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A STUDY IN SELF-DEFEAT: THE PUBLIC HEALTH
VENEREAL DISEASE CLINIC*

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ABSTRACT

This paper relates the results of three months of participant observation and interviews in a public venereal disease clinic. The research was directed toward assessment of the relationship of clinic efficiency (a smoothly operating bureaucratic clinic) and clinic effectiveness (a major reduction of illness within a community). The venereal disease clinic is described as an efficient and well planned health unit with three major objectives: a) checking the increase of V.D. through preventive medicine; b) detection and treatment of V.D. within the community; and c) provision of health services to lower S.E.S. segments of the population. Research results indicate that these (effectiveness) goals are systematically defeated through pursuit of bureaucratic (efficiency) objectives alien to the patient population, and, secondarily, through the more common problem of value conflict between staff and patients. The report concludes with evidence which indicates the extent of the damage done to effectiveness goals and suggests that effective health delivery systems may best be attained apart from present concepts and mechanisms of public health programs and philosophies.

Sociologists are increasingly becoming involved in the evaluation of health programs and services. Related to this involvement is the realization by the sociologist, and occasionally by the public health agency, that effectiveness and efficiency are not synonymous, particularly regarding the potential contribution of health services to the community. An efficient, smoothly operating clinic, even if optimally located, cannot guarantee an effective public health program when effectiveness is defined as a major reduction of illness within a community.

To be effective, public health programs must not only address their resources to the needs of a community, but to its values and customs as well. It is a sociological fact that varying cultures and classes differ

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in definition of illness, incidence rates, and treatment rates (Bullough, 1972; Koos, 1954; Wilson, 1970:71-84). Lower socio-economic groups are more prone than higher socio-economic groups to contract most acute or infectious diseases, and possibly many chronic diseases as well (Ellis, 1958). Economic differences, though crucial, fail to entirely explain these discrepancies. Class and cultural differences in behavioral and attitudinal characteristics must also be considered.

Historically, the concept of public health has been associated with the treatment and prevention of epidemics. Emphasis has traditionally been placed upon "community" health, primarily as it relates to the health of the higher economic classes. Simmons notes that illnesses such as tuberculosis (and, by implication, venereal disease), which may have infected lower class communities for decades, receive public attention only when they begin to intrude into the middle classes (1957:7). However, as Medicare, European health systems, and other excursions into socialized medicine have drawn attention, public health programs have increasingly become welfare-oriented. Public health agencies have focused attention on the provision of medical services to the lower economic segments of the population, reflecting at once the differential distribution of rewards in this society and the related differential distribution of illnesses and treatment.

Public health programs generally set the following interrelated goals for themselves: a) the prevention of disease in the community; b) the detection and treatment of disease in the community; and c) the provision of medical services to lower economic segments of the community. This paper is concerned with the accomplishment of these goals. Specifically, it examines the problem of efficiency as it is related to effectiveness. This is done through the study of a public health venereal disease clinic.

Methods

The following analysis is based on three months of daily participant observation and interviews, of both staff and patients, in a venereal disease clinic. Entrance into the clinic process was gained under the auspices of a larger community venereal disease study. The community project resulted in both "insider" and "outsider" status within the clinic. The former status was achieved fairly easily through constant involvement in most phases of clinic work. The rewards accompanying this status center around the trust-relationships arising from sustained interaction with staff members. Some objectivity is necessarily sacrificed in building these relationships, but aloofness prevents the tapping of attitudes behind the professional masks of the staff. Piliavin and Briar state the case well in discussing their study of police officers in a juvenile division:

While these data do not lend themselves to quantitative assessments of reliability and validity, the candor shown by the officers in their interviews with the investigators and their use of officially frowned-upon practices while under observation provide some assurance that [this study] accurately reflects the typical operations and attitudes of law-enforcement personnel studied (1964:207).

Underlying attitudes were tapped in this research when staff members dropped their professional masks and displayed quite unprofessional behavior and ideas in the company of the researcher.

