RESEARCH BULLETIN 964 MARCH, 1971

UNIVERSITY OF MISSOURI-COLUMBIA
COLLEGE OF AGRICULTURE
AGRICULTURAL EXPERIMENT STATION
ELMER R. KIEHL, *Director*

Perception of Health Practitioners By Respondents in a Rural Area

EDWARD W. HASSINGER, DARYL J. HOBBS,
F. MARIAN BISHOP, AND A. SHERWOOD BAKER

(Publication authorized February 10, 1971)

COLUMBIA, MISSOURI

CONTENTS

PART I. INTRODUCTION 3
Distinctions among practitioners 3
The study 4
The area 4
The communities 4
Sample selection and Characteristics 5

PART II. PERCEPTION OF THE FAMILY DOCTOR'S ROLE 5
Why do families have a family doctor? 6
Why do families not have a family doctor? 8
General orientations toward family doctors 9

PART III. PERCEPTION AND KNOWLEDGE ABOUT SPECIALISTS . . . 11
What is a medical specialist? 11
Identifying specialists 12
Identifying specialists by age and income of respondent's family 13
Recommendation of doctors in hypothetical situations 13

PART IV. THE PERCEPTIONS AND KNOWLEDGE ABOUT OSTEOPATHIC PHYSICIANS 16
What is an osteopath? 16
Perception of osteopaths by age, family income, and professional type of family doctor 18
Preference for osteopaths and medical doctors 20
Preference for osteopaths and medical doctors by family socio-economic characteristics and type of family doctor 21
Identifying osteopaths 22
Summary of perceptions of osteopaths 22

PART V. PERCEPTION AND KNOWLEDGE ABOUT CHIROPRACTORS 23
What is a chiropractor? 23
What is a chiropractor by age, family income and professional type of family doctor 25
Preference for chiropractors and medical doctors 26
Preference for osteopaths and medical doctors by family socio-economic characteristics 26
Identifying chiropractors 29
Summary of Perception of chiropractors 30

PART VI. CONCLUSIONS 30

ACKNOWLEDGMENTS

Work on this project was supported in part by Public Health Research Grant No. 00252.

Perception of Health Practitioners By Respondents In A Rural Area

Edward W. Hassinger, Daryl J. Hobbs,
F. Marian Bishop, and A. Sherwood Baker*

Part I

Introduction

This report is about the perceptions and information of health practitioners held by people in the Ozark area of South Central Missouri. Evidence from sociological studies indicates that we cannot assume that all segments of the population have similar perceptions and equal knowledge in health matters, for it seems clear that perception and knowledge vary according to such characteristics as social class (Koos, 1954) and cultural differences (Zola, 1966; Saunders, 1954). Thus, the examination of perceptions and information about health practitioners is regarded as one way of gaining insights into differences in use of health services.

Distinctions in practitioners

Both in society in general and in the study area health services are organized so that it is left to the individual who seeks services to judge who among a variety of practitioners is most appropriate to treat a particular condition. Often distinctions that are well understood by health professionals are not explicit or equally understood by the layman. Consequently, even though there may be objective bases for making choices among practitioners, the subjective bases may be as important or more so.

In the regular medical profession, represented by practitioners with the M.D. degree, there are different levels of specialization. The most common distinction is between general practitioners and specialists. However, the distinction is often not clear-cut. General practitioners may have a reputation in the community for expertise in certain ailments while some specialists (especially in internal medicine and pediatrics) may be regarded as general practitioners by those who seek their services. Among specialists, distinctions are made on the basis of whether the specialist is certified by a specialty board and by whether he practices his specialty full-time or part-time.

There are differences in the professional type of practitioners. Osteopathic doctors (D.O.) represent an important professional group in Missouri and in the area we studied. Specialty distinctions are made among osteopathic physicians similar to those among medical doctors.

Chiropractors (D.C.) are yet a third type of practitioner. They represent the largest alternate philosophy of healing to the regular medical profession. Chiro-

---

*E. W. Hassinger, Professor of Rural Sociology; D. J. Hobbs, Professor of Rural Sociology and Sociology; A. S. Baker, Professor of Community Health and Medical Practices; University of Missouri-Columbia; and F. M. Bishop, Professor of Community Health, University of Oklahoma School of Medicine.

practors are widely dispersed in Missouri. They do not tend to be located in the smallest towns.

The study

The purpose of this research is to assess the perception that rural people have of medical practitioners. The same research effort is concerned with patterns of use of services, (Missouri Agriculture Experiment Station Research Bulletin 1965).

The area

The area studied lies in the central Ozark plateau. Much of the land has been allowed to return to the hardwood timber which once covered it. The largest single occupation, although not a predominant one, is agriculture. A majority of the farms are small with relatively little cropland and they are often operated as a part-time activity in conjunction with off-farm employment or provide under-employment for full-time operators. Lumbering is important in certain parts of the area.

The original settlers came from farther east, usually by way of Tennessee and Kentucky. Virtually no Negroes live in the area, a characteristic of the Ozark and Appalachian regions.

As is characteristic of rural areas, services are provided by trade centers that form the nucleus of rural communities. Residents of the area commonly use more than one trade center in meeting their economic, social, and service needs.

The area is a substantial distance from major medical centers. However, it is not isolated in that it is intersected by all-weather roads and attracts a sizable number of tourists.

The communities

Four trade centers were selected that varied in both the population and the availability of medical services. These centers, together with their respective open-country hinterlands, were the study area. The community boundaries were established on the basis of consultation with local informants by making spot checks at the edges of the tenative community areas and by examining school districts and postal routes. Although the four communities were considered discrete and each was sampled independently, they form a nearly contiguous area.

The communities were deliberately selected because of their differences in medical services. (Table 1). In one of the communities, the only medical service was that of an oteopathic physician who divided his time between that town and a neighboring town. The second community had the services of a medical doctor (M.D.) and an osteopathic doctor (D.O.). The third community, which was considerably larger, had the services of two M.D.s and two D.O.s (one of the M.D.s was quite elderly but maintained a practice). The fourth and largest community had six M.D.s and two D.O.s (one of the D.O.s had a limited practice due to his age). All the physicians in the four communities maintained a general practice. Four of them (three M.D.s and one D.O.) reported a part-time specialty practice; none, however, was board certified. Two chiropractors were located in each of the two larger communities and the largest had a 42-bed hospital—the only one in the study area.

TABLE 1 -- MEDICAL SERVICE CHARACTERISTICS OF FOUR COMMUNITIES STUDIED

	Community			
	A	B	C	D
Population 1960	420	266	3176	5836
Medical Doctor (M.D.)	None	1	2	6
Osteopathic Doctor (D.O.)	1/2*	1	2	2
Chiropractic Doctor (D.C.)	None	None	2	2
Hospital	None	None	None	42 Beds

*Divides time between two centers.

Sample selection and characteristics

Random samples of households were selected in each of the four communities and personal interviews were conducted with the female heads of the households (if there was no female head then the male head) during the summer of 1967. The female family head was selected as the person to be interviewed because of her importance in making family medical decisions and also because of the greater likelihood of her having information about the health behavior of all family members. In the interview, information was collected about the use of health services by each family member including details about the practitioners used by each. The perceptions and information about the health services are largely those of the respondent although undoubtedly influenced by other family members.

Compared with the U.S. Census data for Missouri, families in the sample have low incomes and are headed by persons of low educational and low occupational status. (Table 2) However, the sample from the communities conforms closely to the characteristics of the population of the four counties in which the communities are located. The correspondence between the income, educational, and occupational characteristics of the sample and those reported in the U.S. Census for the counties affords confidence that the sample is representative of the population.

Part II

Perception of the Family Doctor's Role

The family doctor relationship, at a minimum, represents an established relationship between a doctor and a family. This was a common relationship in the area we studied; 86 percent of those interviewed responded affirmatively to the question, "Do you have a family doctor to whom you usually go?" This finding is

TABLE 2 -- SELECTED SOCIO-ECONOMIC CHARACTERISTICS OF THE POPULATION IN THE STATE AND IN THE COUNTIES IN WHICH THE FOUR COMMUNITIES WERE LOCATED (1960); AND IN THE SAMPLE OF FOUR COMMUNITIES (1967)

	Percent of employed persons in white collar occupations	Median school years completed/ persons 25 years & over	Median family income	Percent of families with income under $3,000
Missouri[1]	40.0	9.6	$5,127	27.0
Howell[1]	30.2	8.7	2,998	50.0
Ozark[1]	26.0	8.5	2,107	66.5
Shannon[1]	22.5	8.3	2,565	57.8
Wright[1]	25.2	8.6	2,588	56.8
Four community[2] sample	31.1*	8.0**	2,737	55.0

*Percent employed male and female heads in white collar occupations.
**Median school years completed by female heads of households.

