody else. Let it be a free-wheeling experiment, if you will, putting our best into it, and then let's see what it has to teach all of us when we get through with it.

DR. COLEMAN: In this connection, I would like to raise the question as to how we would make this a kind of free-wheeling experiment. It seems to me that we start out with a team that is defined not arbitrarily but in terms of the experience that has been gathered over a period of many years, and which is based upon concepts derived from various sources, including psychiatric teamwork, teamwork in the hospital, and so on.

I think some of the experience we have had with teams indicates that they tend to develop certain characteristics, determined by the nature of the professions which participate in them, and then by the team itself as an organism whose component parts work together.

In general I would think that the professions in the team try to protect their own identity in terms of their background of training and their current position, and that while they tend to define their problem by the needs of the patient, they select out the needs which are best suited to the skills they can perform. If one is interested in professional roles and their changes, one has to be aware that this might be a problem and be prepared to do something about it.

The second point is that the members of the team will have to work out some way that will make it possible for them to adjust to each other despite the difference in their working philosophies, their backgrounds, their orientations, the differences in status and prestige, and

a great many other factors. This isn't just a question of morale, because if it were, these differences could be reconciled in ways which are determined only by personal interaction of the people who are working together. But if this is to be a research project, then consideration has to be given to the way the members of the team from the different professions work together.

I think with this in mind, in this kind of project, it would be extremely useful to have some machinery to keep this problem in view, on-going machinery which makes it possible for members of the team to examine their own activity as they go along from the point of view of just these considerations; and that they have perhaps the help of some member of the team who is not identified in any way with care of patients, perhaps a sociologist, whose function it is to act as a mediator in relation to the problem.

DR. AARON: I would like to thank Dr. McIntosh and the other discussants.

First of all, I would like to talk a little bit about the doctor's role, which was mentioned by Mrs. Ginsburg and also by Dr. Duncan Clark, who, by the way, is a former professor of mine and I hope what I say here won't get back in my records in school.

I was rather surprised to hear that both thought that the physician's role would be reduced. On the other hand, it seems to me, if anything, the physician's role would be expanded. Mrs. Ginsburg specifically mentioned the method of history-taking.

As I mentioned in my talk yesterday, my own feeling is that the physician on a program such as this should be one who takes care of the entire family, and I mentioned why we had not done this. The pediatrician in our program is not a full-time participant. I don't know if that has been made clear. Our pediatrician takes care of all our children, makes the home calls, but has hours only twice a week. Although at the beginning the pediatrician was present at all our conferences, at the present time the pediatrician consults with each team one morning a week about certain children, but is not a full participant in the demonstration.

We have almost as many children on our program as adults. I want to say my remarks here are restricted to the demonstration and not to HIP in general. So that the pediatrician can complete all the functions and obligations to the patient, the social worker is now obtaining

most of the developmental history, although a great part of it is still obtained by the pediatrician.

There is one other thing I would like to make clear. Dr. McIntosh perhaps gave you the wrong impression that we believe in complete permissiveness in the children. I believe I can speak for the team when I say this is not exactly the case, but that we feel as a group—and we probably came about this independently, if that is possible—that the parents as well as the child deserve a place in the family.

As far as noting the emotional trauma, which was mentioned yesterday and was also brought up again today, it was mentioned today in terms of symptomatology. I might say all this is recorded, because whenever there is any symptom of emotional trauma as well as physical trauma, it is recorded by the person who is aware of this, and we are usually aware of most of it. So this is on the record.

Dr. McIntosh pointed out something which I was glad to hear him say, because it was obvious to me when we first started this program, that here we have a very well controlled and observed population to carry out any kind of scientific research which may be applicable.

On the question of genetic observation, infection, home accident studies, et cetera, we have this material but not on a planned scale. I think the reason for this is quite obvious, especially in genetics. We are going to have 150 families, and we may get one or two families that have a certain genetic principle which we can follow up. There is no question that if the study were on a larger scale or on the general HIP population, for instance, there would be no limit to the amount of work that could be done in these fields for investigations. Anything that turns up we do investigate, such as when we had bacteriological studies in some families with the hope that in the future we could perhaps do something about the incidence of rheumatic fever. We don't have enough population in our study to consider this seriously at the present time.

I would just like to leave you with the thought again that as an internist, I think my colleagues would agree that I am doing internal medicine in the strictest sense of the word. Perhaps it is standard. Perhaps I know a little more about the families. Perhaps the families know me a little better. In doing medicine I am doing internal medicine.

I don't say this is the best sort of thing to be done on this Demonstration, as I mentioned before. I believe firmly, especially in rural areas—

and perhaps this can only come about elsewhere with education—not only education of the medical student to be a complete doctor and a family doctor, taking care of both children and adults as it has been in the past and is still going on in this country, but also perhaps education of the public. As I mentioned yesterday, I think this lack is one of the major reasons why there is an internist and a pediatrician on this program, and not simply a personal physician who can take care of all.

DR. SEVERINGHAUS: The hope was expressed that in the Family Health Maintenance Demonstration we would not lose the great opportunities which it offered for undergraduate medical instruction.

Being a representative of the Medical School which is actively participating in this Demonstration, I should like to make a few additional comments in this connection.

In the first place, we are witnessing today in many medical schools a renewed emphasis on programs which aim to bring the student into earlier and closer contact with the patients, especially in the patients' homes. The reorganization of curricula in many places stems in a basic way from this point of view. There is some rebellion, let us say, against the long and increasing domination of scientific medicine which we have witnessed during the last fifty years. In spite of the important contributions and the progress of medicine, there is a realization, I think, in some quarters that our scientific progress has out-stripped our sense of social consciousness and that the new doctors being developed today are apt to be more sympathetic to attitudes attributed to "the ivory tower" than motivated by the time-honored philosophy of "the horse and buggy" doctor of years gone by.

I think no first-rate school of medicine is unaware of this trend and unaware of the need to emphasize the factors of social and environmental medicine in the education of their undergraduates. Although they may not be training them to be general practitioners at the end of four years, they are training them to understand their job at the present time, which is to provide the best possible medical care for their patients. As for the College of Physicians and Surgeons, we are fortunate in having Dr. McIntosh and others like him who exemplify the qualities of the personal physician and to whom we point with pride. Moreover, the establishment of our Group Clinic some seven years ago, whereby we completely reorganized our out-patient teaching

so that sick people could be treated with competence, which nevertheless maintained their personal dignity, is clear evidence of our attitude toward the patient.

I would point out in relation to what Dr. Evans said that I believe no first-rank medical school fails to show its students that they face limitations in their own competence, due to the fact that they are unable to encompass the whole body of medical knowledge which exists today; that they must know their limitations and they must also know where to find the professional services which provide for the patient that care which, because of their own limitations, they cannot personally offer him.

The first point, then, which I want to make is that the well-educated undergraduate who goes through medical school today is aware of his limitations and is aware of how to add the services of other more competent persons, be they medical specialists or be they persons in the areas of social service, nursing or medical social work about whose fine contributions we have heard much during the last day or two.

The second point I wanted to make is this. I believe that even some members of our Board are a little critical of the College of Physicians and Surgeons because it has not already availed itself of the opportunities for instruction which may be inherent in the Family Health Maintenance Demonstration.

May I digress at this time to refer to the essential ingredients of education, whether or not it is medical education. These ingredients, as I see them, are: first, making observations; second, sifting these observations for relevance; and third, correlating the relevant observations. Of course, finally, it is important to remember some of the things which one has observed, evaluated, and correlated.

There are two things, I think, that are important in connection with teaching undergraduate medical students in the Family Health Maintenance Demonstration. So far as the students are concerned, the Committee on Instruction must determine at what level they should be introduced to this sort of material; so far as the Demonstration is concerned, at what time will it have developed to the stage where instruction will be profitable.

To take an inexperienced observer into a research project which itself, as judged from the discussion we have heard here, doesn't yet have all the answers, might, I think, leave a student in a very confused and muddled state unless we can carefully prepare and supervise the

educational program. I, for one, have been unwilling to go along with the idea of introducing the student into a situation in which I am not reasonably sure he has the opportunity to make significant observations and to correlate these observations under adequate supervision. Hence although we are intensely interested, we are moving cautiously in using the Demonstration for undergraduate instruction.

I am tempted to add another word of general caution. Some of the university schools which have not entered into obvious programs (and by "obvious" I mean curricular changes which would give even to the layman a definite impression) of introducing the student to the patient as a whole man in his home are accused of being interested only in the disease which the patient might have. They infer that rather than a sick man, we see only a sick liver. There are different ways of educating a man to take professional responsibility in the practice of medicine and my word of caution is justified. Just because a plan is new and because it does incorporate certain features which on the face of it lead along the road which we all believe we are traveling, I think there is danger of confusing change with progress. Conversely, a change in subject matter or a readjustment in the emphasis of teaching within the old curricular framework lacks drama and goes entirely unnoticed.

May I illustrate what I have in mind. Let us assume that we are all interested in the patient as a whole man—and I personally do assume that we all are. How could any medical educator be interested in training men and women for professional responsibility who are not expected to be interested in the patient as a whole man? They are, regardless of whether or not the curriculum takes it into account.

Parenthetically, the curriculum, no matter how it is adjusted, never teaches attitudes. If the individual teachers are themselves not interested in the patient as a whole man and if the students have not developed such an interest long before they get to medical school, the outlook is rather dismal indeed. So perhaps the important thing is not a change in the curriculum, but renewed efforts to improve the selection of faculty and of students for the study of medicine to the end that we will recruit individuals into the profession who are themselves properly motivated.

To get back to the illustration I had in mind. Let us assume that we all are agreed that the student in working with a patient must consider social and environmental factors. The important thing is to

train the student to extract from the patient information concerning the patient's attitude to his home environment. That must always be our aim. A good history will always record what the patient has to say about his own environment to the end that the doctor, who is taking the history, will know not only what the environment is like but also, more important, what the attitude of the patient is to that environment.

May I raise the question: Are we likely to get more valid evidence from an inexperienced freshman observer sent into a home and coming back possibly with his impression of the home or from an experienced third-year clerk who is still being shown how to take better histories, thereby learning of the home through the patient and coming away with the patient's idea of the home? For, after all, what is important? A home may be a hovel to the freshman student, one in which he doesn't see how anyone could exist; but it may be home to the patient, one to which he is well adjusted and in which he is very happy. It may be a palace of which a student would say, "How could any man be anything but well and happy here?" But it may be a palace from which the patient is trying his level best to escape.

I wanted to make these few general remarks before I had to leave for an early appointment at the office, just to indicate that as a medical school participating in this study, we are neither unsympathetic toward the goal of having every graduate treat the patient as a whole man, nor are we unaware of the opportunities in this study. With us it is largely a matter of being able to decide, first, when can the student best avail himself of the opportunity and, second, when is the opportunity ripe for instructional purposes.

Dr. Gruenberg: Dr. Severinghaus' remarks brings to my mind a problem that I think is very prevalent in the training of physicians at the present time. At Syracuse Medical School we had a number of discussions last year on the very kinds of questions that Dr. Severinghaus is bringing up and which are pertinent to our discussion, the concept of the physician's relation to the other members of the team.

At the risk of alienating some of my good social workers and nursing friends around the room, I would like to advance for consideration a concept of the role that such a unit as this ought to have in the training of future physicians. The rest of the team should be teaching medical students how to do the jobs that are being done in family health maintenance by the social worker and the public health nurse,

and possibly also by the psychologist. I am not so clear on that. If we are interested in the kind of physician envisaged by Dr. Sigerist, the physician of the future who is a social scientist, educator, community leader, a friend of the patient, ready to enter the teamwork relationship with others in protecting and maintaining and treating the health of the patient, then the physician must learn to do what the social worker is now doing in this scheme and what the public health nurse is now doing in this scheme. That doesn't mean that there would be no role for the professional in working with the physician so trained, but that many of the operations that they are now carrying out, if one pursues this concept, the physician of the future would be doing himself.

I would be very hesitant, myself, about seeing medical students projected into a team of this kind unless the concept was very clear that the student was not to identify with the physician alone in the present team organization of the family health maintenance operation, but to identify with the whole team, with the idea that everything the team is doing is something he is supposed to learn how to do.

I would be concerned that the student get the picture that your division of functions reflects the way that he will be expected to relate to social workers and to nurses in the future when he is in practice, the way in which the physician is currently relating to these members of the team.

DR. SILVER: I personally would want to second what Dr. Gruenberg said, and it would certainly be my hope that the use of family health maintenance demonstrations as teaching mediums would be in just that kind of setting, where the medical student would have an opportunity to partake of the different roles of social worker and public health nurse and, by achieving an understanding of those roles, come to be a physician more of the kind that we have discussed and of the kind that we believe would be a much better representative of his profession than perhaps the superscientist who is being trained today.

CHAIRMAN BAEHR: My own thinking on this subject is based upon observations of medical practice in this urban area. I observe a steady deterioration in the quality of medical practice as represented by the so-called general practitioner or general physician.

I do not think that the selection of medical students is at fault. Men and women enter medical schools with high ideals of public service. In the medical schools they are exposed, because of necessity, to factual

and casuistic teaching by specialists. They are taught only by specialists. In recognition of this deficiency, some effort has been made in some schools in recent years to expose the students to some kind of comprehensive medical care program in a small way, one or two families carried through by each medical student during his four years. This can do very little to counteract the effect upon the medical student of the 99 per cent exposure to specialist teaching.

The medical graduate then enters a hospital for his internship and residency training. With our multiplying American boards, he soon learns that he cannot get any place in medicine unless he has his American boards. Throughout their internship and residency years, the young physicians serve under specialists who are engaged in the private practice of medicine in their special field. The senior specialists in charge of the clinical services of the hospitals have arrived at the top of the heap not only because of their success in the practice of their specialty but because of the economic as well as social position that they have achieved. There is very little in the medical school and often nothing at all in the internship and residency years that would persuade a young man to assume the mission in life of a family doctor. We speak of the nobility of this part of the profession and all the multiple facets that we can see in it and what we think ought to go into the training of a future family physician. What is there today to persuade a young man to follow such a career in view of the economic and the social pulls to specialization? Within the medical profession itself, a caste system is developing. The public regards the general physician as a jack-of-all-trades and master of none. The "untouchables" are the family doctors at the bottom of the professional and social ladder. Today in every good hospital most residents in medicine are planning to practice in a sub-specialty—cardiology, gastroenterology, thoracic diseases, hematology, allergy. Few good men trained in a good hospital want to care for families.

In the Bronx, Queens, or Brooklyn, where most of the people in New York live, the family doctors are now largely older men of a past generation in medicine, or graduates of inferior medical schools or foreign graduates unaccustomed to American practice.

In one of the boroughs of this City a study was recently completed of the physicians who had settled in that borough in practice in a five-year period. More than twenty-five per cent were graduates of unapproved medical schools, and many of the rest had inferior train-

ing. Less than six per cent were graduates of the better schools on the eastern seaboard. The young man in the medical school and in his internship and residency training years should be brought into continuing contact with physicians who can inspire him with a mission of public health service as a family doctor or with a mission of service in public health.

It is becoming increasingly difficult to recruit for public health or for general practice those men of high type who previously entered these fields. The fault must lie with our educational system as well as the times in which we live and the economic pulls. We cannot blame it all on the lower financial rewards of general practice. Men go into public education or the ministry without any idea of great material rewards. They also go into university teaching when inspired by the example of their teachers.

A challenge is posed for the medical schools. They should examine the problem more realistically than has hitherto been done; the courses in preventive medicine and the participation in comprehensive medical care programs have proved inadequate.

Dr. McIntosh: I agree with the difficulty in recruiting people for general family practice and for public health, although I believe that interest in these areas often evolves with the passage of time and with the maturing of the physician's interests. I doubt that the medical schools are going to provide the answer; I think the answer is going to come from somewhere else.

I do take satisfaction in the feeling that a pediatrician in practice is a general practitioner at a limited age level more than he is a specialist. I would view with alarm my own competence if I had to take on the problems of the adults in family medicine unless they happened to have a pediatric disease. At the same time, pediatrics as it is now practised can be comprehensive medicine of the kind that you almost idealize in your description, and I am all for that. So I have no quarrel with you there, but I can't help you directly in your recruitment of people to be family physicians.

I would be inclined to think that you can't expect to build up an interest in family practice by any manipulation of the undergraduate medical curriculum. More is to be expected from the influences of the student's own family life, from the inculcation of ideals that occurs earlier, even before professional training commences.

SOCIAL WORK

LEONARD W. MAYO, S.SC.D.

