ETHNIC AND SOCIAL FACTORS IN MEDICAL CARE ORIENTATION

EDWARD A. SUCHMAN

The purpose of this report is to examine ethnic variations in health-related knowledge, attitudes and behavior in terms of the different forms of social organization found among the different ethnic groups in an urban community. The general hypothesis is that, within a community with as heterogeneous an ethnic composition as New York City, significant differences will be found among ethnic subgroups in responses to illness and medical care; and that, furthermore, these differences will be associated with variations in the form of social organization of the ethnic groups.

The specific hypothesis is that a "cosmopolitan" form of social organization will be more highly related to a scientific approach to illness and medical care than will a "parochial" social organization, which will be more highly related to a popular health orientation. Thus, one would predict that the more parochial an ethnic group is, the more likely it is that its members will adhere to a popular or nonscientific health orientation.

Finally, the more ethnocentric and cohesive the social group, the more isolated and alienated it will be from the larger society and the less likely to accept the objectives and methods of the formal medical care system.

To test the hypothesis, this paper will (1) determine how ethnic groups vary in their responses to illness and medical care; (2) analyze these ethnic groups for differences in form of social organization; and (3) relate any significant differences in social organization to the ob-

served variations in sociomedical factors, in an attempt to determine the extent to which such ethnic variation can be attributed to underlying differences in social organization.

PROCEDURE

This report is based upon information obtained by personal interviews with a subsample of 1,883 adults living in a probability sample of households in the Washington Heights Health District at the time of the 1960–1961 Master Sample Survey.[1]

Respondents were classified according to race, religion and country of origin into six ethnic groups:[2] Negro, Puerto Rican, Jewish, White Protestant, Irish-born Catholic and Other White Catholic. These six subgroups constitute meaningful sociocultural entities with diverse cultural traditions and social structures. We may expect to find among them differences in health-related knowledge, attitudes and behavior.

Ethnicity is, of course, related to social class, with the Puerto Ricans and Negroes belonging predominantly to the lower socioeconomic level, whereas the white Protestants and Jews are in the upper socioeconomic level. A socioeconomic status index was formed from the person's education, occupation and total family income.[3]

Health Orientation Index: "Scientific-Popular"

Each respondent was asked a series of questions dealing with various aspects of health, illness and medical care.[4] Using responses indicating (1) knowledge about disease, (2) skepticism of medical care, and (3) dependency in illness, a combined index of sociomedical variables was derived by multivariate analysis. This index measures the degree to which the individual maintains an informed, favorable and independent approach to illness and medical care. This dimension we have labeled as a "scientific-popular" health orientation, with the scientific end of the scale indicating an objective, formal, professional, independent approach; the popular end indicates a subjective, informal, lay, dependent health orientation.

Social Group Organization Index: "Cosmopolitan-Parochial"

On the basis of a series of questions dealing with the individual's friendship groups, his family and community relations, respondents were scored on five indices of social organization: (1) ethnic exclusivity, (2) friendship solidarity, (3) family tradition and authority

orientation, (4) social group cohesiveness and (5) religious attendance. The first three indices were combined, on the basis of multivariate analysis, to indicate the degree to which the individual comes from a social group that may be characterized as homogeneous and highly cohesive.[5] This dimension is called "cosmopolitanism-parochialism." This measure may be taken to indicate the degree of identification of an individual with a parochial or limited, traditional, narrowly confined and closely-knit "in-group" point of view, as opposed to a cosmopolitan or more worldly, urban or less personal way of life.

FINDINGS

The observed distributions of responses are presented in Table 1 and show quite conclusively that ethnic differences do occur in relation to each of the selected sociomedical factors. In regard to "knowledge about disease," Puerto Ricans are least informed, white Protestants are best informed. On a measure of "preventive medical behavior," the Puerto Ricans again score lowest, with the Jews and Protestants scoring highest. In regard to attitudes toward medical care, the Puerto Ricans score highest on "skepticism of medical care;" Protestants score lowest. An analysis of responses to illness shows the Puerto Rican group having the greatest difficulty in "acceptance of sick role," whereas the Irish-Catholic group shows the highest "dependency in illness."