[1]Based on 1960 U.S. Census of Population.
[2]Based on field interviews.

consistent with other surveys showing that a predominant proportion of the families report a "family" or "regular" doctor (Gaffin, 1955: 1; Hoffer, 1950: Hay, 1960: 22).

The doctors named as family doctors were almost always general practitioners. Only 28 of the 813 families named a full-time specialist as a family doctor. When specialists were named as family doctors they were most often specialists in internal medicine (14 of 28). Also characteristic of the nature of the family doctor relationship was that 90 percent of the family doctors named practiced in one of the four communities or in one of the immediately adjacent centers. Although doctors in larger, more distant centers were widely used by the families in these communities, they were seldom named as the family doctor.

Why do families have a family doctor?

The basis for the family doctor relationship and the expectations people have for the family doctor were determined from responses to the interview question, "What are your reasons for having a family doctor?" The small percentage of families who did not report having a family doctor were asked, "How does it happen you do not have a family doctor?" Through an examination of the

TABLE 3 -- REASONS GIVEN FOR HAVING A FAMILY DOCTOR

	Number	Percent of those having family doctor (N= 813)*
Knows the patient; knows his history.	357	43.9
Convenience and having service available when needed.	222	27.3
Keeps records of illness.	212	26.1
Depend on family doctor; have faith in him.	142	17.5
Need a doctor for everyday things.	94	11.6
Medical contingency; have a condition requiring a doctor.	77	9.5
Understands, considerate, etc.	65	8.0
Like the doctor.	59	7.2
Prefer to use only one doctor.	36	4.4
Respect the competency of the doctor.	25	3.1
TOTAL REASONS	1,289	

*Adds to more than 100 percent because some responses were placed in more than one category.

responses to the first question, it was determined that they could be summarized by the general categories reported in Table 3. (The total number of responses reported exceeds the number of persons asked the question [813] because many gave more than one reason.)

The most common response to the question was, that the family doctor knew the patient and his history. More than two in five of the respondents in families with a family doctor gave answers that were classified in this category. This idea was often combined with others that elaborated it. Examples of the "nearly verbatim responses"* which express this idea are:

[It's] "Better if a doctor knows something about the family rather than having a stranger come in."

"You can rely on them when you know them well and they know you."

It is not clear from these responses why personal familiarity is so important in the family-doctor relationship. It is not known, for example, whether familiarity is perceived to be associated with a higher quality of medical service (more individual

*The term "nearly verbatim response" is used to alert the reader to the fact that these responses were recorded by interviewers in the field. Although the instructions were to copy the exact statements, they were subject to intervention of the recording interviewer.

attention) or whether this factor is considered as something that minimizes social distance and makes the doctor more "accessible."

Accessibility can have both a social and a physical dimension. Social accessibility is interpreted as making the practitioner more approachable while physical accessibility is interpreted in terms of both distance and convenience. The second most frequently mentioned reason for maintaining a family doctor relationship concerned physical accessibility. More than one-quarter of all the respondents who had a family doctor mentioned that having a doctor nearby was important–implying that the family doctor was chosen on the basis of location rather than perceived quality. These responses included the idea that patients could see the doctor without appointment and might expect him to come to the home in case of emergency.

> "Guess it is because we can take the kids to him anytime we need to. He is always there and can depend on him when you need him."

> "If anything serious arises we can call on him day or night at home or at the office."

Records were also mentioned by more than one-quarter of the respondents who had a family doctor. In some instances, it was difficult to determine if statements referring to the medical history of the family or knowing the family were different from expression of keeping records. For example:

> "He's got your shot record and knows what you've had."

> "For one thing, if you did get sick and have to go back for a check-up, he'd have your records and can check back. For instance, when I take my little boy in he knows what for, as he has tonsilitis all the time."

More personal or affective reasons were also expressed by a fairly large number of respondents in the form of dependency, confidence, faith, and understanding.

> "Because he knows about us and we know him. It's good to have one we consider a friend."

> "He kept my mother alive seven years...somebody to trust."

Close to the responses that emphasized convenience in the case of need are those that reported the desirability of family doctor relationship for everyday problems, or for regular need of a doctor for chronic or recurring conditions.

> "For minor things such as colds or childhood diseases. He is handy to get to and will come to us."

> "I have to go each month for blood tests–blood pressure runs high. It's handier to have a doctor to rely on."

It is interesting to note that competency or professional qualifications were seldom cited as important in maintaining a family doctor relationship. This does not mean, however, that such considerations are not important in the selection of family doctors. Virtually all responses pertained either to matters of convenience, accessibility, or to the personal relationship with the physician.

Why do families not have a family doctor?

Reasons for not having a family doctor are reported in Table 4. (Again the

responses exceed the number of respondents because multiple reasons were given by some.) The reason most often given was that a family doctor was not needed because the family was in good health. Another frequent reason was that the family doctor relationship had been interrupted by family moves or deaths of family doctors. Other respondents expressed preference for not being "tied" to one doctor and/or to using specialists or medical institutions directly. Antagonism was openly expressed and is found in the categories "don't believe in doctors"; however, there were only nine responses in each of these categories.

General orientations toward family doctors

The categorization of responses to the question about why the family doctor relationship was or was not maintained, together with the verbatim responses, gives us some insight into the development and characteristics of this relationship. On examining the responses, there appear to be two general orientations toward the family doctor. One is the desirability of maintaining the relationship in order to provide service when needed or to have better service through maintenance of records and case histories. These can be regarded as emotionally neutral expressions and as *instrumental* to getting services. The other theme, in its most extreme expression, includes not only faith in the doctor but also expressions of trust and confidence. These responses have the element of personal involvement and are considered as *expressive* relationships. In most cases, expressive statements were not

TABLE 4 -- REASONS GIVEN FOR NOT HAVING A FAMILY DOCTOR

	Number	Percent not having family doctor (N= 138)*
Don't need a doctor often.	69	50.0
Recently moved or move about.	23	16.7
Prefer not to use one doctor.	22	15.9
Family doctor died.	18	13.0
Don't believe in doctors.	9	6.5
Don't like local doctors.	9	6.5
Prefer to use specialists.	8	5.8
Use medical institutions.	7	5.1
Quit using.	2	1.4
Financial resources.	2	1.4
TOTAL REASONS	169	

*Adds to more than 100 percent because some responses were placed in more than one category.

TABLE 5 -- ORIENTATION TOWARD FAMILY DOCTOR

Orientation	Number	Percent
Instrumental	407	50.5
Mixed	189	23.4
Expressive	210	26.1

TABLE 6 -- ORIENTATION TOWARD THE FAMILY DOCTOR BY AGE OF HOUSEHOLD HEAD AND FAMILY INCOME

	Age of Female Head					
Orientation	Under 40 years,		40-60 years,		65 years & over,	
	Family income of		Family income of		Family income[1] of	
	-$3,000	$3,000 +	-$3,000	$3,000 +	-$1,000	$1,000 +
	(N=55)	(N=163)	(N=197)	(N=180)	(N=68)	(N=124)
	(Percent)		(Percent)		(Percent)	
Instrumental	36.4	51.5	55.8	51.7	48.5	47.6
Mixed	30.9	30.1	22.3	21.7	22.0	17.7
Expressive	32.7	18.4	21.8	26.7	29.4	34.7

[1]Income divided at $1,000 for oldest families because few had incomes of $3,000.

the extreme form of this theme and it appears that the doctor as a confidant in other than health matters was not common.

Some of the responses are mixtures of both *expressive* and *instrumental* themes either because the respondent stated both or gave a statement that was intermediate; for example, "that the doctor knows his patient and his background of illness." These were placed in a *mixed category*. Generally, the expressions in this category tended to be toward the instrumental direction.

More than half of the statements were regarded as instrumental while about one-quarter were judged to be expressive, and about one-quarter were mixed. (Table 5) It seems clear that the family doctor relationship was perceived as one that contributed to the convenience and the assurance of needed services more often than one based on deep personal attachments of doctor and patient.

Finally, in our analysis of this relationship we sought to determine if the types of reasons for having a family doctor were associated with age and income of the family. The only apparent differences occur in the youngest families, whereas those with higher incomes were more likely than those with lower incomes to express instrumental orientations. Conversely, those with lower incomes were more likely than those with higher incomes to have expressive orientations. Overall there was little difference in the responses on the basis of either age alone or of income alone of the families. (Table 6)

The lack of a clear relationship between age and income of the family and their justification for maintaining a family doctor relationship suggests the continuing viability of the family doctor practitioner.

The young family heads give reasons similar to those a generation older for maintaining the relationship. The lack of correlations with income also suggests that the basis for the family doctor relationship is not economically determined. Instead it appears to be a part of the culture in providing medical services and is generally accepted by a large majority of the people of the area.

Part III

Perception and Knowledge About Specialists

A common observation about the distribution of physicians in rural areas is that specialists' services are greatly underrepresented. The area in which the present study was conducted exemplifies this situation. There were no full-time specialists in the communities and no one in the four communities was closer than 60 miles to a regional center with a large number of medical specialists; however, specialists were used. The extent to which respondents differentiate between specialists and general practitioners and the basis for such distinctions is the focus of this section.