WHEN I was at Western Reserve University a few years ago a colleague made a brief but interesting survey of conferences of all types. One conclusion stood out as common to all the conferences studied, namely, that the morning of the third day showed a decided slump in interest and a deepening of fatigue, so much so that not even the most brilliant speakers were able to lift the depression that seemed to settle like a pall upon the group. So you see the handicap under which I now labor.

Those of you who have taken part in this discussion to date have expressed a sense of humility. I join you in that sentiment and the more so because I have been able to attend only two of these sessions.

The purpose of this Demonstration as I understand it is to help determine how a selected group of families may be helped to achieve and maintain a high level of health in the broad sense of that term; in such an objective there is a high element of prevention, i.e. alleviation of adverse conditions that already exist and prevention of others to whatever extent that is possible. It would appear then that the Demonstration is primarily an educational process involving both families and team members, that there should be an analysis of the health status of each family at the start of the demonstration, and that control groups should be set up.

The question should be squarely put as to whether this Demonstration is in fact primarily a venture in education, i.e., health education, in which teaching is the principal skill, or whether it is primarily medicine, social work, or nursing, in which treatment or therapy is the main method and objective. It may be worth noting here that "treatment" in the psychological and psychiatric sense is not the only method of changing personality. Formal and informal education are responsible for a great deal of personality change.

Such an approach may not be adequate for those who are emotionally or mentally ill, but it is effective for most children and adults who fall within the normal range of social adjustment.

I believe first of all that an analysis of movement is essential in the Demonstration, that is, an evaluation of the process by which a family is motivated to "move" from where it is found in its understanding of or desire for health, to whatever point it is able to reach. An evaluation of the movement of the team is also called for as well as some analysis of what transpires in the community in the development of the resources that families need if they are to maintain a high level of health.

Second, this kind of demonstration requires something more than the ordinary description or analysis of a family and how it behaves. It requires an analysis that includes psychiatric, medical, public health, cultural and anthropological material. Moreover the description should be unweighted by one's own value judgments. It is difficult not to give weight to elements that have special meaning for us as most of us are prone to imply that such and such an influence or factor is good or bad, black or white.

Third, sound administration and consummate skill in teaching are indicated.

Fourth, skills in the development of community resources are called for so that when the Demonstration is over the families will have the benefit of additional health facilities.

One of the papers presented earlier implied strongly that all necessary medical care and other therapy of the families should be provided by the team. The wife in one of the families is reported to have said on one occasion when a referral was suggested, "Are we so sick that you have to send us to someone else?" While one can understand the problems inherent in such situations the question arises as to whether there is such a thing as a little treatment and whether if the team takes on any treatment at all it might not find itself trying to carry the whole job, with the result that the study aspects of the demonstration might suffer and the development of permanent community resources be delayed.

Fifth, this type of demonstration requires teamwork skills which

can be learned only as individual members actually take part in the team process.

What then is the role of the social worker in this Demonstration, which I hold to be primarily an educational process? First she has an important part to play in the evaluation of families and in the education or treatment, if treatment is to be carried on. Though I do not have full knowledge of the Demonstration I would be much more inclined to select a family caseworker as a member of the team than a psychiatric social worker. In general a family caseworker has had more experience in dealing with families in their own settings, while psychiatric social workers usually carry on most of their work outside of the family setting, i.e. the home. It seems to me to be highly important that the social worker on the team should have intimate knowledge of the *total* environment in which these families live.

One of the intriguing things about this Demonstration is the role of the public health nurse who is deeply involved in child-parent relationships, habit training, and other aspects of orthodox family casework. The lines that usually separate social work and nursing are less distinct here and I am all for seeing what happens when competent and thoughtful members of these two professions consciously cross such lines for demonstration and research purposes.

If therapy is to be carried on in the Demonstration there is certainly a place for the psychiatric social worker in it but I would not place all therapy under her supervision. The therapies are so interwoven and interrelated that it seems to me only sound from the point of view of good administration to place them under the supervision of the team captain.

Rather than trying to make a sharp differentiation between the function of the psychiatric social worker, the social scientist, other consultants, and the public health nurse, I would be inclined to work out these functions and relationships in staff conferences on the basis of each family under care. In this way there could be some clear cut and controlled experimentation. One should not feel bound to stick to orthodox relationships but it is important to adhere to the principle that team members should do only what

they are equipped to do from a professional point of view; and the competence of a team member for any given assignment should be the decision of the team captain.

The social worker is also needed in basic social studies and analyses of the families, in helping to determine what should go into the record, and what things are essential to the fulfillment of the purposes of the Demonstration. Certainly her participation is indicated in the family conferences in which both parents take part. The experience of social workers should be especially pertinent here. I believe it has been shown that it is difficult to handle a conference on family problems with the mother and father present with equally good results for both.

Some very important data on "normal" families are emerging from this Demonstration. This is of special importance to social workers whose interests and concerns now embrace families in the range of normality but whose experience with such families is usually limited. I trust that additional material on the cultural and anthropological background and sociological settings of the families will also be forthcoming before the Demonstration is much older.

Somewhat apart from my specific assignment but of general interest is the question which arose as to how much tension is normal, or at least to be expected, in family life. This observer believes that some tension is not only inevitable, but necessary. In any event it should not always be considered as a wholly negative factor. I was also interested in the discussion concerning early influences on children and the query as to whether one should be concerned about what happens to a child before he is three. I do not know whether three years or two years eight months and five days is the magic age, and not knowing I choose to act as though what happens to a child before he is one or what happened to his mother before he was born is of vital importance. We have so much to learn and to apply in the field of human behavior that we dare not discard those ideas and theories which have any basic validity until they are disproved.

Certainly it is logical in a health demonstration that the captain

of the team should be a physician. Without disparagement to the skillful captaincy which the team now enjoys I submit, however, that the skills and capacities of leadership are much more matters of personality than of profession and that as we develop teams which include representatives of many professions, we should not regard any one profession as automatically producing the captain. One day, I believe, we will recognize no one profession as dominant in community health projects but rather the team, the team process or, better yet, the objective of the team process, in this case the family. When that time comes the leader or captain will emerge in most instances as the person best suited to lead by virtue of personality, experience, and training not merely by professional background.

Finally I hope that along with the other consultants who are giving attention to this Demonstration there may be added the advice of a person or persons whose major skills are in community organization. It might then be possible to set a process in motion whereby additional facilities or a new constellation of existing facilities and resources could be created to help the families maintain an adequate level of health when the Demonstration as such has completed its work.

Discussion

Dr. Aaron: I think probably for the first time during the course of Dr. Mayo's excellent presentation I noticed a smile on the faces of the team members simultaneously. I would like to thank Dr. Mayo, because I think that he has grasped what we who are working on the Demonstration feel.

Some of the specific points which were made I think we have felt and are doing in practice already. For instance, Dr. Mayo mentioned that all therapy should not be under the supervision or the direct control of the social worker. I think that statement is not true in practice. As we tried to demonstrate at the outset, the social worker on the program is the only one experienced in these methods and it has been an educational process, for myself and also for Miss Kahn and Miss Ringenberger, the public health nurses.

You also mentioned new relationships; in other words, not keeping

the old line of the public health nurse and social worker in strict order. This, too, I think from the original conception of this program has been the case.

Just one other point about the family conference to add a little clarity. I don't know if we are quite sure in our own minds, and some of us differ in this, as to what we are attempting to do at the family conference. By this I mean that the family conference may not have any so-called therapy involvement except for the fact that the persons are meeting with the team and talking. Besides the small amount of therapy that may be inherent in that, we also use the family conference to gain more knowledge about the family, seeing them together in this setting and letting them talk freely. Another important purpose is to interest the family if the recommendation has been made previously at the staff conference to have one or two members of the family come back to see one of the members of the team, and not necessarily the social worker.

So again I would like to thank you Dr. Mayo, because I really feel that you have grasped the way most of us on the program are thinking.

MRS. ALT: Apparently the families are getting good handling, because there has been no loss. We would agree in general with the kind of handling that has occurred. But there are some points where we would like to be certain that at the end of the research there will be data on which we can base more precise understanding of the roles of the different professional groups.

I go along completely with the point of view that this is a research experiment and that we are eager to find out the ways in which the various professional groups can make a contribution.

However, I would want to feel certain that there were steps being taken as early as possible to assure collection of necessary information so that we would not take for granted certain functions as belonging to the public health nurse or to the social worker.

Many of us have been interested in the handling of families and their problems when care has come from a medical setting rather than a family or children's agency. For example, the problem that Dr. Mayo knows so well, that of children who have been taken out of their own homes on a purely physical basis, such as orthopedically handicapped children placed in an institution sometimes for as long as ten or fifteen years. I would like to feel certain that the members of the team will

be able to enlighten us at the end of some of the differences that their services make possible in these situations. This would help us know more clearly why these families have not had to make such decisions, like removing a child from home because he is ill. We would like to have the data from the point of view of both the public health nurse and the social worker, and of course the other members of the team.

I am asking that full observation of the home and of all the elements in the situation be made by various members of the team, but especially these two, so that we will have a basis for understanding many new things that we have not been able to know about in the past.

It would be very helpful to clarify what is happening if there is more precise recording and if we include definition of the purposes of interviews or visits.

These are details, that come quite appropriately at this point in the development of the project. I have had the advantage of visiting at the center and seeing the care given these people at first hand, and therefore perhaps come to this with a little prejudice on the side of having seen some of the ways in which people have been dealt with there.

I do feel that the gathering of more precise data on the role of the professions is exceedingly important. I am speaking particularly for the data needed to differentiate the contribution of the social worker and the public health nurse in dealing with the social aspects of health care.

MR. DAVIES: When Leonard Mayo said he felt quite sure that the role of the social worker in this undertaking was expected to be different, if I heard him right he meant that it should be different in at least two respects. First, this matter of flexibility in the division of labor, professionally speaking, is one way in which we should be open-minded and ready to be different in this Demonstration if that is indicated. Second, I think he meant also that the social worker's role might well be different in this Demonstration in going beyond treatment to teaching within her own area of knowledge on a preventive and positive basis.

I believe that when we are all through with this Demonstration and begin to assess it, we will be particularly concerned to know to what extent all of the team participants have been largely engrossed with the treatment of pathology or to what extent they have dealt with the

kind of effort that is concerned with reinforcing people before serious trouble occurs.

I think, too, it will be interesting to note a cross-section of people of this kind to what extent the team has felt it necessary to be concerned with the treatment of pathology, how much pathology that needs to be treated turns up in a group of this kind. Or to what extent on the contrary have these people been found to be already "coping" quite well so that we can proceed to do this more constructive job of fortifying families, fortifying parents to do a still better job in family relationships, parent-child relationships.

I suppose another way of putting the question is: How far are our professionally trained practitioners in this undertaking going to be able to break away from their habitual interest in treating social or physical pathology; how far will they be able to succeed in playing the new role that I think is called for, at least in large part, in this undertaking, of strengthening people before trouble occurs.

CHAIRMAN BAEHR: Dr. Cottrell yesterday laid emphasis upon the coping phenomenon which you, Dr. Mayo, now reemphasize, and the fact that much of the work of the team is to fortify the members of the family in their methods of coping. Although that may prove to be the most important part of the Demonstration, it is the part that is least measurable.

It is possible to fortify families in coping when you are welcomed into the family group in the wholehearted way that this team is. These families are already paying for their own medical care. They receive nothing from charity but pay for their medical care themselves or with the assistance of their industry. Their attitude is therefore more self-reliant and more responsive.

Visiting nurse services are used much more freely by this medical group at Montefiore, perhaps because the doctors have been conditioned by their experience with the home care experiment for which this hospital is noted. It is an indication that ultimately, if you have patience and time, you can teach a team of doctors to use visiting nurse services and even social workers increasingly.

In order to improve the utilization by physicians of visiting nurses, we have employed a full-time public health nurse consultant at HIP who endeavors to develop this part of the program among the medical groups.

More recently we have engaged Mrs. Alt for the development of the social work program of the medical groups. To disarm the doctors we called her consultant on community resources. Gradually some of the medical groups are learning that they need some people with these skills on their staffs. It is going to take time before they use public health nurses and social workers. There is, however, considerable flexibility within the financial structure of prepaid group practice to permit some of the lessons of this Demonstration to be applied by the medical groups to meet broad problems of family medical care and family service.

MRS. GINSBERG: Mrs. Alt's title as a matter of fact relates very nicely to Dr. Mayo's point about community resources, the point that he made about the function of a demonstration in developing resources within the community for the continuous maintenance and promotion of the family health on an on-going basis and the role of the demonstration in that function, which of course is the traditional social work role in most institutions, that of relating the service that is given by the program to the on-going community resources for education, health, recreation, and so on.

MR. SHAPIRO: I should like to respond somehow to what Dr. Mayo said and what Mr. Davies said about teaching and learning and trying to differentiate the concentration on support and the ability to cope, rather than on pathology. I am interested in the difficulty involved in trying to define what is meant by pathology, concentration on pathology, particularly in the emotional area, rather than concentration on support, thinking particularly of the kinds of things that occur or come up in a parent discussion group, the fact that a mother may be quite upset about a child's refusal to behave in a certain way, with which experience she can get some specific help in addition to the generalized help. Does that problem as she sees it constitute a pathology, or does it constitute an aspect of normal living with which she is getting some help and for which she is getting some support?

I am not trying to suggest that there is a clear-cut differentiation between teaching and any other aspect. I think we all accept the fact that definitions are useful as concepts for clarity of thought, and also that teaching is inherent in every aspect of one-to-one contacts when one is working with someone else. Certainly it is basic in social work

and nursing, and I think to a great extent in medical practice where the effort is to get the patient to cooperate and understand the need to behave in a certain way. I would rather look at it as learning, if—. As Dr. Evans pointed out, it is more a matter of establishing a climate within which the individual can learn best.

I am a little concerned or confused about how you differentiate the team's concentration on what might be considered pathology—this is aside from germ infection or gross injury of some kind—how you differentiate pathology from support or ability to cope with a particular problem.

Dr. Mayo: That is a sixty-four dollar question. As Mr. Shapiro was talking, I kept thinking of a town Dr. Baehr and I know well. I have very close neighbors there who are delightful people, all of them at about the same income level. Most of them have young children. Every one of the families has one or more really tough problems to deal with. The parents are all college people, but that alone doesn't solve their problems. They have problems of child and adult relationships, some of which they discuss with disarming candor really asking for help and advice.

What I am saying is that if the team in this Demonstration went to work on my street in New England it would discover almost the same kind of problems it now finds in the families in the Demonstration. The problems would be different in some respects but they would have the same general characteristics. There is very little pathology in the situation I am describing. The fact is that most of these people are not going to get professional help, either psychiatric or psychological, as such. They are fortunate, however, in having a physician who is a trained man with a broad concept of health.

This leads me to say that I hope that the professional educational potentialities of this Demonstration will not be overlooked. The possibilities of enriched professional education for medical, nursing, and social work students in this Demonstration are enormous. There are elements here that may well help to change the face of professional education and we must not be blind to them.

Mr. Davies: It is all a matter of degree, but we might ask ourselves this question: Most of the families in this Demonstration are comparatively young families, that is, fairly young parents with fairly young children. Do the parents who have no obvious difficulties with

their children get as much attention from the workers in this Demonstration as do those where there are manifest problems of parent-child relationships?

I think they should if this is a health maintenance and social and emotional maintenance demonstration. It is that kind of thing I mean.

DR. SILVER: I am not a member of the team, so I may proceed promptly to answer the questions. I think what Dr. Mayo said is practically a concrete description of the difference in some of the things that we were discussing and arguing about in terms of definition yesterday. It has to do with the fact that maybe his neighbors could use a service like this and would be very grateful for it, and when they come to Dr. Mayo and more or less hint around that they would like some kind of help, I don't know whether he interferes in that setting or not. Is that the kind of setting that you have been trained to work in? If not, do you invite them to come down to your office and get the kind of help that they obviously want and desperately need?

It seems to me it is perfectly obvious that the community need on the level of information alone, which is what these people are coming to you for, is exactly what we are set up here to give and what we are giving, and that the words that are being thrown around here about psychopathology are actually masks and covers for a fundamental problem, which is, What do you call this thing that people have that they need help for?

Don't call it pathology, because pathology is behind bars in a locked ward in a sanitorium. Let's call it something else. I am willing to call it anything that you people want to call it, and maybe one of the reasons for this conference was to get a definition of terms in that regard. If you want to add some new words to an already overpopulated group of professional jargons, you can.

