

The Effect of Medical Institutions on Doctor-Patient Interaction in Costa Rica

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PATIENT SATISFACTION AND COMPLIANCE WITH medical instructions have been the objective of many studies of doctor-patient interaction and communication (Davis, 1968, 1971; Friedson, 1960, 1963, 1973; Korsch and Negrete, 1972; Larsen and Rootman, 1976; Ley and Spelman, 1967; Locker and Dunt, 1978; Ordonez Plaja et al., 1968; Mechanic, 1976; and Svarstad, 1976). These studies demonstrate the importance of interaction and communication as determinants in adequate health care delivery. Kleinman (1978:88) has expanded this discussion by bringing attention to the importance of individual and cultural explanatory models of clinical processes in determining appropriate health behavior. He argues that when the expected models of sickness and treatment conflict, then patient-physician interaction breaks down and therapy is impeded.

Changes in economic and political systems have also been shown to affect the success of health care through inconsistencies in health care structure (Lasker, 1977), the development of interest group coalitions (Alford, 1975), and inequalities of resource allocations (Janzen, 1978). These studies employ a macroanalysis of power and authority as well as a microanalysis of clinical setting to provide a more

inclusive model of health systems and health process (Elling, 1978; Frankenberg, 1980; Janzen, 1978; Field, 1973; Waitzkin, 1979). Further, studies of political ideology in developing countries suggest that there is a direct relation between the ideologically based health policies of these countries and inadequate health care delivery (Pearce, 1980; Mburu, 1981; de Miguel, 1977). The reliance on physicians' professional values to define national health care needs has created urban, hospital-based medical systems that ignore the overwhelming national problems of sanitation, nutrition, and rural health care (Ugalde, 1980; Navarro, 1978).

The study of doctor-patient interaction in Costa Rican outpatient clinics provides new evidence and more comprehensive interpretation of patient dissatisfaction and interactional style by integrating the interactional data with an analysis of institutional and ideological factors. Patient behavior, physician performance, and social interaction in the medical consultation are found to be influenced by the institutional and political setting. A comparison of the differences in medical institutional ideology and in doctor-patient interaction explicates the relation of medical system politics to the success of the therapeutic encounter.

This paper traces the social history, economic development, and political affiliation of the two Costa Rica medical institutions, linking the microanalysis of doctor-patient interaction to the macroanalysis of the sociopolitical evolution of medical institutions. Patient strategies within the medical setting are examined and related to individual social status, interactional style, and consultation expectations. The reactions of physicians are explained by their social rank, the institution in which they work, and the degree to which they can fulfill a therapeutic role within the consultation. This multilevel analysis is then presented as a series of policy recommendations for improved health care delivery in these institutions.

The presentation is divided into six sections. The first section reviews the research procedure employed for data collection. The following two sections describe the Public Health and Social Security medical institutions. The fourth section compares the institutions, and the fifth, the doctor-patient interaction within those settings. The conclusion outlines the policy implications of the health care study.

Research Procedures

The research data upon which this paper is based were collected in San José, the capital of Costa Rica, located on the Meseta Central of this small Central American republic. With a metropolitan population of over 460,000, one-fourth of the national total, San José is a primate city (i.e., larger than all other urban centers combined), representing 53 percent of the country's total urban population (Ministerio de Economía, Industria y Comercio, 1974). Costa Rica's agrarian capitalist economy is based on major exports of coffee, bananas, cattle, and sugar (Ministerio de Economía, Industria y Comercio, 1970), yet a diminishing proportion of workers participate in the agricultural sector. Traditionally, Costa Rica was a society of equally poor and hard-working small landowners. The equality of social relations, however, shifted with the advent of coffee production; land was amassed by a few wealthy landowners who controlled coffee processing and created a growing class of landless peasant laborers. Today, Costa Rica, like many developing countries, is experiencing rapid urbanization in which a large proportion of the rural population has moved to the capital, straining social services and physical resources.

The choice of an urban field site derived from the medical anthropological study of complex health systems in Latin America (Teller, 1972, 1973; Richardson and Bode, 1971; Press, 1969, 1971, 1973; Erasmus, 1968; Foster, 1962, 1969; Fabrega et al., 1967; Fabrega and Metzger, 1968; Adams and Rubel, 1967). Because of the nature of the research problem, a genetically and culturally homogeneous population was chosen to minimize biomedical and sociocultural variation. San José, Costa Rica, offered this necessary homogeneity as well as the entire hierarchy of political, economic, and administrative levels to be found in the nation's capital city. Thus, the patient population and complex health care system of San José became the focus of this study, which excluded rural health care settings. The urban health care sectors were identified and a research procedure developed that would describe a cross-section of medical institutions, their staff, and their patients.

The methods employed varied according to the setting and sequence within the overall research design. The initial phase of research focused on medical administration interviews and observation of doctor-patient

interaction in the consultation office. Between consultations, doctors, nurses, social workers, and other auxiliary clinic personnel were also interviewed with reference to their perceptions of patient behavior and clinic function. The second phase began after the pattern of consultation interaction was established. A structured interview covering patients' perception of their illness and treatment was administered by a research assistant in the waiting room before and after the observed medical consultation. Finally, interviewed patients were selected for a home visit during which the researcher and her assistant conducted an open-ended family interview that emphasized personal and family health histories, genealogical and family network material, health utilization patterns, and general questions of values, preferences, and health beliefs.

All observations of doctor-patient interaction and staff interviews were collected by the researcher—who was accompanied by a Costa Rican assistant only in the first meetings as a check on the researcher's language proficiency—so that the need for interviewer standardization was eliminated. Consultations were recorded in notes taken in diary form and included relevant material on the situational context. The hospital outpatient general medicine clinics of both the Public Health hospital, San Juan de Dios, and the Social Security hospital, Calderon Guardia, were selected to illustrate primary care services in San José. Two psychiatric clinics and one psychosomatic clinic were added to provide a perspective on secondary care in the institutional description (Table 1). Patients were observed by a schedule alternating hours and days of the week with as many different doctors as possible to detect variations in patient attendance patterns. Approximately 12 to 20 patients were observed with each doctor, depending on his or her case load. All patients who entered the office during the observation period were recorded to minimize selection bias of the researcher. The resulting 457 patients constitute a theoretical rather than a statistical sample, which was used to produce a typology of doctor and patient behavior, and of interactional style.