Complete "insider" status was never won, however. Speaking "off the record" is one concession the public employee and bureaucrat will accord the investigator, yet baring the record itself is risking too much. A lesson learned quickly by students of public social agencies is that administrators define agency (and job) security as dependent upon tight control of agency records. Access to files, for this investigator, was limited to their use in the community study. Prolonged and systematic analysis of records was prevented. Yet, any and all clinic files could be surveyed briefly and this provided valuable insight into bureaucratic typification processes (see Ci-courel, 1968), patient background data, and other points of interest discussed throughout this paper. In more than a few instances, cases were discovered which contradicted the clinic's official administrative policies.

The price exacted in retaining "outsider" status becomes apparent in the results described below. Absent are hard, quantifiable data capable of supporting the more qualitative results achieved through participation in the clinic process. This does not represent a lack of rigor, however. Indeed, the mode of analysis employed in this study strove to emulate Becker's (1957) rigorous formulation of methods of inference and proof in participant observation.

The clinic studied, unidentified here, may be considered typical of most venereal disease clinics, perhaps even of higher quality. Presented below is a description of some of the problems which plague public health clinics in general but which may not be perceived by administrators and personnel. Failure to perceive these problems, in all probability, results in the clinic's ultimate failure to attain its primary goals.

The V.D. Clinic: Goals, Staff, Clientele, and Out-Patient Treatment

The public health venereal disease clinic studied is located within a larger, general public health clinic serving a metropolitan population of over 800,000. In accord with the public health goals noted above, the V.D. clinic has set for itself the following objectives: a) checking the rapid increase and spread of venereal disease through preventive medicine, especially in the form of increased community education and awareness of the V.D. problem; b) detecting and treating venereal disease within the community; and c) providing adequate treatment, detection, and prevention of V.D. for the welfare segment of the population, i.e., those unable to afford private medical services. Secondly, the V.D. clinic must meet certain state and county-imposed bureaucratic standards. These include the accurate reporting of all cases of venereal disease detected by the clinic.

An administrative physician supervises all clinic work, yet is generally absent from actual clinic processes. One physician, a retired, rural practitioner, generally performs all diagnoses and treatments. His workload is

sporadically alleviated by the occasional, part-time employment of young, newly-graduated physicians. The nursing staff consists of one public health nurse, three registered nurses, and two female clinic assistants.

The lay staff is headed by the chief venereal disease investigator whose primary task is to interview patients with venereal disease and to locate their sexual contacts for examinations. A second V.D. investigator is also employed. When the daily workload is overly heavy, the nurses often conduct the clinic interviews along with the investigators. The secretarial "up-front" staff consists of three, middle-aged women who compile records, act as receptionists, and handle phone appointments and inquiries.

Patients are primarily of two types: a) lower class black and Mexican-American youths; and b) lower-middle and middle class white youths.¹ The latter comprise the major portion of the patient population and are often characterized by staff members as "fringe-freaks," "the hippie element," and "dropouts." More accurately, the majority of the white patients may be described as "anti-establishment" in values and demeanor. Patient population is predominantly male. Average patient age is approximately twenty, with few patients younger than seventeen or older than twenty-five.²

The clinic sees approximately thirty new patients per day. (Over 2,000 new patients were seen in the three-month study period.) The clinic process which handles these patients may best be described through a summary of the steps through which a patient proceeds during a clinic visit.

Step I. The patient enters the clinic and approaches the receptionist's desk. He is asked the general nature of his problem, is assigned an identification number and a file, and is told to wait in an outer waiting room until called.

Step II. The patient is called by name from the outer waiting room and is brought into the V.D. investigator's office. Here he is interviewed concerning his name, age, address, and phone number. He is asked to provide the name of a person, preferably a relative, to be called in case of an emergency. Finally, he is questioned concerning his symptoms, any previous venereal disease infections, number of sexual contacts, and drug use.³ The patient is then sent

¹Class status was estimated from patient's residence, education, occupation, and father's occupation, to the extent that these items were available in clinic files and through interviews.

²National statistics (see 1965-70 figures of U.S. Public Health Service, Publication No. 341) indicate that this age group is highest in V.D. incidence. Blacks, for various reasons, are also overly represented in this country's current V.D. "epidemic."

³Drug use is questioned in an effort to determine if patients are treating themselves or if they are allergic to clinic prescriptions. However, any reported drug use (including heroin, marijuana, and L.S.D.) is also recorded in the patient's file.

into a smaller, inner waiting room until he is called to see the clinic physician.

