

A STUDY OF APPOINTMENT KEEPING
OF SELECTED PARTICIPANTS
IN A
CHILD DEVELOPMENT
STUDY

By

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CHAPTER I
INTRODUCTION

The Child Development Study is a collaborative study carried on by fifteen medical centers and is sponsored by the National Institutes of Health. The objectives of the study are as follows:

The purpose of the collaborative project is to investigate the relationship between factors and conditions affecting parents and the concurrence and course of abnormalities in their offspring.... The abnormalities of the offspring to be evaluated are disorders of the nervous system apparent at the time of delivery or appearing during infancy or early childhood, including cerebral palsy, mental subnormality, behavior disorders, and other specific neurological or sensory defects, as well as abnormalities of other body systems. (19)

As indicated by this statement, The Child Development Study is a longitudinal project, starting when the gravida is selected in prenatal clinics.

The process of collecting standardized data then begins. The gravida is observed carefully and the data are recorded. At birth, the baby is observed meticulously, and the facts are painstakingly set down.

The examination at the birth of the child is only one of several which will follow until the child is approximately seven years old.

The age schedule and the protocols for the pediatric follow-up examinations are established by the National Institutes of Health. This centralized control provides consistency in the collection of the standardized data by the fifteen participating institutions.

Examinations are scheduled as follows: four months, a physical examination; eight months, a psychological examination; twelve months, a neurological examination; eighteen months, a home visit (made for a health history and observation of sociological factors); twenty-four months, a repeat of the home visit; thirty-six months, a speech examination; forty-eight months, a repeat of the psychological examination; and sixty months, a third home visit. Between the seventh and eighth year, complete physical, psychological, and speech examinations are planned; some, if not all, of the children will be followed for an additional period of five to six years.

The protocol examinations and the home visits are not performed for the purpose of medical care. Rather, their primary purpose is to collect data for the collaborative research study. The majority of the babies are healthy.

The University of Oregon Medical School is the setting for this study. Here, when results of project examinations suggest the advisability of medical care, referrals are made to the Pediatric Outpatient Clinic, as well as to other health facilities in the area. For the purpose of this study, the Child Development Study Clinic will be considered a health facility, since referrals are made on the basis of examinations conducted by trained medical personnel.

Statement of the Problem

This study has been undertaken to ascertain why a selected group of Child Development Study mothers do, or do not keep their Child Development Study Clinic appointments.

Indicated behavior may or may not occur because of the interaction of

environment and individuals. The behavior of an individual is influenced by her total environment.

The subjects of this study are of a lower socioeconomic level. This assertion is based on the fact that to establish eligibility for medical care the patient must be without sufficient funds to pay for all or most of her medical care. She must be physically able to come to clinic for treatment, and she must be a resident of Oregon. The behavior of these subjects and their attitudes toward utilization of health facilities and health care seem to adhere to patterns found in other studies of lower socioeconomic groups.

In studies done by Brightman, et al. (4), Freidson (11), Koos (16), and Ross (22), it was found that less utilization of health facilities was closely related to socioeconomic factors. It is indicated in their studies that people of a lower socioeconomic class do not fully accept scientific medicine; the values and beliefs of this class tend to come into conflict with the acceptance of modern health care.

Importance of the Problem

The gravida is informed by an interviewer of the desire on the part of the Child Development Study to follow her child after its birth.

The mother is notified by telephone, by letter and by reminder cards when her child is scheduled for a Child Development Study Clinic appointment.

To keep this appointment, the mother is offered help with transportation. This may be in the form of mileage reimbursement, bus fare, or taxi fare, depending on the location of the individual and other family conditions.

Even with help in transportation and with reminders of appointments, responses such as the following are received from mothers:

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This card is being mailed back to you saying that I am not sure I can keep the appointment. If I can, I will be there at 10:30. If not, just go on with your regular clinic. (7)

The value of the outcome of the collaborative study is dependent partially on the quality of the follow-up. The quality of the follow-up, in turn, is influenced by the extent to which the sample remains intact.

Hughes (13), in writing about the Tennessee Project Site, stated that the follow-up problems were complicated by the fact that patients change not only their addresses but also their names.

Breanden (3), at the Johns Hopkins Project Site, indicated that more than one half of the first study mothers in the Johns Hopkins' study failed to return for the four-month pediatric examination.

A statistical report prepared by Lessel (18), at the University of Oregon Medical School, covering a period from March, 1959, to February, 1962, showed that of a total of 1,026 first study cases, 80.7% had four-month protocol follow-up examinations, 74.4% had eight-month examinations, 77.2% had twelve-month examinations, and 73.3% had eighteen-month home visits. This would show that the largest drop occurs in the birth to four-month age group.

Walter L. Johnson (15) conducted a "Longitudinal Study of Family Adjustment in Myocardial Infarction". In his study, he had this to say about sample maintenance:

In varying degree some loss is always experienced and has come to be expected.... Longitudinal studies, in addition to having to cope with the usual difficulties in non-response in the selection of the original sample, have been subject to later losses due to such factors as migration, mortality, and non-cooperation.

Non-response is wasteful in research effort because time and energy are expended to establish the conditions for observation of units which are not subsequently

observed. More significantly, the question of biasing the results of the observed sample by exclusion of the non-observed sample is almost always raised.

Johnson further pointed out that in addition to the danger of biasing a sample, the loss of subjects is very costly: it wastes the time of medical and other professional examiners, and it costs the Study money whenever a scheduled individual does not show for her appointment.

A basic premise of this study is that the identification of Child Development Study mothers' reasons for attending or not attending clinic will provide information that can be used to improve pediatric follow-up. The data collected for the purpose of the study will promote a better understanding of the Child Development Study mother through her stated opinions. It will indicate behavior on future Child Development Study Clinic appointments, and therefore point to possible improved methods for the follow-up staff to approach mothers for clinic attendance.

Hypotheses

1. The Child Development Study mother who keeps her clinic appointment understands more about the purpose of Child Development Study Clinic than does the mother who does not keep her appointment.
2. The more favorable relationship a Child Development Study mother has with clinic and hospital staff during prenatal visits and hospitalization, the more apt she is to "follow through" in attendance in Child Development Study Follow-up Clinics.

Definitions

Child Development Study Clinic: A clinic organized for the examination of children for the collaborative research study.

Protocol Examinations: Specific examinations given to all children in the Study at specific ages.

Gravida: Pregnant woman.

First Study Mother: A mother who has been selected for the first time for a Child Development Study.

Favorable Relationship: A relationship which would indicate by the patient's response that the patient had a feeling the staff was concerned with her physical, mental, and emotional well-being.

Limitations of the Study

1. The participants interviewed were thirty-six (36) selected mothers with four-month-old babies, who kept their first or second Child Development Study Clinic appointments; and fourteen (14) selected mothers with four-month-old babies, who failed to keep two clinic appointments for their babies. This has been discussed further in Chapter III.
2. The participants were limited to Caucasian, married mothers, between the ages of 17 to 40 years.
3. The participants were limited to mothers who have only one child on the Child Development Study Project.

4. Participants who were foster mothers or other forms of mother surrogate were not included.
5. The study is further limited to information that could be obtained from the participants of the Study.

Assumptions

1. The behavior of mothers toward the Child Development Study Clinic attendance can be identified, systematized, and interpreted.
2. The behavior of an individual and her ideas of utilizing health facilities are influenced socially and culturally by a complex of factors, such as socioeconomic status, educational level, and commonly shared behavior characteristics.
3. The interview is a tool that will adequately describe and measure behavior for the purpose of this study.
4. The participants will express their opinions freely to the interviewer.

Design for the Research

In order to study certain aspects of the Child Development Study mother's behavior in relation to her Child Development Study Clinic attendance, an interview schedule consisting of both closed and open ended questions was used. This has been reviewed in Chapter III.

The interview schedule was constructed to elicit information about the social characteristics of the Child Development Study mother, as well as reasons expressed by the mother for attendance or non-attendance at the Child Development Study Clinic. Responses to the open ended questions on

the interview were recorded verbatim.

Procedure

The procedure for the study was as follows:

1. The sample was selected for study from mothers participating in the Child Development Study, and who had been scheduled for a four-month pediatric protocol examination at the University of Oregon Project Site.
2. An open ended and closed Interview Guide was constructed to collect the data.
3. The Interview Guide was pretested in the Child Development Study Clinic four times and on four home visits.
4. The tool was found to be satisfactory for the interviews conducted for this study.
5. The qualitative data were categorized for general content analysis and for exploring Child Development Study mothers' behavior toward clinic attendance.

Overview of the Study

The remainder of the thesis is organized and presented as follows:

- | | |
|-------------|---|
| Chapter II | contains a survey of the literature and related studies |
| Chapter III | provides a report of the procedure and the findings |
| Chapter IV | embodies the summary, conclusions, and recommendations for further study. |

CHAPTER II

REVIEW OF THE LITERATURE AND RELATED STUDIES

In reviewing the literature, an effort has been made to examine significant cultural and social features which are related to the acceptance and utilization of health care. The literature on cultural aspects of health in other societies has been reviewed as background information. The areas of literature in which reading has been concentrated are primarily studies concerning ideas and attitudes toward health, illness, and medical care. One portion of the reading was limited to studies concerning the use of clinic and health facilities.

Cultural Aspects of Health

Jelliffe (14) gave two definitions of the term, culture. One:

Culture covers not only the arts, sciences, religions and philosophies to which the word is historically applied, but also the system of technology, the political practices, the small intimate habits of daily life, such as the way of preparing or eating food, or of hushing a child to sleep.

and:

The common way of life shared by members of a group, consisting of the totality of their tools, techniques, social institutions, behavior patterns, attitudes, beliefs, motivations, and systems of values.

Jelliffe describes how, in a rural area of West Bengal, India, the local customs are taken into consideration in the operation of a modern maternity home.

Since no particular beliefs appear to be held concerning the length at which the cord should be cut, as in some countries, no difficulty arises here. With regard to the placenta, in the traditional home delivery this is buried by the dai (midwife). The exact details of this practice are not extremely important in this locality, so that the mothers are quite content for the placenta to be disposed of by the maternity home staff in a deeply dug rubbish pit.

The seclusion ritual universally practiced by Hindu mothers after birth is adhered to, at least functionally, by visitors who take care not to approach nearer the bed than a few feet, and by relatives who bring the food from home and empty it into a plate which the mother has left outside the door. In the latter case, care is taken not to touch this plate with the food container during the process of pouring the food.

Attitudes toward the disposal of the shriveled umbilical stump vary. Many mothers do not mind if this is thrown away, although there are some practices of using it as a maduli (protective charm) to be worn around the baby's neck. These practices are permitted by the maternity home.

Various ceremonies are performed during the neonatal period. One of these, jata karman, can be and is carried out by the mother, herself, who puts a drop of honey on the neonate's tongue. Similarly, on the sixth evening, the mother will be anxious to be home for the night vigil kept during Shosti puja (the dedication of the baby to Shosti, the goddess of children). Should it be necessary for the mother to remain in the maternity hospital for a longer period, a satisfactory compromise can be achieved by having the relatives perform part of the ceremony at home, the rest of it being completed by the mother on the twenty-first day, when she

has returned home.

There are two days, however, on which the mother is very anxious to be home--on the eighth day for the ceremony of atkore-batkore (name giving ceremony), and on the tenth day when the purification bath is taken. Knowing this, the maternity home staff makes every effort to see that the mother leaves the hospital in sufficient time for the ceremonies.

Baily (1) undertook a study to investigate beliefs and practices pertaining to the reproductive cycle among Navaho Indians. The data were gathered from sixty-six informants, both men and women. The material was collected from three areas in New Mexico: the Ramah, the Pinedale, and the Chaco Canyon regions.

From this study, recommendations were made as to how to integrate Navaho beliefs into medical and educational programs. Since certain Navaho practices are sanctioned by mythology and reinforced by ritual, these people offer great resistance to change unless such changes can be made to fit the pattern of Navaho logic.

It was found to be of primary importance to gain the support and confidence of influential members in each family group if a program of health education were to be successfully implemented. Group decisions in matters of health are common practice when a healing ceremonial is involved.

In dealing with patients during pregnancy, as well as after their admission to the hospital, it is important to phrase medical suggestions in terms of Navaho reasoning. The Navaho concept of keeping the fetus small, so as to insure an easy delivery, includes hard work, exercise, and no sleep in the daytime. There are magical applications of certain medicines which work on the "like-produces-like" formula, such as sucking

honey from the pentstemon (hummingbird's food), or eating a hummingbird's eggs, shell and all, because this bird is so tiny. If the medical worker is to suggest other methods, such as engaging in moderate exercise, the use of vitamins, or an increased calcium intake, he might explain by using Navaho phraseology, "It will make the baby strong, even though he remains small so he will be born easily".

If the mother remains in the hospital until the baby's navel is healed, it is important that the cord be given to her on discharge. There is a belief that the cord holds some magical properties.

Paul (20) presented a series of case studies of several different cultural groups. In these studies he considered both literate and non-literate society responses to health projects. He indicated that many non-medical practices were closely related with health behavior.

As was pointed out by Jelliffe (14), and Baily (1), Paul also was convinced that before asking a group of people to assume new health habits it was necessary to ascertain the existing habits, how these habits were linked to one another, what function they performed, and what they meant to those who practiced them.

It was his conclusion that, "...the threads of health and illness are woven into the sociocultural fabric and assume full significance only when perceived as part of the total design".

Saunders (24) has done an extensive study among the Spanish-speaking people of the Southwest. He discussed folk medicine and how these beliefs affected the use of scientific professional health care. He emphasized the point that medicine is a part of culture:

In its totality, medicine consists of a vast complex of knowledge, beliefs, techniques, roles, norms, values, ideologies, attitudes, customs, rituals, and symbols that interlock to form a mutually reinforcing and supporting system. Such a system is designated by the term "institution". Medicine as an institution is integrated with other major institutional complexes--government, religion, the family, art, education, the economy--into a functioning whole, which is culture. Each culture has its own unique system of elements constituting the institution of medicine.