TABLE I. RELATIONSHIP BETWEEN ETHNICITY AND INDICES OF HEALTH ORIENTATION

Indices of Health Orientation	*Negro*	*Puerto Rican*	*White Protestant*	*White Catholic*	*White Jewish*	*White Irish*	*Total*
Total cases*	442	170	165	354	490	174	1,795
Knowledge about disease: low score	29.5%	48.2%	18.1%	26.4%	26.2%	28.3%	28.6%
Preventive medical behavior: low	12.8	20.1	14.6	21.2	10.5	15.6	15.0
Skepticism of medical care: high	23.1	38.2	12.7	23.2	16.9	17.2	21.3
Physician's interest in patient's welfare: low interest	18.1	18.2	18.8	16.7	26.5	13.2	19.7
Acceptance of sick role: low	40.5	50.0	42.4	44.9	37.4	50.6	42.6
Dependency in illness: high	26.2	37.7	17.0	31.1	20.0	34.5	26.5
"Popular" health orientation	27.0	51.8	15.2	27.1	16.5	24.7	25.2

* Total number of cases in each table may vary slightly depending upon frequency of "no answer" category.

TABLE 2. RELATIONSHIP BETWEEN ETHNICITY AND INDICES OF SOCIAL-GROUP ORGANIZATION

Indices of Social Organization	*Negro*	*Puerto Rican*	*White*				*Total*
			Protestant	*Catholic*	*Jewish*	*Irish*	
Total cases	442	170	165	354	490	174	1,795
Ethnic exclusivity: high	18.1%	36.5%	9.7%	12.4%	6.9%	15.5%	14.7%
Friendship solidarity: high	29.2	56.5	15.2	42.6	33.1	56.9	36.8
Social-group cohesiveness: high	27.5	37.6	29.3	32.7	19.6	33.7	27.7
Family orientation to tradition and authority: high	24.0	43.4	16.9	32.9	20.2	42.4	27.8
Religious attendance: high	23.2	43.5	16.0	48.9	11.1	80.8	32.1
"Parochial" social organization	29.0	60.6	12.7	33.3	24.5	48.9	32.0

TABLE 3. HEALTH ORIENTATION ACCORDING TO ETHNICITY AND SOCIAL ORGANIZATION

Ethnicity	*Social Organization*		
	Cosmopolitan	*Mixed*	*Parochial*
	Per Cent "Popular" Health Orientation		
Puerto Rican	24.0 (25)*	35.7 (42)	65.0 (103)
Negro	18.0 (128)	23.2 (185)	41.4 (128)
White			
Irish	12.9 (31)	20.7 (58)	31.8 (85)
Other Catholic	13.7 (80)	23.1 (156)	41.5 (118)
Protestant	7.5 (80)	15.6 (64)	42.9 (21)
Jewish	9.1 (186)	17.4 (184)	26.7 (120)

* Numbers in parentheses refer to total cases in each group.

In general, it would seem that the greatest ethnic-group contrast in regard to sociomedical factors occurs between the Puerto Ricans on the one hand and the white Protestants and Jews on the other. In most aspects of health knowledge, attitudes and behavior, the Puerto Rican group stands out as most divorced from the objectives and methods of modern medicine and public health. This finding may help to explain why the Puerto Ricans (and, to a lesser extent, the Negroes) constitute the core of the "hard-to-reach" in public health and medical care.

Differences were also found among these ethnic groups for specific indices of social organization, presented in Table 2. Jewish and Protestant groups show the least amount of ethnic solidarity in regard to "ethnic exclusivity;" Puerto Ricans and white Catholics show the most, with Negroes falling in between. Again, the Puerto Ricans and Irish tend to belong to highly cohesive friendship groups, and white Protestants, Jews and Negroes belong to rather loose friendship groups. Finally, in regard to the authority structure of the family, the Puerto

Ricans and Irish also show the strongest orientation toward tradition and authority.

In general, the Puerto Rican group, the Irish and other Catholics are all highly parochial; the white Protestant and Jewish groups are highly cosmopolitan; and the Negro group is more inclined toward cosmopolitanism than parochialism.

Social Organization and Health Orientation

As hypothesized, differences in health orientation parallel these differences in social organization. Table 3 shows that the most highly parochial group, the Puerto Ricans, are twice as likely to have a popular health orientation as any other ethnic group. White Protestants and Jews, the most cosmopolitan of the ethnic groups, are also the most scientific in their approach to health and medical care.

Looking at the effect of social organization on health orientation within each ethnic group, it is found that in each case greater parochialism is associated with a more popular or nonscientific health orientation.[6] This relationship is strongest among white Protestants. The individual's degree of identification with his social group (ethnocentrism) strengthens or weakens his conformity to the overall medical orientation of his group. For example, Puerto Ricans who are highly limited in their associations to other Puerto Ricans are nearly three times as likely to have a popular health orientation as those for whom such ethnic ties are relatively weak. But the "cosmopolitan" Puerto Rican with weak ethnic group ties is less likely to have a popular health orientation than those "parochial" members of other ethnic groups who hold strong allegiances to their own ethnic group. Thus, the relationship between social organization and health orientation is independent of ethnic-group membership. Both ethnicity and form of social organization contribute independently and cumulatively to health orientation.

