A study conducted in the Out-Patient Clinic of the Yale School of Medicine disclosed the importance of rapport between patient and doctor. The authors describe the methods used and some of the findings.

OUT-PATIENT CARE—THE INFLUENCE OF INTERRELATED NEEDS

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IN PREVIOUS examinations of "needs" in outpatient care, it has generally been the custom to focus on patients' needs, particularly as perceived by the staff. Less often, some attention has also been directed to the staff's own needs. Only rarely has there been any recognition of a third, important set of needs in outpatient clinic care—those of the clinic itself as an institution. Nor has sufficient exploration been made of the interrelationships between these three sets of needs—patient, staff, and organizational—and their influence on the quality of the clinic's operation.

Our general thesis, drawn from social anthropology, was that where these needs and relationships appeared compatible, smooth clinic functioning would be fostered; conversely, where the needs and relationships were incompatible, potential "trouble spots" would be found. The present exploratory study was designed to shed some light on these needs and relationships and to disclose areas of conflict and/or agreement between them. A further stimulation was our knowledge of the apparent leveling off of both mortality and morbidity rates among primiparous mothers, especially in urban areas.

Finally, we hoped that our "fishing expedition" type of approach would indicate ways in which the various needs might be met and the personal relationships strengthened, with consequent improvement in the quality of patient care and staff training.

This brief report will focus on the "problem" areas where conflicts seem to exist.

Method

This study was carried out in the Out-Patient Obstetrical Clinic of the Yale School of Medicine, which is housed in pleasant surroundings with adequate space in the Grace-New Haven Community Hospital. Approximately 1,200 patients per year register in this clinic.

In all, 30 patients were studied, 28 of them being interviewed in the clinic itself. Two patients were interviewed in their homes, but, contrary to hope, this technic did not give any meaningful opportunity to evaluate the possibility of qualitative differences in the patients' responses. Almost one-third of these patients (9) were in the age range 15-19 years; almost one-half (14) were in the age range 20-24 years. Only two patients (less than 7 per cent) were in the age range 35-39 years, the oldest in our sample.

There was an interesting difference in our patient sample in that patients

in the youngest age group (15-19) were heavily skewed toward Social Classes IV and V, a distinction which did not appear in other age groups.

To eliminate many potentially complicating factors, we selected only married patients who were expecting their first babies; we hoped in this way to obtain responses which would less likely be colored by previous clinic experience. In order to avoid confusion, patients who were already in other obstetrical research projects were eliminated from this study. Further, because the first clinic visit is usually a complicated and tiring one, patients were selected only after the first visit; consequently, they were interviewed during any prenatal visit after the first one.

The questionnaire schedule that was used as a guide in the patient interviews included, although not necessarily in the order listed, such items as:

1. Data re: age, occupation, race, educational achievement, and so forth.
2. What did the patient expect from, hope to get from, liked best, and liked least about her clinic experience? Why?
3. How did the patient feel about her over-all clinic experience? Why?
4. In the patient's opinion, what are the roles of the various clinic personnel? What does the patient think these roles should be?
5. How did the patient feel about seeing several different doctors? Why?
6. Did the patient mind waiting? Did the patient think that much of the waiting time was unnecessary? How could this waiting time be shortened or eliminated?
7. Concerning the clinic experience, what things worried or frightened the patient or made her unhappy? What calmed, reassured, or helped her?
8. Did the patient feel free to ask questions? If asked, were they answered? By whom? Adequately?
9. Did the patient do any reading? Why? Who stimulated it?
10. Were Mother's Classes attended? Why? Where?
11. Who did the patient want with her during labor, and why did she want this particular individual?
12. Were there any specific problems in regard to the expected baby?

The questionnaire schedule was pretested on four patients who were not included in the study. The questionnaire was then administered to the 30 patients. These single interviews lasted from approximately 60 minutes to 90 minutes or more. The schedule was completed in each instance, but the interview was by no means rigidly structured, and the patient was encouraged to feel free to deviate from any of the items at will. Following termination of the formal interview, the patient was encouraged by the attitude of the interviewer to amplify further any of her reactions concerning the clinic, its personnel, and its program.