Step III. The patient is brought into the examining room where his symptoms are checked and cultures taken. The physician then makes a preliminary diagnosis and prescribes treatment. The patient is told to call the clinic in three days for the official diagnosis (a delay necessitated by the time involved in processing the cultures). If the preliminary diagnosis is negative (no V.D.), the patient is told he may leave the clinic. If positive (V.D.), he is returned to the small waiting room.

Step IV. All male gonorrhea patients and all syphilis patients preliminarily diagnosed positive are immediately reinterviewed by the V.D. investigator concerning the names and addresses of sexual partners so that they can be brought to the clinic for examination.⁴ After this step, the patient leaves the clinic. All patients preliminarily diagnosed negative but whose cultures show them to be positively infected are called back into the clinic for re-examination and prescribed treatment. All male patients called back in this manner are also reinterviewed by the V.D. investigator concerning sexual partners.

Step V. All patients officially diagnosed positive are asked to return in two weeks for re-examination. If he is again diagnosed as positive or if his culture again indicates positive infection, the patient is again taken through the clinic process.

The patient's initial visit to the clinic will consume approximately thirty minutes on a "low traffic" day (few patients in the clinic) and an hour or more on a "high traffic" day (many patients in the clinic). Actual physician-patient interaction requires about ten minutes. Records, including both investigator's and physician's reports, are compiled for each patient entering the clinic. The names of all patients diagnosed as positive are reported to the state bureau of public health which records the information.

Staff-Patient Relations

A careful examination of the clinic's staff-patient relations, staff perception of clinic goals, and the out-patient treatment process suggests serious weaknesses in the clinic's ability to achieve its primary community health goals.

The problem of conflicting values of staff and client in welfare-oriented agencies is well documented (Blau, 1960; Cloward and Epstein, 1967; Howard, 1969). The public health agency is not excepted from this problem. The ideal sick role

⁴It is assumed that all male gonorrhea cases will exhibit symptoms and report for treatment. Therefore, female gonorrhea patients are not interviewed for contacts. Male gonorrhea patients are interviewed, however, because gonorrhea in the female is usually asymptomatic.

(Parsons, 1951:428-473) reflects a middle class value pattern upon which physicians and patients presumably agree. However, research has indicated that the poor, and especially the ethnic poor, misunderstand a major fraction of conventional terms spoken to them by physicians (Samora et al., 1961; Davis, 1968). Wilson notes that probably more important are differences in the assumptions that lie behind the terms (1970:24; see also Saunders, 1968). He states further:

The health professional wears his own set of blinders. Not only may he be limited to a middle class stereotype of the responsive and responsible patient and yearn for the client to be more nearly like himself, but he also customarily carries a certain moral freight. ... [T]he disadvantaged patient is not just different but morally bad or inferior (1970:26).

Various studies indicate that lower class patients do not perceive time and the future in middle class terms; nor are they as willing to defer gratification (Davis, 1946; Horton, 1967). Lower class individuals are less likely to define responsibility for their health as theirs alone, deviating from the classic sick role assumptions about preventive and recuperative attitudes. Indeed, lower class socialization patterns differ markedly concerning orientation to health (Simmons, 1957; Whiting and Child, 1953).

It is not necessary to describe in detail these problems as they occur in a public V.D. clinic. Suffice it to say that while at all times maintaining a professional demeanor before patients, clinic personnel privately confide prejudiced opinions concerning patients. In the clinic studied, patients were often referred to as "ignorant," "selfish," "lazy," and "ill-trained." One investigator considered female patients to be simply naive, while male patients were regarded as "hippies, more like animals or bums who don't worry about V.D. because they can always come here [the clinic] and get fixed up." The staff appeared especially resentful of young, white patients who were thought to be "anti-society" but who used society's health facilities. The staff also questioned the ethics of treating such patients through public funds because most are from homes which can afford medical care.

Were these underlying attitudes hidden completely behind professional demeanor (which is doubtful), the clinical mask itself is likely to alienate the patient. What is efficient, professional, scientific, and value-free for clinic staff may be precisely the opposite for the patient -- perhaps regardless of his social background. This is borne out somewhat by the fact that terms like "non-specific-urethritis (NSU)," "positive blood test results," "culture," and even seemingly more common terms such as "prophylactic," "condom," and "douche," while not questioned by patients when with staff, are in follow-up interviews demonstrated to be misunderstood by or meaningless to patients.