My point is that we are not talking about pathology in the same sense that you are now. These people are competent, coping people in every sense of the word. They are people who are working, well integrated in their community. They belong to organizations, and they have all kinds of interests. They have had a background and a history of communication with the citizenry of this country for a long time, and they will continue to have such for a long time after we have gone out of the program. But while we are there, while we are cutting

across, interfering, so to speak, in their lives in this fashion, we have found that they have certain needs. We set out to find that they had certain needs, and we are exploring what we can do about them.

One of the things we can do about them is to give them information through a number of professional skills. It is very interesting to see that whatever quarrel you may have with the role that we have assigned to the social worker or the public health nurse or the doctor, everybody has shown tremendous enthusiasm about the possibility of using this as a training medium. If you don't particularly like the role that has been assigned to the social worker, then why should we train her in this medium?

In other words, you must feel quite positively, Dr. Mayo, that even though we have used the psychiatric social worker where a family caseworker might have been a better choice, the fact remains that what we are doing with the psychiatric caseworker is an eye-opener and a blockbuster, and it has tremendous importance and impact for the profession. That is what teaching means in this connotation.

Dr. Gruenberg: I would like to make a suggestion regarding this question of how a team in a position like this can move from the traditional coping with a manifested need on the part of the patient, to an insistence of the kind that Dr. Mayo was referring to, if I understood him, on the person's coping with the life situations that they meet. The thing it brought to my mind was Dr. Aaron's discarding infections and injuries, and turning around and facing questions of family relations.

It seems to me that it is much harder for us to see what the problem is that a parent has in coping with the family relationship since we don't have an objective way of perceiving what the problem is. We can only see the problem as the person who is concerned about it sees it, or tells us about it, and guess as to what really aroused the mother or father to anxiety. It is very difficult for us to see objectively and independently what is the problem there.

However, these infections and injuries are problems that we can perceive ourselves. We know what the injury is. We can define the injury independently of the person's complaint. We know the natural force of these injuries from extensive experiences as clinicians. It would seem to me that one place that it might pay off to concentrate on would be the emotional reactions of the sick or injured person to

the sickness or the injury, and the reactions of the rest of the family to this physical disability, because physical disability, as I said, is a problem for people that we think we understand independent of the patient's understanding, and we can compare our perception of the illness with the patient's perception of the illness with a fair degree of objectivity. We have here what one might call a stress situation for the personality and for the family that we think we can assess independent of the family's assessment of it.

So I should think it might be a point to concentrate on to develop a picture of family patterns of responding to stress situations, and exploring where the professional relationship can help in this response.

DR. SIKER: There is a time factor concerned with whether the team spends the same amount of time with families who do not have any serious problems at the moment, as with those families who have anxieties and more problems, and who will come for help more often. I think, at the moment, we do tend to get bogged down with families who are having crises, anxieties, and who need a great deal more support.

However, we are still conscious of the fact that other families need support. For example, if we feel a certain mother needs support, whenever she comes in with the baby for a routine examination we would deliberately make sure that we gave her reassurance and discuss certain things that we thought might be disturbing her.

MISS TANZER: I would like to ask Dr. Gruenberg how one can more objectively evaluate the patient's emotional reactions to the stress of illness and his emotional reaction to any other kind of stress.

DR. GRUENBERG: The increased objectivity, as I see it, is in the objectivity of the nature of the investigation. I am not trying to say that we see a broken arm the same way that the person sees it, but yet we can see the broken arm independent of the patient's seeing it so the patient's perception of this broken arm can be put up against our perception of it.

Contrast that to a behavior problem in a child who won't go to bed on time. The fact that the child doesn't go to bed on time is a simple fact in a way, and yet it involves a relationship immediately between the parents and the child and a whole host of forces that we

can more or less try to get a picture of. However, a fractured arm is a fractured arm. The circumstances surrounding the fracture can be put down relatively easily, and therefore are relatively independent. Our evaluation of the degree of stress involved in the focus of anxiety, that is, the stimulus for the anxiety, we can assess on the basis of a very broad experience that is well integrated on the basis of years of clinical work with broken arms. We know the natural course of the disease. We know what is going to happen to it.

We really don't know very much, comparatively, about the little disturbances, that don't seem so little to families, that occur day in and day out. We know that most children, when they don't go to bed on time for a while, later on start going to bed on time, but I don't think that we have anything like as much understanding of the nature of this stress as a cause of irritation and disturbance to the constellation of daily life, as we can define for an infection or a fracture. These are forces that come from outside the family, as it were, and cause pathology. They are not caused by the set of personal interrelationships that we wish to examine. They are external stresses acting on the family, and therefore we can see the family's total response to these external stresses, of which we have a great deal of understanding.

I don't mean we understand them completely, but we understand them much more than the internally developed stresses. When you try to understand response to stress and the stress is due to the very set of circumstances that govern response, you have a much more complicated situation to analyze. That is the sense of objectivity I was trying to emphasize.

Dr. Clausen: It seems to me that both in terms of understanding strengths in families that have particular problems and in families that do not present those problems, and in terms of data collection for the evaluation of family coping or movement, it might be desirable to focus on certain critical areas or critical periods in the experience of these families.

Dr. Gruenberg has suggested one type of critical experience: the family's reaction to illness. I take it childbirth is fairly frequent among these families and provides another period in which certain types of observations might be made on how the family members mutually support each other.

What are the things that are problematical for these families and

how are they handled? How are the resources within HIP, within your own project and other community resources, utilized by these families?

I take it one of your objectives is to achieve better utilization of all resources in the community. The child's entering the school might be another such period. I would like to suggest that observations be systematically made with reference to some of these critical areas or critical periods as a basis both for understanding and for evaluation.

DR. ORBACH: May I make a comment on Dr. Gruenberg's observation? For the past three years I have been at Memorial Center for Cancer and Allied Diseases in a research program which has been specifically studying the impact of serious illness upon the patient and his family. My own experience there has led me to believe that focusing on one critical situation does not necessarily simplify the research problem. You are not only concerned with the objective aspects of the disease and medical treatment, but also with the meaning of this experience to the patient. Once you get into the problem of meaning it is necessary to gather a great deal of life history data as a context for the patient's interpretation of his illness and the family's reaction to him. In addition, the disruption of adaptive maneuvers and long-term patterns of mastery in a situation of stress may add to the complexity of the evaluation, as well as highlighting individual emotional problems and family relationships.

SOCIAL WORK

JEANETTE REGENSBURG, PH.D.

I HAVE a profound respect for the spirit and courage which are prerequisite to such an undertaking as the Family Health Maintenance Demonstration. As a staff member of the Community Service Society I have double identification with the Demonstration. The CSS, as you all know, of course, is a participant in it, and furthermore, within the CSS program we, too, are working on a collaborative team effort which embraces primarily the public health nurse and the social caseworker.

Through my experience in the Community Service Society the achievements and strivings and still unresolved problems of the Demonstration take on a special significance and increase the respect and humility with which I offer my comments and questions; and I must say, too, that from reading prepared material which is second-hand to the raw material which exists in case records or to the observation of conferences, and so on, one feels especially hesitant to offer all of one's questions and comments.

It should be taken for granted, therefore, that much of what I say I am saying to myself and my colleagues in my own agency who are struggling with this kind of thing, and not only to the participants in this meeting.

The development of service through teamwork is one of the current major tasks of our society. I am not talking about CSS. I am talking about the society in which we all live. The trend is a natural outgrowth of the desire to make available the rich variety of knowledges and skills which no one profession or individual practitioner alone can claim.

I would like to state a few concepts about teamwork service that will provide a frame of reference for my comments. I hope you won't mind my doing that. We haven't really discussed what all of us around the table mean by teamwork, and I imagine there are

almost as many different ideas as there are people. So I am presuming on you to give a framework for my own comments.

A team is defined in a recent article—this was written by a physician—as an organization of individuals cooperating for a common goal. The author goes on to say that the first problem of team practice is the integration of the specialists composing the team. To accomplish this integration, he says, requires what he calls clinical maturity, that is, the ability of the individual team members to "relinquish some of their autonomy and modify their personal and professional needs to meet the needs of the group."

The needs referred to I understand to be such things as the satisfactions a professional person may derive from status, authority, self-sufficiency, and so on. These satisfactions must in the course of developing teamwork be modified in a process of mutual identification and esteem. I would understand, furthermore, that the relinquishment mentioned by Dr. Drew does not refer to areas of professional skill, responsibility, or function which are inherent in any given profession. The process of integration, that is to say, results in becoming a more proficient practitioner in one's own field. It does not result in becoming a practitioner who combines two or more professional competencies. I know there are many different opinions on that, but for what it is worth I want to bring you mine.

Teamwork and integration can be conceived of on two levels. First, there is the integration of multi-discipline service to patients or clients. This is illustrated by the coordinated efforts of two or more professional persons in behalf of an individual or family group. Such coordinated efforts may take place entirely behind the scenes, that is, only one practitioner may be in direct continuous contact with a patient, though he draws on the experience and opinions of colleagues from other fields of practice for use in his own contacts; or the patients may be served directly by two or more practitioners who synchronize their efforts by planning together their respective treatment processes.

Second, there is the integration which takes place within a team member as he assimilates what is learned from other team members into his own specialized practice. This kind of integration is illus-

trated when a professional person makes modifications in his own practice as a result of new ideas incorporated from other disciplines.

With these ideas as background, careful study of all the papers describing the work of the team members and consultants in the Demonstration with special attention to my assignment as a social worker leads me to make the following comments.

I would like to add to those a little bit as I go on, if there is time available, from the very interesting and stimulating points that have been made so far in our discussions.

The social work coverage in the Demonstration seems excellent for the study period which culminates in the team conference prior to the family conference. Following that point, it is less clear to me what role the social workers play. From some of the papers, I understand that the social worker plays her strongest role as an informant and consultant to the other team members. This I infer from the statements that the treatment of interpersonal and behavior problems per se is so often effected by the internist, pediatrician, or public health nurse.

The findings so far available indicate that a great number of the patients are already inhibited in or dissatisfied with their functioning as individuals and members of a family group. This area of maladaptation is one in which the social caseworker can frequently function by giving direct service as a therapeutic agent. I am therefore interested in knowing why so little of the social worker's time goes into such direct service, that is, if I read correctly; or conversely, why so much of that service is given by other team members. I am not, either, talking about a "hands off, don't touch" sign hung over problems of that kind and reserved for any one team member, but there seems to be a weighting which is not clear to me and which I would be interested in having discussed.

I have speculated on the answers and can only speculate in my position as an outsider.

First, there is the possibility that the concepts of the members of the Demonstration about teamwork and the teamwork process differ from those I have suggested. I rather think from a good deal of the conversation we have had so far this day and a half, that that is

true. That kind of flexibility which I might see in the roles of the various professional team members differs in degree and direction from what some others of us would conceive.

Second, there is the possibility that the primary emphasis on educational method, which is not the primary method of the social caseworker, has modified the role of the caseworker to a considerable extent. Actually, social caseworkers are not trained in the educational method either with individuals or with groups, except as something secondary. Our role there I think is not well defined, that is, as educators from the service standpoint.

Third, there is a question about the invitation interview—you do not have a particular name for it and I call it that. It is the interview in which the social worker or public health nurse sees a couple in order to invite them in to the Demonstration. I am wondering what kind of preparation the patients received in that interview for the social worker's interest and role, since she is, as far as I can see, a less familiar person to them. She represents territory which they do not know so well as they know that of the other team members, and also it touches their lives in quite a different way. Therefore you may get a more rapid rapport with the doctors and nurses whose roles and areas of interest are more familiar, more acceptable and more readily accepted.

Fourth, there is the possibility that modifications in the method of conducting the initial interview with the social worker might eventuate in an easier acceptance of her services. I am particularly interested, if there is time later in this Conference, in having some discussion of those intake interviews, the length of them, the way in which they have therefore to be used, whether in itself the method might not create some hostility on the part of the subjects. I wonder in particular whether one does not run a greater risk of their not returning by conducting two or three-hour interviews than by having several interviews of fifty minutes to an hour, in which one may choose one's tempo and one's areas of inquiry in a way which is more tempered to the interests and readiness of the subject at any given time.

Fifth, there is an implied possibility that the time devoted by the

social worker to obtaining information during the study process has, so far, precluded her giving direct service to the patients in the degree the problems indicate. I assume that is so for both the public health nurse and for the social worker, from what we said yesterday; that the matter of history-taking, gathering data, making observations, and so on, for the first step in the Demonstration has been very time-consuming. One way, I suppose, by which one can release more time for necessary services is to increase the personnel to complete the study process. I think it is less important, perhaps, than we sometimes think, for the same person to carry responsibility for both the study process and the continuing contact.

In summary, the descriptive papers suggest that the social worker functions most often as an informant to other team members and as a participant in evaluative and planning conferences. This is an invaluable aspect of professional teamwork and perhaps always has to precede the development of the other aspect, which is coordinated direct services.

My understanding of what is happening may be incorrect and reflect a breakdown of communication, so to speak, for which I heartily apologize. If my inference is correct, it will be interesting to consider the possibilities of next steps.

Before closing, may I again express appreciation of the significance of the Demonstration to the general public welfare and of the backbreaking efforts that enter into a project such as this—I feel as though I do know something about that from our own process —and of the generous way in which you have thrown open the door of your experience for the benefit of others who are struggling with similar and sometimes identical problems.

Discussion

Mrs. Alt: The question of the role of the social worker seems related to a broader issue—the clarification of the specific roles and skills of the social worker and the public health nurse as they are utilized in the project. This has long been a subject of great interest to us. I don't know whether this is the point at which this should be brought out more clearly or not, but I think it is a question that Dr. Dean Clark touched on and it is of tremendous interest to all of us who were

concerned with developing the broader services for people who have health problems.

I do feel that the project offers a unique opportunity to gain new information on the way in which these skills are being utilized. It may give us a fresh look at the entire subject.

DR. SILVER: If I may take the two questions of Dr. Regensburg that I left for myself, I would like to point out that these follow along with Mrs. Alt's comment and the point that Dr. Duncan Clark made this morning about why is the team constituted in this fashion.

It seems to me that fundamentally the question we are asking ourselves here or the question that you are asking us is: Why did you do it this way and not some other way? I think that there may be as good reason for doing it another way as there is for doing it this way.

We felt—and I would like to clarify this without actually defining too many of the terms—that the public health nurse had a skill which had been developed over a period of years with regard to health education in the environmental control, so to speak, of the family's relationship to medicine, and that the social worker had a skill which had been developed over roughly the same period of time with relation to sick people that was part and parcel of helping them to help themselves in the emotional area.

These two things are not mutually exclusive and at no time was it ever thought that it was absolutely vital that there had to be two such people in order to work in these areas and bring in the information and help the doctor to do the best possible job of medical service. It was felt that these two disciplines had developed special skills over a period of time and that we would try to use these skills in conjunction with what we were trying to do.

There is no assumption whatever that the job can't be done just as well by one person. Either one person could be developed in some new training technique for which possibly some additional funds may be made available to us so we can experiment in that direction as well, or it may be that one of the existing persons in these categories, either the public health nurse or the medical social worker, can be given some of the skills of the other and then used in that connection.

Under the circumstances and in order to avoid complicating our particular problem by introducing an additional one of training a new kind of person to do this job, we took over the existing skills just as

we took over the existing skills of medicine, and yet through the pervasiveness of the team technique it has been pointed out time and time again that this doctor is a little bit different from the doctor that he was and from the doctor in the general run of our experience. In the same way, perhaps the social worker and the public health nurse, having been taken over as they were, have been re-sorted, perhaps, but not in any way transmuted into something entirely new.

The process of direct casework service that you mentioned, Miss Regensburg, is obviously part and parcel of the skill that the medical social worker brings, and to emphasize again that she operates in her capacity as a social worker to do her job, but also to bring her skill to the aid of the others. In other words, the team operates by virtue of the fact that each of the separate skills more or less fertilizes the others. In this connection you quoted from Dr. Drew, for example, and Dorothy Robinson in the same issue makes mention of the fact that function of the team is to help an individual to do his own job better. It is in that connection that the social worker has just as much an opportunity as the public health nurse.

DR. ZUBIN: I would like to speak apropos of this discussion and raise one point which arises from Dr. McIntosh's talk, but which has not been dealt with sufficiently.

It seems to me we have stressed the matter of gains to the family practitioner arising from this project. We seem to have more or less neglected or passed over lightly the gains that this project may bring about for the other professional members of the team. I would be very happy to hear from the social workers what kind of changes in their point of view have taken place as a result of this particular experience. I am sure that in the other professions, too, there have been tremendous changes—at least we hope there have been—when they are faced with this particular problem of integrating information from various sources.