The patient perspective was obtained in the second phase of the research project, during which the observed patients were also interviewed before and after the consultation. A structured questionnaire elicited open-ended responses of patient expectations, concepts of disease causation and treatment, and degree of satisfaction with the therapeutic encounter. The format was adopted from questions used

TABLE 1
Distribution of Patients by Institution, Hospitals, and Clinics—Outpatient Observations

Institution	Ministry of Public Health	Social Security Fund System
Number of Patients Observed	201	256
Hospitals	San Juan de Dios	Calderon Guardia
Number of Patients Observed	151	206
Clinics	Chapui	Mexico
	Extemporaneous	Psychiatry
	General Medicine	Psychiatry
Number of Patients Observed	101	50
	Extemporaneous	General Medicine
	50	103
	50	52
	51	50
Total number of patients observed:	457	50

in other cultural settings (Korsch and Negrete, 1972; Ordonez Plaja et al., 1968), and structured to test hypotheses that developed through observations of doctor-patient interaction. The 117 interviews carried out before and after consultation were collected by one research assistant who consecutively interviewed the same patients that the researcher observed in each clinic setting.

The family interviews included the 9 interviewed and observed patients who agreed to a home visit by the researcher and assistant. The intensive home interviews combined demographic factors, socio-cultural variables, network analysis, and health histories of the entire household and provided intricate data on self-concept, cultural beliefs and attitudes, health care utilization, and family organization.

Analytic procedures were both quantitative and comparative. The 457 consultation observations were coded for 112 variables. The coding for doctor style and patient attitude followed a typology used by Ordonez Plaja et al. (1968) for doctor-patient interaction in Colombia. Patient requests and complaints were recorded with reference to a format suggested by Korsch and Negrete (1972) for doctor-patient communication in the United States. The majority of categories and scaling procedures, however, were derived from the empirical data that used the naturally occurring variable groups and analytic descriptive labels.

The following two sections describe the research setting; that is, the two medical institutions that provide the majority of health care services to the residents of San José. The descriptions include both hospital statistics and brief accounts of the patients' entry experience in the outpatient clinics.

The Public Health System

The Ministry of Public Health—renamed the Ministry of Health in 1973—is an executive governmental agency whose chief administrator is appointed by the president. The ministry defines national health policy and organizes and coordinates the health services of the country. An extensive preventive medicine program that includes control of the importation and use of drugs and preservation of the environment is maintained in order to protect personal health (Ministerio de Salubridad Publica, 1973:4–5).

Until October 3, 1973, when a law was passed transferring all public hospitals to the Social Security administration, the ministry also provided free or low-cost medical assistance to persons not protected by the Social Security system or insured by the Instituto Nacional de Seguros, an autonomous government agency that handles workmen's compensation and private insurance cases. To fulfill these various functions the public health system in 1973 directed 62 community clinics, 10 mobile clinics that travel to remote regions, 205 nutrition and education centers, 10 nutrition recuperation centers, 52 dental clinics, 13 rural assistance centers, 27 rural dispensaries, 19 rural health posts, and 15 hospitals. Six hundred and thirty-five doctors, 588 nurses, 2,009 aides and other professionals staff these facilities (Ministerio de Salud 1974:7).

Hospital San Juan de Dios, the oldest and largest Public Health hospital in San José, is governed by a board of trustees appointed by the *Junta de Protección Social de San José*, a group of distinguished community members who advise the hospital in its social responsibility under the auspices of the ministry. For over 40 years, a single physician has been the director of both the administrative and the medical treatment sectors and the liaison between the board of trustees and the hospital (1973 interview). The national lottery and soccer betting, a portion of the general sales tax, and 4.5 percent of the national budget allotted to health, finance the rising costs of hospitalization: \$14.50 per hospital day in 1973 and \$5.50 per outpatient consultation (Ministerio de Salud, 1975). An average of \$0.12 per hospital day of these costs is paid by the patient. Patients pay according to their ability; the public registry of land and property ownership is investigated, and income and possessions are used to calculate the patient donation. In January 1973, 11 percent of all patients paid the full cost of treatment, 53 percent paid a part, and 35 percent paid nothing. Of the 11 percent who paid, 8 percent stayed in the private wing (*pension*) of the hospital and paid separate doctor, nursing, and hotel fees. San Juan de Dios serves the entire country in specialties not locally available and is the principal public inpatient and outpatient facility. Inpatient and outpatient service statistics are presented in Table 2.

Patients enter the hospital in four ways: 1) seriously ill patients go directly to emergency; 2) patients are referred to a specialty clinic by a private doctor; 3) patients are referred by another clinic in the

TABLE 2
Comparison of Hospital Services for January, 1973

	<i>Public Health System¹</i>		<i>Social Security System²</i>	
	San Juan de Dios	Chapui	Calderon Guardia	Mexico
Inpatient				
Number of beds	1024	1037	509	709
Occupancy	90%	92%	72.3%	80.3%
Outpatient				
Average number of consultations	525/day	78/day	996/day	827/day
Total number of doctors	147	11	155	216
Average number of patients seen	6.3/hour	2.5/hour	3.6/hour	3.3/hour

¹ From: Ministerio de Salud, Departamento de Estadística, 1974.

² From: Caja Costarricense de Seguro Social, Departamento de Actuarial y Estadístico, 1974.

same system because the clinic does not offer the required specialist; or 4) patients self-refer and enter the extemporaneous outpatient service. Outpatients at San Juan de Dios may wait an entire day, standing in a line to see a doctor, or may be required to return the next day.

The nurses report that they try to see first those patients who have travelled the farthest. The consultation room is very small and noisy as the nurse fights with waiting patients, urging them to remain outside the door. Sometimes the patient starts speaking immediately without responding to the doctor's introductory "Que le paso?" or "Que es lo que tiene?" (What happened? or What do you have?). The patient speaks rapidly, listing a series of symptoms modified by descriptions of the kind and duration of the pain. The doctor generally nods, writing as he listens, and rarely touches or examines the patient. The doctor may smile or joke in response to some friendly gesture by the patient, but usually the doctor makes his diagnosis, and gives instructions on proper medication and conduct for successful treatment. Most examinations are brief, 2 to 4 minutes, and the entire consultation often lasts only a few minutes more.

At Hospital San Juan de Dios the doctor is contracted for a morning or an afternoon to see as many patients as possible, or as many as are waiting. The number of patients seen therefore varies with the number waiting or with the number scheduled and was observed to range from 4 to 30 consultations with an average of 6.3 per hour. The tone of the consultation also depends on the number of patients and the press of those outside, so that a doctor may take more time to give instructions and answer questions when fewer patients are around. Patients may make appointments to see a particular doctor, but most often see the one who is available at the time.