Goal Confusion

The clinic has somehow confused its primary goals of venereal disease detection and treatment and the medical servicing of lower class groups with its secondary goal of statistical compilation. This is further complicated by the

clinic's generation of yet another set of objectives: increased bureaucratic efficiency and cost reduction. The latter is clearly set for the clinic's own benefit while the former is actually motivated in part by concern for the patient.

State law requires the compilation of data on all V.D. cases detected by the clinic. County bureaucratic procedural standards demand the accurate registering of "pertinent" information about all patients entering the clinic. Reasons for these procedures and standards vary from moral to purely administrative. However, these procedures and standards, justified or not, do much to detract from the accomplishment of the prevention and treatment goals, and detract still more from the welfare aspects of the clinic program. When these bureaucratic goals are given priority, the damage may be irreparable.

Examples are numerous. Attainment of the treatment goal ultimately fails when patients are denied service because they refuse to provide all of the information requested of them and when patients leave the clinic untreated because they could not be guaranteed anonymity, i.e., more than "confidentiality." Both treatment and prevention goals are diminished when patients will not return for follow-up treatment or for treatment of new infections because the treatment aspects of previous visits were down-played in light of information gathering. It is noteworthy also that the V.D. clinic depends greatly on "word-of-mouth" publicity to draw potential cases to its services.

The clinic's self-generating goals of bureaucratic efficiency and cost reduction are also its greatest source of failure to meet not only its treatment and prevention goals but, more especially, its welfare goal. The very system which the clinic seeks to perfect is strictly opposed to the values held by its clientele. Sociologists, in line with Merton's classic formulation of "bureaucratic ritualism" (1957:199), are aware of the tendencies of bureaucratic functionaries to make cost and efficiency ends in themselves, even at the expense of primary goals. The out-patient treatment process provides a clear case in point.

Out-Patient Treatment Process and Patient Values

Bureaucratic procedure is alien to both types of clinic patient, the ethnic youth and the white youth. Mexican-American and black youth often describe the clinic process as a "hassle." Most are aggravated that actual physician-patient interaction lasts but ten minutes while the entire clinic procedure sometimes exceeds an hour. This seems consistent with what is described above concerning class and cultural differences in perception of time, urgency, and deferred gratification. Black and Mexican-American patients see no purpose in the elaborate file compilation which consumes the greater portion of their clinic visits. Not only does purpose escape them regarding time spent in the clinic, but the necessity of files for future reference is questioned. Typical is this statement: "If I pick it up, I pick it up. I come here and get medicine and split. So why do they have to know all about my life just to give me some medicine?"

Male gonorrhoea patients cannot understand the clinic's seemingly exaggerated

concern with female sexual contacts. In their view, it appears needless to bother a friend with public health department "pressure" when the contact will probably be seen by the patient within a few days and will then be informed of her possible infection. This somewhat nonchalant approach toward detecting venereal disease, while shocking to clinic staff, is seemingly in line with what appear to be lower S.E.S., ethnic patients' perceptions of venereal disease. In the present study, blacks, more than Mexican-Americans, and both groups, more than whites, appear to view venereal disease and the risk of infection fatalistically, i.e., as somehow beyond their control. Not only does this view tend to greatly lessen moral connotations attached to V.D., but it causes the amount of pressure placed upon these groups to divulge names of contacts to be perceived as needless and time-consuming.

Similar problems arising with young, white patients are further complicated by a sense of treat. While both ethnic and white patients agree on the undesirability of the bureaucratic process, white patients, more than their ethnic peers, generally resist the process as demeaning and representing a corrupt and threatening "establishment." All questions asked by the V.D. investigator are considered suspicious. Files are perceived as records kept for future, damaging use.⁵

An examination of the white group indicates that, unlike the ethnic patients, white patients are very much future oriented. For some of these patients, a moral stigma accompanies venereal disease, and anonymity is therefore valued. However, anonymity is threatened during the clinic process when the patient is asked to provide information about sexual contacts and about past history. It is further threatened when the patient is asked to provide the name of a relative or friend in case of an emergency.⁶ Finally, the situation is perceived by the patient as threatening since he is aware that information about him is

⁵This fear is not groundless. Unlike many communicable diseases, previous gonorrhea infections do not resurface. Each infection is a new one which, when cured, presents no danger to patient or society. The argument offered this investigator by the administrator of the clinic -- that state-imposed statistical reporting is not aimed at morally branding a patient but at assessing trends -- appears weak in light of the state's demand to report names of infected persons.