What is a medical specialist?

Respondents were asked, "What is a medical specialist?" Their responses reported in Table 7 were largely in terms of treatment for specific conditions or a particular area of medicine; citing examples of specialists, i.e. pediatricians, surgeons, eye specialists, etc.; and statements regarding the greater skill, knowledge

TABLE 7 -- CATEGORIZATION OF RESPONSES TO THE QUESTION: WHAT IS A MEDICAL SPECIALIST?

Category	Percent of the Sample* (N=951)
Restricts practice to a special area or gives example of a specialty, i.e. obstetrician.	66.7
Higher skill, training, knowledge.	20.5
General expertise, better in all areas.	12.8
Locational response.	2.3
Affective response.	1.4
Response of no knowledge or irrelevant to the question.	14.3

*Adds to more than a 100 percent because some responses placed in more than one category.

and/or education of specialists. A few respondents indicated that a specialist was synonomous with a particular type of specialty; for example, that he *is* a heart doctor (this type of response was placed in the first category in Table 7). Almost the opposite of this response was the idea that a specialist is a general expert with the implication that he is better for all conditions. Geographical location, on the other hand, was seldom used as a basis for description, and almost no one described specialists in terms of interpersonal relations (affective category) such as friendliness, its opposite, or some other personal qualities. However, this is not to say that such a response could not have been elicited if a different question had been asked.

Most of the respondents had at least minimum knowledge of the term medical specialists; the responses they gave were often quite specific to a type of practice or else they gave examples. The responses were almost entirely in terms of the technical work or the characteristics of specialists and rarely in terms of personal relationships.

Identifying specialists

As a measure of the ability to accurately differentiate medical specialists from general practitioners, the respondents were asked to identify by name any medical specialists they could think of in southern Missouri or northern Arkansas.

Roughly one-half of the respondents named one or more doctors in response to the question. Of those named, approximately 80 percent were correctly identified as full-time practicing specialists. Thus only about 40 percent of the sample members were able to identify at least one full-time medical specialist by name.

In total, 1,042 names were provided (the number named ranged from one to nine practitioners). The names were compared with those in official directories of the American Osteopathic Association and the American Medical Association. Of those designated as specialists in the interviews, 80 percent were actually full-time specialists as indicated by the doctors' self-statements in the directories and a majority (53 percent) were board certified (Table 8). About 3 percent were reported in the directories as part-time specialists and about 6 percent were general

TABLE 8 -- SPECIALTY STATUS OF PRACTITIONERS DESIGNATED AS SPECIALISTS BY RESPONDENTS

Specialty Status	1,042 Designations	
	(Number)	(Percent)
Full-time specialty, board certified	556	53.4
Full-time specialty, not board certified	274	26.3
Part-time specialty	32	3.1
General practice	58	5.6
Chiropractor	8	0.8
Undetermined	114	10.9

practitioners. As stated before, in these latter cases, certain doctors may have a reputation in the community for special skills even though the records indicate general practice. A few of the specialist designations were chiropractors. In about 11 percent of the cases, the specialty status of the practitioners named could not be determined because the names given by respondents could not be matched with those in the directories. Following the practice of the National Center for Health Statistics (May, 1966, pp. 62-63), these were regarded as inaccurate designations.

Our conclusion is that while a sizable proportion of the respondents did not name a practitioner at all in response to the request to do so, those who named a practitioner did so with a considerable degree of accuracy. Those who declined to name a specialist were at least implicitly making a distinction between local general practitioners and specialists, because almost all of the respondents in the sample were able to identify a local general practitioner as a family doctor.

Identifying specialists by age and income of respondent's family

The ability to correctly name a medical specialist was compared on the basis of the age and income level of the respondent. The comparisons (Table 9) reveal that differences in income account for much more of the variation in responses than is accounted for by age. Higher income families, regardless of age, were more likely to name a specialist than lower income families.

Recommendation of doctors in hypothetical situations

To assess the choice of doctors in common situations, respondents were asked in three different hypothetical situations if they would recommend a doctor to a new family in the community. The three hypothetical situations were:

1) Suppose a couple with two grade school children moved into the neighborhood. Although they had no illness, they thought they should have a family doctor in case they needed one.

2) Suppose a young couple from outside the community had just moved into your neighborhood. The wife is a few months pregnant. Because they were new and unfamiliar with the medical facilities, they did not know whom to contact.

3) Suppose a couple who has recently moved into your neighborhood asks

TABLE 9 -- RELATIONSHIP OF AGE AND INCOME TO CORRECTLY NAMING A FULL-TIME SPECIALIST

Correctly Named a Full-Time Specialist	Age of Female Head: Under 40 years, Family income -$3,000 (N=64)	Under 40 years, Family income $3,000+ (N=186)	40-64 years, Family income -$3,000 (N=238)	40-64 years, Family income $3,000+ (N=203)	65 years & over, Family income -$2,000 (N=172)	65 years & over, Family income $2,000+ (N=64)
	(Percent)		(Percent)		(Percent)	
Yes	33.4	48.4	32.3	50.3	27.3	50.6
No	65.6	51.6	67.7	49.7	72.7	49.4

your advice concerning a medical problem. The husband has had heart trouble for a number of years and needs the services of a doctor. They want to know if you can recommend a "good" doctor; especially one who might be able to help with his particular condition.

The questions were phrased so that failure to make a recommendation was acceptable. If a doctor was recommended, then a series of questions were asked about the practitioner, including his name.

Progressively fewer respondents were willing to recommend a doctor in each of the above situations (Table 10). More than four in five recommended a family doctor; three in four recommended a doctor for a pregnant woman; and two in four recommended a doctor in the heart condition situation.

In the first situation, most of the respondents recommended a local general practitioner. Of those making a recommendation, less than 2 percent named a full-time specialist (Table 11). In most cases (95.0 percent), the recommendation was the family doctor of the respondent.

The other two situations were more apt to receive the suggestion of use of a specialist.

In the situation dealing with pregnancy, 75.1 percent of the respondents would make a recommendation (Table 10). Of those who did not, most said they did not have current information on the best doctors for this situation and/or they did not know any obstetricians. Of those who made a recommendation only 4.6 percent named a physician who had declared obstetrics as a full-time specialty (Table 11). Such a choice, by necessity, would have been a doctor at a considerable distance from the respondent's residence. The doctor most often recommended was the family doctor of the respondent (62.2 percent). There were some local doctors recommended in this situation relatively more often than they were named as

TABLE 10 -- RECOMMENDATION OF A DOCTOR TO A NEW FAMILY IN THE NEIGHBORHOOD IN THREE HYPOTHETICAL SITUATIONS

	Hypothetical Situations		
	Family Doctor	Doctor for Pregnant Women	Doctor for Heart Condition
	(N=951) (Percent)	(N=951) (Percent)	(N=951) (Percent)
Would recommend doctor	81.8	75.1	51.4
Would recommend a clinic	——	——	3.5
Would not recommend a doctor	18.0	24.7	44.8
Don't know or no answer	0.2	0.2	0.3

TABLE 11 -- TYPE OF DOCTOR RECOMMENDED IN THREE HYPOTHETICAL SITUATIONS BY RESPONDENTS MAKING A RECOMMENDATION

	Family Doctor	Pregnancy	Heart Condition
	(N= 778) (Percent	(N= 714) (Percent)	(N= 489) (Percent)
General practitioner (includes part-time specialists)	98.1	94.4	83.0
Full-time specialist	1.7	4.6	15.7
Chiropractor	0.1	0.3	0.8
Can't determine	0.1	0.7	0.4

family doctors. This indicates that even in communities where all the doctors are general practitioners there may still be some locally defined degree of specialization of service and skills.

Only about half of the respondents were willing to make a recommendation in the hypothetical situation dealing with heart disease. In addition to those recommending a doctor, 33 respondents recommended a clinic (Table 10). Most gave as the reason for not making a recommendation that they did not know a doctor who was especially good in this field and/or a heart specialist or that none was available in the area. Some did not make a recommendation on the principle that everyone should make his own decision or that they did not want the responsibility.

To a greater extent than in other situations, doctors who were recommended for the heart condition were located outside the communities or immediate vicinity (25.4 percent). They were also more likely to be full-time specialists; although this amounted to only 15.7 percent of the total (Table 11). In about two-thirds (64.8 percent) of the cases, the doctor recommended for the heart condition was the respondent's family doctor. Most of the respondents recommending a doctor as a specialist knew whether or not he was a specialist; 10 identified a doctor as a specialist when he was a general practitioner, and only one was identified as a general practitioner when he was a specialist. As in the second hypothetical situation, certain local doctors were recommended more frequently than they were named as a family doctor. The interpretation is again that, within the community, doctors gain reputations as having special skills.