Saunders pointed out that the practice of medicine often involved the application of elements of the institution of medicine as found in one culture to the people of another culture. Often, then, that which was attempted by those in the medical role was not interpreted correctly, or fully understood, because of cultural differences.

The author described how the culture of the Spanish-speaking people had a determining influence on their behavior. There were important culturally derived differences between the professional health personnel and the Spanish-speaking people and their families; these differences tended to limit the kind and amount of health and medical care they would accept. This was demonstrated by the description of a Cooperative Health Association, organized in Taos County, New Mexico, to give care to nine hundred seven paid-up member families. Even though medical care was provided at a minimal cost, within a six-year period the membership decreased until the Association ceased to function. It was found that many members of the Association never understood much about the organization or their relationship to it. The Association attempted to provide Anglo medical care to a people who were not ready culturally to receive or support it. It was concluded, then, that those responsible for planning and carrying out the program in the Taos County Health Association did not take cultural

differences into account.

Clark (5) studied the Mexican-American community of Sol di Puentes, California. She described how the social, economic, religious, and folkloristic characteristics of the community affected problems of health and illness. Among the families of this community there were beliefs and customs regarding pregnancy, childbirth, and child rearing, all of which directly influenced health practices. Although many women would have preferred to have been at home, there was general acceptance of obstetrical service provided by the local county hospital.

Dr. Clark pointed out that there were "...many factors involved in whether or not a woman will go to a doctor for prenatal care", one major factor being that the pattern of family authority may determine if an individual is free to seek and receive medical care.

This was illustrated in relation to child care in an incident described wherein a Public Health Nurse was very emphatic that a mother bring her child in to clinic to complete a series of immunizations. The mother had never attended a child health conference until she moved into a district of a different Public Health Nurse. The latter nurse made the home visit and suggested that the mother talk to the child's maternal grandparent about the value of immunization. She further added that she would drop by later to find out what the grandparent thought about bringing the child to the health conference. It was unnecessary for her to make the second call, since the mother, the child, and the grandmother attended the health conference.

Fischer and Fischer (10), conducted a cultural study on "The New Englanders of Orchard Town, U. S. A.". It was an attempt to describe the

social, economic, political, and religious factors, among others, that functioned as the culture of this community. The study was presented in two parts, the ethnographic background and child training.

Some of the ideas held by the residents of Orchard Town concerning health and medicine were presented. The residents subscribed to the scientific theories of Western medicine to explain disease. The doctors were expected to control medical knowledge. Every adult in Orchard Town had a rich store of ideas about the cause and cure of all but the most unusual diseases.

It was considered, for example, that germs caused most diseases. Germs were sensed as tiny, invisible animals that swarmed around sick people, especially when they sneezed, coughed, or exhaled. For this reason, sick people were generally isolated and avoided. A person who sneezed or coughed was expected to cover his mouth and to turn his head. Germs were thought to infest dirt of any kind, and particularly feces; therefore, children were taught at an early age to wash their hands before eating.

Good health was thought to be promoted by a good diet, proper exercise, and the avoidance of excess. Many people took vitamin pills or liquid preparations presumed to prevent "tired blood" or "that run-down feeling". Regular bowel movements were thought necessary for good health. Constipation was believed dangerous, and medicines were taken to correct the situation.

No matter how the person felt, a fever was necessary for him to be defined as "ill". A child went to school, and an adult carried out his regular duties, unless the thermometer registered at least one hundred degrees.

Smallpox vaccinations were required by state law and were generally accepted by the parents. Salk polio vaccine was permitted to be administered

by ninety per cent of the parents who had children in the first and second grades in Orchard Town.

Social Class Influence on Health Behavior

Social class, used as a frame of reference for utilization of health care facilities, includes not only cultural attitudes and values, but also economic status.

Roemer (21) defined social science as being concerned with man in society. One aspect of this complex is the effort of man to obtain the benefits of science for treating his illnesses. From the earliest societies this has involved group action. The organization of medical care in the current world is a "many-splendored" process--both in its definition of the precise needs to be tackled and in the economic and technical methods of tackling them.

Medical care is a problem of life-and-death importance to everyone in our society, although to ordinary people the complex issues that lie beneath the surface may be obscure.

Koos (16) conducted a study involving five hundred fifty families in an "average small community" in upstate New York. Interviews were used to obtain data concerning health attitudes and behavior. The study was conducted as "pure research" and not for the improvement of health facilities in the community.

Koos used a threefold division to describe the membership of the family in the social class system in the community where the study was carried out: Class I consisted of business and professional men; Class II was comprised of skilled and semi-skilled workers and farmers; Class III

was made up of industrial and farm laborers, as well as of the unemployed.

The hypotheses which Koos tested and adequately supported were:

The health attitudes and behavior of a family are related to its position in the social class hierarchy of the community, and are significantly affected by the prescriptions and proscriptions regarding health shared by those who are members of the same social class. Further, there is a difference in the way and degree to which people participate with their membership in a social class.

Descriptions of the beliefs and health practices were given for the community. Koos found a consistent difference between social classes in how they perceived the presence of illness and in their acceptance of health care. Factors which were found to be contributive to these differences were variations in educational attainment, experience, and ability to purchase medical care, together with an actual knowledge about health and disease.

Koos concluded his report by indicating that the health of the community was based on the individual and the ideas of his family, his ideals, and his behavior patterns. Perception in all aspects of illness and health must be acknowledged as varying from one level in the social hierarchy to another, these class-related differences having an importance which cannot be denied. "For these are the differences in perception, and from perception stems acceptance or rejection of what is professionally known to be necessary for health."

Freidson (11) was concerned with three types of medical practice in the Bronx, New York. This study:

....explored the attitudes and behavior of patients who have had experience with more than one way of organizing medical practice, and thereby sought to suggest some of the ways in which lay and professional social structure figure in the utilization of medical care.

The three types of medical plans were: (1) The Montefiore Medical Group, in which service was provided by individual physicians who worked within the organization of a prepaid centralized and somewhat bureaucratic medical group; (2) The Family Health Maintenance Demonstration, an experimental group composed of a random sample of the group previously described, for whom health services were provided on a prepaid centralized medical group that functioned not as the individual physician, but as an inter-professional team; and (3) the "solo practice", or the traditional practice, in which everyday care was provided by private physicians in a "fee-for-service" practice.

The emphasis made was that a medical practice involved much more than applied technical knowledge and expertness. The author viewed the medical practice as a system of relationships which included, (1) the patient, (2) the physician, (3) the organization of medical practice, and (4) the organization of the patient's community life. These factors all function together as part of medical practice.

Data for this study were obtained from three sources: interviews conducted in the homes, a series of questionnaires administered through the mail, and observations of both patient and medical personnel in waiting-rooms.

Freidson indicated that the separate worlds of experience and reference of the layman and the professional worker are always in potential danger of conflict one with the other. This would appear inherent in medical practice.

The practitioner remains detached from particular cases. He sees the patient as a special instance to which he applies the general rules learned

during his training. The patient, being personally involved in what happens, may try to judge and control what is being done, and this from other than a professional point of view. "While the professional worker and client are theoretically in accord with the end of their relationship--solving the client's problem--the means by which this solution is to be accomplished and the definitions of the problem itself are sources of potential difference."

The patients recognize that good health care requires both technical competence and a sincere interest in the patient by the physician. Patients' attitudes about their illnesses are not formulated only in the doctor's office, but are influenced by a multitude of events outside of the doctor's office. An important element contributing to the forming of lay opinions is the importance of lay interpersonal relationships. These relationships may be so influential that a doctor's diagnosis may be rejected in favor of a lay opinion. The "lay referral system" consists of a network of consultants for potential or actual illness.

Ross (22) examined the relationship between social class and utilization of medical care. It was found that the office calls of upper class people were of a more preventive nature and did not always involve the presence of discomfort or immediate goals. In contrast, it was found that a lower class people go to the physician mainly for a felt complaint. They seek an explanation of "what is wrong" with the ailing part of the body and something to "fix it up".

This information was obtained through the use of data from the 1957-1959 National Health Survey. In re-examination of the connection between social class and medical care, Ross concluded that the traditional, direct relationship between social class and the use of physicians still existed

and was present on a nationwide level.

Simmons (26) pointed out that most public health precepts were prescribed by middle-class people, but were primarily directed at a lower-class people. He discussed the conflicts that occur between the values of the health worker of a higher social status and those of the patients of a lower social status.

The author described six major differences in value orientation between middle-class and lower-class norms which may stimulate conflict.

These were significant in regard to public health emphasis on the prevention of illness. In contrast with a lower-class people, middle-class persons tended to: (1) give health a relatively high place in the hierarchy of values, (2) emphasize cleanliness, (3) defer immediate gratifications in the interest of long term goals, (4) develop a strong sense of individual responsibility, (5) accept scientific medicine, and (6) manifest rationality in planning and allocating resources in the most efficient way.

Lower-class norms could be described as contrasting with the above values in several different ways. For example, lower-class people did not emphasize uncleanliness, but, rather, failed to emphasize cleanliness. In the same vein, they did not accept scientific medicine.

Deasy (6) indicated that there was a relationship between socioeconomic status and participation in the poliomyelitis vaccine trials conducted on a random sample of mothers of second grade children in five public schools.

It was expected that there would be a relationship between socioeconomic status and participation in the poliomyelitis vaccine trials which would be reflected in differential knowledge about, concern with, and participation in the program.

To determine whether this was the case, respondents were classified into three groups, these groupings being based on the Edwards (8) Rating Scale. Group I was comprised of college educated mothers whose husbands were college trained. Group II, occupationally heterogeneous, included professional as well as skilled workmen, more than three fourths of the men and women either having been graduated from high school or having gone to school beyond high school graduation. Group III was made up of men at the level of skilled workmen or below, who were not high school graduates and who were married to women who were not high school graduates.

The data thus collected demonstrated that there was a clear relationship between socioeconomic status and participation in these vaccine trials. This indicated that the "less privileged" members of the total population also may be the ones who were least likely to avail themselves of services that medical experts consider would decrease the chances for their children contracting the disease.

It was believed that the differences found to exist possibly would be accounted for by the differences in the basic value orientations of the respondents in these three groups. It was possible that members of Group III had less experience with and confidence in doctors. Perhaps they had less understanding of "research" and attached less importance to it. Possibly, they did not think in terms of trying to prevent illness, but rather fatalistically accepted those diseases which befell them and their families.

Brightman, et al. (4) undertook a study to ascertain the extent to which recipients of public assistance made use of health services available to them and compared this utilization with that of other socioeconomic groups.

Three study groups were selected. For the basic study groups, it seemed most desirable to select those families which included children and which had been receiving public assistance for a sufficiently long and continuous period so as to stabilize their pattern of living at that economic level.

Then, a first comparative study group was chosen, being selected from a low income group, but of sufficient income to make the participants ineligible for public assistance.

A second comparative study group was selected from the employees of a single large factory. The salary range was from \$5,000 to \$7,000. These employees could not be considered typical of the middle income group, since nearly all of them were covered by a medical insurance plan.

There were three main areas in which the data were collected: sources of health information, knowledge and reported utilization of school health services, and knowledge and reported utilization of community health services.

It was found that there were no basic differences in the receipt of health information and health literature in the three groups. All three groups appeared to have received considerable information directly from physicians and nurses.

There seemed to be no gross differences in the knowledge and use of school health services between the public assistance group and the comparative groups.

Knowledge of community health services seemed adequate among all three groups. However, there appeared to be a marked deficiency in the extent to which the community mass chest x-ray was used by the lower income groups.

The public assistance women frequently failed to receive any antepartum care. They applied for such care later during pregnancy, and they made fewer visits to the doctor than did the two comparative groups. The proportion of women in both of the lower income groups failing to receive postpartum care over a five-year period was much higher than in the middle-income group.

In summary, the deficiencies in knowledge and utilization of preventive health resources among public assistance recipients appeared to be primarily in the areas of: (1) maternity services, (2) regular chest x-rays, and (3) follow-up on defects noted during school and medical examinations.

Utilization of Clinic and Health Facilities

Several studies have been undertaken to determine the use of health facilities, as well as the follow-through once care had been initiated. Numerous factors seem to play a role here: those discussed in reference to culture, those discussed in reference to the socioeconomic status, and those factors pertaining to the immediate environment.

Lackey (17) found in a study that attendance of children registered for child health clinics had been poor, despite obvious needs.

Consequently, a pilot study was designed to determine whether families who fail to keep conference appointments after the first visit were (1) less likely to have received a prenatal visit by a Public Health Nurse, or (2) less likely to have had a prenatal visit in which well-child care was discussed.

In regard to the records of families with an infant born in 1961, the author found that those families who attended child health conferences in

four districts in Berkeley, California, were grouped into those who had Public Health Nurse visits before the birth of the infant and those who did not have such visits. The first group was further divided into those with whom the subject of well-child care was discussed. The visits and discussions were found to have a significant statistical association with regular attendance at the child health conferences.

Berkowitz, et al. (2) did a study on follow-through of patients in an outpatient clinic, examining nursing performance in outpatient departments. The level of patient follow-through was employed as a measure of clinic effectiveness, and by extension, as one aspect of the quality of patient care given in those clinics. Patient "follow-through" referred here to the extent to which patients carry out requirements regarding return appointments, tests, medications, treatment, referrals, and restrictions. No matter how accurate and expert the clinic personnel might be in diagnosis and prescription of treatment, their efforts would be rendered largely ineffective if the patient failed to carry out on those prescriptions.

By the nature of the procedure used, the patients comprising this sample were not completely representative of the total population of clinic patients, since data could be obtained only on patients who had returned to the clinic. Therefore, these patients had already complied to some extent with instructions, although they may not have returned at the proper time. In the light of the nature of the bias in the sample, it was likely that the data overestimated the amount of follow-through in the total population.