One of the incidental results of the project would be not only along the lines of improving medical practice but also improving the methods of nutritionists and statisticians, who are going to have to cudgel their brains for new techniques appropriate for dealing with this multivaried material. I hope, that the biometricians will tell us, too, after a couple of years what new inventions they have had to resort to in dealing with this tremendously interesting human material.

Dr. McIntosh's talk and some of the things that Dr. Gruenberg said this morning, and Dr. Aaron, I believe, too, makes me take a little courage to revert back to what we talked about yesterday afternoon. You notice three ideas were enunciated this morning. Someone spoke of symptomatology, and you can get symptomatology out of the records. Someone spoke of pathological data. Someone spoke of traumatic experiences recorded in the data. I believe someone also spoke of the positive aspect of mental health which arises as you deal with this project.

When Dr. McIntosh spoke of the various ways he wanted to go about evaluating the available material, he spoke of the genetic aspect, and he spoke of the infectious disease aspect. Then he also went on to talk about the emotional attitudinal aspect, and there his examples were meager and that is where I want to take my point of departure.

This project can help a great deal in supplying new dimensions, by providing the markers of normal emotional development or of normal emotional health, not of the variety that we are prone to discuss when we discuss psychopathology because, after all, that is a different problem. You may have two or three people in the whole group who are psychopathologically tainted if the expectation of such events is no greater than in the rest of the general population. That is not the problem. The problem is that of finding markers or indicators of normal emotional deviation, the kind of thing that on the physical side you speak of when you speak of minor digestive difficulties that are transient but occur to all normals or minor headaches or insomnia.

It is true that you get these indications in talking to the patient. The patient will tell you, "Yes, I had a trauma this past week" of one sort or another, but you don't get them on a continuing basis. You don't get them in a way which will give you a picture of what is the normal amount of, not pathology, but of deviation, let us call it, of an emotional sort that you expect in the normal population.

I don't mean to turn this project inside out and say let's devote ourselves entirely to a study of the delevopment of emotional growth, but can this project provide concepts out of its data which will then later on serve as a point of departure for making further studies? What are the things that are measurable, that are observable, that can be counted, and out of the records available can we then get an idea of what should be done in the future in counting such things?

DR. BOUDREAU: Let me make an observation on the point that was raised by Dr. Zubin. All the information that we will have from this investigation will be information that has been filtered through the minds of the persons who are carrying on the studies in the field. In natural science, a paper or a monograph contains conclusions drawn by the authors, and then in the appendix all of the original data appear.

I would like to see a lot of the original data published. I don't know how to get it except possibly by recording the interviews. It seems to me if it were possible to record the interviews, we would have the original questions and answers as they were contributed by the families and by the interviewers. Readers could then judge for themselves whether those who prepared the report drew the proper conclusions.

DR. COLEMAN: I would like to bring up the question of what kind of data are being gathered. I run into some difficulty because of my own very special experience in psychiatry where patients come in because they have a problem for which they want help. We get spontaneous information under the stimulus of suffering and in response to an anxious pressure inside of themselves.

I wonder in this kind of procedure where the patient is seen over a long period of time and where observations are made not in relationship to suffering but to a systematic schedule of observations, whether the information might not be distorted by the situation itself, that is, whether a lack of motivation might play a role in distorting the data.

We know, for example, that it is awfully easy, even in psychiatric interviewing, for data to be distorted by the interest of the patient in supplying the kind of data which he thinks the interviewer wants. I think there is perhaps this kind of danger here, too, that information will be supplied in terms of the concept that the subjects have about what their experience is like and what is required of them, what they think they are expected to give. I don't know how this can be controlled. I think one consideration is that any kind of interviewing procedure which is directive in nature will tend to produce more highly distorted information than an interviewing procedure which is not directive.

On the other hand, a procedure which is not directive will tend, I think, to encourage the production of material related by and large to psychopathology. Psychopathological material when you first get it—and I think it is almost always present; whenever one enters a situa-

tion of this kind one can always find it—psychopathological material is more likely to be brought into perspective by a treatment process.

One asks, therefore, whether the important skill is not that of getting information but of conducting what would amount to treatment.

This again brings up the question of what the possibilities for treatment are in a situation of this kind where the patient really isn't asking for specific help but has a general need for help or he wouldn't be in this project. I raise these questions out of a sense of my own inability to see the situation clearly, without expecting that an answer to these questions would be readily available.

DR. GRUENBERG: Following up what Dr. Coleman just said, the implication is important from the point of view of the kind of questions that Dr. Zubin was suggesting, and it is the kind of question that occupies me a good deal, too, about the wonderful experimental group we have had. In the treatment situation when a patient comes to the doctor, our first focus of attention is the patient's perception. What does this relationship mean to him and what does he want from it?

I think that is one of the most important things to be found out here. I don't feel that methods have yet been discovered by the team for getting to see the patients' perception of what this special service team means, why they want it, why they accept it, what they are expecting from it, what expectations the team has modified by its behavior. I don't see how we can get the answers to Dr. Coleman's crucial question—how are the expectations of the team modifying the expression of the patients—unless we seek to understand what the patients' concept is of the expectations of the team: the physicians, nurses, and social workers.

We haven't a method yet for finding out what the patient thinks this team is doing for him or feels they are doing for him and why they want to participate in it. That is an approachable question, and if one did approach it, then we would be able to evaluate the problem that Dr. Coleman raised, which was, I believe, how much we are influencing what they say of our approach to them.

DR. COLEMAN: I don't think it makes an awful lot of difference which professional group approaches the patient in terms of bringing help. It seems to me that the need of the patient determines the response rather than the patient's awareness of a particular professional

group. I say that on the basis of experience in a psychiatric clinic in various settings where the patient is treated directly, either by a social worker, psychologist, or psychiatrist, and it has been my observation that for the patient it doesn't make any difference what the professional identity of the particular person is. The important thing is the nature and quality of the patient's need for help and how the particular professional person is able to respond to that.

NURSING

RUTH W. HUBBARD

SINCE I have sat among you during a day and a half, as "the lady from Philadelphia," I think it will not be necessary for me to indicate the tenor of my remarks. All of you including our friends from other countries regard us as the conservative area of the Eastern Seaboard. Being the sole representative of Philadelphia at this Conference I shall probably not give you a new impression of that City.

I would like first to thank you for including me. If I have another misqualification for this post, it is that I have not at any point in my career been actively engaged in a health maintenance center. Because I have been engaged for a long period in the curative side of medicine and nursing, I am heartily in accord with any effort to eradicate disease by its prevention.

Therefore, I address myself at once to a tremendous note of appreciation for the family-centered program. It seems to me that we have spent a great deal of time, properly, on the procedure by which this project is being carried out and upon the objectives which the professions involved seek to achieve. But every time that we have listened to a member of the project speak in this room, in the corridors, or downstairs, we have heard a unified expression of concern for what the family seeks, wants, or can use. That to me is the heart of this undertaking.

Perhaps I was conditioned to expect that, knowing as I have had the privilege of doing, not only Dr. Cherkasky and Dr. Silver and several members of the present team, but also something of the organizations from which this experiment emanates.

To me, the heart of this project is that your concern is to develop a procedure by coordinating the skills of several professions which can be of use to a particular family, and you have given evidence of your readiness to vary any adopted procedure on behalf of the

need of the family. Illustrations of that have appeared in the discussion this afternoon.

Miss Ringenberger was quite clear yesterday that at present she is functioning in four fashions, which are characteristic of public health nursing as we know it in this country. She is primarily, she says, a teacher and the counselor in the area of health. The particular knowledges which she endeavors to convey on evidence of interest and need are knowledges in the area of child development physically, nutrition, and environmental living. She conveys them to families and to other members of the group. I am not sure that it is safe for me to use the word "team" at this point, but I shall probably slip it in before my remarks are completed.

Secondly, she assists with health examinations which take place at the headquarters of the project under the direction of and with the physician and the pediatrician in charge. These are both functions which families and other professions expect to see nurses perform. Thus, she has the benefit of being called upon to behave in a manner that her families and her colleagues expect.

She is doing a third thing, and that is to assist in the determination and evaluation of the family environmental health and their needs. In other words, she shares, as do the other members of the group, in a group conference. She is in a sense a scout because, as far as I have been able to understand, she is the one person who surely will have visited the home of the family prior to the program planning or evaluation conference.

It is very heartening to hear the discussion that has centered around the value of knowing the home at first hand, not only through one of the professions in the group, but also through all.

Then fourthly, she shares in the team planning conference with the family to meet these needs. Therefore, at the point at which the following of the advice or the actual action on the recommendations begins to take place, she is as well known, if not better, known by the family as are all the members of the group.

I need not identify again, because her paper did so well, the specific things that she does as a professional person in fulfilling those

four activities, but I would like to mention six things which to me seem like definite assets in the project undertaking to date.

Quite frankly, for me the first asset is the fact that four disciplines with a related group as a sort of a periphery are working together as a team in behalf of a family. Despite the problems that we have discussed as to who carries the ball at what point, they display a unity of approach which is most heartening. I would put it first in the assets of the project. It is an extremely fine No. 1 asset to bring four disciplines together and relate them to others who are not going to see the patient or the family so as to achieve a unity of effort which is sustained in the family experience.

Although I have not met any family in this project, I get the impression that the family senses the unity of the team in the approach. To me this is very important.

I think there must be much less confusion in any household working in this plan than there is in a household seeking equally skillful independent counsel in the fields of medicine, nursing, and social work. I am sure there are many families in any of our communities who seek all those services independently out of no more conscious sense of problem than do the hundred families that we are discussing here. I venture to suggest that the confusion which can exist in families, not even in the control group but just in the citizenry, can be extremely great, and any one of the disciplines working in such a situation is conscious of that confusion but is unable to avoid it as readily as are the team in this situation.

The second asset is the accessibility of the worker—and now, quite frankly, I refer to the public health nurse—in the home, in the school, in the office, and possibly in the shop or place of work. That, I say with respect to the particular individuals whom you are fortunate to have, is due to our inheritance in public health nursing. The privilege we have to move freely in the community and to be accepted is ours only as a trusteeship, and we hope to hand it successfully to those who follow us. The groundwork for that was laid some sixty or seventy years ago. The fact that one only has to say she is the public health nurse to open a door in almost any home in this land is a great privilege. I believe this has had something

to do with the splendid first year of your project. This does not in any way minimize the capability of the representatives of the other professions who are members of the project.

The third asset is the fact that it displays continuity. You really are going to know these families over a period of at least five years. It was suggested yesterday that conceivably you may know some only four years because of the problem of establishing your total group. Five years is a relatively long time in the life of a family, even though we now know that we may achieve age 70 or 76, depending on whether we are female or male.

The preschool becomes the school age, the school age becomes adolescent, the adolescent gets married and has a baby of her own. Five years from now your families will not all be families in which no one is older than 45 or 47. You will have some older people. Some changes will occur by the introduction of a generation that appears in only six households now where you have the parents or grandparents living.

In five years, however, you can establish a continuity which is far more valuable, I believe than any of the types of studies that I have known of in this sort of thing.

I am reminded of Sir James Mackenzie who thirty years ago retired from London to Saint Andrews in Scotland simply because, as a cardiologist, he wanted to live with people long enough to see what their particular heart ailments did to them or what they did with their hearts in terms of living. I think you have this opportunity in excess of most of the experiments we have known about.

The fourth asset that I became aware of last night as I traveled back and forth to the City that is so conservative, is an asset you have clearly displayed in your report. Your families feel your interest. You have said it in a number of different ways. You have said that they did not expect to tell you some things, yet they did. You have said that they call you over and over about things. You have said that you have gone into a family when a situation arose which would seem to you to indicate that the presence of one member, the doctor, the social worker, or the nurse, about a specific matter would be of value, would be supportive.

I think they definitely feel that you care. In a period when, as Dr. Baehr has so helpfully said, we all have problems, it is good to hear that one hundred families in this City do know that some people care about them healthwise. It makes it a little easier at eleven at night when you think about the families who don't yet know that there is even one person who cares.

The fifth thing that I think the nursing arm of this unit displays, by the very fact that the nurse is frequently in the home, is a practical teaching skill. Quite honestly she is dealing with material which the family wants to know about very concretely. "Is it true, as advertised by one maker or another, that one brand of orange juice is better?" The public health nurse, having talked with the physician and the pediatrician knows his wishes and answers hopefully, concretely. "Is it true that Starlac really will do this job? I hear it here; I see it there. My neighbor tells me. What am I to do?" She is working in a very practical area. But it does strengthen a sense of relationship which can lead to some of the other things you all want to do.

The sixth asset that I see in this picture is that the whole team is able to get a very much greater understanding about what family life is like. Each looks at the family with his own eyes, comes back and makes his comment. The team gets actual factual information, some of which is accepted, some of which is tested against another's report. The team gets some understanding of attitudes. Because you have the privilege of going in and out of these households and they come to you, some understanding develops in a period of five years of what I would call competitive influences, because after all, these families are not exposed just to this project. Other people are telling them what to eat and how long to sleep and what to do if they are worried about their children.

You begin to understand something of the other influences that are meaningful to this particular family. We touched yesterday on still other sources of influence, some of which seem to be active and some do not.

I have just four questions; and start with one in relation to the team. I would like to offer these as observations or suggestions.

Is it possible that the nurse member of the team, a public health nurse, could practice a complete program of public health nursing with her families within the restriction of the program properly drawn by Dr. Cherkasky's definition? As I have talked with the nurse members of the project, I sense that something may happen —it hasn't yet happened, I think, because experience is still too short—to the nursing setup that cannot conceivably happen to the medical setup. If sickness occurs, Dr. Aaron is the HIP physician for these families, but Miss Ringenberger may not be the nurse. It is possible that the Visiting Nurse Service of New York will be the nurse.

I know why it was arranged that way and it is very understandable. However, if this project is as good as we very sincerely hope it will be, you will begin to think of reproduction in other communities. Therefore, I would like to suggest that it is conceivable that certain so-called bedside nursing services which might be needed in the event of illness could best be rendered by the public health nurse who is already known to the family as the health adviser. I deplore the necessity presently occurring through the arrangement to fractionate the nursing service.

I raise this question about the project here, and of its reproduction or adaptation elsewhere, because in some communities it might be very valuable to work it out the other way.

I would also like to ask whether the team believes that the team concept as they are practicing it could be carried out if the team members were not all in one unit? Again I ask that question, because it is possible that a community might use its caseworking agency, its public health nursing agency, and its medical group in a similar relationship, without developing an additional organizational structure, after you have completed the work you are doing.

Finally, in relation to the team I would ask, again very humbly, if it is conceivable that the leadership in the team might shift from time to time on the basis of the major family need. I will not pursue that further, but it is something to which I have given a great deal of thought.

The second question: Is five years long enough? I ask this be-

cause of the things I said a bit ago. This project will teach us a great deal about the concerns of families during their childbearing and rearing years, but family health as we are coming to know it in the United States is just as important for parents and children when the parents are in the late forties, the fifties, and sixties and the children are in the twenties and thirties. I venture to suggest that fifteen years from now we shall consider family health something that relates itself also to persons in the seventies and eighties. I also suggest that although only six of the one hundred families now have grandparents, by the end of five years you will have more, and the situation will be one which you will then approach on the basis of a three-generation household.

Therefore, the third question is: Can we envision a less restricted group of families? I think this is the spot at which to start, but I am curious to know if we could anticipate a similar effort that included a wider range of grouping. In this very room I heard several years ago a most helpful and stimulating presentation by a physician from Wolverhampton, England, who talked of families all of which were in the later years of life, and the problems of health that concerned them and their children.

My final question is not so much a question as an observation. It is actually directed only to my own profession, of whom there are but three or four in the room. As we in nursing have watched medicine make its tremendous scientific strides, we have shared medicine's own concern about the consequent change in emphasis in the practice of medicine and medical education and we have come to feel that our own function in nursing may shift. We, now in the second generation of our nursing, have seen it alter so that things we were taught should be done by doctors, are now being done by our daughters who are in schools of nursing. We therefore know that functions which were entirely medical a generation ago may become or are already nursing functions and others may be added to them.

Because I am in an organization whose primary concern is not the care of those who are well but who unfortunately are sick, we know that a great deal of medical therapy now is done with a hypo-

dermic syringe. Almost forty per cent of all the visits that we make today involve the administration of a medication by hypodermic. But because research moves so rapidly I am willing to wager that by the time the study is done, medicine will have developed a better way to give medications and we shall be learning to do something else for patients in the homes.