From these data, it can be said that respondents were quite willing to recommend doctors under hypothetical situations. These were made most frequently for family doctors and least frequently in a situation involving a heart condition. But even in the latter case, more than half would make a recommendation. In each of the hypothetical situations, the respondent's family doctor was most likely to be recommended. This suggests that when people in the area go to the family doctor they expect to be treated for a wide range of ailments including more serious conditions.

The apparent willingness of lay persons to recommend physicians in these hypothetical situations suggests an extensive lay referral system in which people give advice about physicians.

Part IV

The Perception and Knowledge About Osteopathic Doctors

Osteopathy emerged as a profession in 1892 when Andrew T. Still organized and instructed his first class* (Hildreth: 1938, pp. 29-31). The philosophy and practice was based on the theory that the normal body, when in correct adjustment, is capable of producing its own remedies against infection and other toxic conditions. The role of the physician was to search for and remove, if possible, any peculiar conditions of joints, tissues, diet, or environment. The principal therapeutic technique was body manipulations. (See Stedman's Medical Dictionary, 19th edition.) Almost from its inception, however, osteopathy moved closer to "regular" medicine in practice. Although surgery was not taught in the beginning classes, it soon became a part of the curriculum (Hildreth: 1938, p. 211). The question of whether or not to use drugs was a major one that threatened to divide the profession, but was resolved in favor of drug use. The manipulative techniques and osteopathic philosophy that distinguishes the profession were retained. Presently, there is a range of specialities that almost duplicates those of the regular medical profession and in recent years osteopathy has been accorded full recognition by the military and the U.S. Public Health Service. Recognition by the regular medical profession has proceeded farthest in California where the state medical society has admitted osteopaths to membership and the former osteopathic training school has become a medical school. Recent action (July, 1969) of the AMA has made it possible for osteopathic physicians to join that organization (American Medical News, July, 1969, p. 6).

Missouri, in addition to being the home of osteopathy, has two of the five training schools in the country and the largest number of osteopathic physicians per capita in the nation; about one in five physicians in the state is an osteopath. Osteopathic doctors are more likely than medical doctors to be in general practice and to be located in rural areas. (Hassinger and Hobbs: 1967: 6-10). As a consequence, in many rural areas of the state osteopathic doctors outnumber medical doctors.

As was indicated, osteopathic doctors are prominent as practitioners in the studied area. In one of the communities, an osteopathic physician was the only resident doctor. In two of the communities osteopathic physicians and medical doctors were present in equal numbers. In the largest community medical doctors outnumbered osteopathic doctors six to two.

What is an osteopath?

An attempt was made to determine the respondent's perception of osteopaths

*The original class numbered 17 and included three members of Dr. Still's family. It met in a 14 x 28 foot building in Kirksville, Mo.

by asking them, "What is an osteopath or a D.O.?" The categorization of the responses of this question are reported in Table 12. The most frequent descriptions of osteopaths referred to their therapeutic procedures such as "massages" and "adjustments" and/or the physical location of the therapy. A common expression of therapeutic procedure was "rubbing doctor"; about one in five used it. Physical manipulation was referred to as "giving treatments." References to the bones, muscles, spine, and neck were common. The term "bone doctor" was sometimes used, although this term was more commonly applied to chiropractors.

Responses placed in this category included:

"D.O. deals with body instead of giving medicine; he rubs you and works on joints."

"Guess he is one that works on back."

"That's what we call a rubbing doctor and he pops your bones. Dr. is a D.O. (correct identification)."

Another common theme emphasized, apparently to indicate similarity to M.D.s, was that an osteopath gives medicine *and* treatments. Responses to illustrate this perception of osteopaths were:

"They use medicine and treat too; give adjustments."

"Bend your neck around, pop your bones and rub you; (then he said) no, that's a chiropractor. They are different from a chiropractor; they give medicine, too."

To a lesser extent, but in substantial numbers, osteopaths were described in terms of general medical competence. For example,

"A general medical doctor; does what any doctor can do."

"Just a regular doctor who can take care of you when you are sick."

TABLE 12 -- RESPONSES TO THE QUESTION: WHAT IS AN OSTEOPATH?

Categorization of Responses	Percent of Total Sample (N=951)*	Percent of Total Responses Categorized (N=1164)
Characteristic therapeutic procedure, i.e. rubs; or therapeutic location, i.e. works on spine	56.2	45.9
Gives medicine and treatments	30.5	24.9
Lower professional status, marginal, practitioner, or like a chiropractor	20.5	16.8
General doctor or regular doctor	15.2	12.5
No knowledge or response irrelevant	15.1	——

*Adds to more than 100 percent because some responses in more than one category.

Finally there were frequent references to the professional status of osteopaths. Included were statements that confused D.O.s with chiropractors or equated the two.

The purpose of asking these questions was not to determine the "correctness" of information about osteopaths, but to ascertain the perceptions held by people in the area. It should be pointed out, however, that most of the responses were well within the possible experiences of respondents. Emphasis upon manipulation of the skeletal-muscular system is consistent with the historical osteopathy and remains part of the osteopathic philosophy of healing currently taught in training schools. On the other hand, osteopathic physicians generally use drugs and employ surgical techniques (although some confine their practice to manipulation). In Missouri they are licensed by the same laws and rules for medical practice as doctors of medicine. Commonly, osteopathic doctors are general practitioners in the role of family doctor. At the same time, although osteopathic doctors are becoming more accepted, they do not have the full access to hospital facilities, nor as close a professional and referral association with medical specialists as do M.D.s. These factors probably contribute to their assignment of lower professional status by some respondents. The historical change in osteopathy from reliance on manipulation to extensive use of drug therapy is reflected in the description of some specific osteopathic doctors as being both D.O.s and M.D.s.

Perceptions of osteopaths by age, family income, and professional type of family doctor

Responses to the question, "What is an osteopath?" were examined by age of respondent, family income, and type of family doctor (D.O. or M.D.) (Tables 13, 14, 15).

It was found that the respondents in the youngest age category (under 30 years) had a somewhat different pattern of responses than those in the other age categories (Table 13). They were more likely than other age groups to describe osteopaths in terms of their "professional status" and as a "regular doctor." At the same time, there were fewer responses that were classified as "characteristic therapeutic procedure." This may reflect the recent trends where the differences in therapeutic practices of medical doctors and osteopathic doctors have become less distinct.

A similar but less distinct pattern of responses was identified when classified on the basis of family income (Table 14). Those respondents whose income was above $3,000 displayed a somewhat greater tendency to characterize osteopaths on the basis of status criteria. However, since age is inversely related to income for this sample, it is probable that this tendency reflects an influence of age rather than income.

It might be expected that there would be substantial differences in the description of osteopaths on the basis of reporting an M.D. or a D.O. as a family doctor; however, the data do not clearly support this expectation. Osteopaths were described more often as being a regular doctor who gives medicine *and* treatment and less often in terms of lower professional status and characteristic therapeutic procedures by respondents with D.O.s as family doctors than by those with M.D.s

TABLE 13 -- RESPONSES TO THE QUESTION: WHAT IS AN OSTEOPATH BY AGE OF RESPONDENT.

	Age of Respondent (Female Head of Household)			
	Percent of Total Responses Categorized			
	Under 30 years	30-49 years	50-64 years	65 years & over
Categorization of Responses	(N= 122) (Percent)	(N= 368) (Percent)	(N= 381) (Percent)	(N= 293) (Percent)
Characteristic therapeutic procedure, i.e. rubs; or therapeutic location, i.e. works on spine	28.7	44.6	46.7	53.6
Gives medicine and treatments	22.1	25.8	24.7	25.3
Lower professional status, marginal practitioner, or like a chiropractor	26.2	17.9	16.8	11.3
General doctor or regular doctor	22.9	11.7	11.8	9.9

TABLE 14 -- RESPONSES TO THE QUESTION: WHAT IS AN OSTEOPATH BY FAMILY INCOME OF RESPONDENT'S FAMILY

	Family Income				
	Percent of Total Responses Categorized				
	$0-1,999	$2-2,999	$3-4,999	$5-9,999	$10,000+
Categorization of Responses	(N= 373) (Percent)	(N= 228) (Percent)	(N= 240) (Percent)	(N= 242) (Percent)	(N= 42) (Percent)
Characteristic therapeutic procedure, i.e. rubs; or therapeutic location, i.e. works on spine	51.7	49.6	41.7	40.1	38.5
Gives medicine and treatments	25.7	22.8	26.2	24.4	28.8
Lower professional status, marginal practitioner, or like a chiropractor	12.9	15.8	19.2	21.5	19.2
General doctor or regular doctor	9.6	11.8	12.9	14.0	13.5

TABLE 15 -- RESPONSE TO THE QUESTION: WHAT IS AN OSTEOPATH BY PROFESSIONAL TYPE OF FAMILY DOCTOR (M.D. or D.O.)