The number of low correlations obtained indicated that follow through was not a unitary phenomenon, but rather consisted of a series, at best, of only partially related performance variables. Thus it would appear that a patient's degree of "follow-through" in one area was not necessarily related to his performance with respect to another. A linkage analysis performed on these data resulted in the emergence of two links. Link I involved medication, treatment, and restrictions. Link II was composed of return appointments, referrals, and tests.

It would seem that the level of patient compliance was affected by the nature of the follow through requirement. Link I consisted of items most directly relevant to patient self-care, whereas Link II was made up of those items important to the internal function of the organizations as well as to the patient. It was noted that "follow-through" was lowest at Link I-- those areas in which the patient had exclusive responsibility for his care at home.

Elling, et al. (9) introduced a study with the following quotation: "Health cannot be simply given to people; it demands their participation".

The study focused on children who had been treated for rheumatic fever in the pediatric cardiac clinic in a selected hospital. The ingestion of daily prophylactic penicillin tablets and regular visits to the clinic were behaviors directly related to the objectives of maintaining and promoting the proper health of these children. Thus the regularity with which the patient took pills and kept appointments provided a measure of his degree of participation.

The study was summarized with several findings. The lack of patient participation, a general medical problem, was studied in a rheumatic fever

program where, in spite of a strong motivation on the part of the clinic personnel to encourage participation, the patients were found to be low participators.

In this situation where the availability of the program was assured, family income and family social class position showed no statistically significant relationship to the degree of participation.

Certain family characteristics--vertical mobility of the social class structure, harmony of family relationships, residential stability, and ethnic background (Negroes as a deprived group)--were significantly related to conceptions of rheumatic fever and penicillin and to the degree of participation.

It was suggested that these relationships occurred, in part, through the effect these family characteristics had on the mother's reflective self concept; in other words, the mother's estimate of how she was evaluated by clinic doctors.

Hansen (12) undertook a study to determine the causes of broken appointments in the Child Health Conference, sponsored by the Maternal and Health Division of the Johns Hopkins School of Hygiene and Public Health.

Two approaches were used. First, patients' clinic records and the appointment books were used to select and study certain factors which might influence the breaking of appointments. The factors examined were race, weather, sex, frequency of change in physicians, immunization status, and the availability of a telephone. Second, there were home visits to the families who broke appointments during the months under study.

Immunization status appeared to be important in determining whether or not an appointment were kept. Children who had completed their immunizations

broke more appointments than those who had not completed the series.

Race was not a significant factor.

Other factors were of borderline consequence. Illness of the child or illness within the family accounted for nearly half of the reasons volunteered by parents as causes for their failure to keep appointments.

Schonfield (25) engaged in a study to determine if reasons could be identified by analysis of family characteristics as to why some parents permitted their children to participate in a mass tuberculin screening program while other parents did not.

The study was performed, in 1960, on 344 mothers of grade school children in Cambridge, Massachusetts.

No differences were obtained between the families on such variables as mothers' ages or education; grandparents' birthplaces; the location of family residences; the children's sex, race, grade in school, or type of school attended (public versus parochial).

Children whose parents refused permission for a tuberculin test, but who said that such testing had been done by their own physician, were found to have fathers in the upper educational and occupational brackets, when compared with the remaining children. The mothers of these children displayed the most favorable attitudes toward doctors. They were the most knowledgeable group when it came to information about tuberculosis and diabetes. By contrast, they represented a larger proportion opposed to compulsory tuberculosis screening than the parents of participants.

Mothers who refused to give permission for their children to be tested, and who did not report having them tested privately, revealed more fearful attitudes toward physicians and seemed less favorably inclined toward

doctors in general. This group of mothers displayed the least knowledge about tuberculosis and diabetes, as well as about present mass tuberculin testing. More of this group displayed opposition to compulsory testing. Further, it was found in this group that the fathers had a more active role in decisions about immunizations for the children.

In contrast to both of the previously mentioned groups, the mothers who allowed their children to be tuberculin-tested in the schools displayed a much more favorable attitude toward the screening program. These mothers were slightly more in favor of a compulsory program. In comparison with the mothers who reported not having their children tuberculin-tested at all, these same mothers were more knowledgeable about tuberculosis and diabetes. They were more favorably inclined toward the physician and less fearful of him.

Stifler (28) conducted a study on children seen in diagnostic centers in the State of Maryland. The study was divided into two parts.

The first part dealt mainly with the administration of the centers.

The second part of the study pertained to the children, but took into account 1,326 separate diagnoses and 1,245 specific recommendations made by the centers. The primary purpose of this study was to determine the extent to which the recommendations had been carried out and the effect of their implementation on any improvement shown by the children.

A careful look at the 1,245 recommendations made for the children indicated that they were essentially what would be expected from the diagnoses. The most frequent of the recommendations were for special educational facilities, speech therapy, appliances, mental health clinics, and for follow-up in seizure clinics.

Seventy-two per cent of the total of 1,245 recommendations made to the participants were carried out. Another six per cent of the total recommendations were planned to be carried out. Information was unavailable on four per cent of the recommendations that had been made. Nine per cent of the recommendations were not carried out by the parents of the participants, their reason being simply "unwillingness". The remaining nine per cent of the recommendations made failed for lack of facilities.

In summarizing, the main points of the review of the literature were as follows:

1. Culture influenced the value orientation of the individual, and, in turn, the utilization of health facilities was dependent on these values.
2. Several studies have indicated that there was a relationship between utilization of medical care and social class status of a family.
3. The follow up of the use of health facilities indicated that other factors beside socioeconomic status and cultural groups must be considered. Among these were the relationship which the patient has with clinic personnel.

CHAPTER III
PROCEDURE AND FINDINGS

Procedure for Study

Description of the Setting

The Child Development Study Project is an on-going research conducted at the University of Oregon Medical School. The participants for this Study are selected in the Prenatal Outpatient Clinic at the Medical School.

Information is recorded about the participant as a person, and about events of her pregnancy. These data are to be used later in relation to the child's physical, mental and emotional development.

To obtain information about the child, the Child Development Study conducts a pediatric follow-up clinic. Examinations and observations are carried out at time intervals as follows: four months of age, a physical examination; eight months of age, a psychological examination; twelve months of age, a neurological examination. At eighteen months of age, a home visit is made and a health history is obtained; at twenty-four months of age, a second home visit is made and another health history is obtained. At thirty-six months of age, there is a speech and hearing examination; at forty-eight months of age, a psychological examination is conducted. At sixty months of age, a home visit is made and an additional health history is obtained. Plans are not complete for the examination at eighty-four months of age. Between seven and eight years of age, a complete evaluation of the child will be made. Some, if not all, of the children will be followed

for an additional period of from five to six years.

The examinations are administered by pediatricians, psychologists, and speech therapists. A Public Health Nurse schedules the children for their examinations; she interviews the mothers of the children for the health histories and for other pertinent information.

Although the examinations are specified, such as the four-month examination, a time period is given so that the child could be scheduled between fourteen days prior to the four-month age date and twenty-one days after the age date and still stay within the protocol of the examination.

The Child Development Study Pediatric Follow-up Clinics are conducted in the Crippled Children's Division facilities, located at the University of Oregon Medical School. This is in contrast to the Prenatal Clinic for the mothers, which is held in the Outpatient Clinic of the Medical School.

There are four Public Health Nurses working in the active follow-up. Geographically, this is defined as consisting of families living in Multnomah, Clackamas, and Washington Counties.

One Public Health Nurse is responsible for scheduling the child and interviewing the mother for the four-month age group. The four-month age group is the only age group with which this study was concerned.

Scheduling the child for his/her examination involves, first of all, locating the child. An appointment letter is sent to the mother. Enclosed is a self-addressed postal card in order that the mother may reply as to whether she plans to keep the appointment. A reminder card is then sent two days prior to the scheduled appointment. A home visit is often made to reinforce and confirm the appointment. Aid with transportation is offered to enable the mother to keep her child's appointment.

Sampling

In the original study design, it was planned to have fifty Caucasian, first study mothers who attended clinic; and fifty Caucasian, first study mothers who failed to keep two Child Development Study appointments for their children. It was designed to have matched the mothers who attended clinic with the mothers who did not keep their clinic appointments in relation to the number of children they had residing in their homes. Due to sampling difficulties, however, it became necessary to modify these criteria.

After interviews were started in the clinic, very few mothers meeting the criteria of this study failed to keep their children's Child Development Study Clinic appointments.

No obvious explanation can be given for this sampling difficulty. Two possibilities were weighed. First, the nurse scheduling the children for appointments may have considered that the study was evaluating her work, and this may have stimulated behavior changes. Second, the interest of the researcher in this age group may have stimulated the nurse doing the scheduling, thereby causing behavior changes.

The final study consisted of thirty-six (36) Caucasian, first study mothers who kept their children's Child Development Study Clinic appointments, and fourteen (14) Caucasian, first study mothers who did not keep their children's appointments for Child Development Study Clinic. Within the limitations of the original design of the study, the mothers who kept their children's clinic appointments were interviewed in the clinic by the researcher prior to their interviews with the nurse who took the children's health histories and before the children's physical examinations were

conducted by the doctors.

Modification of the total number of mothers participating in the study made statistical analysis of the data to test the hypotheses impossible.

Collection of the Data

This study involved data collected from a total of fifty Caucasian, first study mothers participating in the Child Development Study Project. Thirty-six of the mothers kept their four-month Child Development Study Clinic appointments, and fourteen failed to keep two Child Development Study Clinic appointments. For the mothers who attended Child Development Study Clinic, the data were collected in the spring of 1964. From the mothers who did not keep their first two clinic appointments, the data were collected during the spring, summer, and fall of 1964. Collection of data was terminated at this time because the physical setting of the Child Development Study was being moved, thus introducing a new variable.

The participants for this study were obtained through the follow-up nurse working with the four-month age group. It was she who notified the researcher when she had scheduled mothers who met the criteria of the study. She also notified the researcher when a mother failed to keep two clinic appointments and supplied the necessary address for the home visit.

The data were collected in the Child Development Study Clinic in the Crippled Children's Division and in the active follow-up area.

The collection of the data was by means of response to an interview. In composition, the interview contained both open ended and closed questions, and was constructed to obtain information in the following areas:

1. socioeconomic and cultural data

2. patients' opinions about the prenatal clinic and the hospital
3. patients' knowledge of the purpose of the Child Development Study Clinic.

An explanation of this study was not given to any of the mothers participating.

The researcher introduced herself for the interview in the following manner:

"I am Mrs. _____, a Graduate Nurse. I am doing some advanced study. It would be very helpful if you would answer some questions for me. The answers to the questions will not be identified with your name. You will notice that some of the questions pertain to the Child Development Study, but please understand that I am in no way related to this Project.

May we proceed with the questions?"

This introduction was used both in the clinic and on the home visits, with the variation that on the home visits nothing was said about the Child Development Study until the researcher was inside the door. Approached in this way, no mother refused to participate in the study. It was necessary on one home visit to reverse the sequence of the questions, asking the personal questions last.

The researcher was dressed in street clothes for the interview, both in the clinic and on the home visits.

The answers of the respondents were recorded verbatim. The Interview Guide is in Appendix A.

Validation of the Tool

The Interview Guide was constructed in such a way as to lend itself to comprehension at the educational level of the mothers selected to

participate.

The Interview Guide was submitted for review and suggestions to fifteen graduate nurses in the School of Nursing at the University of Oregon. In addition, it was submitted to the Director of the Child Development Study Project, to an anthropologist, and to four nurses employed by the Child Development Study Project. Suggested revisions were then made in the Interview Guide. It was further pretested on four mothers who had kept their children's clinic appointments, and on four mothers who had not kept two clinic appointments for their children.

It was found that the data obtained from the answers to the questions on the pretest were of sufficient content to yield to analysis.

Findings of the Study

The findings of this study were based on the responses obtained by interviews with fifty Caucasian females who were or had been married. Thirty-six of the women were interviewed in the Child Development Study Clinic at the time they brought their children in for their four-month examinations. Fourteen of the women were interviewed in their homes after they had failed to keep two appointments for the four-month examinations scheduled for their children.

The first portion of the study was involved with the personal aspects of the participants' lives. Tables 1 through 15 described the social and living conditions of the mothers.

Table 1 dealt with the age grouping of the mothers participating in this study. It was shown that the ages of the mothers range from 17 to 40 years. The mean age for the mothers who kept their appointments was 23.7 years. The mean age for the mothers who did not keep their appointments

was 25.7 years. It may be noted, then, that the mothers who did not keep their appointments were slightly older.

Table 1. Comparison of Ages of Mothers Who Kept and Did Not Keep Their Clinic Appointments

Ages of Mothers	Mothers Who Kept Appointments ^{1/}		Mothers Who Did Not Keep ^{2/} Appointments	
	N	%	N	%
17 - 21 yr.	13	36.1	5	35.7
22 - 26 yr.	16	44.5	4	28.6
27 - 31 yr.	5	13.9	2	14.3
32 - 36 yr.	2	5.6	2	14.3
37 - 40 yr.	0	0	1	7.1
Total	36	100.1% 100 %	14	100 %

^{1/} The mean age for the mothers who kept their appointments was 23.7 years.

^{2/} The mean age for the mothers who did not keep their appointments was 25.7 years.

The number of living children the mothers had borne, and the number of children residing with them, in relation to clinic attendance or non-attendance, were given in Tables 2 and 3. For the mothers attending clinic, the mean number of children borne was 2.7 children; the mean for the same mothers, but for the number of children residing with them was 4.8 children. In contrast, for the mothers who did not keep clinic appointments, the mean number of children they had borne was 3.4 children. The mean for the number of children these mothers had residing with them was 2.6 children. Thus, it was shown that the mothers who kept their clinic appointments acquired more children in their families than they had borne.