In the Public Health clinics the nurse and doctor work together to try to see all patients and attend to their problems. Although the doctors appear brusque, their observed actions were usually to speed the patient on his way. There was a personal camaraderie among those working in one area that the patients could see and respond to; patients often tried to use that relationship to encourage the nurse to tell the doctor something on their behalf. The nurse also made the doctor's appointments in the same office, unless the patient was referred, and would consult the doctor if there was at any time conflict or patient confusion. Drugs were dispensed at a nearby counter so that patients stayed in one area.

The Hospital Psiquiátrico Manuel Antonio Chapui, next to Hospital San Juan de Dios, is the Public Health psychiatric facility. About half the inpatients have chronic disorders and live there; some patients have been residents for more than 20 years. Other patients visit the hospital in the mornings for food and medication because the family is too poor to adequately support the patient or because the patient has been abandoned. Chapui, as Costa Rica's only chronic-care psychiatric hospital, is similar in size and occupancy to San Juan de Dios, but has a much smaller outpatient service and provides only specialty patient care (Table 2).

The psychiatric-service waiting area is filled with rows of people on benches facing one another, talking and sharing lunches, advising one another on how to take medication or produce a cure, or waiting in line for the pharmacy. A male secretary calls out patients' first names, instructs patients to pick up their charts from "Don Edgar" and then go in to see the doctor. The consultation varies in length and style from a first visit, when the doctor asks a long series of medical history questions and makes his diagnosis, to the brief and familiar interaction of a patient in treatment who has come to renew prescribed medications. Chapui's outpatient service is popularly known for its friendly atmosphere and personal attention, possible in the limited context of a specialty hospital.

The Social Security System

The Costa Rican Fund for Social Security (Caja Costarricense de Seguro Social) in 1973 covered 60.2 percent of the nation and 50.2 percent of the workers in the economically active sector. Within the next 10 years, by law, the Social Security must extend its medical and dental assistance, hospitalization, pharmaceutical services, sick pay, and burial benefits to the entire country (Caja Costarricense de Seguro Social, Seccion de Relaciones Publicas, 1973). Social Security employee coverage in 1973 was 30 percent in social and personal services, 20 percent in industry, 17 percent in agriculture, 14 percent in business, 7 percent in construction, 5 percent in transportation, 7 percent other (Caja Costarricense de Seguro Social, Departamento de Acturial y Estadístico, 1974) with the participation rate higher in office or fac-

tory-oriented occupations and lower among independent workers. The reason for these differences is that, to qualify for the mentioned Social Security benefits, a worker pays 4 percent (plus an additional 1 percent on income in excess of \$360 per month) of the monthly salary, the employer contributes 5 percent, and the state 2 percent; if there is no employer the individual must pay both employee and employer shares. The subscriber may also allot an additional 2.5 percent, the employee another 2.5 percent, and the state 2 percent to accrue disability, old age, and pension rights for the surviving spouse. The pension amounts to monthly payments of 70 percent of the first \$36 of the pensioner's monthly salary and a diminishing percentage of each additional \$36 per month earned (Caja Costarricense de Seguro Social, 1971).

Disability, old age, and death insurance was carried by 45.3 percent of the total population and 37.8 percent of the economically active population in 1973 (Caja Costarricense de Seguro Social, 1974). Medical and pharmaceutical assistance is provided to the insured worker's family, which includes a wife or companion, children under 18 or students under 22 years of age, mother or father if incapacitated or over 65 years of age, illegitimate children if recognized, and a husband who can't work and depends on a wife who is insured (Caja Costarricense de Seguro Social, Seccion de Relaciones Publicas, 1973). The Social Security system structure and benefits were adapted from the Chilean program (Bell, 1971:30), and closely resemble the Spanish *Instituto Nacional de Prevision* developed during the 6-year period, 1938-1944, approximately the date of the development of the equivalent program in Costa Rica (Press, 1973).

Benefits and limitations of services are carefully listed in the Social Security bylaws; nonetheless, some Costa Ricans do not fully understand the complex rules:

An employer sent his agricultural worker to the Social Security clinic to have a twisted wrist looked at and to have the *peon's* 14-year-old daughter's cavities filled. Because the clinic was an hour's bus ride and it was often difficult to go, the father also took another child to have his teeth checked. Upon arrival at the clinic, the dentist explained that one child must come back another day as only one family member per day is allowed to visit the dentist. The dentist proceeded to extract the daughter's four front teeth and

then explained she would have to come to him privately to have the teeth replaced because Social Security benefits for a family member do not include reconstructive dental work (prosthesis). The father was dismayed; he was poor and his daughter could never marry well without front teeth. He had received a balm for his wrist and was told not to work for 3 days; this meant his employer would have to pay him for the days not worked—Social Security pays for work loss only after the 4th day of inactivity due to illness or injury. They returned home commenting that they wondered why they bothered to even go to the clinic (Fieldnotes, 1974).

Hospital Doctor Rafael Angel Calderon Guardia and Hospital Mexico are administered by the Junta Directiva through the medical directorate of the Social Security system. Each hospital is headed by a physician and includes over 4,000 employees and 750 doctors (Interview, 1973). The country is divided into two geographical service sectors: Calderon Guardia serves the eastern zone of Limon, Turrialba, Cartago, and the eastern half of San José; Hospital Mexico serves the western zone of Puntarenas, Guanacaste, Alajuela, and the western half of San José. In addition to these hospitals, the Social Security maintains 5 clinics in San José (1 is within Calderon Guardia) and 68 clinics in the outlying areas, in some cases sharing the rural Public Health facilities. If these local community services are insufficient, the patient is referred to 1 of the 2 main hospitals in San José. The San José hospitals also have specialty services not found in local clinics: Calderon Guardia directs the psychiatric, tuberculosis, and venereal disease sections; and Hospital Mexico administers psychosomatic medicine and neurosurgery. Special services are being expanded, but many need expensive equipment and technical personnel. Each hospital's desire to have its own facilities to enhance prestige has led to the duplication of specialized units that are underutilized and costly to maintain.

The hospital system is financed 60.5 percent by salary deductions, 37.2 percent by the state's contribution, and the remainder from interest and investments (Caja Costarricense de Seguro Social, 1972); 72 percent of this income is used to defray the cost of hospitalization (\$23.70 per hospital day in Calderon Guardia, and \$27.50 per hospital day in Hospital Mexico) and outpatient consultation (\$5.00 per visit in Calderon Guardia and \$5.50 per visit in Hospital Mexico) (Caja

Costarricense de Seguro Social, Departamento de Actuarial y Estadístico, 1974). The sizes, occupancy rates, and services provided in both hospitals are comparable, Hospital Mexico being slightly larger and treating fewer patients because of its specialty emphasis (Table 2).