For that reason I would earnestly suggest that we do not crystallize roles too prematurely.

Discussion

Miss Ringenberger: On the question concerning the possibility of the nurse providing full public health nursing services, I would agree with Miss Hubbard. Health Insurance Plan contracts provide public health nursing services through Visiting Nurse Service of New York. Originally when we worked out the agreement with the Visiting Nurse Service it was a matter of not having enough nursing time available to make all morbidity home visits. So far we have not had any real home nursing problem. To the best of my knowledge requests for service from the Visiting Nurse Service of New York have been confined to those of our families with children requiring antibiotic injections.

However, if some member of one of our families is home ill, it would be better for the nurse from the Demonstration, whom they already know, to provide the public health nursing services necessary. I think it is undesirable to have an unfamiliar public health nurse enter the situation when the family has already established a relationship with a nurse whom the family considers its health counselor.

Dr. Silver: As far as whether the project could be carried out if the team were not all in one unit, that is an interesting question, and it is related, for example, to the problem that we discussed frequently about home care.

For example, in Philadelphia, home care operates in that fashion. We like to believe that there are tremendous positive advantages that accrue from working together and being able to consult with one another; in other words, almost socializing some of the professional problems to the extent that it becomes second nature to consult with other people, which it is very difficult to do if you are removed in space.

Miss Hubbard: You are absolutely right, Dr. Silver, and it would

have to be really a dedicated interest. I think it is exactly what has transpired in some of the communities that were mentioned here, where a doctor and a public health nurse and a single social worker in a small community are working together. There you actually have it, because they do see each other. They don't see each other as often, as you do, by any means, but they do have an acquaintanceship with each other which makes a telephone conversation a profitable one.

In our community, as you have pointed out, we are very happily and successfully working with the Family Service Society on our home care program, just as closely as if we had a caseworker in the agency staff. At least we think that. It has taken about two years, but it reached that point when the Family Service Society voluntarily offered its function to the program. Therefore, it is not anything that has been pressed. In consequence, we have not hesitated to involve them in time-consuming activities. It has had tremendous meaning.

It has definitely been our experience, again around a home care program and not a health maintenance program, that leadership does shift on the basis of what is discovered by the team to be the primary problem to approach as far as the family and its needs are concerned. We have there the same disciplines as are represented in this undertaking.

Miss Ringenberger: About the problem of social workers, nurses and doctors working together when not in the same unit, it has been my experience that the difficulty is one of communication and lack of understanding of the roles of the various workers in the health field. I think the nursing curriculum should provide nurses with an opportunity to gain an understanding of the role of the psychiatric social worker in the health field.

For example, when I first joined the staff at Community Service Society I attended classes at the New York School of Social Work in order to learn more about the concepts, principles, and objectives of psychiatric social work.

Mrs. Ginsburg: As Miss Hubbard was talking, and remembering what Mr. Davies had said earlier about the fact that this is a health maintenance program and not a medical practice program in the pure sense, it seemed to me—and I wondered if others felt it, too—that in Miss Ringenberger's and Miss Hubbard's discussion of the services of

the public health nurse you have a real picture of health maintenance. Miss Ringenberger's paper was concerned with health maintenance as a positive program. Her reason for visiting the home is the maintenance of the family's health not the uncovering of its pathology. She looks at the family's living arrangements; she talks with the family about many things—rest and sleep, recreation, nutrition, the father's availability to the family, the child's play and so on—in the total context of the family's health and wellbeing.

Certainly in Miss Ringenberger's material you got the feeling that she was well versed in psychodynamic theory, that she understood the interpersonal relationships of family life but saw herself in her health maintenance-public health nurse role and did not go outside of it to use or interpret or attempt to treat the emotional problems of the family. Recognizing that by doing and recommending certain things at certain points, she might relieve the family's tension cycle, she would suggest changes in routine which often helped parents deal with small crises before they could mushroom into large problems. This was in marked contrast to some of the other material from which I got the impression that the emphasis was on pathology and on the treatment of psychiatric problems rather than on health maintenance and the family's ability to make a go of things.

Miss Hubbard: Here I am definitely out of my department, but is it not true that we still are learning what constitutes the content of health maintenance information? I think that Miss Ringenberger and Mrs. Stiber, from their associations with the families, are getting many things which they are very naturally discussing together and paying attention to, because we don't yet know, as someone over here said this morning, whether five years from now these things will have resolved themselves the way some thumb-sucking does, or whether they will not. So at this moment anybody involved in this kind of thing is looking at anything that comes up which conceivably would be in the same area.

I would expect that we may have rather different weighting of information that comes to us from families on the basis of what we have seen those families do with that situation themselves.

I go back to Dr. Cherkasky's definition of the objective. We talked yesterday a lot about how you are going to evaluate it, and we really went out of the room pretty much thinking that it will prove itself, if

you can see these one hundred families, coping with the situations of life which will occur. There will be different situations five years from now, but they will have gained confidence.

I have the feeling that if you instill some confidence in the family, you will find some way to measure what will begin to be a controlling factor in what you identify as the warning signal to deal with and what you identify as a normal evolutionary experience in a family, because as Dr. Baehr has said repeatedly, there is no one in the room who hasn't in his or her family connection worried about most of the things that have been presented as illustrative material in the papers that we received and have heard presented.

Miss Freeman: I would like to second Miss Hubbard's statement about making nursing as much a complete job as possible. I think it is a tremendous handicap to fractionate the nursing job and then try to evaluate a whole product.

The only other observation I have to make is a general one. I would hope very much that the focus of this project could continue to be on the function and not on structure or role of particular professional groups. There is so much to be learned about what people want and need in family health maintenance, and what is involved in providing care. It would seem much better to concentrate on what needs to be done and what can be done rather than worry about who does it or who is the boss at a particular moment. I don't think those things are tremendously important.

If we work along with the functions, we will find some surprising things. I heard twice today, for example, that social workers really don't know anything about teaching, and yet the material I have read on interviewing and counselling in social work, particularly that directed at advisement, could be placed in a textbook on public health nursing and you wouldn't be able to tell the difference. We have heard that nurses are primarily teachers as contrasted to social workers who help people to help themselves. Yet the textbooks on public health nursing of twenty years ago include self-determination and helping families make their own plans as being extremely important. I know of no course in public health nursing at the moment that doesn't have some course work on nondirective interviewing, which certainly is pretty close to helping people to help themselves.

It would be very difficult, I think, to sort out social work and nursing,

provided you could separate the vocabularies and restate the ideas in words free from professional jargon of the two professions. In many cases functions and activities would be much the same.

Administratively there are differences in emphasis and differences in depth. Just as the doctor and the nurse may do exactly the same thing in terms of teaching the diabetic patient, so may the social worker and the nurse do exactly the same thing in relation to the mental hygiene case, but they may be able to do it at different levels of intensity. There will be points at which the nurse is out of her depth in helping people to help themselves, and there may be points at which the social worker or the doctor are out of their depths in relation to getting people to apply the information that is available for them to use if they will choose to use it.

I think that there is much more overlapping than there is separatism in these services to families. For that reason it seems to me that it would be tragic to crystallize roles too early and to begin to compartmentalize what is done. I don't think, incidentally, that is the case in this demonstration. I have the very strong feeling that there is little compartmentalization at present. That is good, and I don't want anything to interfere with that in its progress.

I hope also that the administrative applications don't become too important a determinant in the services provided. Obviously, we are going to face a great many problems in administrative application—whether to include social workers in direct services to patients and in what proportion, how much the physician does in counseling and teaching.

Just as nurses are taking on responsibilities formerly carried by physicians, physicians have taken on responsibilities previously considered the province of the nurse, social worker, or health educator, particularly in the teaching areas. Nurses don't always want to give up these responsibilities. I have heard nurses get very irate because pediatricians in the clinic were doing "their" job, teaching patients.

So there is an unloading in both directions. That means that we need to think in terms of the function, and then perhaps on the basis of a particular situation decide who can best perform that function. That decision will rest not only on the competencies that are within a given profession, but upon the people that are available in a particular situation. It is not possible to do the same thing in Twin Falls, Idaho, in terms of using direct services by social workers and physicians and

nurses, that can be done in New York City, because the people available will be different, both qualitatively and quantitatively. But the things that people need to have done will probably be much the same.

I think another factor that will come up relates to communication methods and costs. I agree thoroughly with Dr. Silver that the best possible method of communication is personal, face-to-face, day-by-day contact. That is fine. But, it is expensive. I have been an administrator long enough to know that you cannot and should not cut time for communication too short. If you have long distances, or relatively large numbers of personnel, or problems that are intricate, it may be necessary to find other methods of communication that are less costly and still relatively effective.

This cost factor in communications increases very strikingly as the number of people on the team increases. I think we have to consider both the actual cash cost of communication that is involved, reflected largely in the conference time of the participants, and the emotional cost to the patient and families (clients, if you wish, or subjects) when they are exposed to a large number of different people.

A recent nursing study shows, for example, that sick children in one hospital were served by fourteen different people in one day. I can't believe that we are saving a great deal by that kind of process. It must be terribly hard on a child, who is already away from home and sick, to have to adjust to that many different people. We don't want to fall into the trap in relation to the use of the team, of getting ourselves so "complexed up," as my daughter would say, that we are going to have a hard time getting the job done.

I think part of our decision about the size of the team to use must rest on the cash cost and the emotional cost involved in the use of a large number of different people to provide health maintenance services within a single family.

Miss Goldberg: Some ideas ran through my mind as I listened to the discussion. First of all, Dr. Gruenberg this afternoon threw out a challenge that no one has really taken up, about the doctor again becoming a socially oriented doctor. This could mean that he does not need a team at all times, but that he might call on the social worker and the public health nurse in their consultative capacity on appropriate occasions.

As I went around America looking at some of the experiments in

medical education—particularly at Western Reserve—I began to speculate about what the doctors of the future would be like. They would be very different indeed from past generations, these new "social" doctors, and this would inevitably lead to a readjustment of all our functions. This meeting offers a wonderful opportunity for discussing these ideas much further, and I am sorry that they were not taken up.

My interest in this project is so great because I am engaged in a similar type of investigation into so-called "normal" families. One of the problems seems to be that most of us who are doing this kind of research have been trained in clinical settings where we searched for pathology, and this became our guiding light by which we could explain people's behaviour and attitudes. I feel that we haven't learned yet to discover the positive assets—I think Dr. Cottrell called it "capacity to cope"—the kind of supports that carry people through crises. We are still looking for evidences of crises. This became very clear in Mrs. Stiber's paper. I was somewhat frightened by the picture she drew of the marriage pattern in this country. It looked pretty gloomy. I wondered what these generalizations were really based on. What are our goals of health and health maintenance to which we implicitly compare these families? The psychologists also mentioned that the T.A.T. material showed much pathology and that the Rorschach tests had to be abandoned because they revealed so much psychopathology which seemed unsupported by clinical evidence. What are we carrying in our minds as objectives or ideals of mental health? Are they closely related to the reality situations of our society in which so-called "normal" people find themselves? That is the question which bothers me most.

I feel we also have a great deal to learn yet about the techniques we use—the interview for example—the instrument so many people talk about. The question Dr. Regensburg raised about the two-hour interview was passed over rather lightly: whether this really is the best method of finding out about a whole chunk of people's lives. We need to experiment with different types of interview. It may be more fruitful, for instance, to have shorter interviews at intervals in order to observe a *process,* in order to see how people cope in changing situations, how their relationship with the interviewer develops, what their attitudes are towards the project, and so on. Perhaps the two or three-hour effort could be broken up into four forty-five minute interviews, or whatever it may be. We may then begin to see quite different kinds

of behaviour than if we try to telescope it all into one interview. Also, some of the areas that are being touched upon seem very sensitive ones, sexual behaviour for instance. I can't imagine that social workers would be able to touch on this in a first interview in England; but this may represent cultural differences. I wonder whether the information obtained in this kind of first interview does not represent stereotypes, rather than the true picture which might only emerge very gradually through continued contact.

Lastly, I would like to urge as other speakers have done: Let's not crystalize the roles of the future health team too soon. I think we should keep a very open mind at this stage as to who is going to do what.

DR. SCHLOSSMAN: I want to address myself to the remark on psychopathology. This has come up in a number of discussions, and I feel this subject of psychopathology is quite a bugaboo.

I had been working in a child psychiatry clinic for many years before I came on the Montefiore project. Shortly after starting it surprised me that the families on the Montefiore project, perfectly normal families who do not come asking for any psychiatric help, did not differ in any marked degree in the psychopathology that they showed, from the familes that were present in the clinic. The only difference was that on the Montefiore Project the family was still in a state of balance, while in the other something had happened to break the family down. Yet psychopathology was present in both.

In one of Freud's earliest writings, "Psychopathology in Everyday Life," he pointed out psychopathology in all the things we do. For example, during the conferences I noticed Dr. Silver is always doodling. There is no question that there is some psychopathology behind that. I can speculate; I can bring up all kinds of horrible sounding things about the doodling, but it is still perfectly normal that he doodles. This is psychopathology, but it doesn't have to shock anyone. It doesn't seriously interfere with his functioning.

About some of the elements in Mrs. Stiber's paper. She didn't present a family as though the average man is passive and doesn't take care of any of his responsibilities and that the average woman in the family is aggressive and runs the whole show, and so forth. And that it is all very disturbing and we don't know what to do about it; but rather, that within a particular family she was describing, or in a number of

the families, the men on a relative basis but still certainly within average levels were functioning even though the man was somewhat passive and the woman was somewhat more aggressive.

I felt one of the goals in our project was to pick up these elements of psychopathology and, as far as we can in the study of the family, label them, though the label may be obsessive compulsive disorder or hysterical disorder. Once we see what the situation is, we can then work for lessening the tensions within the family so that this element of psychopathology doesn't at some later date break out into a full-blown neurosis or psychosis with serious disturbance of function.

DR. GRANT: I was having lunch today with Sam Proger of the Bingham Association of Boston, and I happened to say where I had been. He said, "Just what is this Health Maintenance program? You have HIP, and they are giving comprehensive medical care. Just what are they doing in this health maintenance thing that HIP can't do?"

I said, "To generalize, as far as I can make out, HIP is largely limited to clinical diagnosis, therapy and prevention, and Family Health Maintenance is an extension into the field of social and psychological pathology, therapy, and prevention."

I would like Dr. Cherkasky to tell me whether I am wrong in that over-all generalization, because when I come to your tables, when I come to your rubrics, your instruction for completing individual evaluation summaries, I find that you can take each and assign it to one of these two fields. Certainly the personal adjustment rubric is not clinical pathology as we commonly use the phrase.

Then when I come to your provisional data, the several categories list conditions within clinical pathology. I find no corresponding list of what you found in social and psychological pathology. Would it not be possible, over the course of the years, to evolve techniques and tools so that we can have some bench points in social and psychological pathology, because it seems to me that this family health maintenance may prove or could prove to be a starting point to improve a defect in medical education today, namely: We have through the natural sciences evolved a course in physical diagnosis in which the student is given the tools and methods for diagnosis and therapy of clinical pathology. Some of the schools now are sending the student out into the community. But as yet there is no comparable diagnostic course in social pathology.

This will take years and years to develop, but don't you have the opportunity of beginning to collect the data that later may be systematized so that clinical diagnosis can be extended to include social diagnosis in a comparable manner?

MRS. GINSBURG: Our visitor from England touched on a question that I had wanted to raise: on what are the psychiatric diagnostic generalizations based? Are they based on psychiatric interviews plus or minus evidence in the recorded picture of the adoptive patterns of the family? In the case record which I saw today there was a description of a young couple with two children who, by and large, got along reasonably well and were able to handle and use and move on from advice and help which they were given about health problems.

Then one finds a diagnostic statement about the personality structure and gross pathology of the father and mother that seemed to bear no relationship to the two people who were described in the remainder of the record. While reading the material prepared in advance of this meeting I was similarly impressed by the apparent preponderance of emotional disorders in this random sample of the population and wondered: first, how these diagnoses were arrived at; second, whether this kind of approach is useful in a health maintenance program; and third, what the team plans to do about it.

DR. SCHLOSSMAN: First of all, a large part of it is psychiatric description rather than a final diagnosis in the profile that you read of the family. The social worker in her interviews with the family will, on the basis of just one session with the family, as long as it may take, arrive at certain impressions as to what the character structure of the husband and the wife, the children, and the family may be, and she puts down her impressions. In the course of the conference which takes in the entire team, these are expanded. They are discussed with other members of the team. But they are principally on the chart as impressions of a character structure rather than a diagnosis of psychiatric disorder that has to be treated immediately.