The mothers who did not keep their clinic appointments differed in that they had given birth to more children, but did not have as many children living with them as they had borne.

Table 2. Comparison of the Number of Living Children of Mothers Who Kept and Did Not Keep Their Clinic Appointments

No. of Living Children	Mothers Who Kept Appointments ^{1/}		Mothers Who Did Not Keep Appointments ^{2/}	
	N	%	N	%
1	12	33.4	3	21.4
2	5	13.9	3	21.4
3	8	22.2	2	14.3
4	6	16.7	2	14.3
5	2	5.6	2	14.3
6	3	8.3	0	0
7	0	0	1	7.1
8	0	0	1	7.1
Total	36	100.1% 100 %	14	99.9% 100 %

^{1/} The mean number of living children of mothers who kept their appointments was 2.7 children.

^{2/} The mean number of living children of mothers who did not keep their appointments was 3.4 children.

Table 3. Comparison of the Number of Children Residing with Mothers Who Kept and Did Not Keep Their Clinic Appointments

No. of Children	Mothers Who Kept Appointments ^{1/}		Mothers Who Did Not Keep Appointments ^{2/}	
	N	%	N	%
1	11	30.5	3	21.4
2	5	13.9	4	28.6
3	9	25.0	4	28.6
4	7	19.4	2	14.3
5	2	5.6	1	7.1
6	2	5.6	0	0
Total	36	100 %	14	100 %

^{1/} The mean number of children residing with mothers who kept their appointments was 4.8.

^{2/} The mean number of children residing with mothers who kept their appointments was 2.6.

Tables 4 and 5 indicated the working status of the mothers. A slightly higher per cent of the mothers who did not attend clinic had worked since they were married (71.4 per cent), in contrast to 69.5 per cent for the mothers who kept their clinic appointments. There was a greater difference seen in the two groups in the number of mothers working at the time of the interviews. Of the mothers who did not keep their clinic appointments, 21.4 per cent were working; of the mothers who kept their clinic appointments, 16.7 per cent were working. The greater portion of both of these groups were not employed.

The findings of Tables 4 and 5 follow:

Table 4. Comparison of the Employment Status Since Marriage of Mothers Who Kept and Did Not Keep Their Clinic Appointments

Have worked since Marriage	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	25	69.5	10	71.4
No	11	30.5	4	28.6
Total	36	100 %	14	100 %

Table 5. Comparison of Mothers Employed at the Time of the Interviews of Mothers Who Kept and Did Not Keep Their Clinic Appointments

Employed at Time of Interview	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	6	16.7	3	21.4
No	30	83.3	11	78.6
Total	36	100 %	14	100 %

The marital status of the mothers was compared in Table 6. A considerably higher per cent, 83.3 per cent, of the mothers who kept their clinic appointments were living with their husbands. Of the mothers who did not keep their clinic appointments, 64.3 per cent were living with their husbands. There was a considerably higher per cent, 21.4 per cent, of the mothers who did not keep their appointments who were separated from their husbands than the 2.8 per cent who kept their appointments and who were separated from their husbands. There was a smaller per cent difference among mothers who were divorced; 13.9 per cent for mothers who kept their

appointments, and 14.3 per cent for mothers who did not keep their appointments.

Table 6. Comparison of Marital Status of Mothers Who Kept and Did Not Keep Their Clinic Appointments

Marital Status	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Living with Husband	30	83.3	9	64.3
Separated	1	2.8	3	21.4
Divorced	5	13.9	2	14.3
Widowed	0	0	0	0
Total	36	100 %	14	100 %

Elling, *et al.* (9), found in their study that social class did not influence participation in the study as much as did other factors, one of them being harmony in family relationships. It was indicated in Table 6 that the mothers who attended Child Development Study Clinics expressed more harmony in their family relationships.

In answers to the question, "Are you living in the same household with friends or relatives", there was not an appreciable amount of difference between the two groups, as shown in Table 7. It was found that of the mothers who kept their appointments, 25 per cent were living with people other than their immediate families, whereas of those mothers who did not keep their appointments, 21.4 per cent were sharing their households with others than members of their immediate families.

Table 7. Comparison of Household Status--Members Other than Immediate Family--For Mothers Who Kept and Did Not Keep Their Clinic Appointments

Others in Household	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	9	25.0	3	21.4
No	27	75.0	11	78.6
Total	36	100 %	14	100 %

Tables 8 through 11 were comprised of the educational data pertaining to both groups of mothers. From the standpoint of those who had finished high school, it was found that a greater portion, or 50 per cent, was made up of mothers who had not kept their appointments, in comparison to 38.9 per cent, which represented the mothers who kept their appointments.

Table 8. Comparison of High School Completion of Mothers Who Kept and Did Not Keep Their Clinic Appointments

School Completion	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Finished High School	14	38.9	7	50.0
Quit School	22	61.1	7	50.0
Total	36	100 %	14	100 %

As for a comparison based on educational achievement, Table 9 indicated that mothers who did not keep appointments, as a group, completed more grades than did the mothers who kept appointments. Of the mothers who kept their clinic appointments, 11.1 per cent had an eighth grade, or less than eighth

grade, education, as compared with 7.1 per cent of the mothers who did not attend clinic, who had a comparable amount of education.

Of the mothers who attended clinic, 2.8 per cent had had some college education, while of the mothers who did not attend clinic, 21.4 per cent had had some college education. One of the mothers held a master's degree.

Deasy (6) found in her study that the group with less education participated less in vaccine trials. The findings of the present study indicated that those mothers who did not attend Child Development Study Clinic had a higher educational level than did those mothers who kept their clinic appointments.

Table 9. Comparison of Educational Achievement of Mothers Who Kept and Did Not Keep Their Clinic Appointments

Grade Completed	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Eighth Grade or less.....	4	11.1	1	7.1
Ninth to Eleventh Grades.....	18	50.0	5	35.7
High School.....	13	36.1	5	35.7
Some College Work..	1	2.8	3	21.4
Total	36	100 %	14	99.9% 100 %

Table 10 compared the ages of the mothers when they finished high school or quit school. The data showed that a slightly higher per cent of the mothers who did not attend Child Development Study Clinic left school at the ages of 12 and 13, compared with the mothers who attended clinic. Of this age bracket, 7.1 per cent were mothers who did not keep their appointments, while 5.6 per cent

were mothers who kept their clinic appointments. In the category of mothers who kept their appointments, the larger per cent left school or finished school between the ages of 16 to 17 years, representing 55.5 per cent. The next largest per cent leaving school or finishing high school occurred in the 18 to 19 year age group and in the group of mothers who did not keep their appointments, or 42.9 per cent.

Table 10. Comparison of the Ages at which Mothers Quit School or Finished High School For Mothers Who Kept and Did Not Keep Their Clinic Appointments

Ages at which Quit School or Finished High School	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
12 - 13 yr.	2	5.6	1	7.1
14 - 15 yr.	5	13.9	2	14.3
16 - 17 yr.	20	55.5	5	35.7
18 - 19 yr.	9	25.0	6	42.9
Total	36	100 %	14	100 %

Reasons given by both groups of mothers for not completing high school fell into four categories, as given in Table 11. The most frequently given reason by both groups was, "To get married". Of the mothers who kept their appointments, 54.5 per cent stated that they left school to get married. The mothers who did not keep their appointments had an even higher per cent leaving school for this reason, or 71.4 per cent.

The next two categories of Table 11 were, "To go to work", and "Problems at school". Both groups of mothers had the same per cent for each of the two categories: i.e., the mothers who kept their appointments reported an

18.2 per cent for each of the two categories, while the mothers who did not keep their appointments reported a 14.3 per cent consecutively in each category.

As for the final category, "Family problems", the mothers who did not keep their appointments gave no response. For the mothers who kept their appointments, a 9.1 per cent was given.

Table 11. Comparison of Reasons For Not Completing High School Given by Mothers Who Kept and Did Not Keep Their Clinic Appointments

Reasons Given	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
To get married	12	54.5	5	71.4
To go to work	4	18.2	1	14.3
Problems at school	4	18.2	1	14.3
Family problems	2	9.1	0	0
Total	22 ^{1/}	100 %	7 ^{2/}	100 %

^{1/} Of the total of 36 mothers interviewed, the 14 mothers not accounted for in this Table had completed high school or had had some college work (Table 9).

^{2/} Of the total of 14 mothers interviewed, the 7 mothers not accounted for in this Table had completed high school or had had some college work (Table 9).

Some of the statements from which the above categories were derived were as follows:

"I got married."

"I got married in June and didn't go back this year."

"I didn't like school, and I liked kids. So I quit school and started having kids. Besides, I didn't have mind enough to learn anything."

"I went to work."

"I didn't finish because of my reading. Something keeps me from reading."

"We lived on a farm and my father was unable to work. So I had to quit to help with the work."

Tables 12, 13, and 14 were concerned with schooling for husbands of both the mothers who kept and did not keep clinic appointments. Seventy-five per cent of the husbands of the group of mothers who kept their clinic appointments had not finished high school. This was a higher per cent than for the husbands of the mothers who did not keep their clinic appointments, or 57.1 per cent.

Table 12. Comparison of High School Completion by Husbands as Reported by Mothers Who Kept and Did Not Keep Their Clinic Appointments

School Completion	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Finished High School	9	25.0	6	42.9
Quit School	27	75.0	8	57.1
Total	36	100 %	14	100 %

Table 13 indicated that the husbands of these two groups had less educational achievement than did the mothers comprising the two groups (Table 9). In terms of educational achievement, 22.2 per cent of the husbands who were reported to have had an eighth grade, or less than eighth grade, education were husbands of mothers who kept their clinic appointments.

For the group of mothers who did not keep their clinic appointments, 21.4 per cent of the husbands were reported to have had an eighth grade, or less than eighth grade, education. As for having had some college work, a smaller per cent of the husbands had had some college education than had their wives. Under the grouping of mothers who kept their appointments, 5.6 per cent of the husbands had had some college work, whereas in the grouping of mothers who did not keep their appointments, a higher per cent, or 14.3 per cent, of the husbands were reported to have had some college work. Two of the mothers of the group that kept their appointments, representing 5.6 per cent, did not know how much schooling their husbands had completed.

Table 13. Comparison of Educational Achievement by Husbands of Mothers Who Kept and Did Not Keep Their Clinic Appointments

Grade Completed	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Eighth Grade or less.....	8	22.2	3	21.4
Ninth to Eleventh Grades.....	17	47.2	5	35.7
High School.....	7	19.4	4	28.6
Some College Work..	2	5.6	2	14.3
Unknown.....	2	5.6	0	0
Total	36	100 %	14	100 %

Table 14 listed the major categories of reasons reported by the mothers as to why their husbands did not complete high school. These differed in form and order of importance from those given by the mothers (Table 11).

Table 14. Comparison of Reasons For Not Completing High School Reported for Husbands of Mothers Who Kept and Did Not Keep Their Clinic Appointments

Reasons Given	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
To join the Service	9	33.4	1	12.5
Problems at school	6	22.2	1	12.5
To go to work	7	25.9	4	50.0
Unknown	5	18.5	2	25.0
Total	27 ^{1/}	100 %	8 ^{2/}	100 %

1/ Of the total of 36 mothers interviewed, 9 reported their husbands had completed high school or had had some college work (Table 23).

2/ Of the total of 14 mothers interviewed, 6 reported their husbands had completed high school or had had some college work (Table 13).

It can be noted from the above Table that for the husbands, the most frequently given reason was, "To join the Service". This was true for 33.4 per cent of the husbands, as reported by the group of mothers who kept their appointments. Fifty per cent of the husbands giving the reason, "To go to work", were paired with the group of mothers who did not keep appointments. It was unknown to 18.5 per cent of the mothers who kept their clinic appointments why their husbands had not finished high school. Of the group of mothers who did not keep their clinic appointments, 25 per cent did not know why their husbands failed to finish high school.

The categories for the husbands not completing high school were derived from such answers given by the mothers as the following:

"He joined the Air Force."

"He joined the Marines."

"He got into a fight with one of his teachers, I think."

"His father died, and he had to support the family."

"His father died, and he had to help his mother out."

In answer to the question, "What kind of work does your husband do", most of the mothers reported, "labor", or "common laborer". Those that defined labor, said that their husbands were "truck drivers", "mechanics", "helpers on trucks", or "farmers". The highest position held by a husband was that of an assistant accountant; he was identified with the group of mothers who kept their appointments. Of the group of mothers who did not keep their appointments, two of the husbands were professional musicians; one travelled the night club circuit, and the other was in legitimate theater. The latter held a master's degree.

As for employment status (Table 15), it was found at the time of the interviews that fifty per cent of the husbands paired with the group of mothers who kept their appointments were not working. This was in contrast to a higher per cent, 57.1 per cent, of unemployment for the husbands of mothers who did not keep their appointments.

Table 15. Comparison of the Employment Status of Husbands of Mothers Who Kept and Did Not Keep Their Clinic Appointments

Husbands Employed At Time Of Interview	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	18	50.0	6	42.9
No	18	50.0	8	57.1
Total	36	100 %	14	100 %

Elling, et al. (9), found that social class and family income showed

no significant relationship to participation in their study. The findings of the present study in reference to attendance or non-attendance at clinic would be inclined to adhere to the findings of Elling, et al.

The second portion of the study dealt with the opinions of the mothers regarding the prenatal outpatient clinic and the hospital. These opinions were formulated during their prenatal care and during hospitalization for the births of their children.

Tables 16 and 17 undertook a comparison as to whether the mothers of both groups were able to differentiate between the Child Development Study and the Outpatient Clinic.