According to the chief of the Social Security outpatient services, every person sees the same general medicine physician each visit; if the patient comes in without an appointment and demands attention, the patient is seen briefly in the extemporaneous clinic, where the doctor orders medicines or a referral to the appropriate specialty (Interview, 1973). The Calderon Guardia clinic consists of a large central waiting room full of chairs and benches, turned away from one another; long administration and receptionist counters run the length of one side of the room, and doctors' offices on two sides open onto the waiting room. The long room echoes with the noise: crying children, patients scolding children, nurses and clerks giving instructions to patients, and employees gathering for coffee and conversation. Richardson and Bode (1971:258) describe the Social Security clinic in Puntarenas: "People, not infrequently as many as a hundred, crowd into waiting rooms and sit patiently—or impatiently—while the staff scurries about processing their records and establishing contact between the people and doctors." The patient enters this room, presents a card and an *orden patronal* (a receipt that certifies that the deductions have been paid for the previous month) to the receptionist, who verifies the appointment. The patient then goes to the nurse who works in front of the physician's office to leave a name and order the chart. The patient is seated and instructed to enter the consultation room, following another patient. The patient is expected to be ready to enter the office immediately after the designated person, and is chastised if slow or forgetful. If the patient is more than 15 minutes late, the appointment is automatically cancelled.

The doctor is contracted to see 6 patients per hour, but the actual number averages 3.6 consultations per hour, with a wide range of varying consultation lengths. The pace is leisurely; the doctor is generally relaxed and there is time to discuss fully the patient's problem and possible treatment. After the consultation, the patient returns to the administration counter to request another appointment of the doctor's recommendation. The delay for some specialty appointments

may be as long as 6 months. Finally the patient goes to the pharmacy to pick up the prescribed medicine.

Fragmentation and separation of medical and administrative services is a dominant characteristic of Social Security clinic activities; making an appointment, waiting, seeing the doctor, and getting medication—all are located in different places and the facilitating personnel have limited contact and few opportunities to exchange information. Relationships between doctors and secretaries, nurses and patients, doctors and nurses, reflect a lack of communication and misunderstanding of rules and responsibilities. Secretaries give patients appointments based on their rules of availability without consulting or considering the doctors' treatment schedule. The doctors cannot understand why patients do not appear in the time period suggested for the next visit. Nurses are teased by doctors for gossiping and accused of being paid for doing nothing. Nurses, however, receive the brunt of patient displeasure; they deal with aggressive patients who verbally abuse them during the long preconsultation wait and criticize them for any lapse in attention or service.

The Public Health and Social Security institutions provide parallel services for inpatient and outpatient health care. The Public Health hospitals have a larger number of beds and provide more inpatient care, but the Social Security hospitals provide more outpatient consultation (Table 2). The difference in the ratio of patients to doctors in the various outpatient clinics is also very striking (Table 2); however, these differences are minimized when the number of beds is added to the number of consultations, which is the total doctor workload. The hospital differences presented in the table reflect the manpower emphasis on inpatient care at San Juan de Dios and on outpatient care at Calderon Guardia. The chronic inpatient population at Chapui is a special case in that there is little physician care available, while Mexico functions as a secondary care service that provides a better overall ratio of doctors to patients. The real difference in outpatient care is encoded by the number of patients seen per hour, which is almost twice as large in San Juan de Dios as in Calderon Guardia, and certainly influences the quality of care. These differences in service provision, however, are less apparent when contrasted with their ideological differences produced by their distinct histories and political affiliations. The following sections compare the institutions

and discuss the implications of these differences in terms of doctor-patient interaction and patient dissatisfaction.

Comparison of Medical Institutions

The sociopolitical histories of the Public Health and Social Security institutions account in large part for the basic structural and interactional differences in patient and staff behavior within the observed medical consultations. The histories identify the basic value orientation and political goals of the institutions' founders and describe how these values influence the course of institutional development.

The Public Health institutions in Costa Rica evolved from charity services initiated by the Catholic church in 1781. In 1826 the religious control of public health was limited by a Constitutional Assembly decree that a general hospital of San José would be founded; but the building was delayed and the plans were not executed until 1852. The Sisters of Charity, with the support of the executive government, opened the doors of the first public hospital, San Juan de Dios, in 1863 (Schapiro, 1962:492-494).

The impetus for government participation in the creation of a Public Health hospital was an emerging republicanism stimulated by their independence from Spain in 1821, and the advent of coffee production on a large scale, roughly from 1830 to 1890, which precipitated the formation of an upper class and concomitant concentration of wealth. The wealth accumulated during the period went into the social welfare needs and material progress of the nation (Bell, 1971). The rapid growth in coffee production concentrated land, once held by a number of small landowners, in the hands of a few families who had the financial backing for the processing and transport of coffee (Seligson, 1980). From this new class emerged the "Generation of 1889," which perpetuated a noblesse oblige tradition through legislative means, establishing universal education and instigating national social reform through public health services. The development of an elite with both economic means and political power transferred the traditional religious and upper-class concerns of charity, personal security, and welfare ideology to their representatives in the National Legislative Assembly (Stone, 1974; Bell, 1971). This control was maintained up

until 1935, when the political power of elite descendants was diluted by economic diversification, immigration, and population growth. The new group was no longer able to mandate social welfare projects (Sancho, 1935; Stone, 1969, 1974).

The social relationships developed during this period were those of interdependence:

The success of the enterprise (coffee production) was subject to the productivity of the *peon*, and this to the paternalistic rapport which the planter could maintain with his scanty labor force. If the *peon* depended on the planter for his salary and home, the planter depended on the *peon* for good production, which was the basis of both his wealth and prestige within his own class (Stone, 1974:408).

The resulting *patron-peon* relationship permeated the interactions of the classes in all institutions and activities where services and goods intersected, including the doctor-patient encounter in the Public Health facilities. The Public Health hospital became an extension of the *patron-peon* relationship in which doctors were members of the upper class, and patients, *peons*, were willing to return respect, devotion, and agricultural goods for services that only the upper class could employ. This system of local dependency can also be explained by the larger capitalistic model of class alignment.