Socioeconomic Status and Health Orientation

A test of the relationship between socioeconomic status and medical orientation for each of the separate education, occupation and income measures composing socioeconomic status reveals that each measure is independently related to medical orientation. The less-educated, blue-collar and lower-income groups are less informed about disease, hold more unfavorable attitudes toward professional medicine and are more dependent upon lay support during illness. Of the three factors,

TABLE 4. HEALTH ORIENTATION ACCORDING TO ETHNICITY AND SOCIOECONOMIC STATUS

Ethnicity	*Socioeconomic Status*			
	Upper	*Upper Middle*	*Lower Middle*	*Lower*
	Per Cent "Popular" Health Orientation			
Puerto Rican	*	33.3 (39)**	53.0 (83)	70.3 (37)
Negro	13.5 (37)	21.1 (123)	24.7 (170)	47.6 (84)
White				
Irish	5.0 (20)	20.0 (65)	31.7 (60)	37.0 (27)
Other Catholic	27.6 (29)	20.3 (123)	25.0 (128)	44.3 (61)
Protestant	2.9 (35)	13.1 (61)	27.5 (51)	*
Jewish	8.9 (101)	13.8 (210)	24.5 (110)	29.5 (44)

* Less than 15 cases.
** Numbers in parentheses refer to total cases in each group.

TABLE 5. SOCIAL ORGANIZATION ACCORDING TO ETHNICITY AND SOCIOECONOMIC STATUS

Ethnicity	*Socioeconomic Status*			
	Upper	*Upper Middle*	*Lower Middle*	*Lower*
	Per Cent "Parochial" Social Organization			
Puerto Rican	*	59.0 (39)**	55.4 (83)	73.0 (37)
Negro	16.2 (37)	23.6 (123)	26.9 (171)	40.5 (84)
White				
Irish	40.0 (20)	36.9 (65)	50.0 (60)	71.8 (27)
Other Catholic	17.2 (29)	17.9 (123)	43.7 (128)	55.7 (61)
Protestant	2.9 (35)	9.8 (61)	21.6 (51)	*
Jewish	20.8 (101)	16.7 (210)	34.5 (110)	43.2 (44)

* Less than 15 cases.
** Numbers in parentheses refer to total cases in each group.

education appears to be the most highly related to health orientation.

The social-group differences become even more apparent when socioeconomic status and ethnicity are examined simultaneously as in Tables 4 and 5. Lower-class Puerto Ricans are both most parochial and most popular-health oriented; upper-class white Protestants and Jews are most cosmopolitan and scientific in their approach to health and medical care. Note that socioeconomic differences are quite pronounced within the various ethnic groups, showing the extent to which current ethnic differences in health orientation are reflections of the relative socioeconomic positions of these groups. Thus, in Table 4, upper-class Negroes give fewer nonscientific responses on health orientation than do lower-class Jews.

Even within any single socioeconomic or ethnic group, the greater the degree of ethnocentrism, the more nonscientific the health orienta-

tion; that is, ethnocentrism is related to health orientation even when social class and ethnic group membership are controlled (Table 6).

Finally, looking at the relationship between social organization and health orientation for the combined ethnic and social-class groups in Table 7, one finds that within each ethnic and socioeconomic group, parochialism continues to be associated with a popular or nonscientific health orientation. Thus, for example, although Puerto Ricans *as a group* are more parochial and more popular-health oriented than Protestants and Jews, within each of these groups the more parochial an individual is, the more likely is he to be popular-health oriented. The extreme contrasting groups are lower-class, parochial Puerto Ricans, 71 per cent of whom hold a popular-health orientation, and upper-class, cosmopolitan Protestants, only five per cent of whom have a popular-health orientation.

A possible interaction effect is also seen, with social-class differences being quite pronounced among the parochial groups, but small and

TABLE 6. HEALTH ORIENTATION ACCORDING TO SOCIOECONOMIC STATUS AND SOCIAL ORGANIZATION

Social Organization	*Socioeconomic Status*			
	Lower	*Lower Middle*	*Upper Middle*	*Upper*
	Per Cent "Popular" Health Orientation			
Cosmopolitan	29.6 (27)*	14.4 (153)	11.2 (251)	10.4 (106)
Mixed	33.0 (103)	26.5 (230)	15.5 (252)	10.0 (90)
Parochial	57.1 (147)	43.1 (239)	36.2 (149)	12.0 (50)

* Numbers in parentheses refer to total cases in each group.