Of the group of mothers who kept their clinic appointments, 97.2 per cent indicated an opinion that the Child Development Study was a part of the Outpatient Clinic. Of the group of mothers who did not keep their clinic appointments, 92.9 per cent also considered the Child Development Study to be a part of the Outpatient Clinic (Table 16):

Table 16. Comparison Between Mothers Who Had and Did Not Have the Opinion that Child Development Study was a Part of the Outpatient Clinic

Considered Child Development Study To Be Part of the Outpatient Clinic	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	35	97.2	13	92.9
No	1	2.8	1	7.1
Total	36	100 %	14	100 %

When asked whether they thought the nurses to be the same for Child Development Study as for their medical care, (Table 17), 50 per cent of

the mothers who did not keep their Child Development Study Clinic appointments reported that they considered the nurses to be the same for both the Child Development Study and the Outpatient Clinic. A higher per cent, or 63.9 per cent, of the mothers who kept their Child Development Study Clinic appointments considered that the nurses were the same for Child Development Study as for the Outpatient Clinic.

Table 17. Comparison Between Mothers Who Had and Did Not Have the Concept that the Nurse was the Same for Child Development Study as for Outpatient Clinic

Is the Nurse the Same	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	23	63.9	7	50.0
No	13	36.1	7	50.0
Total	36	100 %	14	100 %

Table 18 reported the opinions of the mothers as to whether their visits to the prenatal clinic had been pleasant. It was found that more mothers, 71.4 per cent (and of the group of mothers who did not keep their Child Development Study Clinic appointments), stated that their prenatal clinic visits had been unpleasant. As for the mothers who kept their appointments, 33.4 per cent reported that their prenatal clinic visits had been unpleasant.

The findings of Table 18 follow:

Table 18. Comparison of Answers to the Question, "Did you find your visits to prenatal clinic pleasant", from Mothers Who Kept and Did Not Keep Child Development Study Clinic Appointments

Were your Prenatal Clinic Visits Pleasant?	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	24	66.5	4	28.6
No	12	33.4	10	71.4
Total	36	99.9% 100 %	14	100 %

The mothers of both groups gave several reasons why they considered the prenatal clinic visits had been unpleasant. (Table 19). The most common reason given was, "The long wait". Of the mothers who kept their Child Development Study Clinic appointments and who reported their prenatal clinic visits as unpleasant, 50 per cent gave this reason. Sixty per cent of the mothers who did not keep their Child Development Study Clinic appointments gave "the long wait" as the chief cause for unpleasantness experienced in attending prenatal clinics.

Second among the reasons given for unpleasantness in prenatal clinic visits was the medical examination and care received. Of the mothers who kept their Child Development Study Clinic appointments, 33.4 per cent gave this reason; of the mothers who did not keep their Child Development Study Clinic appointments, 40 per cent also gave this reason.

Elling, et al. (9) indicated that how the mother felt she was evaluated by the clinic doctors influenced her participation in the study. It would seem, then, that possibly the mothers who found their prenatal clinic visits less objectionable would be more apt to attend Child Development

Study Clinic.

Table 19. Comparison of Reasons for Unpleasantness of Visits to Prenatal Clinic Given by Mothers Who Kept and Did Not Keep Their Child Development Study Clinic Appointments

Reasons Given	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
The long wait.....	6	50.0	6	60.0
Medical exam and care received.....	4	33.4	4	40.0
Children bothered clinic personnel.....	1	8.3	0	0
Too many people...	1	8.3	0	0
Total	12 ^{1/}	100 %	10 ^{2/}	100 %

^{1/} The 24 mothers not accounted for in this Table indicated that their clinic visits were not unpleasant.

^{2/} The 4 mothers not accounted for in this Table indicated that their clinic visits were not unpleasant.

In reply to the question, "How were the clinic visits unpleasant", both groups stated reasons from which the following examples were taken:

"....the long wait, and taking blood every time I went."

"It was very uncomfortable during the long wait."

"The change of doctors all the time.... They got me all upset.... They told me I had cancer; they think I have a tumor.... They stood there and scratched their heads and said, 'I think you have, but I don't know'."

"Unpleasant! You had to wait so long. Nothing was efficient. You were treated like a guinea pig. You were shown no respect."

"....the long wait. There was an additional wait on Child Development Study."

Most of the mothers in the two groups knew that the Child Development Study planned to follow the children after their birth. One hundred per cent of the mothers who did not keep their Child Development Study Clinic appointments were aware that their children were to be followed; 91.7 per cent of the mothers who kept their Child Development Study Clinic appointments knew that their children were to be followed.

This was depicted in Table 20:

Table 20. Comparison of Answers to the Question, "Did you know that Child Development Study wanted to follow your baby after it was born", from Mothers Who Kept and Did Not Keep Their Clinic Appointments

Did you know . . .	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	33	91.7	14	100.0
No	3	8.3	0	0
Total	36	100 %	14	100 %

As indicated in Table 21, the interviewer was the chief source from which the mothers were informed that their children were to be followed after the birth of the child. It was found that 86.1 per cent of the mothers who kept their Child Development Study Clinic appointments learned from the interviewer in the prenatal clinic that their children were to be followed in Child Development Study. This was in contrast to the 92.9 per cent of the mothers who did not keep their Child Development Study Clinic appointments.

Table 21. Comparison of Sources of Information That Child Development Study Wanted To Follow the Baby After Its Birth For Mothers Who Kept and Did Not Keep Their Child Development Study Clinic Appointments

Sources of Information	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
The interviewer..	31	66.1	13	92.9
The nurse in prenatal clinic.....	1	2.8	0	0
The follow-up nurse in hospital.....	1	2.8	0	0
The four-month appointment letter.....	2	5.6	0	0
Unknown.....	1	2.8	1	7.1
Total	36	100.1% 100 %	14	100 %

As was shown above, other sources of information were the nurse in the prenatal clinic, the follow-up nurse in the hospital, and the four-month follow-up letter. Of the mothers who kept their Child Development Study Clinic appointments, 2.8 per cent learned from the nurse in the prenatal clinic, while of the mothers who did not keep their Child Development Study Clinic appointments none reported having learned from this source. As for the follow-up nurse in the hospital, it was the same per cent, 2.8 per cent, for the mothers who kept their Child Development Study Clinic appointments, while for the mothers who did not keep their Child Development Study Clinic appointments there was no response.

In both groups, it was found that there were mothers who could not

recall how they were informed. This was true of 2.8 per cent of the mothers who kept their Child Development Study Clinic appointments, and of 7.1 per cent of the mothers who did not keep their appointments.

Table 22 indicated that the majority of the mothers in both groups "liked" the doctor who delivered their babies. It was found that 100 per cent of the mothers who did not keep their Child Development Study Clinic appointments liked the doctor who delivered their babies. Among the mothers who kept their Child Development Study Clinic appointments, 86.1 liked the doctor who delivered their babies.

Table 22. Comparison of Answers to the Question, "Did you like the doctor who delivered your baby", From Mothers Who Kept and Did Not Keep Their Child Development Study Clinic Appointments

Did you like the doctor?	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	31	86.1	14	100.0
No	5	13.9	0	0
Total	36	100 %	14	100 %

The following reasons were given for dislike of the doctor:

"He sent me home, and I hardly made it back to the hospital."

"He didn't seem like a doctor to me.... Too young.... He seemed too much like a youngster himself."

"....although, at the time I didn't like nobody."

"I just didn't like anything about him. I thought he was very abrupt."

"He had a terrible bedside manner. He told me I wasn't in labor and sent me home. He told me to shut up and quit screaming. He was very abrupt, cold, and unfeeling."

In Table 23, it was found that most of the mothers reported their hospitalization as having been pleasant. Of the mothers who kept their Child Development Study Clinic appointments, 83.3 per cent found their hospitalization pleasant, in comparison to 71.4 per cent of the mothers who did not keep their appointments.

Table 23. Comparison of Opinions Regarding Pleasantness of Hospitalization From Mothers Who Kept and Did Not Keep Their Child Development Study Clinic Appointments

Was your hospitalization pleasant?	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	30	83.3	10	71.4
No	6	16.7	4	28.6
Total	36	100 %	14	100 %

As for the mothers who found their hospitalization unpleasant, the following statements are examples of the reasons given:

"I couldn't have very many visitors. There were too many in one room. I don't know what all I didn't like."

"The way they handled kids."

"I was up there about 18 times, and they kept sending me home for pains in my back. If I had of waited for a pain in my back I would of had her at home."

"They had me in the solarium, and it was terribly cold."

"No care was given. The nurses paid little attention. We tried to get things from them, and they ignored us."

"Fourteen dollars was stolen from my purse while I was in labor."

"The warm milk."

The primary method of notifying the mother that her child had a Child Development Study Clinic appointment was by letter, as shown in Table 24. The letter was the source of notification for 88.8 per cent of the mothers who kept their clinic appointments, and for 78.6 per cent of the mothers who did not keep their clinic appointments. The telephone served as a method of notification for 5.6 per cent of the mothers who kept their appointments, as well as for 14.3 per cent of the mothers who did not keep their appointments. A home visit by the follow-up nurse was the means of notification for 5.6 per cent of the mothers who kept their clinic appointments, and for 7.1 per cent of the mothers who did not keep their appointments.

Table 24. Comparison of Methods of Notifying Mothers of Child Development Study Clinic Appointments for Mothers Who Kept and Did Not Keep Clinic Appointments

Method of Notification	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Letter	32	88.8	11	78.6
Telephone	2	5.6	2	14.3
Home Visit	2	5.6	1	7.1
Total	36	100 %	14	100 %

Transportation for clinic attendance was discussed in Tables 25 through 27. It was indicated in Table 25 that 50 per cent of the mothers who kept their Child Development Study Clinic appointments needed help with transportation to be able to attend clinic. A slightly higher per cent, 57.1 per cent, of the mothers who did not keep their Child Development

Study Clinic appointments expressed a need for transportation.

Table 25. Comparison Between Mothers Who Needed and Did Not Need Help with Transportation For Attending Child Development Study Clinics

Needed Help with Transportation	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	18	50.0	8	57.1
No	18	50.0	6	42.9
Total	36	100 %	14	100 %

As shown in Table 26, a much larger per cent of the mothers were offered transportation than needed it. Of the mothers who kept their Child Development Study Clinic appointments, 91.7 per cent were offered help with transportation. Of the mothers who did not keep their clinic appointments, 92.9 per cent were offered help with transportation. This did not indicate an appreciable difference between the two groups.

Table 26. Comparison of Whether Help with Transportation was Offered to Mothers Who Kept and Did Not Keep Their Child Development Study Clinic Appointments

Was Help Offered With Transportation	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	33	91.7	13	92.9
No	3	8.3	1	7.1
Total	36	100 %	14	100 %

Transportation by taxicab was the most frequent type offered to both

groups of mothers. (Table 27.) All of the mothers who did not keep their Child Development Study Clinic appointments were offered taxi fare. Of the group of mothers who kept their Child Development Study Clinic appointments, 83.3 per cent had been offered taxi fare; mileage reimbursement had been offered to 2.8 per cent. It was unknown what type of transportation had been offered to the remaining 13.9 per cent of the mothers who kept their appointments.

Table 27. Comparison of the Types of Transportation Offered to Mothers Who Kept and Did Not Keep Their Child Development Study Clinic Appointments

Type of Transportation	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Taxicab (fare)	30	83.3	14	100.0 ^{1/}
Mileage Reimbursement	1	2.8	0	0
Unknown Type	5	13.9	0	0
Total	36	100 %	14	100 %

^{1/} This is contrary to the percentages given in Table 26. The responses given by the participants created this contradiction.

Home visits concerning the appointments were made by the follow up nurse to 50 per cent of the mothers in both groups. (Table 28.)

In reply to the question, "What was the nurse like", all of the answers were in the affirmative. Comments such as these were given:

"Oh, I think she was very nice."

"She was very nice."

"Real nice."

"Beautiful."

Table 28. Comparison of Whether a Visit Concerning the Clinic Appointment Was Made by a Nurse to Mothers Who Kept and Did Not Keep Their Child Development Study Clinic Appointments

Visit by Nurse	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	18	50.0	7	50.0
No	18	50.0	7	50.0
Total	36	100 %	14	100 %

Lackey (17) found that home visits by the Public Health Nurse were influential in whether or not the mother kept the Child Health Clinic appointment for her child. In the present study, home visits were made, but not in the prenatal period, as in Lackey's study. There seemed to have been no significant differences between the mothers who kept their Child Development Study Clinic appointments and those who did not attend Child Development Study Clinic.

Table 29 compared the reasons reported by mothers who kept their Child Development Study Clinic appointments. The most frequently given reason was "concern for the child's health". This reason accounted for 47.1 per cent of the responses of this group. An almost equally high proportion of the group, 44.5 per cent, reported that they kept their clinic appointments because of a "desire to be cooperative". A much smaller proportion, 5.6 per cent, stated that they had "a friend on the Project". Another 2.8 per cent did not know why they attended clinic.

The findings of Table 29 follow:

Table 29. Reasons for Attending Clinic Given by Mothers Who Kept Their Child Development Study Clinic Appointments

Reason	N	%
Concern for child's health.....	17	47.1
Desire to be cooperative.....	16	44.5
Had friend on Project.....	2	5.6
Unknown.....	1	2.8
Total.....	36	100 %

Examples of the statements from which these figures were derived were as follows:

"I don't know. I am always concerned about my children and want the best for them."

"I'm interested in it, and I have a friend whose little girl is on it [the Project]."

"I thought it would be good for him."

"We followed her appointment. We had to."

"I don't know why, they just wanted to follow him, so I thought I might as well."

"I hardly know what a baby is. I want to know more about it."

The reasons given by mothers who did not keep their Child Development Study Clinic appointments have been listed verbatim below:

"They said they wanted me to call up there and I just haven't called yet."

"I was worrying about moving."

"The baby was sick."

"They gave me an appointment at 8:30 A.M., and I have other children and I'm unable to keep appointments in the A.M."