The later evolution of the Social Security institution partly represents this tradition of legislative concern with security and welfare, but instead was implemented through the efforts of socialist forces working in a voting compromise with the vestiges of the elite. During the mid-1930s the socialists, under the competent and respected leadership of Manuel Mora Valverde, gained considerable strength and established themselves as the national ideological party (Bell, 1971). When Dr. Calderon Guardia (president of Costa Rica, 1940–1944) lost the support of many elite and white-collar groups because of confused public administration and prolabor policies, his party had to rely more heavily on *Vanguardia Popular* supporters, Mora's socialist-influenced and operated labor union (Denton, 1971). The Social Security system, at the insistence of Mora in exchange for his political support of Calderon Guardia's social reform program, was created in 1941 (Caja Costarricense de Seguro, 1972). In 1942 the medical institution began to provide illness and maternity insurance in San

José, and in 1943 the Labor Code was completed, consolidating a number of health and social welfare guarantees (Bell, 1971). Disability, old age, and death insurance was extended to specific occupational groups in 1947. Subsequent Social Security laws and modifications both raised the deductions and progressively extended services to an increasing proportion of workers and, in 1948, to their families (Caja Costarricense de Seguro Social, 1972).

Costa Rican social relationships were also affected by the social and political ideology reflected in Calderon Guardia's program of social guarantees. According to historian Bell (1971:82), "basic human relationships were changed and many felt uncomfortable with the changes: a *patron* could no longer deal arbitrarily with 'his' workers." A new ideology of social equality and welfare rights permeated the Social Security system and its institutional problems reflected the new social alignments and relationships.

The historical ideological differences are further maintained by the physicians who tend to work for the system that is consistent with their political position and social values. Upper-class physicians, particularly those of old landowning families, tend to work in San Juan de Dios. Some feel that Costa Rica will return to a free election medical system and refuse to work for a system where a secretary tells the physician who will be seen and when. The Social Security system, on the other hand, attracts middle-class physicians who are socially mobile, without elite status and family connections. The life history of a young aspiring physician reveals how employment in the Social Security is used to accrue the professional status and adequate income that would allow the family to then patronize upper-class schools and clubs, and enjoy upper-class privileges: "The doctor thought that it wasn't necessary for his wife to work. He thought that by omitting luxuries they could live only on his salary. But, he added, his wife had set her mind on sending the children to St. Francis High School and so she also works at the Social Security to pay for the children's education. They are paying off the house they built in an upper class *barrio* and she helps her parents with money also." Physician recruitment, therefore, reinforces the association of the historically derived class ideologies with specific medical institutions. These differences are then played out in distinct doctor-patient interactions within the medical consultation.

Doctor-Patient Interaction

Patient Attitude

The examination of doctor-patient interaction illustrates how the structural and historical construction of the medical institution is reflected in everyday clinic function and participant behavior. By noting differences in patient attitudes and doctor style in the medical consultations, the observer can distinguish the effect of ideology on the expected pattern of interaction.

Patient attitude and doctor style have been coded according to characteristic types from the observed clinic consultations. The typology for patient attitude was generated from the data that describe a simple dichotomy between the submissive, shy patients and the confident, demanding patients. The two types are illustrated by cases drawn from the consultation data.

The doctor-style typology was developed from a study by Ordóñez Plaja et al. (1968) of physician-patient communication at outpatient clinics in urban Colombia. This typology describes the four characteristic manners in which physicians presented themselves to patients: 1) bureaucratic task-oriented, 2) insecure and detailed, 3) self-assured and interpretative, and 4) amiable-expressive oriented. These categories referred to the style by which the physician treated the patient. The bureaucratic physician was concerned with the immediate task of diagnosis and disposing of the case, and therefore showed limited sensitivity toward patient feelings and problems. The insecure and detailed physician tended to carry out a lengthy interview and offer prolonged explanations in order to establish rapport. The self-assured and interpretive physician had a sense of correctness about the questions asked and offered interpretations about underlying problems. The amiable, person-oriented physician showed an awareness of feelings of the patient and the social factors that influence behavior, but appeared to have less insight or flexibility as to the appropriate use of this knowledge.

The typology from the Colombian study was used to code the Costa Rican doctor style; as a slight modification, authoritarian behavior was added to the bureaucratic category. The consultation data showed that authoritarian behavior often accompanied the bureaucratic, task-

oriented style of a physician. Illustrations of each of these physician types is presented in the doctor-style discussion.

Public Health patients were observed to be more submissive, shy, and withdrawn in their interaction with the doctor. The following three cases from San Juan de Dios characterize the patient attitude in this Public Health system.

A young man complains of a problem with his eyes. He can see, but he has had pain in both eyes for over 2 years. The doctor examines his eyes. The young man is very shy and doesn't look up. Doctor questions him many times, as if he doesn't understand or believe the patient. Patient is quite nervous and doesn't seem to focus on the doctor. Doctor gives him a prescription for conjunctivitis and states that he believes that it is just an infection as the man does not have any trouble seeing.

A man of 28 says he has stomach pain and has been vomiting for the past 2 days. Doctor examines his stomach. Doctor wants exams done of the stomach area and wants him to come back in a day for the results. Doctor keeps repeating that the patient should come back tomorrow as the patient acts as if it is difficult to understand. Patient acts as if he feels very bad and is confused; he has a great deal of difficulty reading and puts his head on his hands. Doctor says he will give him an injection to stop the vomiting and pain. The doctor keeps an eye on the patient as he writes; he tells him, "Roberto go out and get this injection you will feel better. Do you understand?" As the patient begins to walk out the doctor says, "Wait, I will also order an X-ray."

A young woman from a small town outside of San José. Doctor asks if married; she answers no. Doctor asks "sexual relations?" Woman answers "yes." "OK," says the doctor, "Please undress and get on examining table." She complains of pain in vaginal canal, existing since September. Doctor does vaginal examination. Much pain is experienced when she has sexual relations. She grimaces during the examination but does not say anything. Doctor refers to gynecologist. Tells me in front of patient that they must investigate for cancer.

In each case the patient dutifully answers questions and responds minimally to the doctor's examination or interaction. The submissive, shy, and withdrawn manner of the San Juan de Dios patient is encouraged, if not conditioned, by the doctor. The patient normally passes by only one gatekeeper before reaching the physician. It is the

physician, in the medical institutional setting, who maintains the traditional role expectations of the patron-client relationship, and the patient who reinforces this socially acceptable pattern.

In contrast to the Public Health patients, patients in the Social Security system were more frequently confident, difficult, and demanding. In the following cases from Hospital Mexico and Calderon Guardia the patient attitude of demanding attention and services is clearly demonstrated.