The questionnaire designed for the clinic staff was developed after the patients were interviewed. Thus, we could be certain that any key points brought up by the patients would receive ample coverage in the complementary interview of the clinic personnel. The obstetrical staff who were interviewed included 8 of the 12 obstetrical house doctors, the chairman of the Department of Obstetrics and Gynecology, and the director of the Women's Clinic, as well as a physician concerned with out-patient administration. In addition, eight nurses representing nursing service, teaching, administration, plus the instructor of the Mother's Classes; one dietitian; two members of the hospital's Social Service staff; and two lay clinic administration personnel were also interviewed.

These 24 one-session interviews lasted from over an hour to three hours, the

average being about two hours. The questionnaire that was administered to each staff individual included, again not necessarily in the order listed, such items as:

1. Data re: age, race, position in clinic, etc.
2. In the opinion of the staff members, what are the needs of the patient? What does the patient find most reassuring, calming or helpful? What worries or frightens her or makes her unhappy?
3. Did the patient make any complaint concerning her clinic experience to the staff member, or has the staff member heard the patient make complaints to others?
4. How does the staff member think the patient feels about seeing several doctors? How does the staff member himself feel about this? What arrangements would the staff member prefer?
5. From whom should the patient expect answers to her questions, and why that particular person? Should anyone find out if the patient has unanswered questions? Who? Why that person?
6. What are the major problems of the clinic? How could these problems be alleviated or solved?
7. Are there difficulties in communication between the staff and patients or between staff members themselves? How could communication be improved?
8. What is the role of the physician in the clinic area, and what should it be? Nurse? Social worker?
9. What is the attitude of the patient concerning waiting during her clinic visits? Does the patient consider this time wasted? Could this time be better utilized?
10. What role does education of the patient play in the clinic function? How is education of the patient best accomplished?
11. What are the major things that staff members should be doing for patients that they are not now doing? Why are they not doing them?
12. What does the staff member like most about the clinic? Least? Why?
13. What is the most effective part of the clinic program? Why? Least effective? Why?
14. What changes in the clinic program would the staff member recommend? Why?

Here again, in the completion of these interviews, the investigator's experience and attitude permitted him successfully to encourage the staff members to "ad lib" and to give greater depth to their responses.

Findings

The tentative results of this study suggest that:

1. The primary needs of a maternity patient in the clinic situation are centered around those of:
   a. Good physical care.
   b. The need for adequate emotional support.
2. The major needs of the clinic staff personnel could be defined as follows:
   a. To delineate and appreciate their individual roles and functions, as well as those of their fellow staff members.
   b. To have provided for them and to take advantage of all opportunities for training and learning in obstetrical out-patient care.
3. The proper organization of the clinic must allow for:
   a. Adequate service to all eligible patients who seek care from the clinic.
   b. The provision of adequate facilities for learning and training opportunities for the obstetrical and student nurse staff.
   c. Participation in appropriate research activities for those interested.

A. Patient Needs

Patients who seek care at the Obstetrical Clinic of the Grace-New Haven Community Hospital do so of their own volition. They are expected to pay appropriate clinic and hospital fees, in so far as they are able to do so. There are other medical resources available to them. Therefore, their use of this clinic would indicate that they are prepared to accept, as a matter of faith, the premise that they will get good technical medical care in this clinic. These patients, of necessity, have to make this assumption for purposes of their own morale. With rare exceptions (e.g., a physician or a nurse), the patients have no alternative to the quasi-religious faith that their expectations of good technical, medical care will be achieved, precisely because the patients have no adequate basis for evaluating this aspect of their care. To the extent that patients are not informed about such things as the procedures they undergo, the reasons for these procedures, and the like, this lack of criteria for evaluation of the care received is perpetuated. The second of their basic needs, emotional support, therefore comes in for much closer scrutiny on the part of the patient. This is an area in which the patient is able to evaluate, or at least feels that she is able to evaluate.

Those patients who consider that they are getting adequate emotional support are also those patients who most readily accept the fact that they are getting adequate technical medical care. This group of patients is the one which accepts medical direction most easily, follows medical orders most closely, and is willing to accept directions which may not at the moment be particularly clear or understandable to them. As one patient said, "It makes you feel good when the staff is nice to you; it reassures you and makes it easier to accept what they do for you."

Patients themselves helped to define in broad terms the basic concept of emotional need when they spoke of their desire to be a person, not just a case or a number; to establish rapport—a personal relationship with at least some staff member; and to develop feelings of confidence, reassurance and being at ease in the clinic situation.

