readings or a lowering of compliance in test reporting might lead to this situation. Therefore, we would recommend that physicians perform their own pilot studies prior to adopting this system in their practices or clinics.

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REFERENCES

Encounters in Training Clinic Support Staff

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Unless patients utilize available clinic facilities and services, the medical technology and staff are wasted, and the program is a failure. Patient cooperation is absolutely necessary if any medical program is to be successful. Program acceptability by patients leads to cooperation, which, in turn, leads to program success. A well-planned community medical program should be satisfactory for about 65 to 75 percent of the patient population; with modifications necessary to meet the social, cultural or ethnic needs, and practices of approximately 15 to 25 percent of patients; and with special tailoring of the program to meet the individual needs of the remaining 10 percent. In the larger metropolitan areas throughout the United States, the population is multiracial, multiethnic, and multicultural, with widespread variations in education and economic status. Thus, it is impossible to design a program, without modifications, that will satisfy the total patient population served. Although these facts are well known and have been demonstrated repeatedly, they are frequently forgotten, overlooked, or ignored.

Since program acceptability is the key to success, it becomes mandatory to review patient problems and staff attitudes as seen by patients, not necessarily as seen by staff. It was found that when patient problems were resolved, “problem patients” disappeared; and when staff attitudes were friendly and cooperative, program acceptability was more readily achieved.

PATIENT COMPLAINTS

Repeated discussions with many patients from a wide variety of racial, ethnic, social, cultural, and educational groups revealed a list of frequently occurring complaints, most of which could be readily resolved by a little planning and with changes in staff attitudes. Although there were eight major complaints, surprisingly the foreign language barrier was listed last by the patients at the time these studies were done. The eight major complaints were as follows:

1. Lack of Clinic Appointment System. Patients were taken on a “first-come, first-served” basis, without any special consideration for working patients, mothers with little children, the elderly or infirm, or any other special condition. This resulted in long waiting lines formed an hour or more before the clinic opened by patients who wanted to be among the first served.

2. Another Long Wait after Registration. The wait was frequently for hours in an overcrowded room on uncomfortable benches, with skid row drunks or extremely ill patients alongside mothers with young children.

3. Lack of Continuity of Medical Care. The patient was frequently seen by a different physician at each clinic visit. Thus, the patients felt there was no one physician with whom he could identify or to whom he could relate with a special problem. Furthermore, different members of the same family were frequently seen by different physicians, on
different days. This often resulted in unnecessary loss of work and financial hardship for parents of poor and marginal-income families.

4. Failure of Staff to Communicate with Patients. Physicians and nurses failed to communicate in understandable terms regarding the diagnosis, treatment, and medical regimen. Most frequently, it appeared that the medical staff was communicating only with each other and not with the patient. The professionals embarrassed the patient, so that important questions concerning medications and treatment were neither asked nor answered. This often led to the patient questioning the real need for medication and treatment; or, if the patient was well motivated, an explanation was sought from an orderly, porter, clerk, or another patient in the clinic.

One could readily detect a deep-rooted resentment and hostility toward the clinic staff, because of professional failure to communicate medical information in a manner that was understandable to the patient. This language barrier was one which, in the opinion of the patients, was inexcusable, because it could readily be overcome by a sincere effort by the professional staff. The patients recognized this language barrier as entirely different from the foreign language problem, which they felt was excusable.

5. Punitive and Judgmental Attitudes of Staff. These attitudes were manifested toward patients who failed to keep appointments or failed to take medications as prescribed, or when skid row alcoholics appeared at the clinic in a drunken and dirty condition. Occasionally these patients were reprimanded in the presence of others, so that they were embarrassed and further dehumanized.

6. Disparaging Remarks by Staff. Occasionally, certain members of the staff made disparaging remarks regarding the racial, ethnic, cultural, or religious beliefs and backgrounds of patients, which further alienated the “problem patient” or created a problem where one did not previously exist.

7. “Gracious-Giver” Attitude. Patients complained with deep resentment that some staff members had the attitude of “the gracious giver to the grateful recipient;” or, as some described it, “here we are, you lucky people.” Most patients felt strongly that, if services were accepted without questioning, they were treated better, and there were fewer problems.

8. Foreign Language Barriers. Language barriers existed because multilingual staff persons were not available. The patients frequently attempted to resolve this problem by bringing a bilingual friend or family member to act as interpreter. However, sometimes this proved embarrassing for the patient, because through the interpreter, friends and neighbors often learned of the patient’s personal and medical problems.