PROBLEMS IN EVALUATION OF THE FAMILY HEALTH MAINTENANCE DEMONSTRATION

ARE THE RECORDS SUITABLE FOR PURPOSES OF EVALUATION?

RICHARD V. KASIUS

DISCUSSION of the topic, "Are the Records Suitable for Purposes of Evaluation?" requires that before the records of the Demonstration are described, some attention be given to its aims and to the plans for its evaluation. The basic purpose of the Demonstration is stated in Dr. Cherkasky's paper presented at the round table two years ago in which he said that "The Family Health Maintenance Demonstration . . . [is] designed to determine what services can reasonably be added to a comprehensive medical care program which would result in favorably influencing the health of the families concerned." (1) The papers of the team members on the operation of the program have described the services which have been added to the basic HIP medical program, those of a public health nurse, a social worker, and the consultants, and the primary question with which the evaluation of the Demonstration should deal is whether this system of medical care has favorably influenced the health of the members of the participant families.

Two problems will arise when we attempt to answer this question. These are, first, how to determine whether the health of the families has been favorably influenced or, in somewhat different terms, how can changes in health be measured; and secondly, if improvement in health of the participants does occur, on what basis can it be attributed to the Demonstration?

The first step in treating the problem of estimating changes in health is to establish a base line from which such changes may be measured and a review of the intake process will indicate the information available for accomplishing this. When a family joins the program an inventory is made of the positive and negative aspects of the health of each of its members. This is done by means of a

complete physical examination, an interview with each adult by the social worker, and the administration of the Thematic Apperception Test by the psychologist. Prior to the physical examination each adult fills out the Cornell Medical Index Health Questionnaire. On a visit to the home, the nurse obtains a description of the environment and pattern of living of the family, and additional information on conditions of housing is obtained from a questionnaire filled out by the husband or wife. An estimate of the food habits of the family is gained from a detailed list of all food eaten by each person on one day and a record of consumption of certain foods during one week. Following the various examinations and tests, the staff conference and family conference are held at which the findings and recommendations are discussed with the family. All stages of the intake process, from the invitation to join the program to the family conference, are thoroughly documented, and these records constitute the beginning of the history of each family's experience in the Demonstration.

As the program continues this history will be augmented in two ways. Some of the initial procedures, such as the physical examination, the recording of food consumption, and, when needed, the housing questionnaire are repeated annually; and, second, the record of all services provided by the team, such as medical treatment, therapeutic sessions with the social worker, or home visits by the nurse are written up in as much detail as necessary.

The last of the major records, one which is based on some of those already described and which is expected to be one of the chief tools for evaluation, is the Individual Evaluation Summary. This represents an effort to grade each participant in the program on a four-point scale, in each of the ten different areas, as follows:

1. Family medical history
2. Physical condition
3. Nutrition
4. Sleep and rest
5. Personal adjustment
6. Family relationships
   (a) with spouse

(b) with children
(c) with siblings
7. Occupational adjustment
8. Education
9. Recreation
10. Housing

The rating for each item may run from 1, the most favorable, to 4, the least satisfactory, and as an aid in rating, criteria have been established for each score within each area. Each team member rates each person in those areas for which he has sufficient knowledge of that person to permit a valid judgment. The Summary is filled out after the initial examination and, thereafter, at intervals.

Associated with certain items on the Summary, primarily those pertaining to emotional adjustment, is a set of questions to assist the team member in isolating some of the factors which should be considered in making the rating. While some of these sets include as many as a dozen questions, the short list of those dealing with the child's relations to his siblings might be cited as an example of the type of question. They are:

1. Excessive sibling rivalry: Yes No
2. Valuation of sibling: Overvalued Appropriate Undervalued
3. Submissiveness or compliant behavior with respect to sibling: Marked Moderate Little or not at all.

This describes in rather general terms the information being collected for evaluation of changes in health during the Demonstration. The next subject which should be considered are the plans for the utilization of this material and the suitability of the records with respect to those plans.

Change in the strictly medical aspects of health will be studied primarily through analysis of morbidity rates for whatever groupings of diseases and population seem appropriate. The data from which these rates will be derived is contained in the individual medical histories, which contain, for each visit to the team physician, a description of the complaint, the diagnosis, and recommendations, if any are made. In addition, a similar entry is made for

all visits to specialists on the HIP staff and for all radiological and laboratory services.

From the information available in the medical histories we should be able to gain an accurate picture of the incidence and prevalence of various types of illness during the course of the Demonstration. The major source of error to be expected is underreporting which could result from any of three causes: incompleteness of our own medical records, consultation of a doctor not in the HIP group, or self-treatment of illness. The physicians responsible for the majority of entries in the program records are aware of the importance of accuracy and completeness, so it is likely that underreporting from this source will be at a minimum. At this time no estimate can be made of the extent to which physicians not in the HIP group are utilized, but it is known that some families continue to see their previous physician for a time after they join the program. However, it is not felt that this is extensive enough to lead to any serious error. Self-treatment will undoubtedly occur but only for minor illnesses, and, in view of the availability of medical service to members of the Demonstration, the degree of underreporting for this reason is not expected to be large. Thus, we feel confident that the medical records will provide information of high quality for the evaluation analysis.

A second method of examining changes in health among the participants in the Demonstration would be to approach the question on an individual basis and to attempt to classify each person as to whether his health has improved, remained the same, or deteriorated during the program. The primary source of information for this type of analysis would be the records of the annual physical examinations and the ratings of physical condition on the Individual Evaluation Summary. These records should be satisfactory for this purpose, and the only difficulty that might be anticipated is the possible failure of some participants to have a physical check-up every year.

It is in the area of emotional or psychological health that we expect to find the most difficult problems of evaluation. For a population of the type represented by the Demonstration families,

that is, normal persons not actively seeking psychotherapy, the tools which have been developed to measure change or movement in adjustment do not seem to be applicable. Three approaches to this problem of detecting change in emotional health are under consideration. One method of evaluation which has been suggested is that of having the records reviewed at the end of the Demonstration by a team, previously unconnected with the project and representing appropriate disciplines, who would evaluate the extent of any movement which may have occurred. A second attempt is that being made by the psychologists on the staff to establish an objective scoring system for the TAT tests given at the beginning and end of the Demonstration. If this is successful, analysis of the changes in scores should prove very valuable. The third approach is by study of changes in the ratings of Personal Adjustment, Family Adjustment, and Occupational Adjustment on the Individual Evaluation Summary.

The material required for the first method of evaluation suggested, the review of the social worker's records, cannot be adequately criticized from a statistical point of view. Since the initial interviews are conducted according to a fixed outline and written up in detail, as are reports of all therapeutic services, by team members aware of the research needs of the program, there is good reason to believe that the records will be suitable for this evaluation procedure.

The second scheme of evaluation, the comparison of scores of the projective personality tests, hinges not on the suitability of the records, which may be assumed, but on the success of the development of a scoring system.

It is not possible at this point in the Demonstration to gauge the utility of the Individual Evaluation Summary as a tool for revealing change in emotional health. There are several factors affecting the scoring procedure for the items in this area, however, which might be mentioned. The reliability of a rating will be dependent upon how well the team member is acquainted with the individual being rated, and since some persons are seen by the staff much less frequently than others, it is not likely that all scores should be ac-

cepted as equally reliable. Another source of error to be considered is the possibility that standards for the four points on the scoring scale may be unconsciously changed during the four or five year course of the program. Although criteria are given for each score for each item, the rater's judgment as to whether those criteria are met in any given case might be somewhat different at the end of the Demonstration than at the beginning. The existence of bias in the ratings cannot be discounted since, if a patient has been under treatment or, on the other hand, has refused therapy, that may influence the score however much the rater may strive for objectivity.

Although the need for the Individual Evaluation Summary was recognized at the beginning of the program and a tentative form established, it took longer than anticipated to evolve an acceptable version. During this process of revision, Summaries for many families were not filled out at the conclusion of the intake process and a large backlog of uncompleted Summaries accumulated that was only recently eliminated. As a result of this delay, the initial ratings for some individuals were not made until they had been on the program for over a year, and, although by reference to the records the team members attempted to rate each person as to his status on entrance, they do not feel that they were entirely successful. Thus the Summaries on a portion of the population cannot be considered as evaluating their condition on entrance as well as is being done for the families coming into the study more recently.

Despite these limitations it is believed that the Summary is an approach to the problem of securing an estimate of changes in emotional health which is worth trying, and unless the criticisms stated turn out to be more serious than anticipated, these ratings should afford a measure, however crude, of such change among the Demonstration families.

These, then, are the records which we consider of primary importance in evaluating changes in the health of members of the study. However, there are several other sources of information which are expected to be of use in more intensive analysis of certain portions of the program. One such source is the nutrition schedule which is filled out by the housewife following instructions by the nurse.

Those on file up to the present seem to be complete and, it is hoped, accurate. The housing schedule is filled out by either the husband or wife, and its accuracy is subject to the care and interest with which it is done. Not all of them are answered completely, the question on rent being an especially frequent omission. The information from this schedule may be supplemented by that from the nurse's notes on her visits to the home.

The items on the Individual Evaluation Summary, not previously discussed, Family Medical History, Nutrition, Sleep and Rest, Education, Recreation, and Housing, might also be considered as records supplementary to those of primary interest. The ratings in these areas might occasionally suffer from lack of adequate knowledge on the part of the scorer but are less likely to be subject to the type of bias which may exist for other items on the Summary. The sets of questions for certain areas covered by the Summary are, at present, looked upon as supplementary, although they may prove later to be of primary interest and importance. In general, this material is subject to the same criticisms stated for the Summary ratings.

During the process of evaluation, once it has been established that changes in health have occurred, the second problem mentioned in the opening remarks must be faced, that of determining whether such changes should be attributed to participation in the Family Health Maintenance Demonstration. The first step in dealing with this question was to select a group of control families, who were the alternate names on the list of eligibles for the Demonstration furnished by the HIP office. The preferred method of assessing the significance of changes in health among members of the study families during the Demonstration would be to study the corresponding changes in the control families during the same period and, assuming the two groups are much the same aside from participation in the program, to explain differences which may be noted between the two groups in terms of such participation. However, such a course is not open to us because information on the controls at the time they were selected, of the variety that was collected from the study families is not available. The decision not to

attempt collection of such information for the control group was based on two considerations: one, that any therapeutic needs which might be found could not very well be ignored, and if treatment were given to persons with such needs their comparability as controls would be compromised; the second reason was the belief that subjecting the controls to the battery of examinations given the study families might, in itself, lead to some modification of their previous modes of adjustment.

Because of the decision to dispense with the intake data on the control families, the study model suggested has been modified. It is planned to give the same tests and examinations to the controls at the end of the program which the study families will receive and to compare the results for the two groups. Then, on the assumption that the study and control families were the same at the start of the program, differences which are observed may be attributed to the effects of the Family Health Maintenance Demonstration. Admittedly, this last assumption may be open to question, but under the conditions under which the program has to be conducted no more rigorous approach seems possible. An operational problem which will have to be solved under this plan is that of motivating the controls to accept the tests and examinations at the conclusion of the program.

One source of information for the control families during the period of the Demonstration which is available are their medical records from the HIP center. These records are subject to the same limitations with respect to underreporting of illnesses as are those of the study families, but such underreporting might be expected to be more extensive in the control group than among the Demonstration families, since, as the study continues, it is believed that there will be less utilization of medical resources outside the HIP system among the latter group than among the control population.

The morbidity experience of the control families will be analyzed in the same manner as that proposed for the participant group, and a comparison made between them. Since both study and control families have good medical care available to them we would not expect morbidity in the Demonstration families to be consist-

ently lower than that among the controls. However, the cumulative effect of the intensive educational and preventive services furnished the Demonstration families might be reflected in the morbidity rates toward the end of the program, and in view of the emphasis the Demonstration is placing on the emotional factors influencing health, differences may be found between the study and control groups in the incidence of those illnesses which are believed to have an emotional component in their etiology.

From this description of the information being gathered during the Demonstration and of the plans for its utilization, it would appear that the evaluation process will not yield final answers to all the questions which will be raised concerning the value of such a system of medical care. In general, it seems reasonable to expect that valid conclusions may be drawn concerning changes in health among the participants during the program. On the other hand, it may prove difficult to convince the skeptic from the data available that such changes, especially if favorable, may be attributed to the Demonstration. The source of this difficulty is found in the design of the study, dictated by external necessities, and not in the records of the Demonstration which appeared to be entirely suitable for the evaluation procedures for which they were designed.

Reference

1. Cherkasky, Martin, M.D.: Research in Public Health. The Milbank Memorial Fund, 1952, p. 183.

Discussion

Dr. Fertig: The Operating Board recognized that there were two main statistical issues. One was the matter of selecting controls and the other was the matter of how to measure the changes in health.

The first group of families that was used was a strictly pilot group which was the basis for constructing some of the team techniques that were used in the main study and for determining what types of families would be most suitable to study. The families of the main study are of two types: new enrollees to the HIP plan and old enrollees who had some previous HIP history.

One plan considered was to take suitable families who were willing

to undertake such a study, and to divide them into two groups at random, one to serve as study, the other as control. Another plan considered was to take suitable families who took the initial evaluation examination and divide these into two groups. Both of these plans were ruled out for some of the reasons Mr. Kasius mentioned.

The decision finally made was to divide the suitable families alternately (by a coin toss) into two groups, one to serve as the study, the other as the control group, not doing anything to the control group. This should start the two groups at the same base-line within chance limits which should not be too wide for 150 families. Of course chance does some funny things sometimes.

The thing becomes complicated by the fact that some of the suitable families who were selected for study did not want to undertake the study. There are ten or so of these out of one hundred-odd. Of course, we cannot identify the families who would be refusals in the control group. The selection of study and control by alternation does not insure that the alternate would also refuse. Consequently, the refusals have to be carried along as a part of the study group, thus giving a diluting effect. They cannot be discarded because it is not known which ones to discard from the control group.

The matter of refusals would have been largely obviated if the study and control groups had been confined to families who were willing to have the study or to families who had initial evaluations. Even in that case some of the disappointed families who were willing to have gone on the study but were used as controls might have been refusals at the end. Presumably the refusals will also be refusals at the end of the study. On these refusals we have only standard HIP data. We get no particular data as concerns their emotional health, etc.

In addition to the matter of refusals, we have the problem of moving out of the Montefiore medical group. This problem will be present no matter how the initial selection of study and controls is made. Something must be done somehow to get a final evaluation on them. This matter of moving out of the area, if it is at all serious, may destroy whatever initial comparability we assume we had present in the beginning. Of course, as Mr. Kasius mentioned, even the controls who are present in the area at the end may present difficulties for the final evaluation.

If it were not for the matter of the refusals diluting the data, and for the matter of the moving out of the group, the difference in move-

ment between the study group and the control group should be measably by the difference in final status of the two groups.

So much for the matter of controls, which in a sense, although a bad enough problem, is the smaller problem. The big problem is how to measure changes in the study group. The initial evaluation summary is a stab at it. It is an attempt to extract some of the relevant data in the records in terms of a few simple scales. Of course, there are many data that are still in the record. Some of the supplementary questions on which the initial evaluation summary was based may prove to be more useful than the initial evaluation summary itself.

The use of a scale having only four divisions, is pretty crude, but that seemed to be the best that the team could produce. Even so, they are not at all sure that the scoring is standardized and reproducible, even by the same person working on the same family, except in so far as the person might remember that family. Two people having somewhat the same degree of contact with a family, evaluating it independently, may not come up with the same score.

In a sense we are at the mercy of the records, which means we are to some extent at the mercy of the team. It is not certain that another team would give the same sort of records on these families. The suggestion has been made that we might have some recorded interviews and that this might help along the objectivity.

At the end it is hoped to be able to apply objectively the same sort of final examination to the study group as to the control group. Whether the examination can be applied with the same degree of objectivity to the two groups is a matter of question, particularly if the examination is to be performed by the present team. There might be some reason for having an independent team perform the final examination.