Categorization of Responses	Professional Type of Family Doctor — Percent of Total Responses Categorized: Medical Doctor (N= 666) (Percent)	Osteopathic Doctor (N= 332) (Percent)
Characteristic therapeutic procedure, i.e. rubs; or therapeutic location, i.e. works on spine	49.1	40.4
Gives medicine and treatments	22.4	29.8
Lower professional status, marginal practitioner, or like a chiropractor	18.3	13.2
General doctor or regular doctor	10.2	16.6

as family doctors (Table 15). This is the direction of the relationship that might be expected, but examination of Table 15 indicates that the differences in response patterns were not large. The fact is that osteopaths are generally described in terms of "characteristic therapeutic procedures" and "giving medicine and treatments" by all components of the population, including those who have family doctors who are osteopaths.

Preference for osteopaths and medical doctors

Thus far we have not directly examined preferences for medical doctors or osteopathic doctors. Now we consider the question, "Does it make any difference to you if a doctor is a medical doctor or an osteopath?" If the response was "yes", then the type of doctor was determined. The results were as follows:

	Number	*Percent*
Preferred M.D.	653	68.7
Preferred D.O.	16	1.7
No preference	279	29.3
No answer	3	0.3

Of those respondents who expressed a preference, almost all of them preferred a medical doctor. However, it should not be forgotten that more than a quarter of the respondents declared no preference. In the following tables and discussion we have combined preference for D.O. and no preference into one category, but the preponderance of responses in this category were "no preference."

TABLE 16 -- PREFERENCE FOR M.D. OR D. O. BY SOCIO-ECONOMIC CHARACTERISTICS OF FAMILIES

Family Characteristic	Preference for Professional Type	
	M.D.	No Preference or D.O.
	(N=652)* (Percent)	(N=294)* (Percent)
Age of Female Head		
Under 50 years	43.7	45.2
50 years and over	56.3	54.7
Education of Female Head	(N=651)*	(N=295)*
8 years or less	46.6	56.6
9-11 years	17.4	19.3
12 years and over	36.1	24.1
Family Income	(N=639)*	(N=286)*
Under $3,000	42.7	64.3
$3,000 and over	47.3	35.7
Professional Type of Family Doctor	(N=554)**	(N=256)**
M.D.	81.0	39.8
D.O.	19.0	58.2
D.C.	----	2.0

*Numbers vary because of no responses.
**Number for those who had a family doctor.

Preference for D.O. and M.D. by family socio-economic characteristics and type of family doctor

There was no correlation between the age of the respondent with a preference for M.D.s over D.O.s or no preference. (Table 15) There was, however, a slight tendency for those preferring M.D.s to be in the higher education and income categories compared to those who had no preference.

A strong relationship existed between the preference for an M.D. or D.O. and the professional type of family doctor (Table 16). Of those who had a family doctor of any type and who also expressed a preference for an M.D., over 80 percent had an M.D. as a family doctor. In contrast, of those with a family doctor expressing no preference (or a preference for a D.O.), about 40 percent had an M.D. as a family doctor. This finding raises the question as to whether the choice of professional type of family doctor follows preference or whether situations which foster the use of one or the other (i.e. availability) change preferences.

Identifying osteopaths

We have developed information on the perception and evaluation of osteopaths by people in a rural area; however, even at this point, it is not clear if the respondents could accurately distinguish between those practitioners who were osteopaths and those of other professional types. In order to determine whether such distinctions could be made, the respondents were asked to name osteopaths who practiced in the area. Over three-quarters of the respondents named one or more practitioners. In all, 726 respondents made 1,135 identifications (Table 17).

Almost 82 percent of the practitioners who were named as osteopaths were accurately placed. It was not possible to determine the professional type of about four percent of the designations. Only three percent of those identified as osteopaths were actually medical doctors. The greatest error was identifying a practitioner as an osteopath when in reality he was a chiropractor; there were 134 (11.8 percent) designations of this kind. This suggests in a fairly large number of instances, a chiropractor served as the individual of reference for perception of osteopaths. That is, for a fairly large number of people, perceptions of osteopaths and preferences expressed are erroneous since they are based upon inaccurate identification of practitioners. One consequence of such erroneous identification is that it effectively reduces the number of medical practitioners who are regarded as "available" to people in the area. If an osteopath who might be qualified to treat a range of illnesses is regarded by a sizable number of people as a chiropractor, it is improbable that they would regard him as "available" to them for treatment of conditions.

Summary of perceptions of osteopaths

In the study area, distinctions between medical doctors and osteopaths were made by a majority of respondents. The osteopaths were often described in terms of the manipulative procedures and the muscular-skeletal focus of treatment. A common perception was that osteopaths give both medicine and treatments (treatments meant physical manipulation). At the same time, a substantial proportion of the respondents cited the general medical character of osteopathic

TABLE 17 -- ACCURACY OF DESIGNATION OF PRACTITIONER AS OSTEOPATH

Type of Practitioner Named as Osteopath	Number of Designations Made	Percent of Total Designation
Osteopath	926	81.6
Medical Doctor	31	2.7
Chiropractor	134	11.8
Other Marginals	2	0.2
Undetermined	42	3.7
Total Designation	1135	100.0

practice, or they said that there was no difference between M.D.s and D.O.s. The youngest respondents were more likely to make the latter observation while the oldest families were more likely to make distinctions on the basis of therapeutic procedures. These differences in perception on the basis of age could be accounted for, in part, by changes in the osteopathic profession itself within the life-time of the older respondents. Also the older respondents may use older osteopathic physicians who have retained more of the manipulative techniques as their point of reference.

More than two out of three respondents preferred a medical doctor over an osteopathic doctor. On the other hand, about 30 percent indicated that they had no preference for one type of practitioner over the other. Preference or no preference for an M.D. was related to whether or not the family doctor was an M.D. or a D.O. The selection of a D.O. as a family doctor, however, is not a rejection of a regular medical practice because, for the most part, D.O.s are engaged in general medical practice and those who reject D.O.s as family doctors do not express a rejection of M.D.s. This suggests the possibility that fairly small differences of convenience and other situational factors can overcome the differences in preference of practitioners and that experience with a D.O. as a family doctor can modify the generally prevalent preference for medical doctors.

Part V

Perception and Knowledge about Chiropractors

The chiropractic profession represents a radical departure in the theory of healing from the regular medical profession. Its major premise is that the nervous system controls the physiological functions of the body. Hence, treatment is by adjustment of the muscular-sekletal system, especially the spinal column. It founder was David D. Palmer who began to practice in 1895. He established the Palmer College of Chiropractic in Davenport, Iowa, in 1898. Since that time, although some differences have arisen between traditionalists and modernists over techniques, chiropractic has remained a system of drugless, non-surgical therapy. Today, still concentrated in the Midwest, chiropractic with about 20,000 licensed practitioners, is the largest healing professional alternative to regular medicine as represented by doctors with M.D. degrees or D.O. degrees. (Chiropractors exceed osteopaths in number by between six and seven thousand.) Missouri has two of the eleven training institutions approved by one or the other of the two chiropractic associations. It has the largest number of chiropractors per 1,000 population of any other state with the exception of New Hampshire and its total number is exceeded only in New York, California, and Texas. (Health Resources Statistics, 1970: 51-54)

What is a chiropractor?

About 10 percent of the sample said they did not know what the term chiropractor meant. An additional 2 percent gave responses that were irrelevant to the question.

TABLE 18 -- RESPONSES TO THE QUESTION: WHAT IS A CHIROPRACTOR?

Categorization of Responses	Percent of Total Sample (N=951)*	Percent of Total Responses Categorized (N=958)
Characteristic therapeutic procedures, i.e. adjustments, or therapeutic location, i.e. spinal column	66.9	66.4
Does not give medicine	15.6	15.4
D.C. similar to D.O.	15.1	15.0
Lower professional status, marginal practitioner	3.2	3.1
No knowledge or response irrelevant	12.2	----

*Adds to more than 100 percent because some responses are in more than one category.

As can be seen in Table 18, about two-thirds of the respondents described chiropractors in terms of therapeutic procedures and/or location of these therapeutic procedures. The therapeutically descriptive terms "bone-cracker", "bone-popper" and "rubbing-doctor" were applied with some frequency to chiropractors. The location of treatment mentioned was commonly the spinal column, although other parts of the muscular-skeletal system were also mentioned.

Counted separately, but related to therapeutic procedures, were statements that chiropractors do not give medicine—about 16 percent of the respondents made this observation. Fifteen percent perceived chiropractors and osteopaths as similar or even identical, while only three percent commented on the lower professional status of chiropractors.

Among the responses illustrating therapeutic procedure and/or the physiological location of the therapy were:

"They work on the spine. They give adjustments on the spine. If the vertebrae are slipped it causes trouble. They work on them and get them back."

"They are more for muscles, nerves, and bones."