While staff members demonstrated a greater emphasis on good medical care as the patients' primary need, they exhibited considerable recognition of patients' needs for emotional support, particularly the nurse group (as contrasted with the physician group), and recognized as well that the lack of attention to these needs represented a definite lack in the care offered by the clinic. This viewpoint was illustrated by a staff member's comment that "Patients need to feel that some one is interested in them."

The problem of "waiting" is closely related to the patients' concern about impersonality. The patient who reports —"I had to wait an hour to be seen, and then I was just shuttled through the mill"—can hardly be described as feeling a sense of personal interest on the part of staff. There seems little doubt that waiting is interpreted by patients, with varying degrees of conscious awareness, in terms of personal affront, and therefore interferes with emotional support. This appears to be particularly true with new clinic patients, and perhaps also with those in the younger age groups. When patients interpret waiting as a lack of individualized personal interest, later efforts of the physician or other staff members to give emotional support will be largely negated. If waiting could be avoided (and this possibility was greeted with considerable pessimism by both patients and staff), the ease of giving emotional support to the patients would be enhanced.

Lack of medical care continuity constitutes another obvious trouble spot for

clinic patients. At the time of the patient interviews, 27 out of the 30 had already been examined by three or more clinic physicians. Patients from the higher social classes tended to be more upset by the lack of continuity than were patients from the lower social classes. Those patients who were unhappy about not seeing the same physician appeared to lose, or never to obtain, a sense of personal relationship. They felt "like a case."

The major explanations offered by those patients who reacted more positively to the lack of physician continuity were:

a. All physicians are equally competent.
b. It is a good idea to get more than one opinion.

These points seemed to be rationalizations on the part of the patient. All of the doctors in the clinic area are obviously not of the same degree of competence, and furthermore, the patient is not able to pass intelligent judgment on the degree of competency. The resident physicians from whom the patients received care in the clinic are at various levels of training and experience, and consequently could not be considered equally competent. On the other hand, most patients are probably not aware of this fact, and are unable to make this distinction. Just as patients accept on faith the notion that they will receive good care, they accept, also on faith, the idea that the physicians who provide such care are equally able to do so. Any recognition of the different levels of training of the staff might jeopardize the patients' evaluation of the care they expect to receive, and thus arouse considerable anxiety. The attitude of considering it a good idea to get more than one opinion is manufactured largely because it does tend to make the patient more comfortable. This two-heads-are-better-than-one attitude may well be realistic and beneficial in some medical situations (e.g., questions of surgery, uncertain diagnosis, and so forth); but in the usual ante-partum situation it seems out of place, and certainly can conflict with patients' other needs to establish a close personal relationship with the physician.

The lack of medical care continuity found in the clinic seems to be associated directly with the organizational needs. In this respect, lack of continuity is analogous to "waiting"; it is seen as a "necessary evil," at least by the staff. Consequently, it may well be that patients' acceptance of the lack of continuity and their positive rationalizations concerning it represent the effort by patients to live up to the clinic and staff expectations of them, and the manner in which they should react. In essence, what is being asked of patients is that they inhibit their emotional needs which are predominant, and patients are attempting to comply with this implicit request. This makes more acceptable the patient's personal relationship with the physician and the staff personnel, as she does not constantly point up to the staff members the inadequacy of the organization of the clinic. It is interesting to note that patients from the lower social classes seem less able to withstand this pressure.

We found a close correlation between the attitude of the clinic patient and staff personnel concerning this matter of organization of the clinic not allowing for adequate emotional support.

Patients and staff agree that education is an important part of the service offered by the clinic. As staff recognizes, the more educated patient will often be less anxious and fearful. She will, in addition, feel a greater personal interest on the part of staff members who are attempting to help her learn, and may feel a greater sense of personal worth. Increased knowledge and understanding may also help to confirm her impression that she is receiving good medical care, and may give her a feeling (real or

illusory) that she is better able to evaluate how well this need is being met. Some of this is implied in one patient's remark that she "learned more in my first visit here than in all of my four visits to the private doctor put together."

There is a very interesting implication concerning the role of the physician and the nurse, which correlates with the general class level of the patient. Those from the lower social classes found much more empathy in the nurse. They tended to see the physician as a medical authority, on a pedestal and relatively unapproachable. The upper class patients, while agreeing that the physician is the medical authority, tended to see him as the primary staff person to whom one turns, and therefore made it much easier for the physician to establish rapport with them.