TABLE 7. RELATIONSHIP BETWEEN SOCIAL ORGANIZATION AND HEALTH ORIENTATION ACCORDING TO ETHNICITY AND SOCIOECONOMIC STATUS

Ethnicity	*Upper Socioeconomic Groups*			*Lower Socioeconomic Groups*		
	Cosmopolitan	*Mixed*	*Parochial*	*Cosmopolitan*	*Mixed*	*Parochial*
	Per Cent "Popular" Health Orientation					
Puerto Rican	*	*	46.4 (28)**	28.6 (14)	42.4 (33)	71.2 (73)
Negro	18.5 (54)	15.5 (71)	28.6 (35)	18.1 (72)	30.4 (102)	47.5 (80)
White						
Irish	14.3 (21)	15.6 (32)	18.7 (32)	10.0 (10)	26.9 (26)	41.2 (51)
Other Catholic	16.1 (56)	20.3 (69)	37.0 (27)	9.1 (22)	24.7 (77)	42.2 (90)
Protestant	5.4 (56)	9.1 (33)	*	15.0 (20)	23.3 (30)	42.9 (14)
Jewish	8.5 (142)	12.4 (113)	21.4 (56)	13.5 (37)	26.7 (60)	33.3 (57)

* Less than 10 cases.
** Numbers in parentheses refer to total cases in each group.

irregular among the cosmopolitan g[illegible] class variations in health orientation are, in part, a function of the type of social organization of the group. Ethnic differences decrease greatly in importance once social class and parochialism-cosmopolitanism are controlled.

CONCLUSION

In general, it would appear that form of social organization transcends the mere fact of ethnic-group membership in determining sociomedical variation. Though ethnicity and social class are both independent contributing factors to parochialism-cosmopolitanism, the latter variable continues to show the strongest and most consistent relationships to health orientation. Thus, the findings would tend to confirm one of two hypothesized models of causation, namely that ethnicity leads to sociocultural differences that, in turn, lead to sociomedical variations.

DISCUSSION

Comparison of sociomedical responses between Puerto Ricans and white Protestants, belonging to groups with contrasting forms of social organization, highlights one of the main implications of this study for the field of medical sociology. Puerto Ricans show the greatest deviation from what might be evaluated as "desirable" sociomedical knowledge, attitudes and responses to illness. The Puerto Rican-born individual lies on one end of a continuum of ethnic variations in relation to health and medical care; the native-born white Protestant is at the other end. The Negro group tends to resemble the Puerto Ricans; the Jewish group is closer to the white Protestants.

Individuals and groups ranking high in parochialism would find it more difficult to accept a highly organized and formal medical care system. A conflict exists between a highly bureaucratic administrative system of medical care and a large segment of the population more at home with personalized care. Puerto Ricans, being in general more parochial than other ethnic groups, appear to have the greatest difficulty in adapting themselves to the modern "scientific," as opposed to a "folk" approach to medical care. The generally restricted outlook and lower expectations of the socially withdrawn groups find expression in narrower health horizons. It is doubtful that the barriers that

now interfere with effective medical care for the minority groups in the large cities can be removed, except as barriers to full participation in other aspects of American society are also removed.

REFERENCES

[1] *See* Appendix for sampling plan.

[2] *See* Wallace, D., A Few Facts About the Residents of the Washington Heights Health District, Table 2, in this volume for ethnic composition of the area.

[3] *See* Appendix for detailed description of Socioeconomic Status Index.

[4] *See* Appendix for questions used in constructing Health Orientation Index.

[5] *See* Appendix for questions used in constructing Social Group Organization Index.

[6] It has been suggested that this relationship may be an artifact of an "acquiescent response set." The use of scale score instead of individual item correlations decreases this possibility. More important, the observed ethnic-group variations and the relationship between social organization and health orientation holds for such non-attitudinal indices as social-group cohesion based on number of close friends in one's friendship group, religious attendance, knowledge of illness based on informational questions and preventive medical behavior based on behavioral items.

ACKNOWLEDGMENTS

Adapted from Suchman, E. A., Sociomedical Variations among Ethnic Groups, The American Journal of Sociology, *70, 319–331, November, 1964; and Suchman, E. A., Social Factors in Medical Deprivation,* American Journal of Public Health, *55, 1725–1733, November, 1965.*

This investigation was wholly supported by Public Health Service Grant No. CH 00010-05 from the Division of Community Health Services.