A young woman is seven months pregnant. She starts out by asking the doctor if there is anything that she can give her children so they won't wet the bed at night? The doctor says "Yes," but she must bring them in to be studied to see what the problem is. The doctor asks her if she is in the prenatal clinic, and he asks how her husband is. She changes the subject. She wants to know if they can perform a vasectomy on her husband. The doctor tells her that they must bring a signed statement of consent for the operation and their reasons for wanting it. She asks about the hospital for having her baby, continually repeating questions. She complains that she didn't get to see the baby for two days and she doesn't want that to happen again. The doctor assures her that it won't. She asks how long she will be in the hospital. She will be there for three days with natural childbirth, and two more if she has anesthesia, the doctor answers her.

The patient is not much better. He saw another doctor who gave him pills. He was riding a motorcycle but can no longer continue because he loses his balance. He must now ride the bus to his job in the electric company. The patient asks for a permanent work leave, but the doctor says he will give him only three months. The patient then adds that yesterday he fell in the bathtub. The doctor examines him by having him shut his eyes, turn around and then open his eyes. He doesn't fall. The patient complains that the pills don't work; the doctor reduces the dosage because the pills make the patient more dizzy. The patient also requests a dandruff prescription, but the doctor tells him to come back in three months for a checkup. He also orders examinations. The patient inquires about his diabetic curve; the doctor tells him a number of the curve points. The patient then asks if he should be careful.

An older woman with a very bad cough. Saturday she went to the emergency room for help. They gave her an injection. In a condemning voice she says that the doctor had given her medication, but that it didn't work. She has had two attacks since her last appointment. Doctor asks her how long has she had asthma? Patient replies, "For a little time."

The demanding attitude of the Social Security patient is characteristic of patients in prepaid group practices. Freidson reports three kinds of demanding patients: those with complaints for which there is little the physician can do or for which he can find no cause, those who attempt to use "pull" to obtain services, and those who demand services as a contractual right. The kinds of demanding patients most often found in the Social Security clinics are identified as the most difficult for the physician to deal with because "they posed demands which the physicians were unaccustomed to dealing with, for the demands stemmed from the contractual framework of practice" (Freidson, 1973:483-484).

The difference in patient attitude may indeed be attributed to the mode of payment. One Social Security physician comments that "they come in for every symptom; because they pay they feel that they must get their money out of the system and don't understand that the payments are to cover major medical expenses when needed. In San Juan de Dios they are more patient and less demanding because they know they are not paying (Interview, 1973). Goffman, in his analogy of doctoring as a tinkering service, suggests that when the doctor (the server) performs major services for very poor clients, the server may feel that charging no fee is more dignified than a reduced fee. The server thus avoids dancing to the clients' tune, or even bargaining, and is able to show that he is motivated by a disinterested involvement in his work (Goffman, 1961:327). If we extend this analogy, then, the prepaid patient would have the right to demand attention, as the server has been paid a fixed sum for unlimited service. The prepayment aspect of the Social Security clinic provides one explanation for the confident, demanding attitude of patients. However, doctor style and patient role expectations based on the ideological social equality of the participants influence the course of doctor-patient interaction in a more direct and dramatic manner.

Doctor Style

Doctor style tends to be the most sensitive indicator of medical-institution, sociopolitical structure. Doctor style was significantly more bureaucratic and authoritarian in the Public Health clinics (Table 3). A consultation interaction was directed, oriented toward making a diagnosis and referring the patient:

A gray-haired woman of about 56. She has a pain in her chest, back, and waist. Has had the flu (*grippe*) for 15 days. The pain is strong in her head and eyes. Doctor states that she has *grippe* complicated by sinusitis. She went to the doctor in Alajuela but he sent her here without an order; he just told her to go. Doctor asks why she didn't use the local Public Health clinic (*unidad sanitario*). She answers it is only open every 15 days. Doctor asks for other symptoms. She says that she has a cough with yellow phlegm. Her throat also seems to close on her when she talks. Doctor takes her temperature, listens to her chest, ordering the patient to "take that thing off" to get the patient to take off her blouse. Doctor gives her medicine and a referral appointment (Field-notes).

In the Social Security clinics, doctor style tends to be more self-assured, interpretative, and amiable (Table 3). The doctors appear interested in engaging the patient in conversation, eliciting social details, and offering interpretation. A consultation from Calderon Guardia illustrates the self-assured, interpretive doctor style:

A woman of 52. Patient says, "I am well and without medicine." Came in to know about an exam for blood sugar; the doctor says that her exam is good. She asks about the *grippe* that she had had. She says that she is in treatment for high blood pressure and now also has hot flashes (*calores*). Doctor examines her blood pressure and says that she is much better. Doctor asks if her high blood pressure is associated with a family problem. She answers yes, her husband was quite sick and had an operation here in the Social Security hospital. He is better now. He is still losing weight, however.

Doctor style in Social Security clinics may also be amiable but is less successful in terms of understanding the underlying factors in the patient's illness:

Young man from Turrialba and now lives in San José. Doctor says to him, "You are well, aren't you?" and repeats when finally the patient answers "No, I'm not. I still have the same problem of the gastritis; there was a time when it was better." He has an intestinal inflammation, the patient says. Doctor explains to him that the problems make it worse but the patient goes on that he has had it so long. Doctor responds that he had said that it was better, and patient reacts again, "Yes, but it still is bad." He has had a *novia*

TABLE 3
 Doctor Style of Interaction by Medical System

Doctor Style	Public Health System No.	Public Health System Percent	Social Security System No.	Social Security System Percent	Total Sample No.	Total Sample Percent
Bureaucratic, Authoritarian	90	53.9	76	34.9	166	43.1
Self-assured, Interpretative	53	31.7	88	40.4	141	36.6
Amiable, Expressive	21	12.6	43	19.7	64	16.6
Insecure, Detailed	3	1.8	11	5.0	14	3.6
Total	167	100.0	218	100.0	385 ¹	100.0

$\chi^2 = 15.519$ d.f. = 3 sig. = 0.001

¹ This number does not represent the entire 457 observed consultations, as a number of consultations had to be dropped from the sample because they did not represent doctor-patient interaction.