"Someone that relieves tension and relaxes muscles and puts discs back in place."

"He works on you when you have bones out of joint."

"Doctor that pops your back."

Statements that chiropractors "do not give medicine" were usually accompanied by the observation that they manipulate one way or the other.

"He don't practice medicine. Just gives adjustments."

"They are not medical doctors. Works on the back and can't give medicine."

Other persons noted the similarity of D.C.s and D.O.s.

"I don't know the difference between a chiropractor and osteopath. He (D.C.) gives adjustments too."

"Like an osteopath. There may be a little difference between them, but I don't know what it is. Treatments and medicine. Treatments for nerves."

"I think a D.C. doesn't go as far as a D.O. It's more or less the beginning of osteopathy. They manipulate as a D.O. They hurt more."

To summarize, the perceptions of chiropractors were heavily concentrated on the characteristic therapeutic procedures. Furthermore, there were common terms used to described the procedures such as: adjustments, manipulation, rubbing, nerves, spine, bones, and the frequent mention of "no medicine." Chiropractors were not described in terms of general medical care, but rather in terms of the specific kinds of treatment. The range of treatment of these practitioners was well encompassed by the respondents' descriptions of what they do. However, treatment as seen by the respondents, did not usually apply to the whole range of healing as the chiropractic philosophy would suggest. Rather chiropractors were described as practitioners who did certain kinds of things which were useful only in certain defined situations.

What is a chiropractor, by family age, income, and professional type of family doctor

The responses to the question, "What is a chiropractor?" were examined by the age of the respondents, the family income, and the type of family doctor (Tables 19, 20, and 21).

TABLE 19 -- RESPONSES TO THE QUESTION: WHAT IS A CHIROPRACTOR BY AGE OF RESPONDENT

	Age of Respondent (Female Head of Household) Percent of Total Responses Categorized			
	Under 30 years	30-49 years	50-64 years	65 years & over
Categorization of Responses	(N= 122) (Percent)	(N= 337) (Percent)	(N= 348) (Percent)	(N= 253) (Percent)
Characteristic therapeutic procedure, i.e. adjustments; or therapeutic location, i.e. spinal column	84.2	72.4	64.9	65.2
Does not give medicine	7.5	10.4	18.1	16.2
D.C. similar to D.O.	4.2	13.6	14.7	16.7
Lower professional status, marginal practitioner	4.2	3.6	2.3	2.0

There was much similarity in the responses of each of the age groups (Table 19). Perhaps the most revealing difference is that the youngest families were less likely to cite the similarity between osteopaths and chiropractors. This is consistent with our earlier finding that the youngest family respondents were more likely than older family respondents to regard osteopaths as general doctors.

The responses did not differ much on the basis of the family income (Table 20). The only linear relationship with income was for the category of similarity between D.O.s and D.C.s. Those in the lowest income category were most likely (17.2 percent) and those in the highest income category least likely (6.5 percent) to mention the similarity in the two types of practitioners.

There were only slight differences in the response to "What is a chiropractor?" on the basis of whether the family doctor was a M.D. or a D.O. (Table 21). Only five of the families had a chiropractor for a family doctor, and they provided the seven categorized responses (some of the responses were placed in more than one category). These are not enough cases for analysis, but because of their relevance to this section, they are reported. Those who had a chiropractor for a family doctor emphasized the characteristic therapeutic procedures as did others in the sample. None with a chiropractor as a family doctor referred to the lower professional status of chiropractors.

Preference for chiropractors and medical doctors

Respondents were asked, "Does it make a difference if a doctor is a chiropractor or a medical doctor?" If the response was "yes," the preferred type of doctor was asked. The results were as follows:

	Number	*Percent*
Preferred M.D.	778	81.8
Preferred D.C.	8	0.8
No preference	159	16.7
No answer	6	0.6

About one in six said that they had no preference with regard to M.D.s and D.C.s. This response, however, may be a result of an unwillingness to express an opinion or of lack of information about practitioners. Of those who expressed a preference, virtually all chose M.D.s. In the following tables, preference for D.C.s has been combined with the "no preference" category. It should be remembered, however, that most of the cases in this category were actually expressions of "no preference."

Preference for D.C. and M.D. by family socio-economic characteristics

There was a weak inverse correlation between the age of the female head of the household and a preference for an M.D. (Table 22). About two-thirds of those who expressed no preference were 50 years or older while about one-half who expressed a preference for a medical doctor were in that age category.

The preference for M.D.s and D.C.s was even more closely related to the education of the respondents. Seventy percent of the respondents with no expressed preference had an eighth grade education or less, contrasted with 44 percent of

TABLE 20 -- RESPONSES TO THE QUESTION: WHAT IS A CHIROPRACTOR BY FAMILY INCOME OF RESPONDENT'S FAMILY

Categorization of Responses	Family Income Percent of Total Responses Categorized				
	$0-1,999	$2-2,999	$3-4,999	$5-9,999	$10,000+
	(N= 373) (Percent)	(N= 200) (Percent)	(N= 209) (Percent)	(N= 211) (Percent)	(N= 46) (Percent)
Characteristic therapeutic procedure, i.e. adjustments; or therapeutic location, i.e. spinal column	66.0	69.0	75.1	73.0	69.6
Does not give medicine	15.0	15.0	11.5	13.3	17.4
D.C. similar to D.O.	17.2	13.0	11.5	10.0	6.5
Lower professional status, marginal practitioner	1.9	3.0	1.9	3.8	6.5

TABLE 21 -- RESPONSES TO THE QUESTION: WHAT IS A CHIROPRACTOR BY PROFESSIONAL TYPE OF FAMILY DOCTOR (M.D., D.O. OR D.C.)

Categorization of Responses	Professional Type of Family Doctor Percent of Total Responses Categorized		
	Medical Doctor	Osteopathic Doctor	Chiropractor
	(N= 619) (Percent)	(N= 280) (Percent)	(N= 7)* (Percent)
Characteristic therapeutic procedure, i.e. adjustments; or therapeutic location, i.e. spinal column	70.3	67.1	57.1
Does not give medicine	13.2	15.7	28.6
D.C. similar to D.O.	13.9	14.3	14.3
Lower professional status, marginal practitioner	2.6	2.9	----

*N not sufficient for stable percentages, but reported because of special relevance to the question.

TABLE 22 -- PREFERENCE FOR M.D. OR D.C. BY SOCIO-ECONOMIC CHARACTERISTICS OF FAMILIES

Family Characteristic	Preference for Professional Type	
	M.D.	No Preference or D.C.
	Percent (N= 778)*	Percent (N= 166)*
Age of Female Head		
Under 50 years	46.7	33.7
50 years and over	53.3	66.3
Education of Female Head	(N= 777)	(N= 167)
8 years or less	44.2	70.0
9-11 years	18.1	16.8
12 years and over	36.6	13.2
Family Income	(N= 762)	(N= 160)
Under $3, 000	53.0	72.6
$3, 000 and over	47.0	27.4
Professional Type of Family Doctor	(N= 675)**	(N= 135)**
M.D.	72.1	48.1
D.O.	27.9	48.1
D.C.	----	3.7

*Numbers vary because of no response.
**Number for those who had a family doctor.

those who expressed a preference for medical doctors. At the same time 37 percent who expressed a preference for an M.D. were high school graduates compared with only 13 percent who expressed no preference (Table 22).

Income was also correlated with the preference for M.D. or D.C. About one-half of the respondents who expressed a preference for M.D.s were in the lowest income category (under $3,000) compared with almost three-fourths who expressed no preference or preference for a D.C. (Table 22).

Income and education are data which determine the socio-economic status of a family. These data suggest as the social class position increases, greater distinctions are made between various kinds of practitioners. It is probable that social class influences preferences in at least two ways: (1) because of higher income, the family has a wider range of choice (that is physically and economically more mobile) in the selection of practitioners; (2) because of higher levels of education, the family possesses more information about the various practitioners.

There is no clear expectation that families who had osteopaths as family

doctors should or should not express a preference for medical doctors when a choice is offered between a medical doctor and a chiropractor. A preference for M.D.s should be expected among those families who had an M.D. as the family doctor. The data show a clear relationship between preference between M.D. and D.C. and the professional type of family doctor (Table 22). Those who expressed a preference for an M.D., had an M.D. family doctor rather than a D.O. in a ratio greater than 3 to 1. On the other hand, those who expressed no preference or a preference for a D.C. were as likely to have a D.O. as an M.D. for a family doctor. The few families who reported a chiropractor as the family doctor also expressed no preference or preference for a D.C.

Identifying chiropractors

As with medical specialists and osteopaths, it was assumed that the ability to correctly identify practitioners is an indication of knowledge about differences between them. All respondents were asked to name any chiropractors who were practicing in the region.