⁶While this practice is legitimate, it was openly admitted by one V.D. investigator that anonymity cannot be guaranteed and that he has and would violate the patient's trust by contacting the emergency reference in order to obtain information to close his files. In a related instance, information about a patient was turned over, upon demand, to her father (a physician) against her will. The V.D. investigator noted that his methods of obtaining information varied from assuring confidentiality, to threatening to refuse service, and, finally, to telling the patient that he was violating the law.

being compiled, and he is denied access to his files.

Estimate of the Damage

In sum, it appears that in pursuing efficiency goals which are alien to its clientele, the venereal disease clinic is ultimately defeating its major goal of effectiveness. However, the extent of the damage is not easily assessed and must rely on estimate. It might be noted that most of the patients who are examined and, if necessary, treated for one infection do not return to the clinic again. Interesting also is the fact that many of those diagnosed as positive V.D. cases do not return for the follow-up examination two weeks later. This could conceivably mean that none of these patients is ever reinfected. However, given a profile of each of the two patient types, this seems unlikely. Both groups tend to admit to more than one sexual partner (but rarely to more than three). The average patient tends to hold sexual permissiveness in a positive or, at least, neutral light, even though white patients more often place moral connotations upon contraction of venereal disease. Black youths in the clinic appear generally less worried about V.D. and certainly unappalled by the dangers of V.D. infection through sexual permissiveness.

It might be suggested that those patients who report to the clinic with symptoms or fears of venereal disease and are diagnosed as negative will, in the future, be less motivated to report as promptly to the clinic with the same or similar symptoms. Rather, they are now more relaxed about V.D. symptoms. Even were this true, any patient who delays in returning to the clinic, even in part because of a dislike for the clinic process, necessarily represents a failure of the clinic to accomplish its goals.

Perhaps the failure of the V.D. clinic to meet its goals is best demonstrated through an experiment performed in a neighboring metropolitan area of similar size and composition, and possessing similar public health philosophies and services. After much publicity, the public health venereal disease clinic provided, for one day, free and anonymous examinations and treatment for venereal disease. All phases of the clinic process were conducted through use of numbered tickets. On this one day, a clinic which normally averages twenty to thirty patients per day received 269 patients (102 at the clinic itself and 167 at five "extension" sites established for the one-day experiment⁷). Patients were primarily white youths, averaging twenty-one years of age, and generally possessing the same characteristics as the everyday clinic patient. It is most noteworthy that the one-day turnout approximately equaled the clinic's average

⁷This raises questions about the efficiency of the clinic's health delivery system. A brief survey of clinic files indicates, however, that location of the clinic bears little on geographic distribution of clientele. While more conclusive evidence is necessary, it is, for the present, felt that location of the clinic is not its major source of difficulty in reaching the population.

weekly patient workload plus one contact for each patient. Sixty-eight percent of the patients, using their anonymous identification numbers, called the clinic later for official diagnoses. These results necessarily raise questions about the need for records-keeping, pursuit of contacts, and, generally, about most of the clinic's secondary, bureaucratic goals.

This paper should not be misconstrued as an exposé of the particular clinic studied or of clinics in general. Nor is its underemphasis of the everyday difficulties of managing a venereal disease clinic to be interpreted as a denial of such difficulties. Yet, the present study clearly illustrates the major problem of the public health venereal disease clinic and, to some extent, of public health clinics in general: alienation of the patient populations they strive to serve. It cannot be denied, given its bureaucratic objectives and its patient-load, that the clinic is fairly efficiently managed. However, effectiveness -- prevention and treatment of V.D. in the community and, especially, among lower S.E.S groups -- is sacrificed for this efficiency. This report suggests that total effectiveness is probably beyond agency reach and that any agency's goal must be to maximize its operational effectiveness. A classic dilemma thus appears: is maximum effectiveness attainable within our present concepts and mechanisms of public health or apart from them? The latter course increasingly seems less an option than a necessity.

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