(girlfriend) but is not thinking of marriage. Sees his family. Has gas and burning pain, doesn't vomit but feels as if he is going to. It hurts him to drink lemon and milk. "And the injections?" asks the doctor. "The injections were good," he says. Doctor examines the patient as he complains of pain. Patient asks if the doctor can't give him the injections; that he is tired of all the pills. Doctor gives him injections and prescribes a diet. Again the doctor asks if the patient has noticed getting better and patient says that he still complains of sinus irritation. Doctor orders X-ray of nasal passage. Patient says hurts with sun. Doctor gives him drops for his nose.

The analysis of the historical development of the medical institution suggests that the Public Health doctors employ a bureaucratic approach with patients in response to the charity orientation of the hospital and the tradition of the upper-class doctor bestowing services without charge on the poor patient. The hierarchical doctor-patient roles are reinforced by the hospital orientation, physician recruitment, and the class differentiation of the patients. An authoritarian style develops in this situation where the socioeconomic and intellectual superiority of the doctor can be overtly manipulated:

Man, 45, from Guanacaste. He speaks very low. He has a pain in his stomach. For the last 8 days has not been well. At first, he reports that the color of his stools had changed from black to purple. Doctor continues to question in curt tone. Doctor asks how the man knows what color his stools are if he eliminates in a hole. The patient, very embarrassed, says that sometimes he eliminates in the fields and therefore notices, but says that the color didn't change and that the stools were still the same color. The patient has never been in the hospital. Doctor roughly examines the patient, and continues to ask, "What kind of work do you do?" "Do you drink the water where you live?"

The physicians who work in the Public Health clinics also reinforce a charity doctrine in their feelings about patients: "They [San Juan de Dios patients] appreciate what you are doing for them. The poor people bring me eggs and chickens because I am not ashamed to carry home a *bolsa* [shopping bag in this context]. They are so grateful" (Interview, 1974). In the Social Security clinics the ideology of social equality is reflected in an interpretative and amiable doctor style.

Nonetheless, doctor discomfort indicates that there are problems involved in the adjustment to social equality in the physician role. Some doctors respond in a detailed and insecure style in which the doctor is overly solicitous, investigates every comment and symptom, and hesitates to give either advice or diagnosis. Doctor interviews corroborate the observation conclusions: dissatisfaction, frustration, and anger at the Social Security system; complaints centering on the difficult and demanding patients, inability to control their hours, appointments, or patients, characterize their discussions. A summary of a coffee-break discussion during an afternoon of consultation reports that

doctors are frustrated as there is not time for treatment of the patient. Doctors are bored with their work. Their satisfaction comes from their private practice. Maybe it is because, before, doctors all had public consultations as well as upper-class patients; then the Social Security began. Doctors felt that the Social Security would not succeed, but it is growing in size and coverage. A majority of doctors work for the institution, but they do not have the same relations with their patients. Patients in the Social Security don't know how to use the system. When they demand services which the doctor doesn't like, the doctor rejects the patient even more. The system doesn't work, but of course it is the patient who suffers. Both the patient and the doctor are unhappy and the system will continue to cover everyone in the country without satisfying anyone. The question is how to change the system so that it can work for the participants (Field-notes, 1973).

A doctor who has worked in both systems comments:

The patient of the Caja comes to use the clinic when he doesn't have anything, but the error is compounded when the doctor doesn't examine the patient and tells him that he has nothing, just giving him a prescription. The doctor is telling the patient who feels some discomfort that he doesn't, which only makes the situation worse. It would be better if the doctor would examine the patient and tell him that he doesn't find anything physical but that the problem could be related to some problem in his life. This approach would reduce the misunderstanding.

The traditional view of San Juan de Dios came from private practice. The doctors were paid very little to give their time and now they are paid the same as doctors in the Social Security and

want to have salaries. Many doctors hold 2 to 3 jobs within the same time period, which means the patient does not receive the doctor's full attention.

The problem between the insured person and the doctors is that the insured have rights but don't have obligations. Politics also influences what happens so that the president goes to open a new clinic and tells people that this is yours and you must make it work, but doesn't say what their responsibility is to the Social Security clinic. The patient enters the clinic and first encounters the administrator, then the nurse, and the receptionist, and fights with each of them. Finally when the patient arrives at the doctor he is furious (Interview, 1973).

An important follow-up to this research would be a study of private doctors and their upper-class patients to observe the quality of interaction in that context.

The two basic patterns of doctor-patient interaction correspond to the two medical institutions. In the Social Security clinics the consultation is characterized by a difficult and demanding patient and an interpretative and amiable physician. The Public Health clinic consultation is of a bureaucratic, authoritarian physician and a submissive, shy patient. These contrasting modes of interaction are best explained by the sociopolitical context of the individual institutions, further influenced by the mode of payment and organizational setting of the hospital clinics. Interactional patterns are further reinforced by the differences in doctors' workload in the outpatient clinics. These different interactional processes can be evaluated by comparing patient compliance and satisfaction in the two institutions.

Patient Dissatisfaction

In consultation, interview, and conversation, Social Security patients complain that the wait for services is extremely long, the medicine is not good, and that the doctors are inattentive. Compared with Public Health patients, who have fewer complaints, the Social Security patient expressed displeasure during the consultation: 7 patients directly criticized doctors, 9 commented on the long wait, and 15 said that the medication prescribed was worthless. Some of these complaints by Social Security patients are certainly valid; there should

be changes in the scheduling of appointments and the comfort of the waiting area. When research observations are compared by institution, however, these complaints do not differentiate clinic function. The wait is long in all clinics. The doctors in the Public Health hospitals have even less time to give attention to patients and do so in a brusque manner. The same medicines are used by both institutions, and both pharmacies dispense drugs in unmarked metal and plastic containers or brown glass bottles that are relatively inexpensive and encourage the doctor to give dosage instructions. The comparative cost of medicine is also nominal, higher in the Social Security hospital, if calculated as part of the total deduction and according to one's ability to pay in Public Health clinics. Yet the complaints concerning medication are directed at the Social Security and not the Public Health facilities.

The complaints about the Social Security medicine may well be a response to a consultation interaction perceived as difficult and frustrating. The Social Security patients are in a relationship with a doctor who is supposed to consider the patient his or her social equal, treat the patient with respect, and satisfy the patient's demands. Both the patient and the doctor, though, are aware of the sociocultural reality that they almost always occupy different social and economic statuses; the few upper-class patients use private practitioners or travel to the United States for treatment. The consultation then becomes a conflicted interaction of compromise and negotiation of the social reality. The actual situation and the expectations of social equality complicate the physician's ability to fulfill his or her culturally prescribed doctoring role and alienate the patient by the absence of expected behavior and role performance. The patient does not directly attack the doctor, because of dependence on the medical services, but instead vents dissatisfaction and alienation indirectly through blaming an ineffective prescribed medication. Mechanic (1976:172) suggests that, even in the United States,

patients tend to have ambivalent attitudes about physicians. They feel extremely dependent on physicians when they anticipate or have serious illness; they also feel some resentment about their dependence and the authority of the physician. This is perhaps exemplified by the tendency to speak favorably about one's personal physician, but to be critical of physicians in general. Underlying this ambiv-

alence are often very high and somewhat unrealistic expectations of the physician and excessive criticism of any failures to live up to this ideal image.