Sixty-two percent of the respondents named one or more practitioners whom they thought to be a chiropractor; 590 persons named a total of 812 practitioners (Table 23). Of these, three-fourths were verified as being chiropractors. The fact that 16 percent of those who were named as chiropractors were, in reality, osteopaths shows that there was considerable confusion in identifying chiropractors and osteopaths. On the other hand, only three who were named as chiropractors (0.4 percent) were medical doctors. The professional type of nine percent could not be determined. From these data, it was apparent that the references for perceptions and evaluation of chiropractors were, in most cases, really chiropractors.

Since the respondents were also asked to name the medical specialists and osteopaths practicing in the region, some comparisons regarding differences in the extent and accuracy of knowledge about specialists, osteopaths, and chiropractors can be made. Of the three types of practitioners, a significantly higher percentage of people were able to name practitioners whom they thought to be osteopaths (76 percent) compared with 62 percent naming chiropractors and 50 percent naming

TABLE 23 -- ACCURACY OF DESIGNATION OF PRACTITIONER AS CHIROPRACTOR

Type of Practitioner Named as Chiropractor	Total Practitioners Named (Number)	(Percent)
Chiropractor	606	74.6
Medical doctor	3	0.4
Osteopath	128	15.8
Undetermined	75	9.2
Total designations	812	100.0

medical specialists. The accuracy of designation, however, varied little—82 percent of those named as osteopaths were verified as osteopaths compared with 80 percent of the medical specialists named and 75 percent of those named as chiropractors.

Summary of perception of chiropractors

The evidence from the Ozark sample is that distinctions are made between chiropractors and other practitioners. They are based largely upon the public's perception of treatment which is focused on the muscular-skeletal-nervous system and involves physical manipulation. In this regard, there is congruence between the professional chiropractic model and the lay perception. When it comes to the range of illnesses appropriate for chiropractic treatment, however, it appears that the public perception varies considerably from the professional chiropractic model. Whereas chiropractic philosophy covers the full range of illnesses, public perception severely limits the conditions that are appropriate for chiropractic treatment. In the process of choice of practitioner (not only D.C. but specialists and others), it is apparent that families commonly make self-diagnosis and select a practitioner accordingly.

Part VI

Conclusions

Perceptions, information, and behavior develop in social situations which are common to the community and produces a similarity of outlook. On the other hand, a diversity of outlook is produced by the unique experiences of each member. This applies to the area of perception and the use of health personnel. This report has presented information on perceptions of and knowledge about health personnel which are held by four Ozark communities.

The families commonly develop a relationship with a doctor so that most respondents were able to name a family doctor. The reasons for having a family doctor varied from the establishment of a "faith and trust relationship" to "convenience." Further, the bulk of the responses were instrumental, emphasizing records, availability, and convenience. These responses appeared to be only slightly related to the socio-economic characteristics of the families.

"Specialist" was a meaningful term to a majority of the sample respondents and they were able to provide a minimal description of specialist. While a substantial proportion were unable to provide the name of a specialist, the names that were provided were, for the most part, full-time specialists. The ability to correctly name a specialist was related to the socio-economic status of the family (as measured by income), but not to the age of the family. From hypothetical situations in which a specialist might be used, it is apparent that local general practitioners would be expected by many to provide the needed services.

There was considerable variation in the descriptions of osteopathic physicians. Rubbing and manipulation were commonly mentioned as characteristic therapeutic procedures, and at the same time, the fact that osteopaths give medicine and/or are general or regular doctors was a common understanding. There was some confusion

of osteopaths with chiropractic doctors by some of the respondents which was reflected by naming chiropractors as osteopaths; however, by and large, respondents named as osteopaths, were those physicians who, in fact, were osteopaths. When the question was asked directly, there was a general preference for M.D.s over D.O.s. While a substantial proportion expressed no preference, almost no one said that he preferred D.O.s over M.D.s. The cultural preference for M.D.s appears to be attenuated to some degree by experience of individual families especially when the family doctor is a D.O.

While there is a considerable variation in perceptions of osteopaths, there appears to be little with regard to chiropractors. They are overwhelmingly described in terms of characteristic therapeutic procedures and the descriptions while varying in detail are similar. With very minor exceptions, chiropractors are not regarded as appropriate practitioners for all illnesses. This does not mean that chiropractors are rejected as practitioners, but rather that they are perceived as limited practitioners.

REFERENCES

Gaffin, Ben and associates, *What Americans Think of the Medical Profession: Report on a Public Opinion Survey for the American Medical Association.* Chicago: Ben Gaffin and associates, (n.d.).

Hassinger, Edward W., and Daryl J. Hobbs, *Distribution of Health Services in Missouri.* Columbia, Missouri: University of Missouri, Agriculture Experiment Station Res. Bull. 917, 1967.

Hay, Donald G., *That They May Have Health Care.* Ann Arbor, Michigan: Edwards Brothers, Inc., 1960.

Hildreth, Arthur Grant, *The Lengthening Shadow of Dr. Andrew Taylor Still.* Macon, Missouri: A. G. Hildreth (private publisher), 1938.

Hoffer, Charles R., *et al., Health Needs and Health Care in Michigan.* East Lansing: Michigan State College Experiment Station, Special Bull. 365, 1950.

Koos, Earl Lomon, *The Health of Regionville.* New York: Columbia University Press, 1954.

Saunders, Lyle, *Cultural Differences and Medical Care:* The Case of the Spanish-Speaking People of the Southwest. New York: Russell Sage Foundation, 1964.

U.S. Dept. of HEW, *Characteristics of Patients of Selected Types of Medical Specialists.* National Center for Health Statistics, Series 10, No. 28, May 1966.

U.S. Dept. of HEW, *Health Manpower Service Book, Sect. 18, Manpower in the 1960's, Public Health Service,* 1964.

U.S. Dept. of HEW, *Health Resources Statistics 1969, Public Health Service,* 1970.

Zola, Irving K., "Culture and Symptoms- An Analysis of Patients' Presenting Complaints," *American Sociological Review,* Vol. 31, No. 5, Oct. 1966, pp. 615-630.

Appendix A – Schedule of Questions

Sample No.____________________

Schedule No.____________________

PATTERNS OF UTILIZATION OF HEALTH SERVICES

University of Missouri - 1967

Date of Interview____________________

Interviewer ____________________

Name____________________

Address ____________________

Open-country____________________

Center____________________

ALL ANSWERS WILL BE HELD IN STRICT CONFIDENCE

A. HOUSEHOLD COMPOSITION
(All persons in household during past year)

(1) Person No.	Name	(2) Age	(3) Sex	(4) Relation to Female Head	(5) High- est grade comp.	(6) 1-Empl. 2-Ret. 3-Unemp. 4-Other	(7) Work Status: Occupation	(8) Place of Emp. (town)	(9) If Not Employed, Principal Source of Income
1.			F	XXX					
2.			M						
Other Adults									
3.									
4.									
5.									
6.									
Children									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									

(INTERVIEWER NOTE: Include all persons who lived in the household during the past year and who consider this to be their residence; i.e., husbands temporarily employed elsewhere (military service, out of area employment etc.), unmarried college students, etc. In addition, include persons who were members of the household but who are now deceased.)

10. Since marriage (or age 18) have you lived in a town of 10,000 or more Yes - 1

No - 2

10b. (IF "YES", ASK:) Where did you live? ______________________

DA - 0

B. TRADE AREA DELINEATION

11a. Do you read any newspapers from this area regularly? Yes - 1

No - 2

b. (IF "YES", ASK:) From what town(s)? ______________________ DA - 0

12. In what town do you buy most of your groceries? ______________________

13. (ASK FOR ALL EXCEPT THOSE LIVING IN WEST PLAINS AND MT. GROVE) What is your main trade center? ______________________

West Plains - 1
Mt. Grove - 2

14. To what town would you usually go for medical services? ______________________

15. If you had to go to the hospital to what town would you usually go? ______________________

C. LEVEL OF HEALTH

16. In comparison with other families of about the same age in this community, would you say your family's health is better than, worse than or the same as other families'?

Better than - 1
Worse than - 2
Same as - 3
No Answer - 9

D. PERCEPTION OF HEALTH PRACTITIONERS

17. Now we'd like to talk with you about some doctors. What is a medical specialist?

18. Do you know of any medical specialists in the So. Mo. - No. Arkansas area?

Yes - 1
No - 2

(IF "YES", ASK:)

19. Who are the different medical specialists that you know about? DA-0

(a) NAME OF DOCTOR	(b) SPECIALTY	(c) TOWN WHERE LOCATED	(d) USED IN PAST 5 YEARS	
			Yes	No
			1	2
			1	2
			1	2
			1	2
			1	2
			1	2

20. What is an osteopath or a (DO)?

21. Have you or any others in your household ever used an osteopath?

Yes - 1
No - 2

22. Do you know of any osteopaths in this county or adjoining counties? Yes - 1
No - 2

(IF "YES", ASK:)

23. What are their names and in what town(s) are they located: DA-0

(a) NAME	(b) TOWN

24a. Does it make any difference to you if a doctor is a medical doctor (MD) or an osteopath (DO)? Yes - 1
No - 2

(IF "YES", ASK:)

b. Which do you prefer? DA - 0
MD - 1
DO - 2

c. What are the reasons for your preference? DA - 0

25. What is a chiropractor?

26. Have you or your family ever used a chiropractor? Yes - 1
No - 2

27. Do you know of any chiropractors in this county or adjoining counties? Yes - 1
No - 2

(IF "YES", ASK:)

28. What are their names and in what town(s) are they located? DA - 0

NAME	TOWN

29a. Does it make any difference to you if a doctor is a medical doctor (MD) or a chiropractor (DC)? Yes - 1
No - 2
No Opin. - 3

(IF "YES", ASK:) DA-0

b. Which do you prefer? DA-0
MD-1
DC-2

c. What are the reasons for your preference? DA-0

30. Are any of the following persons, who are mainly concerned with health services or treatment of disease, located in this or adjoining counties?