"The baby just had surgery. I couldn't get it done up there, so I took her to a private physician and had it done."

"I had hemorrhoids so bad I couldn't sit down."

"The first time it was because of the flood. I had a dream three nights in a row that the bridge fell down and we were on it. The second appointment my husband couldn't take me because he had to go to class."

"I started back to work, and my baby sitter can't take them. I feel now that I'm working I should pay for my care."

"Because I was working. At the time I made the appointment, I didn't know I would have to go to work."

"Well, I forget the pediatrician's name, but she said she would have to be in a cast for three years. She has premature hip joints. But we have our own pediatrician now, and she said she would only have to be in a cast for only seven months. My husbands wants her to have her own pediatrician."

"He was sick with a rash or a real bad cold, and sore throat."

"My brother was going to take me, and my brother started to work the day before."

"Because of weather conditions."

"THINGS! I was upset and didn't make it--two times I forgot it."

It was reported on Table 30 that more of the mothers who kept their Child Development Study Clinic appointments had had their children examined by a doctor since birth than had the mothers who did not keep their appointments. Of the mothers who kept their Child Development Study Clinic appointments, 86.1 per cent had had their children examined by a doctor. Of the group of mothers who did not keep their Child Development Study Clinic appointments, 78.6 per cent had had their children examined by a doctor.

Hansen (12) found that completion of immunization series played an important part in whether parents kept their children's health conference appointments. It was felt by the present author that the fact that the child was seen by a doctor might influence Child Development Study Clinic attendance. As was seen in Table 30, a high per cent of both groups of

mothers had had their children examined by a doctor since his/her birth.

Table 30. Comparison of Whether the Child had been Examined by a Doctor Since He/She was Born as Reported by Mothers Who Kept and Did Not Keep Their Child Development Study Clinic Appointments

Examined by Doctor	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	31	86.1	11	78.6
No	5	13.9	3	21.4
Total	36	100 %	14	100 %

As for the inquiry, "If living with husband, friend, or relative, what do they think of Child Development Study", it was found that the majority of the answers were either in the affirmative or expressed little knowledge about the Project. Negative comments were reported for 28.6 per cent of the husbands paired to the group of mothers who did not keep their Child Development Study Clinic appointments.

The question, "If the Child Development Study could do something to help you and your child, what would be most helpful to you", proved to be a difficult one for the mothers of both groups. The mothers made such comments as, "I don't know", "Gee, I don't know", "We get along just fine", "There is nothing", and "I don't know there is nothing wrong with her".

Specific needs were expressed by 7.1 per cent of the mothers who did not keep their Child Development Study Clinic appointments, and by 39.9 per cent of the mothers who kept their appointments. Examples of expressed needs follow:

"To discover a cure for colic."

"Find me a baby sitter."

"About the only thing is her welfare."

"Fix the hernia; it makes me sick."

"Find out about her chest."

"To find out if he is allergic to his milk;
and get rid of his cold."

"Getting me through school. I don't want
to live off someone else the rest of my life."

The third part of the study was involved with the mother's knowledge of the purpose of the Child Development Study.

Both groups were asked the question, "What do you feel is the purpose of the Child Development Study Clinic?" The majority of the mothers indicated in their responses that the Clinics were for research purposes, although some of their definitions were somewhat vague. Of the mothers who reported that they did not consider the Clinic existed for research purposes, 28.6 per cent were mothers who did not keep their Child Development Study Clinic appointments, and 16.7 per cent were mothers who kept their appointments.

The following statements were some of those given as definitions of the purpose of the Child Development Study Clinics:

"Well, to see if they can take an inventory of a whole bunch of children to see average progress--the course of birth defects--this and that."

"To find out if anything is wrong with the child and try to prevent it from happening to other children in the future."

"To more or less check before and after birth to check what causes diseases in children. To control disease in the future for other children."

"To find out why the baby is born crippled by studying the mother before it is born, and the baby after it is born."

"Make examinations at 4 months, 8 months, then follow them until about six years old. All the information will be compiled and they will find out more about babies."

Schonfield (25), in conducting a study to ascertain reasons why parents permitted their children to participate in mass tuberculin testing, found that the group of mothers who declined permission were those who knew less about tuberculosis and diabetes. It was found in the present study that a higher per cent of the mothers who did not keep their clinic appointments knew less about the purpose of the Child Development Study.

Table 31 noted the awareness of the two groups of mothers as to when they were to return for their next clinic appointment. Of the mothers who kept their Child Development Study Clinic appointments, a higher per cent, 77.7 per cent, knew when they were to return. Of the mothers who did not keep their Child Development Study Clinic appointments, one half of them, or 50 per cent, were aware of when they were to return.

Table 31. Comparison of Responses as to Whether the Mothers Knew When They Were to Return for Their Next Child Development Study Clinic Appointment

Knew When To Return For Next Appointment	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	N	%	N	%
Yes	28	77.7	7	50.0
No	8	22.3	7	50.0
Total	36	100 %	14	100 %

All of the mothers involved in this study lived within the immediate metropolitan Portland area, except for one mother, of the group that kept clinic appointments, who lived about thirty miles outside of Portland.

Summary of the Findings

In reviewing the findings of this chapter, it was found that the mothers of both groups were similar.

The ages of the mothers differed very slightly. Those mothers who attended clinic were slightly younger than those who did not.

The employment status of the mothers showed very little variation between groups, almost the same per cent having worked since marriage. A slightly higher per cent of the mothers who did not keep their Child Development Study Clinic appointments were working at the time of the interviews.

About the same per cent of the mothers of both groups were found to be living with others than members of their immediate families included in the household.

"To get married" was the reason most commonly given by both groups of mothers for not having finished high school. "To join the Service" was the reason most frequently reported for their husbands.

The employment status for the husbands of the mothers in both groups was similar. Husbands paired with mothers who did not keep their clinic appointments showed slightly less employment.

Both groups of mothers were unable to differentiate between the Outpatient Clinic and the Child Development Study.

Home visits were made to the same per cent of mothers in both groups.

Questioned as to whether they found their visits to prenatal clinic pleasant, the mothers of both groups reported their visits as having been "unpleasant". "The long wait" was reported as the cause of most unpleasantness.

All of the mothers who did not keep their Child Development Study Clinic appointments knew that the Child Development Study wanted to follow their children after they were born. Of those who kept their Child Development Study Clinic appointments, 91.7 per cent were aware that the Child Development Study wanted to follow their children after birth.

A higher per cent of the mothers in both groups were informed by the interviewer that their children were to be followed by the Child Development Study after they were born. As for the four-month appointment with the Child Development Study, the larger per cent of the mothers of both groups were informed by letter that their children had appointments.

The need for help with transportation was similar in both groups. Mothers who did not keep their Child Development Study Clinic appointments had a slightly higher per cent of need. Transportation was offered to almost the same per cent of mothers in both groups. Travel by taxicab was the kind most frequently given.

The majority of mothers in both groups had had their children examined by a doctor after they were born.

Differences were to be found, however, between the two groups.

Mothers who kept their Child Development Study Clinic appointments had more children living in their homes than they had borne. The opposite was true of the mothers who did not keep their Child Development Study Clinic appointments.

The marital status of both groups of mothers indicated that a larger per cent of the mothers who attended clinic were living with their husbands. Of the group of mothers who did not keep their Child Development Study

Study Clinic appointments, a significant per cent difference was indicated for those separated from their husbands.

A higher per cent of the mothers who did not keep their Child Development Study Clinic appointments had completed high school, as compared to the mothers who attended clinic. The same relationship was true for the husbands paired with the mothers of both groups.

Among the group of mothers who did not keep their Child Development Study Clinic appointments, a higher per cent reported "unpleasantness" when questioned concerning their visits to prenatal clinic.

All of the mothers who did not keep their Child Development Study Clinic appointments reported that they liked the doctor who delivered their babies.

A higher per cent of the mothers who did not attend Child Development Study Clinic found their hospitalizations "unpleasant" than did those mothers who attended Child Development Study Clinic.

It was found that a higher per cent of the mothers who kept their Child Development Study Clinic appointments knew the purpose of that clinic. Moreover, a higher per cent of the same group knew when they were to return for their children's next appointments.

Summarizing, in many respects, the mothers of both groups had more similarities than they had differences.

CHAPTER IV

SUMMARY, CONCLUSIONS, RECOMMENDATIONS, AND DISCUSSION

Summary

This study presents the findings obtained in interviews from fifty Caucasian, first study mothers participating in the Child Development Study Project at the University of Oregon Medical School. It was an attempt to identify differences between mothers who kept their children's four-month Child Development Study Clinic appointments and those who did not keep the four-month appointments. It was thought that differences might emerge in the opinions expressed by the participating mothers concerning their experiences in the prenatal outpatient clinic and hospitalization for the birth of their babies, as well as in their knowledge of the purpose of the Child Development Study Clinics. These differences were to be based on the following suppositions:

1. The Child Development Study mother who keeps her clinic appointment understands more about the purpose of Child Development Study Clinic than does the mother who does not keep her appointment.
2. The more favorable relationship a Child Development Study mother has with clinic and hospital staff during prenatal visits and hospitalization, the more apt she is to "follow through" in attendance at Child Development Follow-up

Clinics.

The Interview Guide was constructed of both closed and open-ended questions relating to the mother's socioeconomic and cultural characteristics, her expressed opinions about the prenatal clinic and her hospitalization, together with her knowledge of the Child Development Study Clinics. The open-ended questions were arranged into categories wherever possible for comparative data between the two groups of mothers. The closed questions were tabulated and used in comparisons in the attempt to identify differences between these mothers in attendance or non-attendance of the Child Development Study Clinics.

The interviews were conducted in the Child Development Study Follow-up Clinic held at that time in the Crippled Children's Division. As planned in the original study design, the researcher interviewed the mother before she was consulted by the nurse for her child's health history and before the child was examined by the doctor.

Problems encountered during the sampling necessitated a modification of the original study design. It became necessary to reduce the total number of mothers interviewed from 50 mothers attending clinic to 36 mothers, and from 50 mothers not attending clinic to 14 mothers. Due to the small number of mothers not attending Clinic it became impossible to match mothers who did not attend clinic with mothers who did attend clinic as to the number of children they had living with them. The small sample made statistical analysis of the data impossible.

The data were collected in the spring, summer, and fall of 1964.

Information about the social characteristics showed that the mean age for the mothers who attended clinic was 23.7 years, while the mean age for

the mothers who did not attend clinic was 25.4 years. In educational achievement, it was found that mothers who attended clinic had completed fewer grades of school than had the mothers who had not kept their clinic appointments.

Employment status concerning the two groups of mothers showed that approximately half of the husbands were employed at the time of the interviews. As for the mothers who attended clinic, less than one fifth of these mothers were employed at the time of the interviews, while for the mothers who did not keep their clinic appointments, slightly more than one fifth were employed at the time of the interviews. The marital status of the mothers indicated that about 20 per cent more mothers who attended clinic were living with their husbands than for the mothers who did not keep their Child Development Study Clinic appointments.

Conclusions

The conclusions of this study could not be generalized to other Child Development Study Project Sites or to other clinic groups because of the small sample.

The following conclusions were based on the information obtained about the social characteristics of the mothers:

1. The average age for the mothers who did not attend Child Development Study Clinics was slightly older than that of the mothers who kept their clinic appointments.
2. The mothers who did not attend clinic were caring for fewer children in their homes than they had borne. The opposite was true of the mothers who kept their clinic appointments.

3. The employment status of the two groups showed that 5 per cent more of the mothers who did not attend clinic were working at the time of the interviews. The figures also indicated that for the husbands of the mothers who kept their clinic appointments, 7 per cent more of the husbands of this group were employed than were the husbands of the mothers who did not keep clinic appointments.
4. The educational status of the mothers of both groups showed that approximately 11 per cent more mothers who did not attend clinic had finished high school than had the mothers who kept their appointments. In both groups of mothers, the major reason given for not completing high school was, "To get married". As for the husbands of the mothers in both groups, more schooling had been completed by the husbands paired with the group of mothers who did not attend clinic than was completed by the husbands of the mothers who kept their clinic appointments, the difference being about 10 per cent. For the husbands of mothers in both groups, the most common reason reported for not completing high school was, "To join the Service".

Further conclusions were based on the expressed opinions of the mothers concerning the prenatal clinic and their hospitalizations:

1. The majority of the mothers of both groups were unable to differentiate between the Outpatient Clinic and the Child Development Study Project in physical organization or personnel.

2. It was found in this study that 38 per cent more of the mothers who did not attend Child Development Study Clinics reported their visits to prenatal clinic as "unpleasant". The major reason given by mothers of both groups for the unpleasantness was "the long wait".
3. Of the mothers of both groups who reported that their hospitalizations for the birth of their babies had been an unpleasant experience, 11.9 per cent more of the mothers were in the group who did not keep their Child Development Study Clinic appointments.
4. The findings of this study indicated that the interviewer was the major source from which the mother was informed about the Child Development Study Project. Also, the four-month appointment letter was the principal method for informing the mothers of their children's four-month appointment at the Child Development Study Clinic. As for the modes of transportation offered to the mothers in order to facilitate attendance at the Child Development Study Clinics, it was shown that transportation by taxicab was the primary aid given.
5. The mothers who attended the Child Development Study Clinics kept their appointments for two main reasons:
 - 1) concern for the health of their children--47.1%; and
 - 2) a desire to be cooperative--44.5%.

the Child Development Study as expressed by the participating mothers:

1. Of the mothers who did not attend Child Development Study Clinics, a higher per cent (11.9 per cent) indicated that they did not know that the Child Development Study Clinics were for research purposes.
2. A higher per cent (27.7 per cent) of the mothers who kept their Child Development Study Clinic appointments knew when they were to return for their children's next appointments than did the mothers who did not keep their Child Development Study Clinic appointments.