Results of this study would indicate that patients, needing to retain their faith that they are receiving good medical care, must see the physician as an authority figure, unapproachable or otherwise. And since "authority" is not usually equated with optimum emotional support of, and interest in, the individual, patients tend to look elsewhere for satisfaction of their emotional support needs. Social class differences may affect these attitudes; it is possible, for example, that the better educated, upper class patients may find it easier to overcome this stereotype which associates authority with lesser emotional support, and perhaps these patients, for reasons of status and prestige, tend to inhibit attempts to secure emotional support from the nurse. In any event, patients put considerable emphasis on obtaining as much emotional support as possible from either, or both, the physician and the nurse, a particularly crucial point for patients in the younger age groups, many of whom appeared to have greater difficulties communicating with the staff than did the older, "more experienced" patients.

B. Staff Needs

One of the major difficulties in training house staff and student nurses properly is the matter of communicating the subtleties of emotional support. The mode of organization of the clinic unwittingly frustrates even the staff member who recognizes the importance of emotional support. Because of the marked emphasis on good technical medical care, and because the organization of the clinic makes this aspect of care easier to administer, the clinic staff seem to take the line of least resistance and behave in accordance with what is expected of them.

In light of the above, one is forced to ask the following question: Is the obstetrical clinic, as it functions today, the ideal place in which to train the physician of the future, who, more likely than not, will end up in private practice? The negative answer to this question seems obvious, and we realize that many medical educators are aware of this.

The organization of the clinic does not clearly define the functions of the various staff members. This lack promotes a multiplicity of interpretations of function according to the background, training, personality, and so on, of the individual staff member concerned. This hit-or-miss type of function definition hampers the training potential of the physician and the nurse in the clinic area. To put the point more cogently, confusion is engendered by various people with various frames of reference interpreting differently the same experience. Without clear delineation and appreciation of their individual roles and functions, as well as those of their colleagues, clinic staff members cannot begin to operate in a truly cooperative fashion as a team. One result of this situation is that the staff member is forced to develop his own criteria with which to evaluate his performance; these criteria, not surprisingly,

reflect his own perceived primary needs and expectations (more often than not, the development of technical skill). As one staff member commented, "The lack is in the 'art of medicine'—you know, the human relations aspects."

Naturally, staff members have their own individual, personal needs which should also be recognized. These needs are just as varied as those of patients. Staff members, too, need emotional support, and they need to feel that they are accomplishing successfully a necessary and desired task.

There is more to clinic organization than the mere function of supplying service to the clinic clientele. Trite though the observation may seem, a major function of the obstetrical clinic in a teaching hospital is that of teaching. If patients' needs for emotional support are not met, there is every likelihood that patients will be inhibited in their ability to accept and utilize fully the medical care offered. Consequently, it is evident that staff members need to develop skills which will permit them to recognize and meet as effectively as possible patients' emotional needs. Present training opportunities provided to staff do not appear to stress this point adequately; in addition, other factors militate against such learning —e.g., the staff member's focus on developing technical competence, lack of scheduled time for patient counseling, and lack of clarity regarding which staff members provide emotional support at what points in the patients' clinic experience. It is obvious that lack of clear definitions of roles and functions will interfere with the learning experience supposedly afforded the staff by the clinic, as well as the provision of service to patients. It is, of course, true that staff members, in their service function, must meet the patient's needs, but it is equally true that the patients must meet the staff member's learning needs. To see this in an either/or context is both erroneous and misleading.

C. Organization Needs

Problems arise from the fact that a teaching clinic must serve all patients eligible for the clinic who apply for care. As the patient load increases, the available time, space, and staff personnel, which of necessity remain relatively constant, must be spread more thinly. The result is all too often a sacrifice of the patient's individual needs—a point of which many staff members are aware—and, more often than not, those of the staff as well.

Another major problem in teaching in an obstetrical clinic is the fact that far too many of the obstetrical patients constitute little or no medical challenge, precisely because more than 90 per cent of prenatal care is concerned with "normal" patients. The stumbling block of routine is ever present in the obstetrical clinic situation. Consequently, it is evident that those patients with major medical problems in association with their pregnancy get the maximum amount of medical attention and may, as an extra dividend, get much more emotional support than the "average" patient gets.