Staff Reactions

The physicians and nurses working in the various clinics were shocked when they saw the list of complaints, because the vast majority were not aware of any problems of patients; and those who were aware did not view them as seriously as the patients. Even more shocking were the patients’ viewpoints regarding staff attitudes. There were three groups of immediate responses or reactions; two were defensively critical, and one was constructively remedial.

One defensively critical group was composed of long-term employees who had worked many years in the department. They felt that the complaints were the “usual gripes” heard repeatedly from patients over the years and were not to be taken seriously. Furthermore, “the system had worked well and satisfactorily, and to change it was to invite disaster.” Further discussions clearly revealed that this group was firmly entrenched in the routine they had followed for years and that they feared change. When changes were suggested, they resisted and said, “It won’t work; it can’t be done.” Then they did everything possible to prove that it couldn’t be done.

After all attempts to reeducate this group failed, it became necessary to reassign them elsewhere in the department. Immediately, the obstructionist attitudes and atmosphere disappeared. Their replacements were carefully chosen from individuals who were dedicated to making the program workable and were patient-oriented and acceptable. Thus, a nucleus of new employees was obtained to develop a program which would provide better care in a more humane and understanding manner. The following basic criteria were established to measure success or failure: (1) kept clinic appointments (attendance); (2) results of treatment as measured by clinical improvement, sputum conversion, and radiographic clearing; and (3) the number and percent of reactivations.

The second defensively critical group became angry and hostile and clearly demonstrated that the patients’ criticisms regarding their attitudes were true. They were punitive and judgmental toward patients who failed to keep clinic appointments or failed to take medications as prescribed, or toward skid row alcoholics who were drunk and dirty upon arrival at the clinic. It was obvious that the docile, cooperative clean patient was the most desired and most favorably treated by this group.

The hostility increased when the director suggested that perhaps the clinic had failed the skid row
patient by treating only his tuberculosis and by ignoring his other medical and psychiatric problems; and that by attending the clinic, either drunk or sober, and by taking medications, the skid row alcoholic was being cooperative. Furthermore, the group made disparaging remarks regarding the life styles and cultural and religious practices of certain patients, while defending and supporting those that were similar or the same as their own. Their final arguments were, "What are the patients complaining about? They don't pay for their treatment; it doesn't cost them anything." In no way could they comprehend that clinic patients paid for these services through loss of work, embarrassment, and loss of dignity. Because the lack of understanding and compassion was so marked and the anger and hostility caused by the complaints was so intense, this group was transferred from the clinics to other areas of the department.

The third or constructively remedial group readily admitted that the patients' complaints were true, in whole or in part, and recommended immediate and long-term solutions. They noted that most complaints could be satisfactorily resolved by a simple reorganization of clinic services and by a change in staff attitudes.

Thus, the following changes were made: (1) Only working patients would be seen between 7:00 AM and 9:00 AM. (2) All other patients would be given a specific block-time appointment, eg, as many patients as could be seen satisfactorily between 10:00 AM and 11:00 AM would receive a 10:00 AM appointment. (3) All members of the same family would be seen on the same day by the same physician except, under special circumstances, when it would be better that a particular patient be seen by a physician separately from the remainder of the family. (4) One physician would be assigned primary responsibility for the patient, although another physician would see the patient if the primary physician were unavailable. (5) The waiting rooms were painted and redecorated, and comfortable individual chairs replaced the old wooden benches. All-day television and free hot coffee were provided. (6) Drunk, disorderly, or disturbing patients, as well as those who were seriously ill, were removed from the waiting room immediately following registration.

These changes were accomplished rapidly, and the effects on both patients and staff far exceeded expectations; the patients were delighted and responded favorably toward the staff and with a better attitude toward the clinics. In other words, the clinics became patient acceptable.

These results encouraged the group to take positive action towards correcting the attitudinal problems. It was decided to look upon patients as human beings with problems in addition to their medical illnesses. In other words, patients were human beings the same as the professional staff, so that disparaging remarks regarding race, ethnic, cultural, economic, social, or religious backgrounds were entirely out of place. If a patient attends a clinic, it indicates some willingness to cooperate; so the clinic staff would build on this by also demonstrating cheerful and cooperative attitudes. Thus, the physicians and nurses would make every effort to communicate with patients in terminology which the patient can understand. All treatment-related discussions would be conducted by physicians or nurses, or both, in private; and patients would never be reprimanded in front of other patients or staff. Furthermore, it was noted that the clinics were established to treat patients and that the patients were entitled to treatment; if the patients did not attend the clinics, some or all would be closed, and there would be no need for the professional staff. Thus, the role of "the gracious giver to the grateful recipient" or "here we are, you lucky people" may be reversed, because without the patients there is no need for physicians and nurses.