Recommendations

1. Conduct a study on the average time it takes for a patient in prenatal clinic to receive care. In relation to the time involved in receiving care, undertake a further study of clinic procedure to ascertain whether the time period could be reduced.
2. Explore the possibility of conducting prenatal classes to occupy the time spent in waiting to receive care, in order to determine if occupying the time in this way might provide less objection to the waiting period.
3. Repeat this study, using a broader sample, and including both "repeat" mothers (mothers who have more than one child on the Project) and mothers of all races who are participating in the Child Development Study.
4. Examine appointment breaking for all protocol age groups on the Child Development Study Project to ascertain a possible relationship between

weather and appointment breaking.

5. Investigate the reasons given by gravidae attending prenatal clinic for their dislike of the medical examinations.
6. Conduct a study of mothers' prenatal clinic visits in reference to initiation of care, appointment making, and appointment breaking. Compare this information with data concerning the mothers' keeping of the four-month appointments in the Child Development Study Clinic, to find out if the mothers have a pattern of behavior that might indicate attendance or non-attendance at the Child Development Study Clinics.
7. Undertake a study of mothers' personalities in depth, in order to determine how the children are meeting their needs to "mother", or if the children are obstacles in meeting goals that represent stronger needs to the mothers. Such a study could be used as a guide to promote better understanding of these mothers by the personnel working with them.

Discussion

The hypotheses in this study could not be proven statistically, because of difficulty encountered in the sampling. It was found, however, that some of the findings do lend support to the hypotheses. The findings show that a higher per cent of the mothers who did not attend Child Development Study Clinic were discontented with their prenatal clinic visits and hospitalization. A higher per cent of the mothers who kept their Child Development Study Clinic appointments had a better understanding of the purpose of the Child Development Study, and knew when they were to return for their children's next appointments.

The total number of mothers interviewed in this study were 50. Of this total, 72 per cent kept their four-month Child Development Study Clinic appointments.

As indicated by their acceptance in prenatal clinic at the Medical School, the mothers were of a lower socioeconomic group than might be found in a private clinic.

The literature noted that participation of a lower socioeconomic group in preventive medicine is low. The findings of the present study, however, show more participation in the Child Development Study Clinic than is supported by the literature.

The findings of the present study indicate that the mothers who did not attend clinic showed less responsibility toward their children, and that their marital status appeared less stable. Fewer husbands paired to this group of mothers were employed at the time of the interviews. These facts might indicate that the mothers who did not attend clinic were less inclined to conform to the expectations of society than were those who kept clinic appointments for their children. The educational pattern of the mothers who did not attend clinic, however, did not support this concept.

The higher educational level of the mothers not attending clinic could have some bearing on why they did not attend clinic. Once a mother has raised herself to the social level corresponding to her educational attainment, and to the level of her parents, she no longer wishes to be associated with Welfare.

Another factor to be considered is that once families remove themselves from Welfare roles, they tend to rid themselves of all associations with Welfare. Inasmuch as the Child Development Study was introduced to the

mothers in the prenatal clinic when they were on Welfare, it could be that the mothers did not differentiate between their indigent medical care and the on-going research of the Child Development Study (cf. Tables 16 and 17).

Inquiries in the Interview Guide concerning follow-up procedures-- methods of notification for appointments, kinds of transportation offered, and home visits by the Public Health Nurse--were included to ascertain if any of these might have influenced these mothers keeping their Child Development Study Clinic appointments. The findings of the present study show that the follow-up procedures were not of significance as to whether or not the mothers kept their Child Development Study Clinic appointments (cf. Tables 24 through 28).

A higher per cent of the mothers who were discontented with their prenatal clinic visits were also those mothers who did not keep their Child Development Study Clinic appointments. It is possible that they may have projected their experiences in prenatal clinic to the Child Development Study Clinic, even though the settings were not the same, since it was in prenatal clinic where they formed their first impressions of the Child Development Study.

It should be noted that the mothers who did not keep their Child Development Study Clinic appointments had borne more children than they had living in their homes. Some of the mothers reported that their children were living in foster homes, while others reported having placed their children for adoption. In one instance, the children were living with the maternal grandparents. This would support the premise that these mothers are less likely to conform to the expectations of society; however, this premise does not appear to be supported by the higher educational attainment of the group.

The employment status of the mothers of both groups disclosed that a higher per cent of the mothers had worked since marriage than were employed at the time of the interviews. It could be possible that the pregnancies had removed the mothers from the employment status, and that at four months postpartum they had not been able to find work again. Also, the mothers who had worked prior to the births of any of their children may not have been employed since then. If a higher per cent of mothers had been employed at the time of the interviews it might have had a marked effect on their attendance at the Child Development Study Clinic.

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APPENDIX A

INTERVIEW GUIDE

Name: _____

Address: _____

Date: _____

Age: _____

Education: _____

Seen in Clinic _____ At Home _____

Number of Living Children: _____

C. D. S. Number: _____

Hospital Unit Number: _____

Birthplace: _____

Socioeconomic and Cultural Data

1. How many children do you now have living at home? _____
2. Have you worked since you were married? Yes _____ No _____
3. Are you now working? Yes _____ No _____
4. Are you at the present time living with your husband? Yes _____ No _____
- Separated? Yes _____ No _____
- Divorced? Yes _____ No _____
- Widowed? Yes _____ No _____
5. Are you living in the same household with friends or relatives? Yes _____ No _____
6. If relatives: What relationship? _____
7. How far did you go in school? _____
8. How old were you when you finished or quit school? _____
9. (If less than twelve grades completed, ask:)
How did it happen that you didn't go on? _____
- _____
- _____

10. How far did your husband go in school? _____
11. (If less than twelve grades completed, ask:)
How did it happen that he didn't finish? _____
- _____
12. What kind of work does your husband do? _____
13. Is your husband working now? Yes _____ No _____

Patient's Opinions About Clinic and Hospital

1. Is the Child Development Study a part of the
Outpatient Clinic? Yes _____ No _____
2. Are the nurses the same for Child Development
Study as for your medical care? Yes _____ No _____
3. Did you find your visits to prenatal clinic
pleasant? Yes _____ No _____
4. If NO, how were they not pleasant?

5. When you were going to prenatal clinic, did
you know that Child Development Study
wanted to follow your baby after it was
born? Yes _____ No _____
6. How did you find out that Child Development
Study wanted to follow your baby after
birth? _____
7. Did you like the doctor who delivered
your baby? Yes _____ No _____
8. What didn't you like about him?

9. Was your hospitalization for the birth of
the baby pleasant? Yes _____ No _____
10. If NO, how was it unpleasant?

11. How were you notified that your baby had an appointment for his/her four-month examination?
- Letter _____
- Telephone _____
- H. V. by nurse _____
- Other _____
12. Was help with transportation needed to attend Child Development Study Clinic? Yes _____ No _____
13. Were you offered transportation? Yes _____ No _____
14. If YES, what kind?
- Bus fare _____
- Taxi fare _____
- Mileage Reimbursement _____
15. Did a nurse visit you about the appointment? Yes _____ No _____
16. What was she like?
- _____
- _____
17. Why did you keep / or not keep / your Child Development Study appointment?
- _____
- _____
- _____
18. Has your baby been examined by a doctor since he/she was born? Yes _____ No _____
19. If living with husband, / friend, / or relative, / what do they think of Child Development Study?
- _____
- _____
- _____
20. If Child Development Study could do something to help you and your baby, what would be most helpful to you?
- _____
- _____
- _____
- _____
- _____

Patient's Knowledge of the Purpose of Child Development Study

[Definition: The Child Development Study Clinic is set up to examine babies to see if they are developing normally. This information is then used as data for a Research Study.]

1. What do you feel is the purpose of the Child Development Study Clinic?

2. When will you be asked to come in for your next Child Development Study Clinic appointment? _____

APPENDIX B

RAW DATA
AGES OF MOTHERS WHO KEPT AND DID NOT KEEP
THEIR CHILD DEVELOPMENT STUDY CLINIC
APPOINTMENTS

Ages of Mothers	Mothers Who Kept Appointments	Mother Who Did Not Keep Appointments
17	1	1
18	3	0
19	5	1
20	2	2
21	2	1
22	4	1
23	4	0
24	1	2
25	2	1
26	5	0
27	0	0
28	2	0
29	1	1
30	2	1
31	0	0
32	0	0
33	1	0
34	1	1
35	0	0
36	0	1
37	0	0
38	0	0
39	0	1
N=	36	N= 14

Question 1: How many children do you now have living at home?

RAW DATA

NUMBER OF LIVING CHILDREN OF MOTHERS WHO KEPT AND DID NOT KEEP THEIR CHILD DEVELOPMENT STUDY CLINIC APPOINTMENTS

Number of Children	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
1	12	3
2	5	3
3	8	2
4	6	2
5	2	2
6	3	0
7	0	1
8	0	1
N=	36	N= 14

NUMBER OF CHILDREN RESIDING WITH MOTHERS WHO KEPT AND DID NOT KEEP THEIR CHILD DEVELOPMENT STUDY CLINIC APPOINTMENTS

Number of Children	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
1	11	3
2	5	4
3	9	4
4	7	2
5	2	1
6	2	0
N=	36	N= 14

RAW DATA

EMPLOYMENT STATUS OF MOTHERS WHO KEPT AND DID NOT KEEP THEIR CHILD DEVELOPMENT STUDY CLINIC APPOINTMENTS

Questions on Interview Guide	Mothers Who Kept Appointments		(N=36)	Mothers Who Did Not Keep Appointments		(N=14)
	Yes	No		Yes	No	
2. Have you worked since you were married?	25	11	(N=36)	10	4	(N=14)
3. Are you now working?	6	30	(N=36)	3	11	(N=14)

MARITAL STATUS OF MOTHERS WHO KEPT AND DID NOT KEEP THEIR CHILD DEVELOPMENT STUDY CLINIC APPOINTMENTS

Question on Interview Guide	Mothers Who Kept Appointments		(N=36)	Mothers Who Did Not Keep Appointments		(N=14)
	Yes	No		Yes	No	
4. Are you at the present time living with your husband?	30	6	(N=36)	9	5	(N=14)

Where the responses were NO, the breakdown was as follows:

	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
Separated?	1	3
Divorced?	5	2
Widowed?	0	0
	N= 6	N= 5

RAW DATA

HOUSEHOLD STATUS OF MOTHERS WHO KEPT AND DID NOT KEEP THEIR CHILD DEVELOPMENT STUDY CLINIC APPOINTMENTS

Question on Interview Guide	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	Yes	No	Yes	No
5. Are you living in the same household with friends or relatives?	9	27 (N=36)	3	11 (N=14)

Breakdown between
friends/relatives:

	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
Friends	1	0
Relatives	8	3
	N= 9	N= 3

Question on Interview Guide	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
6. If relatives: What relationship?		
Maternal Parents	5	0
Mother & Father In-Law	1	2
Sister	1	0
Brother	1	0
Sister-In-Law	0	1
	N= 8	N= 3

RAW DATA

EDUCATIONAL STATUS OF MOTHERS WHO KEPT AND DID NOT KEEP THEIR CHILD
DEVELOPMENT STUDY CLINIC APPOINTMENTS

Question on Interview Guide	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
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7. How far did you
go in school?

Grade	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
5	0	1
6	1	0
7	0	0
8	3	0
9	2	1
10	9	1
11	7	3
12	13	5
13+	1	3
	N= 36	N= 14

8. How old were
you when you
finished high
school or quit
school?

Ages of Mothers	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
12	1	0
13	1	1
14	0	0
15	5	2
16	8	2
17	12	3
18	8	6
19	1	0
	N= 36	N= 14

The number of
mothers who
finished high
school or quit
school:

Finished High School	14	7
Quit school	22	7
	N= 36	N= 14

EDUCATIONAL STATUS OF MOTHERS. . . . concluded

Question on Interview Guide	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
9. How did it happen that you didn't finish school?		
	<u>Responses</u>	
To get married ...	12	5
To go to work.....	4	1
Problems at school..	4	1
Family problems...	2	0
	N= 22	N= 7

Samples of responses
of those who quit
school:

"I got married."

"I got married in June and didn't go back this year."

"I didn't like school, and I liked kids. So I quit school and started having kids. Besides, I didn't have mind enough to learn anything."

"I went to work."

"I didn't finish because of my reading. Something keeps me from reading."

"We lived on a farm and my father was unable to work. So I had to quit school and help with the work."

RAW DATA

EDUCATIONAL STATUS FOR HUSBANDS OF MOTHERS WHO KEPT AND DID NOT KEEP
THEIR CHILD DEVELOPMENT STUDY CLINIC APPOINTMENTS

Question on Interview Guide	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
10. How far did your husband go in school?		
	<u>Grade completed</u>	
	4	2 0
	5	0 1
	6	1 0
	7	0 0
	8	5 2
	9	6 0
	10	7 3
	11	4 2
	12	7 4
	13+ ...	2 2
	unknown ..	2 0
	N= 36	N= 14

The number of husbands who finished high school or quit school:

Finished high school	9	6
Quit school	27	8
	N= 36	N= 14

11. How did it happen that he /husband/ didn't finish?

Reason:		
To join the Service....	9	1
To go to work	7	4
Problems at school....	6	1
Unknown....	5	2
	N= 27	N= 8

RAW DATA

EMPLOYMENT STATUS FOR HUSBANDS OF MOTHERS WHO KEPT AND DID NOT KEEP THEIR
CHILD DEVELOPMENT STUDY CLINIC APPOINTMENTS

Question on Interview Guide	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
12. What kind of work does your husband do?		
Labor...	33	12
Military service...	2	0
Professional..	1	2
	N= 36	N= 14

13. Is your husband
working now?

Employed	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	Yes	No	Yes	No
	18	18 (N=36)	6	8 (N=14)

RAW DATA - PATIENT'S OPINIONS ABOUT CLINIC AND HOSPITAL

Question on Interview Guide	Mothers Who Kept Appointments			Mothers Who Did Not Keep Appointments	
	Yes	No		Yes	No
1. Is the Child Development Study a part of the Out-patient Clinic?	35	1	(N=36)	13	1 (N=14)
2. Are the nurses the same for Child Development Study as for your medical care?	23	13	(N=36)	7	7 (N=14)
3. Did you find your visits to prenatal clinic pleasant?	24	12	(N=36)	4	10 (N=14)
4. If NO, how were they unpleasant?					