Essentially the same things could be noted of the "research" patients as have been mentioned in regard to the complicated obstetrical patients. They tend to get more attention and in turn, therefore, may get more emotional support, particularly if this increased attention is adequately explained and interpreted.

Conclusions

Patient, staff, and organizational needs have been demonstrated to be interrelated in a variegated and complex manner. It is both misleading and potentially dangerous, in terms of understanding the over-all set-up of the clinic, to view any one category of needs out of context. The staff member who reports that "the whole staff is groping for something better than is being done" and that "the lack of clarity regarding

the clinic's purpose and the staff member's function is at the root of much of the trouble" is not in error; nevertheless, his latter comment suggests an answer which is not in any way complete. Our study showed that when the interrelationships between the categories of need are congruent, they are generally constructive; conversely, when they are incongruent, they are destructive. To cite an example mentioned earlier, an increase in the patient load, created by the clinic's need to serve all eligible patients who apply, frequently results in a lessening of staff effectiveness in meeting patients' emotional needs. Additionally, unequal amounts of attention and care are frequently made available to individual patients because of the emphasis in the clinic on providing training. The likely consequence, in many situations, appears to be that both basic patient needs suffer.

Similar comments pertain when one compares staff needs with those of the organization. Given certain circumstances, the necessity for the clinic to provide service to all eligible patients who apply could contribute to a relatively superficial type of training which is too narrowly oriented and conceived.

Within the clinic itself, the primary dichotomy appears between the service and training functions, with the function of research presenting less probability of conflict and trouble. Because the former two functions are commonly seen as mutually exclusive foci (and that may be valid to some extent), the clinic is forced to put major emphasis on one or the other. If one assumes the bias of the authors—that is, a more long-range and realistic view of a probable setting in which the fully trained staff member will operate—such a completely "black-or-white" attitude seems neither warranted nor justified. Rather, emphasis should be devoted to identifying the potential problem areas, and then making every effort to achieve suitable compromises ("the gray area") which will permit the greatest possible fulfillment of the primary needs and expectations which are operative in the situation. In other words, the task is to maximize the congruencies and to minimize the incongruencies as much as possible.

It is the authors' contention that greater attention to group experiences, especially those which provide opportunity for small group discussion, as well as other methods of "feedback," would be productive. This attitude is based on the concept that such group experiences can be singularly effective as mediating mechanisms between conflicting individual needs (patient and staff) and the demands of the organization. In our study we found that opportunities for such experiences were minimal for patients (primarily the Mother's Classes), and those for the staff so minuscule as to be nonexistent for most practical purposes. In regard to meeting the patients' emotional needs, group experiences and discussions can be beneficial in ways which hardly need further exposition. But it is our belief that the benefits of such experiences to the staff, in clarifying their roles and functions, as well as the purposes and principles of the clinic as an institution, are not subject to such similar common acceptance. The implications of the latter statement for the concepts of cooperation and teamwork within the clinic are obvious.

As a final point, the authors should like to stress that until there is staff roles, there must inevitably be limitation in effective staff functioning. The importance of role interactions must be recognized not only in regard to professional interactions, but also in the area of patient-staff interactions as well. The underlying premise here is that patients' behavior will tend to occur in patterns which are congruent with staff expectations of that behavior, even when

those expectations are not communicated explicitly to the patients.

Basic needs in the three categories (patient, staff, and organization) have been proposed, and should be amenable to further research. In general, it would seem that the patients studied in the clinic are receiving at least adequate care from a technical, medical point of view. As far as patients can indicate their concerns to us, the major lack would appear to be in the fulfillment of their emotional needs—an evaluation in which the majority of staff members concur.

The foregoing discussion clearly indicates that the identification of individual needs is crucial. But the clinic's purpose ideally should evolve from a number of factors, which include its research and training functions and orientation. The authors are constrained once more to point out the fallacies of "either/or" consideration of the situation. The interrelationships of the various factors involved constitute the crux of the matter.

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Graduate Study of the Aquatic Environment

The University of Wisconsin offers a new interdepartmental program for advanced study and research in the chemical aspects of the aquatic environment leading to master of science and doctor of philosophy degrees. The program is designed to train students in fundamental and applied sciences for careers in chemical limnology-oceanography, biogeochemistry, chemical hydrology, or the chemistry of water supply and pollution control. A Water Chemistry Training Grant from the Public Health Service provides funds for master of science, predoctoral, and postdoctoral fellowships.

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