This group did an excellent job in changing the philosophy of patient care in the clinics and in educating and training new personnel, especially the community health workers, who have done so much to overcome the communication barriers between staff and the patients from various racial, ethnic, cultural, and social backgrounds.

**COMMUNITY HEALTH WORKERS**

In the larger metropolitan areas, especially the urban cores, there are many barriers which cause a never-ending series of problems for planners and administrators of medical programs. The multiplicity of these barriers is due to the population mixture, with its multiple races and ethnic groups, social and economic levels, religious and cultural backgrounds, immigrants, and foreign languages. Originally, it was believed that by resolving the foreign-language barrier, all other problems would be resolved; so to achieve this end, bilingual physicians and nurses were hired. Although there was improvement in the exchange of ideas between patients and staff, it was soon found that the interpreter should be bilingual and bicultural; because understanding the language did not necessarily guarantee an understanding of the cultural, racial, or ethnic practices and beliefs. After a long series of trials and errors, it was found that well-motivated bilingual and bicultural individuals with a limited education, less than two years
of college, did a far better job in interpreting and communicating between patients and staff. The need for this type of personnel was identified among other groups in which foreign language was not the barrier, such as the blacks, the elderly, and the skid row alcoholics.

As a result, a special classification, community health worker, was developed so that this support staff could be hired for the various medical programs and clinics. Thus, the community health workers in the senior housing projects are well-motivated, alert, and active individuals 60 years of age and older; while those in the skid row area are “dried-out” alcoholics who live in the neighborhood.

The use of community health workers has greatly improved patient acceptability of clinic services. However, it has been found that these workers must be carefully selected and then well trained regarding the resources of the community and the department. Furthermore, there must be an ongoing dialogue between the community health workers and the professional staff if their effectiveness is to continue. In the opinion of both the patients and the staff, the community health workers have been the most important recent addition to the medical programs.

CONCLUSION

In conclusion, it should be emphasized that a well-planned medical program will satisfactorily serve from 65 to 75 percent of the target population, with modifications necessary for the remaining 25 to 35 percent; 15 to 25 percent of patients will require program modifications to meet social, cultural, or ethnic needs, and approximately 10 percent of patients will require program modifications to meet their specific problems. Among the many problems encountered in the development, implementation, and administration of community medical programs, the major difficulties arose from cultural barriers, rather than the generally designated language barriers. Thus, the use of bicultural personnel improved program utilization and acceptability.

When a new major medical program was planned and implemented, or where a marked revision or change was made in an existing program, three separate categories of staff reactions were found to occur. First, some staff welcomed the changes as a means to better serve patients and the community. Second, certain staff members resisted major revisions through fear of change and personal insecurity. Third, a small number of staff were openly hostile and antagonistic to any change because of deep-rooted prejudices against the recipients. These prejudices were frequently ethnic, racial, cultural, or religious; but could also be for life style ("hippie" or skid row drunk), political affiliation ("commie," "liberal," or "Bircher"), social strata ("bum" or "chiseler"), or any other of a dozen or more reasons. This group felt that "the patients were already receiving far more than they deserved, and to do more or to improve services was a waste of time, effort, and money." The hostility and antagonism of this group was so intense that it was found necessary to remove them from the program if the new medical services were to have a chance to succeed.

A successful medical program insures job satisfaction and job security for staff, while at the same time providing better services for patients. A successful medical program depends upon patient cooperation, which, in turn, depends upon program acceptability to patients. Staff must be repeatedly reminded that program availability and accessibility is not the same as program acceptability to patients. Furthermore, anything that will improve program acceptability will favorably influence program success. In San Francisco, it was found that friendly and cooperative staff attitudes combined with the use of carefully selected community health workers were the two most important factors favorably influencing program acceptability by patients.

**False Tuberculin Test Results**

George W. Comstock, M.D.

For a meaningful discussion of false tuberculin test results, two prerequisites are needed. The first is to specify the purpose of a tuberculin test.

Most of us would undoubtedly agree that its fundamental purpose is the identification of individuals who have been infected with mammalian tubercle bacilli. If this definition is accepted, the specification of the four types of false reactions is straightforward.

A false-negative tuberculin test is one which fails to identify an individual who has been infected with...