ANALYSIS OF RECORDS WITH A VIEW TO THEIR EVALUATION

WILLIAM G. COCHRAN

AS Dr. Baehr said, we are all agreed that the problem of trying to find out what effects this Demonstration has produced at the end of the period is going to be difficult. But there are large areas of biological research, where the experimental subjects may be plants or animals or even, in some cases, human beings, and where the scientist does have enough flexibility and control to run the experiment as he pleases. As a temporary escape from the harsh realities of the problems that face us, I would like to consider what precautions the scientist finds it advisable to take, when he does have this degree of control, in order to make the experiment, in his view, a sound one. I shall suppose that the experiment in question has a control group to whom essentially nothing is to be done, and a study group to whom some kind of procedure or treatment is to be applied.

He will first take some steps that are designed to insure the comparability of the two groups. These steps may include pairing or matching of the groups, member by member, if that is thought worth while. They will include some kind of random assignment of the subjects to the groups. After the groups have been made up, some initial measurements or records may be taken in order to verify that the groups really are comparable on characteristics that he thinks are relevant to their probable responsiveness to the treatment.

Secondly, he will take considerable pains to describe what the treatment is. This is necessary for several obvious reasons. It is necessary for communication, in order that other scientists and readers of his work will know what he has done. It is necessary for interpretation, when he and others begin to speculate about the causes behind any of the effects shown by the treatment. It is necessary also for practical application, if the treatment seems to produce

effects that are beneficial. People who propose to adopt the treatment in practice must know exactly what the treatment was.

There is a third step, which usually comes early in the planning of the experiment. The scientist will think carefully about the range of effects that the treatment might produce. In an exploratory study he may not be able to do this with much detail: all that he may have is a broad list of possible effects. In other studies he may have narrowed down his field of interest to very few items. Whatever the situation is, he will regard this step as an important one, and there are various devices in the different fields for making sure that this step is not overlooked. Some people like to have what they call a list of hypotheses to be tested: others prefer a list of questions to be answered. With either approach, much care is exercised in constructing and revising this list.

The importance of this step is that it determines what we will attempt to measure and what shall be recorded. The system of records, then, is designed to secure data that will answer the series of questions. When the system of records is being constructed, there should be checking to ensure that the purpose of each record is known, and also that we have not omitted records that will be needed to answer some of the questions.

The process of measurement may require the use of a human observer to a greater or less degree. If the observer is used only incidentally so that it would make no difference to the reading obtained if one observer was suddenly substituted for another, we usually call the measurements *objective*. If the human observer plays a significant role, so that it is doubtful whether another human observer would get the same reading for the same situation, we call them *subjective*. In practice, there is of course a wide range of degrees of subjectivity in measurement.

With any measuring process, the scientist will take precautions to insure that it is unbiased as between the groups—that there isn't some sudden jump in the scale of measurements when he changes from the control to the treated group. He will want to know something about the precision of the measuring device. He will want to know something else that is harder to describe: it might be called

the *relevance* of the measurement for his purpose. In other words, he should ask, Does this process really measure what I need to measure? This question of relevance should not be overlooked, because in view of the obvious advantages of objective measurements, it is easy to make the mistake of choosing an objective measurement that isn't relevant in preference to a subjective one that is.

If a human observer is used to a significant degree, the scientist will be innately suspicious and will insist that any observer shall do measurements in each group, that he shall have the same relationship and rapport with the members of each group and that he must not know, when he is measuring a subject, to which group the subject belongs. In some studies the scientist will regard this third precaution as very important, even if the observer is an outside consultant who has no personal interest in obtaining one kind of result rather than another.

After the records are taken, there comes the statistical analysis, which has two general objectives. First, we are aware that the measurements will be affected not only by the treatment, but also by a whole gamut of other influences that are sometimes called the experimental errors. One part of the statistical analysis therefore consists of preliminary computations known as tests of significance, whose purpose is to verify that these experimental errors did not mask the real effects of the treatments. When we get a non-significant result we have reached the disappointing conclusion that whatever real effect of the treatment may have been present, it wasn't large enough to show up convincingly relative to the experimental errors.

The second part of the statistical analysis, which often can be difficult, is an estimation of the sizes of the effects produced by the treatment and an appraisal of the importance of these effects either for practical application or as a contribution to scientific knowledge. This step might seem so obvious as not to need mentioning, but in reading the results of social science studies I have the impression that when the social scientist finds a result that is statistically significant, he sometimes heaves a sigh of relief and says, "Well, that will keep the statisticians quiet," and in his joy he forgets to tell us

whether the effect is a large and interesting one or a small and inconsequential one.

Then finally, the last part of the analysis is the real fun—interpretation and discussion.

Had there been time, I would have liked to discuss why all of these precautions are considered worth while, although for most of them this is fairly obvious. Perhaps it is more important to point out that the precautions are not equally necessary, and the extent to which the various precautions are necessary changes from one kind of study to another, and often can be appraised only by judgment.

But in general, the scientist is trying to avoid two types of failure. He may fail to find effects that really are there. He can fail in this way if the measurements are imprecise, if the sizes of the groups are too small, or if he has taken measurements that are not relevant. The second thing to be avoided is bias; that is, something which distorts all the measurements in one group relative to the other. When there is a bias, statistically significant results may be obtained even when the treatment has been ineffective: or the results may be distorted in size and perhaps even in direction.

Bias is particularly to be avoided, because a biased study from a worker with a good reputation may start a period of dispute and discussion that holds up progress for several years.

I would now like to return to reality and consider some of these precautions in the light of this study. If I am not mistaken, there is trouble in varying degrees all along the line, and when I end this recital, I may well be in tears. So I would like to finish by spending a few minutes trying to cheer myself up.

The study does have controls, which were selected by randomization. I was a little shocked to hear an eminent biostatistician like Dr. Fertig express doubts about the effectiveness of this randomization. He may expect to hear more about this deviation from the statistician's party line. With groups as large as 150, I would not be worried about their comparability.

We will, however, be concerned about losses, trying to keep them down, and trying to find out whether they are selective; and if

they are at all large, trying to check by such measurements as we can take whether the two groups that are compared in the end are really comparable.

There was also a suggestion that earlier measurements might be made of the controls. A number of proposals were put forward for that purpose yesterday, and these deserve consideration by the team. In this connection the question whether the degree of rapport between the measurer and the subject in the control group can be the same as that in the study group may be important. This question arises whether early measurement of controls is attempted or not. This issue is one argument for having some of the evaluation of effects on both groups done by an outside team, as suggested by Dr. Gruenberg. Such a team cannot measure the study group with the same depth and penetration as the staff of the FHD, but perhaps they can measure some significant variables with the same degree of rapport in both groups.

As to the nature of the treatment, we will have a fairly clear picture in the record of all conferences, including what advice was given, and what the outcome of the advice was. But in the discussions here it has been apparent that the visitors are puzzled as to what the team is trying to do. I am not thinking primarily of such questions as: Is their aim to give therapy for pathology or to stimulate the ability to cope? I don't think that the team need adopt any rigid classification. But everybody will be helped in their understanding of this study if the team can at some time produce a statement as to what their education and their efforts are trying to accomplish. As the team members know, this statement is not easy to construct, but it may be of great importance for the selection of the measurements that are to be taken to assay the effects of the demonstration.

In view of the great difficulty of the problems of measurement in this study, it may be well to remember that records can be of various kinds. The basic record can be a recording of an interview, directive or non-directive, or the answers to a questionnaire. From that, at one stage of summarization there can be an unordered classification which shows simply what changes occurred, taking

any classification into which people seem to fall. Then there can be as the next step an ordered classification—much, little, none—and finally, as the last step, there is the metric scale 1, 2, 3, 4, implying an underlying continuum.

I would like to make two general suggestions. First, the less one commits oneself unalterably to the later stages of this classification, the better. This implies that the original records will be kept in an available form so that persons interested can put them together in various ways from different points of view, and that much of the analysis will be done in considerable detail and with fairly primitive classifications. This is not to discourage attempts to construct and utilize metric scales. But the phenomenon under study is very complex, and there is some risk that overall summary scales will contain hidden arbitrary judgments and will have placed together things that are essentially unlike. For example, as Dr. Fertig pointed out, the parts that go into the Individual Evaluation Summary may in the end be more useful than the Summary itself because the implications of the Summary are quite complicated to grasp.

A second maxim is to keep value judgments separate, identified and labeled as far as possible. Naturally, some value judgments are already implied in what the members of the team have decided to try to teach, and this we all appreciate. However, records should be presented so that somebody who doesn't agree with the value judgment of the team can do a different kind of analysis. For instance, the recording of excessive or nonexcessive sibling rivalry is perhaps undesirable in its assumption that we know how much sibling rivalry is good. Recording merely of a scale of sibling rivalry would be safer.

There has been much discussion as to whether some of the changes in emotional health can be measured at all; or at least, whether they can be measured without spending much more time in the process of measurement than is contemplated. I am not competent to discuss that issue and I imagine that the sociologists and psychologists would not agree among themselves about it. If this is the state of affairs, we should not judge harshly those who make a bold attempt and do the best that they can.

It will be extremely difficult to keep the evaluation free from bias. The records taken by the team inevitably will reflect the team's own estimates of what changes are taking place, and an outside group which examines these records for the purpose of evaluation will still be dependent on what the team has put down. Two aspects of the Demonstration have been referred to which may help in this difficulty. The first is the study that Dr. Creedon is proposing on what the people themselves feel about this program, what their expectations were when they came in and how these expectations were changed, which should give a rather independent appraisal of effects produced by the Demonstration. The second device is the use to some extent of an outside team which will construct and take its own records on both groups.

So far as the statistical analysis is concerned, I think that if the other loopholes can be plugged, the statistical analysis will be the least of our worries.

As we have seen, this is a complex area of research and nobody here, I think, would be inclined to promise success in making precise and unbiased measurements of the effects. What can we say to cheer ourselves up?

First, as has been abundantly evident from the discussion, there are a great many facets of interest in this Demonstration, so that despite the difficulties of evaluation, the eggs are by no means all in one basket. Secondly, although this study is unique in a number of ways, it is far from unique in its methodological problems, and particularly in the problem of evaluation. It is, in fact, almost typical of the problem of evaluation that exists in a great deal of current research in public health and sociology. Problems of this kind will probably become more rather than less common. Scientists working in similar field research will be grateful to this project for the constructive ideas that it seems sure to contribute to problems of evaluation, and also perhaps for advice on some pitfalls to avoid.

Then thirdly, a study may be of great value even though the expert looking after the event can point to many things that are unsatisfactory. A reference to Kinsey's studies may be appropriate. Kinsey, as a good quantitative biologist, began to study human sexual be-

havior. What did he decide to measure? He choose principally two quantities—the earliest age at which a given kind of sexual behavior was first engaged in and the number of orgasms per week in the various kinds of sexual behavior that he distinguished. These records obviously leave much to be desired as the raw material for a penetrating insight into sexual behavior. Further, the count data which he obtained are certainly subject to bias, and it is hard to say how large the biases are. The limitations of these data are evident in the volume on the male, in which many of the most interesting statements are not based on the tabular data, and it is not clear to the reader on what evidence the statements are based.

Nevertheless, in my own opinion, Kinsey's is the best study of sexual behavior in a mass population that has been carried out and is methodologically greatly superior to previous studies. Moreover, his work is a valuable supplement to the more penetrating and thoughtful studies that have been done by some others, but which have had to depend on a few individual cases, whose representativeness is unknown to us.

Finally, I would like to mention one piece of advice which is usually given to Scottish boys shortly after they are weaned, at the critical time when father first puts a golf club in the boy's hands: "Keep your eye on the ball and don't press." In a study of this kind, all sorts of suggestions are made for interesting sidelines that might be explored, but if the team is to get anywhere it must construct a system of priorities as to the tasks that it regards as most essential for its own goals in the study, and it must fight to maintain these priorities against blandishments and outside suggestions, unless and until it has the resources to cope with its main objectives with something to spare for additional studies.

And by "don't press," I mean this: This kind of study is very expensive: it takes a long time and attracts many visitors. The members of the team may come to feel that they are under pressure to produce results and they may begin to worry when some things inevitably go wrong. It is most important to do anything that can be done to lighten this pressure and encourage team members to be more relaxed. I am sure that the visitors have all been greatly im-

pressed by the intelligence, courage, and persistence shown by the team, and I hope that the team members do feel relaxed. They can at least heave a sigh of relief when we leave.

Discussion

Dr. Clausen: With some temerity, I would like to question one thing that Professor Cochran said with reference to not freezing too soon the categories in which evaluation data are to be classified. It seems to me that there is one aspect of this problem which might make it desirable to try in the early stages of the project to secure more adequate categories. Let's put it this way: I think it is quite true that in any group of sociologists and psychologists, there are likely to be differences of opinion as to what measures might be used. On the other hand, there are some skills, some measures, that have been developed and have been used in a number of other studies. They might or might not be appropriate for use here.

There are additional types of categorization that might be developed at a later stage. I am sure that the records will have some information that will bear upon these categories. But when it comes to asking, "Can I evaluate this particular sub-question from the data on hand in each record?" so often we find that the data have not been recorded in such a way as to permit adequate analysis. Ninety per cent of the records may contain some information on a point but 40 per cent may have reported this particular item along one set of dimensions, 30 per cent along another set of dimensions, and so on. Thus you never get so you can classify 100 per cent of your cases or anything near that on a single set of dimensions.

It seems to be assumed that many of the measures proposed are uni-dimensional. For example, one of the sub-categories for assessing the child's adjustment is "Nail-biting: little, much, more." In the case of the adult scale there is an item called "social isolation," and again the same set of categories. I suspect that social isolation may be quite a number of different things; and I think it is important, if one is going to use a concept like social isolation, to ask what sorts of data are we getting down that can be evaluated subsequently. If we are going to rely on records to arrive at categories, what kinds of things do we put in the records?

This is why I would particularly suggest taking a look at some criti-

cal periods and asking the question, as of these critical periods: How uniformly are we getting our data along particular sets of dimensions? I would certainly agree that the categories should not be frozen in the beginning, but as one goes along, make sure that the data being obtained do really lend themselves to classification.

DR. MACMILLAN: I would merely like to add a word in corroboration of the same point of view. In our Stirling County study we early came up against the same problem of whether we were, in fact, measuring uni-dimensional factors or if they were multi-dimensional. I set out in 1951 under the assumption that I could measure an aspect of health as a uni-dimensional factor, but after coming back from the field with my data and beginning the analysis process, I found that no significant groupings of the data adequately fitted the uni-dimensional scale-model. Now we are on a form of factorial analysis, essentially the same kind of process that Dr. Clausen discussed. In another aspect of our work—the social science data—we started off making up our questionnaire with certain hypotheses in mind, and so in the analysis we attempted to combine certain queries into a Guttman-type scale to test our hypothesis, but found that sometimes the material would "scale" and sometimes it would not. From here, we were forced into the construction of indices for certain aspects of some of our social variables. This is the sort of work we are doing now, and, while the analysis is going along quite satisfactorily, we are learning important things that we wished we had been able to foresee in the beginning. This experience, though, has been of immense value in enabling us to plan ahead and set the stage much better.

SUMMATION OF THE ROUND TABLE DISCUSSION

MARTIN CHERKASKY, M.D.

IT IS not necessary for me to point out to those of you who have been here through the past two and a half days, the difficulty of summating a conference of this sort. Many of the problems of the "interview" which we have talked about present themselves as problems of summation. An interview does not represent an objective story of the person interviewed, but rather represents an algebraic addition of the attitudes of the interviewer, as well as the attitudes and problems of the one who is interviewed. In the same way, my summation of this conference represents the impact upon me and my reaction, to tens of thousands of words and hundreds of different ideas. I will attempt only to present what struck me as highlights and will take only a few minutes to do this. I know that "a few minutes" will strike a welcome chord in all of you since everybody is quite tired at this point.

The Project. First of all, I would like to re-state in simple terms what it is we set out to do. This project was designed to add the services of a public health nurse and a social worker to an existing comprehensive prepaid medical care program. The primary objective was to determine whether these skills joined in a team relation with a doctor and focused on the family could help that family *help itself* to a fuller and more comfortable life. Our concept of health is not merely the absence of disease, but a state of physical, emotional, and social well-being which would enable each individual and family to realize the fullest potentialities of mind and body in living a complete and fruitful life as a member of society. To achieve this objective it was planned to bring social work and public health nursing knowledge to the families as an educational experience using individual, family and group conference.