In the Social Security clinic, patients' expectations are further complicated by the conflicting social ideology and social reality of the institution.

Another explanation for the breakdown in patient satisfaction is offered by Kleinman (1978:87) in his analysis of "institutionalized conflicts between lay and practitioner views of clinical reality and therapeutic success." The process by which differences in the explanatory models of patient and practitioner create obstacles to effective health care is referred to as "cultural iatrogenesis." In terms of the Costa Rican example, cultural iatrogenesis is occurring with departure from traditional doctor-patient roles to an ideological system that reorients the social status relationships within the consultation. Further, Larsen and Rootman (1976) suggest that satisfaction with medical care is influenced by the degree to which physician performance corresponds to patient expectations. If patients expect doctors to behave in a traditional doctor role, the interpretative style may in fact negatively influence patient satisfaction.

Richardson and Bode (1971:270-271) discuss the differences of explanatory models of clinical reality in terms of the relative social positions of the healer and the patient. The curer and the patient are of the same social rank, facilitating communication through the similar clinical expectations and creating a symmetrical therapeutic relationship. However, "the relationship between the physician and patient is asymmetrical. Carmen (an informant) addresses the physician with the formal *usted*; he replies with intimate *vos*, the Costa Rican equivalent of *tu*. . . . The physician asserts his authority over the curing process and claims that through his superior knowledge he can cure the ills that cause the patient pain." The undermining of the physician's authority without changing the mode of communication may in fact reduce the possibility of a successful therapeutic encounter.

Other factors that mediate a successful treatment relate to the amount and kind of information the patient receives about the type of treatment to be administered (Svarstad, 1976). The failure of the physician to give adequate information concerning medication and treatment reduces the patient's adherence to the prescribed treatment

regime. Inadequate information about treatment in the Social Security clinic then increases the patient's dissatisfaction, expressed in a reluctance to accept prescribed medication. Although the dissatisfaction of Costa Rican patients can be attributed primarily to institutional ideological differences, other factors related to communication and setting must be included in a final explanation.

The two medical institutions contrasted in this paper no longer exist in the form studied. The 1973 health laws transferred all medical assistance responsibilities to the Social Security institution and recreated a Ministry of Health (the former Ministry of Public Health), which would coordinate health services and focus on developing a preventive health program. As the Social Security institution takes over the Public Health clinics, the structural influences on consultation will all change. The following policy recommendations, therefore, will apply to the health care system of the entire country, not just to the observed Social Security clinics.

Policy Implications

The major recommendations focus on the medical institution and its effect on doctor-patient interaction and patient satisfaction. Interactions in the Social Security clinics are often impeded by role confusion on the part of doctors and patients. Neither doctor style nor patient attitude conforms to expectations of role performance. Further, the Social Security institution is now nationalized and the administration is taking over all former Public Health clinics and hospitals. Some adjustment in expectations and translation of ideology into acceptable interaction patterns are necessary in order for patient dissatisfaction not to increase. The difficulty of this recommendation is that the poor quality of interaction in some sense is dependent on the process of social change. As the Costa Rican urban middle class increases, the historical bifurcation of social relations will be minimized. As a transitional solution, workshops and discussions with doctors, patients, and other staff might lower frustration and interactional tension.

There are also possible organizational changes that would increase the success of the Social Security consultation. As the clinic now functions, services are fragmented when viewed from the patient's perspective. The doctor only orders a treatment, a separate agency

distributes the medicine, and another selects a future appointment or referral. If there were a way in which the physician could control return appointments and medicine distribution, or if the patient could at least see the linkages of this therapeutic system, then both the physician role and patient confidence would be reinforced. Physicians would certainly welcome greater control of the treatment. Although this study has not focused on physician satisfaction, there is evidence from interviews suggesting that physician dissatisfaction affects patient reception. The physicians' ability to fulfill patient expectations would be possible with greater physician control and ultimately would increase patient satisfaction.

The Social Security clinic also could be altered so that the waiting times were not so long, through better scheduling or more efficient utilization of physicians' time. The pattern of long coffee breaks in the morning often increases the load of waiting patients and leaves morning appointments to be taken care of in the afternoon. The long consultations provided by the service do not seem to counteract the frustration built up during the long wait. Other solutions include a modification in the number of patients seen, or, better, to make the waiting time pleasant and constructive. Waiting rooms could provide space for children's play and offer preventive health information or general public health services. These changes aimed at the institutional level of health care services could influence the attitude and expectation of the patients before they enter the physician's office.

Recommendations may also be offered at the micro, interactional level of physician consultation. Satisfaction is determined primarily by congruency of expectations. Expectations may be changed externally by education, medical orientation, or socioeconomic access to health resources. Expectations, however, may also be aligned within the consultation by the nature of the doctor and patient discussion. If the content of the consultation could emphasize the clarification and negotiation of expectations, doctor-patient communication would be improved. In such an exchange, expectations could be openly met or rejected and an explanation offered when treatment is refused. This recommendation is based on interpersonal relations rather than on institutional structure, providing still another avenue for the improvement of health care delivery.

The results of this study suggest that there are certain risks to be considered in the development of nationalized health care systems.

These risks may be outweighed by an increase in economic efficiency or access to care in developing countries where medical services are at a premium. Nonetheless, it is important to review the implications of medical system consolidation from the perspective of the Costa Rican data.

The experience in Costa Rica is that the Social Security institution will be responsible for all health care services by 1984. This paper has explored some of the problems that the institution has had in providing patients with satisfactory care. The expansion of the Social Security institution may exacerbate the problems of highly bureaucratized service and confused doctor-patient interaction. The nationalization of this system may generalize these problems throughout the country. The consolidation of a diversity of institutions into one may exaggerate any deficiencies of the original one. Therefore nationalizing an institution without first evaluating that institution's weaknesses and deficiencies may create more serious problems when enacted at the national level. Changing an institution without considering the sociocultural and political context produces disappointing and unintended results.

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