	(a)			(b)	(c)		
PRACTITIONERS	YES	NO	D.K.	LOCATION DA	USED IN PAST 5 YEARS DA	YES	NO
Pub. Health Nurse	1	2	3	0	0	1	2
School Nurse	1	2	3	0	0	1	2
Christian Science Practitioner	1	2	3	0	0	1	2
Faith Healer	1	2	3	0	0	1	2
Other (SPECIFY)	1	2	3	0	0	1	2

E. UTILIZATION

31. Are you or any member of your household limited in your activities because of an illness or physical handicap? Yes - 1
No - 2

(IF "YES", FILL TABLE BELOW)

(a) MEMBER CODE NO.	(b) LIMITATION NUMBER	(c) CONDITION, ILLNESS OR HANDICAP

32. Do you have a family doctor (a regular doctor to whom you usually go)? Yes - 1
No - 2

(IF "YES", ASK:)	(IF "NO", ASK:)
a. Name of Dr. ____________	e. How does it happen you do not have a family doctor?
b. Town where located ____________	
c. What are your reasons for having a family doctor?	(GO TO QUES. 33)

d. About how many visits did each member of the household make to your family doctor in the past 12 months? (FILL TABLE TO THE RIGHT--IF "NO" VISITS MADE ASK QUES. 33. IF ANY VISITS MADE, SKIP TO QUES. 34.)

(f) MEMBER CODE NO.	(g) NO. VISITS	(h) MOST SERIOUS CONDITION FOR WHICH SEEN

33a. Have you or any member of your household been to any doctor during the past 12 months? Yes - 1 No - 2

(IF "YES", DETERMINE NAME AND FILL TABLE IN QUES. 34; IF "NO", ASK:)

b. When was the last time a member of the household saw a doctor? ________ (year)

c. Which member was this? (CODE NO.) ____________

d. What was the purpose of the visit? ____________

e. Name of Doctor? ____________

f. Town where located? ____________

34. Have you or other members of your household been to a doctor other than Dr. ____________ (named in Ques. 32a) during the past 12 months? Yes - 1 No - 2

(a) MEMBER (CODE #)	(b) NAME OF DOCTOR	(c) TYPE/DOCTOR	(d) TOWN	(e) TIMES SEEN	(f) PURPOSE	(g) WHO SUGGESTED YOU SEE THIS DOCTOR

35. Was any member of the household in the hospital overnight during the past 12 months? Yes - 1 No - 2

(IF "YES", FILL TABLE BELOW; IF "NO", SKIP TO QUES. 36)

(a) MEMBER (CODE #)	(b) HOSPITAL	(c) TOWN	(d) PURPOSE OF HOSPITALIZATION	(e) # NIGHTS	(f) REASON FOR GOING TO THAT HOSPITAL

36a. When was the last time a member of the household was in the hospital? ________ (year)

b. Which member was it? (CODE NO.) ________

c. What Hospital? ________

d. What town? ________

e. Purpose of hospitalization? ________

f. Reason for going to that hospital? ________

F. HYPOTHETICAL SITUATIONS IN THE UTILIZATION OF HEALTH SERVICES

37. Suppose a couple with two grade school children moved into the neighborhood. Although they had no illness, they thought they should have a family doctor in case they needed one.

a. Would you recommend someone if they asked you? Yes - 1 No - 2

(IF "NO", ASK:)

b. Why would you not recommend someone? DA - 0

(IF "YES", ASK:)

c. Name of Doctor ________ Town ________ DA - 0

d. Why would you recommend this particular doctor? DA - 0

38. Suppose a couple who has recently moved into your neighborhood asks your advice concerning a medical problem. The husband has had heart trouble for a number of years and needs the services of a doctor. They want to know if you can recommend a "good" doctor; especially one who might be able to help with his particular condition.

a. Would you recommend someone to this person if he asked you? Yes - 1 No - 2

(IF "NO", ASK:)

b. Why would you not recommend someone? DA - 0

(IF "YES", ASK:)

c. Name of Doctor ______________ Town ______________ DA - 0

d. (IF FAMILY DOCTOR IS RESPONSE, ASK WHY RECOMMENDED) DA - 0

e. Is he a heart specialist? Yes - 1
No - 2
DA - 0

39. Suppose a young couple from outside the community had just moved into your neighborhood. The wife is a few months pregnant. Because they were new and unfamiliar with the medical facilities, they did not know whom to contact.

a. Would you recommend someone to her if she asked you? Yes - 1
No - 2

(IF "NO", ASK:)

b. Why would you not recommend someone? DA - 0

(IF "YES", ASK:)

c. Name of Doctor ______________ Town ______________ DA - 0

d. What type of doctor is he? ______________ DA - 0

e. Why would you recommend this particular person? DA - 0

G. OTHER PRACTITIONERS

40a. In the past 12 months, have you or any member of your household gone to a chiropractor? Yes - 1
No - 2

b. In the past 12 months, have you or any member of your household gone to anyone besides a physician such as a healer, Christian Science practitioner or other persons who are mainly concerned with health services or the treatment of disease? Yes - 1
No - 2

(1) MEMBER (CODE #)	(2) NAME OF PRACTITIONER	(3) KIND OF PRACTITIONER	(4) TOWN	(5) NO. TIMES SEEN	(6) PURPOSE	(7) WHO SUGGESTED YOU SEE THIS PERSON

41. Have you or any member of the family used any of the following during the past 12 months?

SERVICE	(a) YES	NO	DK	(b) MEMBER CODE NOS. CHILDREN	ADULTS	(c) TOWN
Public Immunization Program	1	2	3			
Hospital Emergency Room	1	2	3			
Nursing Home	1	2	3			
Mobile X-ray Unit	1	2	3			
Public Health Nurse	1	2	3			

42. Are any of these items a problem in getting to see a doctor?

	Y	N
Doctor is too far away	1	2
Doctor won't make house calls	1	2
Don't have transportation	1	2
Doctor too busy	1	2
Can't afford	1	2
Other (SPECIFY)__________	1	2

43. How long does it usually take you to get to the office of the doctor you use most often?

Less than 15 minutes - 1
15 minutes to 1/2 hour - 2
1/2 hour to 1 hour - 3
1 hour or longer - 4
Does not use doctor - 9

44. How do you usually get to your doctor's office?

Walk - 1
Drives self - 2
Other person in H.H. drives - 3
Someone outside family takes in car - 4
Bus or other public transportation - 5
Doctor comes to home - 6
Other (SPECIFY) __________ - 7

Does not use doctor - 9

45. Do you usually get an appointment with a doctor before you go?

Yes - 1
No - 2
Doesn't go - 9

46. Do you ever get advice over the telephone from a doctor?

Yes - 1
No - 2
Doesn't use doctor - 9

47. Do you ever call out of town doctors on the telephone for...

appointments - 1
advice or information about illness - 2
neither - 3

48a. Have you or anyone in your household changed doctors for any reason in the past ten years?

Yes - 1
No - 2

(IF "YES", ASK:)

b. What were the reasons for making a change? DA - 0

	DA	Y	N
49a. Do you or any member of your household have any kind of health insurance?		1	2

(IF "YES", ASK:)

b. Does it cover...

	DA	Y	N
Hospitalization	0	1	2
Doctors' services for operations	0	1	2
Doctors' office calls	0	1	2
Accidents	0	1	2

50a. What is the most serious illness or medical situation anyone in your household faced the last three years? (PROBE: Any minor ailments not requiring services of a doctor?)

b. Can you tell me exactly how this illness developed and what steps you took in dealing with it?

51. Will you please tell me which letter on this card best describes your total household income from all sources before income and social security taxes are withheld?

	Income	Code
a.	------ - 1,000	- 1
b.	1,000 - 1,999	- 2
c.	2,000 - 2,999	- 3
d.	3,000 - 4,999	- 4
e.	5,000 - 9,999	- 5
f.	10,000 +	- 6
	No answer	- 9