	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
The long wait.....	6	6
Medical exam & care received.....	4	4
Children bothered clinic personnel....	1	0
Too many people.....	1	0
	N= 12	N= 10

5. When you were going to prenatal clinic, did you know that Child Development Study wanted to follow your baby after it was born?

	Mothers Who Kept Appointments			Mothers Who Did Not Keep Appointments	
	Yes	No		Yes	No
	33	3	(N=36)	14	0 (N=14)

RAW DATA

PATIENT'S OPINIONS ABOUT CLINIC AND HOSPITAL, cont.

Question on Interview Guide	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
6. How did you find out that Child Development Study wanted to follow your baby after birth?				
The interviewer	31	.....	13	
The nurse in the prenatal clinic	1	.....	0	
The follow-up nurse in the hospital	1	.....	0	
The four-month appointment letter	2	.....	0	
Unknown	1	.....	1	
	N= 36		N= 14	

7. Did You like the doctor who delivered your baby?

Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
Yes	No	Yes	No
31	5 (N=36)	14	0 (N=14)

8. What didn't you like about him the doctor ?

Samples of responses given:

"He sent me home, and I hardly made it back to the hospital."

"He didn't seem like a doctor to me... Too young... He seemed too much like a youngster himself."

"...although, at the time I didn't like nobody."

"I just didn't like anything about him. I thought he was very abrupt."

RAW DATA

PATIENTS' OPINIONS ABOUT CLINIC AND HOSPITAL, cont.

(8. cont.)

"He had a terrible bedside manner. He told me I wasn't in labor and sent me home. He told me to shut up and quit screaming. He was very abrupt, cold, and unfeeling."

Question on Interview Guide	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	Yes	No	Yes	No
9. Was the hospitalization for the birth of the baby pleasant?	30	6 (N=36)	10	4 (N=14)
10. If NO, how was it unpleasant?				

Samples of responses:

"I couldn't have very many visitors. There were too many in one room. I don't know what all I didn't like."

"The way they handled kids."

"I was up there 18 times, and they kept sending me home for pains in my back. If I had of waited for a pain in my back I would of had her at home."

"They had me in the solarium, and it was terribly cold."

"No care was given. The nurses paid little attention. We tried to get things from them, and they ignored us."

"Fourteen dollars was stolen from my purse while I was in labor."

"The warm milk."

PATIENT'S OPINIONS ABOUT CLINIC AND HOSPITAL, cont.

Question on Interview Guide

11. How were you notified that your baby had an appointment for his/her four-month examination?	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
Letter	32	11
Telephone	2	2
H. V. by nurse	2	1
Other	0	0
	N= 36	N= 14
12. Was help with transportation needed to attend Child Development Study Clinic?	Mothers Who Kept Appointments Yes No	Mothers Who Did Not Keep Appointments Yes No
	18 18 (N=36)	8 6 (N=14)
13. Were you offered help with transportation?	33 3 (N=36)	13 1 (N=14)
14. If YES, what kind?	Mothers Who Kept Appointments	Mothers Who Did Not Keep Appointments
Bus fare	0	0
Taxi fare	30	14
Mileage	1	0
Unknown	5	0
	N= 36	N= 14
15. Did a nurse visit you about the appointment?	Mothers Who Kept Appointments Yes No	Mothers Who Did Not Keep Appointments Yes No
	18 18 (N=36)	7 7 (N=14)
16. What was she like?	Samples of responses:	
	"Oh, I think she was very nice."	

RAW DATA

PATIENT'S OPINIONS ABOUT CLINIC AND HOSPITAL, cont.Question on Interview Guide

(16. cont.)

"She was very nice."

"Real nice."

"Beautiful."

17. Why did you keep /
or not keep / your
Child Development
Study Clinic
appointment?

Reason for keeping appointment	No.
Concern for health of child.....	17
Desire to be cooperative.....	16
Friend with child on Project.....	2
Unknown.....	1
N= 36	

Samples of responses
given by mothers who
did not keep their
Child Development
Study Clinic
appointments:

"They said they wanted me to call up there and I just haven't called yet."

"I was worrying about moving."

"The baby was sick."

"They gave me an appointment at 8:30 A.M., and I have other children and I'm unable to keep appointments in the A.M."

"The baby just had surgery. I couldn't get it done up there, so I took her to a private physician and had it done."

"I had hemorrhoids so bad I couldn't sit down."

"The first time it was because of the flood. I had a dream three nights in a row that the bridge fell down and we were on it. The second appointment my husband couldn't take me because he had to go to class."

RAW DATA

PATIENT'S OPINIONS ABOUT CLINIC AND HOSPITAL, cont.Question on Interview Guide

(17. cont.)

"I started back to work, and my baby sitter can't take them. I feel now that I'm working I should pay for my care."

"Because I was working. At the time I made the appointment, I didn't know I would have to go to work."

"Well, I forget the pediatrician's name, but she said she would have to be in a cast for three years. She has premature hip joints. But we have our own pediatrician now, and she said she would only have to be in a cast for only seven months. My husband wants her to have her own pediatrician."

"He was sick with a rash or a real bad cold, and sore throat."

"My brother was going to take me, and my brother started to work the day before."

"Because of weather conditions."

"THINGS! I was so upset and didn't make it--two times I forgot it."

18. Has your baby been examined by a doctor since he/she was born?

Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
Yes	No	Yes	No
31	5 (N=36)	11	3 (N=14)

RAW DATA

PATIENT'S OPINIONS ABOUT CLINIC AND HOSPITAL, concludedQuestion on Interview Guide

19. If living with husband/friend/relative/, what do they think of Child Development Study?

Samples of responses as reported by mothers:

"He doesn't think too much of it."

"He isn't very fond of it."

"He thinks it is all right."

"He thinks it is all right. He reads all the materials they gave me."

"He thinks it is a good plan."

20. If Child Development Study could do something to help you and your baby, what would be most helpful to you?

Samples of responses by mothers:

"I don't know."

"Gee, I don't know."

"We get along just fine."

"To discover a cure for colic."

"Find me a baby sitter."

"About the only thing is her welfare."

"Fix the hernia; it makes me sick."

"Find out about her chest."

"To find out if he is allergic to his milk, and to get rid of his cold."

"Getting me through school. I don't want to live off someone else the rest of my life."

RAW DATA - PATIENT'S KNOWLEDGE OF THE PURPOSE OF CHILD DEVELOPMENT STUDYQuestion on Interview Guide

1. What do you feel is the purpose of Child Development Study?

Samples of responses:

"Well, to see if they can take an inventory of a whole bunch of children to see average progress--the course of birth defects--this and that."

"To try to find out if anything is wrong with the child and try to prevent it from happening to other children in the future."

"To more or less check before and after birth to check what causes diseases in children. To control disease in the future for other children."

"To find out why the baby is born crippled by studying the mother before it is born, and the baby after it is born."

"Make examinations at 4 months, 8 months, then follow them until about 6 years old. All the information will be compiled and they will find out more about babies."

2. When will you be asked to come in for your next Child Development Study Clinic appointment?

Knew	Mothers Who Kept Appointments		Mothers Who Did Not Keep Appointments	
	Yes	No	Yes	No
	28	8 (N=36)	7	7 (N=14)

Ruth DeFoe King

AN ABSTRACT OF THE THESIS OF

Janet Nothiger Spuck

for the Master of Science in Nursing Education

Date of receiving this degree: June 10, 1965

Title: A Study of Appointment Keeping of Selected Participants
in a Child Development Study

Approved: _____

(Professor in Charge of Thesis)

THE PROBLEM

This study was undertaken to identify differences between mothers who kept their children's four-month Child Development Study Clinic appointments and those mothers who did not keep their children's four-month appointments. Moreover, the differences were to be based on the opinions expressed by the participating mothers concerning both their experiences in the prenatal outpatient clinic and their hospitalization for the birth of their babies, as well as their knowledge of the purpose of the Child Development Study Clinics. These differences were to be based on the following suppositions:

1. The Child Development Study mother who keeps her clinic appointment understands more about the purpose of Child Development Study Clinic than does the mother who does not keep her appointment.
2. The more favorable relationship a Child Development Study mother has with clinic and hospital staff during prenatal visits and hospitalization, the more apt she is to "follow through" in attendance in Child Development Study Follow-up Clinics.

DESCRIPTION OF PROCEDURES

During the spring, summer, and fall of 1964, fifty first study mothers participating in the Child Development Study and scheduled for a four-month pediatric protocol examination at the University of Oregon Project Site were selected for the interviews. The thirty-six mothers who kept their children's Child Development Study Clinic appointments were

interviewed in the Crippled Children's Division, where the clinic was held. The remaining fourteen mothers were interviewed in their residences.

The Interview Guide was constructed of both open and closed questions to ascertain information in three main areas: 1) socioeconomic and cultural data; 2) patients' opinions about the prenatal clinic and the hospital; and 3) patients' knowledge of the purpose of the Child Development Study Clinic. The open-ended questions were arranged into categories wherever possible for comparative data between the two groups of mothers. The closed questions were tabulated and used in comparisons in the attempt to identify differences between these mothers both in attendance and non-attendance of the Child Development Study Clinic. To make comparisons between these two groups of mothers, the findings were tabulated in percentages.

CONCLUSIONS

The conclusions of this study could not be generalized to other Child Development Study Project Sites or to other clinic groups because of the small sample.

The following conclusions were based on the information obtained about the social characteristics of the mothers:

1. The average age for the mothers who did not attend Child Development Study Clinics was slightly older than that of the mothers who kept their clinic appointments.
2. The mothers who did not attend clinic were caring for fewer children in their homes than they had borne. The opposite was true of mothers who kept

their clinic appointments.

3. The employment status of the two groups showed that five per cent more of the mothers who did not attend clinic were working at the time of the interviews. The figures also indicated that for the husbands of the mothers who kept their clinic appointments, seven per cent more of the husbands of this group were employed than were the husbands of the mothers who did not keep clinic appointments.
4. The educational status of the mothers of both groups showed that approximately 11 per cent more of the mothers who did not attend clinic had finished high school than had the mothers who kept their appointments. In both groups of mothers, the major reason given for not completing high school was "to get married". As for the husbands of the mothers in both groups, more schooling had been completed by the husbands paired with the group of mothers who did not attend clinic than was completed by the husbands of the mothers who kept their clinic appointments, the difference being about 10 per cent. For the husbands of mothers in both groups, the most common reason given for not completing high school was "to join the Service".

Further conclusions were based on the expressed opinions of the mothers concerning the prenatal clinic and their hospitalizations:

1. The majority of the mothers in both groups were unable to differentiate between the Outpatient Clinic and the

Child Development Study Project in physical organization or personnel.

2. It was found in this study that 38 per cent of the mothers who did not attend Child Development Study Clinics reported their visits to prenatal clinic as "unpleasant". The major reason given by mothers of both groups for the unpleasantness was "the long wait".
3. Of the mothers of both groups who reported that their hospitalization for the birth of their babies had been an unpleasant experience, 11.9 per cent more of the mothers were in the group who did not keep their Child Development Study Clinic appointments.
4. The findings of this study indicated that the interviewer was the major source from which the mother was informed about the Child Development Study Project. Also, the four-month appointment letter was the principal method for informing the mothers of their children's four-month appointments at the Child Development Study Clinic. As for modes of transportation offered to the mothers in order to facilitate attendance at the Child Development Study Clinics, it was shown that transportation by taxicab was the primary aid given.
5. The mothers who attended the Child Development Study

Clinics kept their appointments for two main reasons: 1) concern for the health of their children--47.1 per cent; and 2) a desire to be cooperative--44.5 per cent.

The final conclusions were based on the knowledge of the purpose of the Child Development Study as expressed by the participating mothers.

1. Of the mothers who did not attend Child Development Study Clinics, a higher per cent (11.9 per cent) indicated that they did not know that the Child Development Study Clinics were for research purposes.
2. A higher per cent (27.7 per cent) of the mothers who kept their Child Development Study Clinic appointments knew when they were to return for their children's next appointments than did the mothers who did not keep their Child Development Study Clinic appointments.

RECOMMENDATIONS

1. Conduct a study on the average time it takes for a patient in prenatal clinic to receive care. In relation to the time involved in receiving care, undertake a further study of clinic procedures to ascertain whether the time period could be decreased.
2. Explore the possibility of conducting prenatal classes to occupy the time spent in waiting to receive care, in order to determine if occupying the time in this way might provide less objection to the waiting period.

3. Repeat this study, using a broader sample, and including both "repeat" mothers (mothers who have more than one child on the Project) and mothers of all races who are participating in the Child Development Study.
4. Examine appointment breaking for all protocol age groups on the Child Development Study Project to ascertain a possible relationship between weather and appointment breaking.
5. Investigate the reasons given by gravidae attending prenatal clinic for their dislike of the medical examination.
6. Conduct a study of mothers' prenatal clinic visits in reference to initiation of care, appointment making, and appointment breaking. Compare this information with data concerning the mothers' keeping of the four-month appointments in Child Development Study Clinic, to find out if the mothers have a pattern of behavior that might indicate attendance or non-attendance at the Child Development Study Clinics.
7. Undertake a study of mothers' personalities in depth, in order to determine if the children are meeting their needs to "mother", or if the children are obstacles in meeting goals that represent stronger needs to the mothers. Such a study could be used as a guide to promote better understanding of those mothers by the personnel working with them.