An Educational Approach. Considerable concern has been expressed by the Conference participants that we may have strayed

from our original concept; that the way to help families to health is by means of an educational process. There has been so much discussion of psychopathology and psychotherapy that the question has been raised, are we concerning ourselves much too much with structure, when we should rightly concern ourselves with function? This has been particularly so in consideration of the presentation which was made by the social worker where so much stress was placed upon the great amount of pathology present in our families. It seems to me that all this criticism and discussion is very helpful and that we will have to re-examine our activities, particularly with regard to the social work aspect of our program, to insure that insofar as it is possible we will adhere to the educational approach. On the other hand, we must accept the fact that you can't help improve the health of families when there is illness present, whether it be social, emotional, or physical, unless that illness is recognized and dealt with. It is very likely that what is required is therapy for psychiatric and social problems where necessary, but with the major continuing emphasis on education. This combination of therapy and the prevention of these problems through education, will take much thought and most assuredly, a further critical evaluation of our social work program.

Reasonably Reproducible. An additional goal of the project was to carry it on in such a manner that if it were proven to be useful in maintaining or elevating the health of families, it could be reasonably reproduced elsewhere. This, of course, is important if the full fruits of our labors are to be meaningful in other places and in other communities. It is for this reason that we have made the basic team: the doctor, the nurse, and the social worker, three professional people who can be found in most modern urban communities. It is in the interests of maintaining the program at a reasonable reproducible level, that we have used our special consultants in psychiatry, health education, and other areas as consultants working with the team rather than as consultants working with the family. For the consultant working with a team member can have the effectiveness of his specialized skill multiplied many times over what it would be if the consultant had to work with each family.

It is very likely that if this proves practical, it would be possible, for example, for one psychiatrist to act as a consultant for several teams of doctors, nurses, and social workers, who in turn can be serving hundreds and hundreds of families.

Measurement and Control. Another goal of our program was to record the material and to devise methods of measurement and control which would enable us and others to objectively evaluate the effectiveness of this program. It must be recognized that while every effort is being made and will be made to develop and use the best methods of measurement, the broad objective of the program is to help people to help themselves to better health, and that measurements, no matter how useful, are weapons and not in themselves the major objective. Mr. Cochran has covered this masterfully and there are only a few comments that I would like to make. We have concerned ourselves a great deal with the matter of controls, how we will measure their health status, and how we will measure and compare the health status of our experimental group to the health status of the control group. It seems to me that a more fundamental problem must be solved before we reach the point of comparing the experimental group with the controls, that is, are the measurements we are planning to use of sufficient sensitivity to be able to demonstrate that a family has moved at the conclusion of the five-year experimental period in relation to its own status at the beginning of the experimental period? In other words, before we can measure and evaluate the relationship between the experimental families and the control families, at the end of the five-year period, we would have to be able to demonstrate that the experimental family has moved from A at the inception of the experimental period to B at the conclusion of the experimental period. We are hopeful that the techniques described by Mr. Kasius will help us to demonstrate such movement to the satisfaction of all. To the best of my recollection no one here has questioned the utility of this program or the effectiveness of our team of the doctor, the nurse, and the social worker in significantly improving the health of families. The concern has seemed to be that we want and need good measurement to convince everyone of the validity of an approach

which most of us here are prepared to accept. I am sorry that Mr. Burritt is not here for a variety of reasons and one of them is in connection with this problem of measurement. He has at all times encouraged us to do everything we could about measuring the effectiveness of what we are doing, not only because of its value to this program, but also because so much needs to be done generally in developing objective evaluation in the field of social work and psychiatry. However, he has felt that it would be unfortunate if this ability to measure were the sole determining factor as to the usefulness of this project.

There have been many times when effective treatment of the ills of man have antedated an understanding of either the mechanics of the illness, or the true nature of the treatment, and while this is not meant to detract from this important aspect of our program, it is meant to place measurement in its proper perspective as just one of our objectives.

With regard to the matter of controls, I believe that your suggestions are so important and have such merit that we will change our procedure in this regard. We decided not to evaluate the controls because they were chosen in such a way and in such number that we could reasonably believe them to be identical in their health status with the experimental families, which we did evaluate at the outset. In addition, it was feared that if we were to do an extensive evaluation of the control families, we would alter their state of health and change their usefulness as controls. Lastly, it was anticipated that if we were to do an evaluation of the control families and did not deal with the many problems which we were quite sure to uncover, we would be faced with a delicate moral question. Suggestion has been made here, however, that while it is very likely true that the control families were at the same health level at the beginning as were the experimental families, it would be very comforting to have some data which would bear this out. It was likewise pointed out that if we were to do a relatively simple evaluation of the control families, it could not be expected to so affect the health of these families as to in any way change their usefulness as controls, or raise any moral issue. We will therefore take these stric-

tures and suggestions which were so well expressed by Mr. Cochran and attempt as soon as possible to learn more about the control families than we have heretofore. One additional suggestion which seems to me to have great merit, was that at least part of the final evaluation of the experimental and control families should be carried out by disinterested persons who have had no part in the project, since members of the project cannot help but be biased in these evaluations, which are still, to so great an extent, subjective. Above all, I think we have had from all of you and particularly from Mr. Cochran, encouragement, to this effect—measurement is something you must strive to do—it is however, very difficult—if you learn a little bit more about how we measure social movement, this will be a contribution.

A New Doctor. Consideration of values already demonstrated in the program, brings me to the presentation made by one of the professional workers—the physician. Everyone, I think, is in basic agreement as to the kind of doctor we need if we are to provide a kind of broad, multidisciplined, preventive service in the future. It seemed to me that the presentation by Dr. Aaron and his subsequent comments represented that *he* was that kind of a doctor, a doctor skilled in scientific skills, but also one whose horizon had been broadened to understand quite fully, the social, emotional, and other factors which are so important if we are to deal with health or even with sickness. You must remember that while Dr. Aaron is a bright, capable physician, he is the product of the same traditional training most of us received. It has been within the framework of this team and in the kind of working relationship the team provided, that he has changed. Because I knew him before and know him now, I can see the tremendous growth and development he has undergone. This seems to me to demonstrate the potential of the program as a resource for the education of physicians and other health workers.

The Social Worker. The Social Worker's presentation caused more critical comment and seemed to elicit more concern than any of the other presentations which were made. Many of the Conference participants were concerned that instead of an educational process designed to help families, we were apparently carrying on

extensive and deep psychiatric case work. This constitutes one of the major points raised by the Conference and it is one that we will have to think about carefully, digest and then determine the modifications that can and need to be made. As Dr. Boudreau said yesterday, we will have to put a lot of this material into a centrifuge, spin it around and then see what we come up with.

Social Scientist. This brings me to our Social Scientist who, as Red Barber, one of our sports commentators, says, sits in the cat bird seat. This seat is one which enables the social scientist to sit in an elevated position apart from the team operation where her professional skills can be used to objectively evaluate the interrelationship of the various team members. This is probably her major contribution for we need to have a clear understanding of the dynamics involved if such team processes are to be fully utilized in medical practice. This role of observer is but half of the social scientist's responsibility. She has another role, but this time as a member of the team bringing to it information about the effect of social and cultural patterns on the behavior and attitudes of the family towards their problems, towards the project and towards the team.

The Right Team? Several times and by several people the question was raised: Is this the right team? We chose the team of the doctor, nurse and social worker, for the following reasons: (1) These professional skills seem to fit the areas we considered critical for the maintenance and promotion of family health; (2) in other areas and in other programs we had had an unusually successful experience in the use of such a team in meeting total family problems; (3) as mentioned previously, these professional skills are generally available in urban communities. This does not mean that other team arrangements are not possible or even desirable. Dr. Clark made a particularly pertinent observation that it is probably necessary to develop a health visitor who might within her person encompass the skills of both the social worker and the health education nurse. However, this is a project in itself, and we feel constrained to involve ourselves in as few side projects as possible. The material which we will gather from our study may very well be of use in determining whether such a health visitor need be developed, and also the kinds

of skills, techniques, and knowledges that she would need, to be able to carry on her job.

The question was raised—should the family's medical problems be cared for by both a family internist and a pediatrician? The internist has stated that, for continuity of care and maximum rapport, it would be ideal if one physician provided care for all the family. However, local custom and the attitudes of the families dictated the use of an internist *and* a pediatrician. This pattern is one that might conceivably be altered since there is a great advantage in having one doctor deal with the problems of the entire family.

In the discussion about the team, there were two points which may have seemed to be in conflict where in fact no real conflict exists. Everybody agreed that it would be undesirable to crystallize and compartmentalize, to make rigid the responsibilities of one team member as opposed to the other; and on many occasions, including this morning by Dr. Mayo, the plea was made, that the team ought within its own conferences to work out who does what. On the other hand, Dr. Evans made some important comments about the fact that it was necessary for us to more clearly understand the roles which the individual skills played in this team. There is no conflict of interest between fully understanding the general areas of responsibilities of the various skills and at the same time welding them together without any sharp lines of demarcation.

Additional Research. There have been numerous suggestions of additional research which could be pursued. The reason for this seems quite obvious to me. You are all people who have been concerned with problems in social research and here you see available the kind of human material which would be so useful to carry out such research programs. It has been of interest to me to note the broad range of programs which have been suggested. From the relatively modest suggestion of Dr. Zubin that we "count noses" by which he meant that it would be useful to try to keep a record of all the little spats and emotional crises which arose in our families to the project which Dr. Gruenberg implied would have to be carried out, that is, a study of society itself, before we could con-

sider ourselves to be studying or to be involved in a study of social pathology. While all the projects have great merit and need to be done, I don't feel that we are in a position to do them. We are going to make changes in our approach to this project as a result of the suggestions you have made here. However, we are going to try to confine the changes within the very narrow limits that we have set for this project. Otherwise we will find ourselves spread so thin as to defeat our purpose.

Extension of the Study. The point was made by several of the conference participants that this project needs to be carried on for more than the stated five-year experimental period. I do not believe that we should consider extension at this time and that we will carry on our project as planned so that at the conclusion of the five-year period we will be prepared to evaluate our work. I do feel, however, that the subtleties, complexities, and difficulties of this problem of maintaining and improving the health of families is of such importance that it would very likely be useful and profitable for the project to continue in some form after the initial five year period. A decision in this regard will have to be made sometime in the future.

Other Important Points. If it is possible to put a project of this sort into a nutshell, I think that Dr. Cottrell did it on the first day of the conference. He stated that what we were trying to do was, by an educational process, help families and individuals "maximize their ability to cope." The only part of this "nutshell" which I don't care for is the word "cope" since "cope" has a defensive connotation. I cannot, however, think of a better word to use. It seems to me that while our program is a positive one, this concept of raising to the upper limit a family's ability to deal successfully with the conditions of the society in which they live, is a concise statement of the social objective of the project.

Dr. Grant raised an important question yesterday which I think we will be able in some way to answer, and that is, "Isn't it important for us to develop the same kind of yardsticks for the diagnosis, treatment, and prevention of social pathology that we have developed so successfully in the field of clinical pathology?"

Dr. Evans raised the point that this was an unparalleled opportunity for us to understand more clearly the relationship of man to his environment, the study of human ecology. I think this, too, is something to which some small contribution might come from this study.

Professional Education. I would like to touch again upon the usefulness of this program as an educational opportunity, particularly for physicians. We can all come to a pretty fair agreement as to the kind of doctor we need for the practice of medicine in the future. Most of us would also agree that by and large, at this point, our medical schools are not producing this kind of doctor. I believe, as Dr. Boudreau said yesterday, that even though this research is complex, it can do no harm to medical students to be exposed to it. One can easily visualize the medical student in our program, first being drawn to it, because the physician on the program has, in abundance, the kinds of skills which the student's medical education has taught him to appreciate. One can then see the student being carried from this point, further, to a place where he will appreciate the importance of social, emotional, and economic factors as being related to health and disease. I can see no way for a student to learn about families unless he has contact with them. I took many a history as a third and fourth year man in medical school, and did the same thing while I was a resident at Montefiore Hospital and I never knew a thing about families and people until I got into programs which dealt with families and people in their own homes. It has been frustrating to note that while some of those concerned with medical education are not prepared to expose medical students to this kind of experience, the medical students themselves are prepared, even anxious, to accept this kind of opportunity for broadening their horizon. The difficulty is, as someone said yesterday, that you have to teach the teachers before you can teach the students. While this program is not fully mature, I am certain that it can be used successfully in medical education to stimulate and excite the doctors of tomorrow about the kind of profession they are going into. I might say, parenthetically, with sadness, that the attitude of devotion, dedication, and enthusiasm which once so

characterized the practice of medicine, to a considerable extent has been lost. The reason for the most part is that the doctor no longer has the kind of intimate contact with people which is so important to patients and so rewarding for the physician. In programs of which Family Health Maintenance is one, there exists the opportunity to recapture this important ingredient which all fine physicians must have.

Dr. Boudreau was joking with me this morning. He asked whether we could cope with an invasion of medical students in our program. My answer is that we would be delighted to have the opportunity to try.

In closing I would like to say that one thing mars the conference for all of us, and that is the absence of Mr. Bailey Burritt. Mr. Burritt in a way is the father of this particular project which had its roots back in Peckham. He has been very close to it, but due to illness he could not be with us during these past few days. I know what a painful loss it must be to him, not to see the fruition in this conference of all that he had planned and thought about and hoped for. To see this would have been important to him, but we know he will read all that has been said here.

I would like to express my thanks to the Milbank Foundation and to Dr. Boudreau who set up this conference for the express purpose of having an unbiased, competent group of interested people, critically appraise and evaluate our project at its midpoint. It was his hope and ours that this critical evaluation would be useful to us in going forward from this point. I want you to rest assured that the objective of this conference has been adequately fulfilled. Every word will be read and every point will be sifted and studied.

Our appreciation to Miss Downes who, in her own quiet way, has been largely responsible for the manner in which this conference was set up and the manner in which it has been conducted. Thanks go to her staff as well.

A bouquet to Dr. George Silver and his staff. I am prejudiced in this regard, but I know you will all agree that they have done a fine job not only in the project but in their reports to the conference as well.

We are all indebted to Dr. Baehr who, in his usual elegant style, has conducted a very difficult conference.

Last, I speak not only for myself but for the members of the team, when I express to all of you our great apprecation for what you have brought us. We come away with the feeling that you all fully agree with our objectives and that what you have done is to point out how we might better reach them.

Discussion

Chairman Baehr: The conference has come to an end. The forebears of this conference from whom some elements of this program were borrowed, Dr. Williamson and Dr. Pearse, entitled one of their three monographs "Biologists in Search of Material." This demonstration might be entitled "Biologists Who Have Found the Material but Must Learn What to Do With It."

The Milbank Memorial Fund has made it possible for the participants in the Demonstration to have the benefit of your criticism and wise counsel. We are very much encouraged, particularly by the remark of Professor Cochran, that we should not hesitate in these untrodden fields to stick our neck out. A few weeks ago I entered an austere office, the walls of which were bare except for one framed motto under a cartoon of a turtle. The motto read, "Observe the Turtle—It Never Moves Forward Until It Sticks Its Neck Out."

In closing this conference, I am going to ask Dr. Boudreau to say the last word.

Dr. Boudreau: I would like to emphasize the fact that this Demonstration originated in the Community Service Society, as you pointed out at the beginning, and that Albert Milbank was the chairman of the committee which made the recommendation to the Board of Trustees of the Society. It is participated in at the present time by the Community Service Society, Montefiore Hospital, the College of Physicians and surgeons of Columbia University, and the Health Insurance Plan of Greater New York. Our Chairman is also the chairman of the board which operates this demonstration.

I would not like you to carry away the impression that the Milbank Fund is the sole supporter of this Demonstration. That is far from the case. It is mainly supported, aside from the contributions of Montefiore Hospital, and HIP and others, which are very substantial, by the

Community Service Society itself, which laid aside certain sums which had been used for other purposes in the field of health and are now being devoted to this Family Health Maintenance Demonstration.

I found it a most exciting experience to be present at this conference and to hear the comments of all the speakers. One of the products of the conference will be a volume in which you will find most of the material recorded. You will all receive copies of this volume and in reading over the record you will recall the pleasure which you experienced during these two and a half days. I assure you that as far as I am concerned, it was a very great pleasure, one which I owe to the speakers and participants who gave of their time and energy freely to ensure its success.

Many of the documents which have been published as a result of these round table conferences have gone all around the world, and I am receiving requests from medical schools and universities in India and other parts of the world for complete files of all the round table conference records. They tell me that they are extremely useful in medical education and in the education of other university students. So the stone that you dropped into the little pond has ripples which carry throughout the civilized world.

THIRTIETH ANNUAL CONFERENCE OF THE MILBANK MEMORIAL FUND

Round Table on the Family Health Maintenance Demonstration

November 17–19, 1953

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Secretary: BAILEY B. BURRITT

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