

1-1-1987

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Recommended Citation

Bruhn, John G. (1987) "The Clinical Sociologist as a Health Broker," *Clinical Sociology Review*: Vol. 5: Iss. 1, Article 16.
Available at: <http://digitalcommons.wayne.edu/csr/vol5/iss1/16>

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The Clinical Sociologist as a Health Broker

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ABSTRACT

One of the key aspects that distinguish clinical sociologists from other sociologists is the former's more active role in intervention and change. The clinical sociologist performs several functions of a broker. This paper discusses the role of health broker and the opportunities it provides for clinical sociologists, especially in large organizations.

Clinical sociology entails the use of sociological knowledge and the sociological perspective in providing consultation and technical assistance to social units ranging in size from single individuals to large-scale organizations (Rossi and Whyte, 1983). The precise role of the clinical sociologist depends upon the situation and the nature of his/her involvement in it. Indeed, the clinical sociologist's role may change or he/she may function in several different ways while involved in a given situation. One of the key aspects that distinguish clinical sociologists from other sociologists is the former's more active role in intervention and change. The clinical sociologist may facilitate, advocate, negotiate, consult, advise, innovate, observe, or perform several of these functions as part of his/her role as broker. A broker is an agent or middleman, an essential third party in an interaction in which some type of change, involving two or more parties, is planned. The purpose of this paper is to discuss situations in which clinical sociologists might function as health brokers.

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Newell (1984) has suggested that brokered partnerships will be a growing option for reducing health costs. The brokered partnership brings providers and purchasers of health care together into one self-regulating group. The group becomes a true broker, negotiating price, use, and quality of health care services from a competitive position, with both buyers and sellers participating in the decision making.

Brokering is not new to the health field. Third-party payers are probably the largest and most common of brokers. Nurses have functioned informally as brokers, providing health information to patients, assisting patients in making health care decisions, and matching the needs of patients with the resources of the health care system (Fine, 1982). Brokering has also been an integral function of other health professional groups such as social workers. The social worker seeks to match family realities and community resources with patient needs (Pruger, 1982). Brokering is not new to sociologists either, especially those involved in criminology (Alinsky, 1984), marriage and family counseling (Voelkl and Colburn, 1984; Church, 1984), organizational development, and employee assistance programs in industry and large business organizations (Gutknecht, 1984), and in universities (Miller, 1985). Health brokering is, however, a new role option for clinical sociologists. It can involve brokering health information to enhance health among employees in large corporations; assisting individuals and groups in accessing health care resources; facilitating change in the health behaviors of individuals or families; or helping to ameliorate intraorganizational or interagency problems which affect the availability or quality of health care. Brokering health is an important and, as yet, unfilled gap in the health care system and in society at large. The clinical sociologist is in an excellent position to help fill this gap.

The Health Broker and the Concept of Health

The clinical sociologist must have a view of health that goes beyond treatment and rehabilitation and includes health promotion and disease prevention. Brokering health involves helping to create optimal or maximal opportunities for the well-being of individuals, groups, and organizations. The health broker is concerned with the social definition and implications of health and normality (Bruhn, 1974). Health and normality are not discrete states and their determination is not a completely objective process. Before a broker can intervene to create change, a determination of what is to be changed, why, and the possible effects of the change must be made. Since health is a continually changing process, no single intervention is likely to have a permanent effect. Indeed, health and human behavior have continually changing interactive effects. One job for the clinical sociologist is the delineation of those aspects of human behavior and lifestyle that facilitate the degree and duration of stages or phases

of "positive health." This is important to health maintenance organizations and to businesses and industry with health programs for employees.

The clinical sociologist broker must be familiar with and comfortable in working with a variety of health models, i.e., medical model, wellness model, epidemiological model, nursing model, and others. Since the broker must often facilitate multidisciplinary teamwork, it is advantageous for the broker to have an interdisciplinary perspective and a degree of optimism about interdisciplinary outcomes. Perhaps even more challenging is the need for the broker to be knowledgeable about strategies and tools for assessing change and measuring outcomes related to a variety of data types and sources. Finally, if the broker is brokering health, it is important that he/she provide a personal model for positive health behavior. For example, a broker who smokes tobacco may not be the appropriate person to facilitate an organization's consideration of a non-smoking policy.

An excellent example of brokering health in an organization is that in which curricular changes that incorporated the teaching of health promotion and disease prevention were implemented in a school of allied health sciences with the help of a clinical sociologist (Bunker et al. 1986). A federal grant provided the initiative and fiscal support for the effort, with strong support from the school's administration. Over a period of three years, Bunker and a committee of colleagues developed 14 student learning modules on health promotion topics. These were incorporated into the curricula of different disciplines through existing courses. The modular format allowed for flexibility by enabling faculty to select modules relevant to a particular profession or to a particular course and, after completion of two core modules, to select them in any order. The same committee initiated a health-screening clinic and health-risk appraisal for all faculty in the school. Faculty in various allied health disciplines performed different aspects of the screening. About 80% of all faculty participated. Clinic participants were given feedback on how to reduce their health risks. The school initiated an exercise program composed of a variety of types of exercise, a smoking cessation course, and a stress management course. The committee led an initiative for a stricter smoking policy in the school, which was endorsed by the faculty. In all of these efforts, a clinical sociologist and a faculty team acted as brokers with an emphasis on advocacy, facilitation, coordination, counseling, and evaluation.

Brokering—Aspects of the Role

Cousins (1985) described four types of sociological practitioners. The consultant offers advice to individuals, groups, and organizations about issues ranging from interrelationships to the purpose, function, and structure of groups and organizations. The counselor is more concerned with interindividual and group relationships and issues surrounding role, status, power, decision making, and

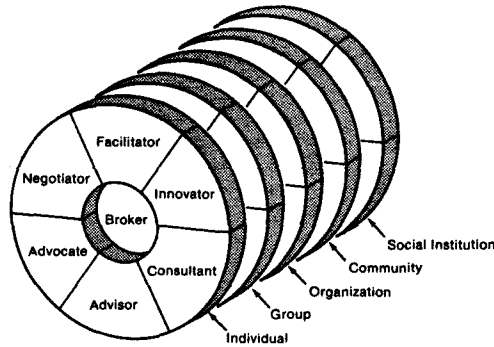


Figure 1. Aspects and Levels of Complexity of Broker Role

adjustment to change. The internal analyst is concerned about the internal "climate" of groups or organizations. The external analyst is concerned about how groups or organizations relate to other social configurations with which they have contact. In all of these roles, the sociological practitioner performs the dual role of inquirer and implementor. These roles require the sociological practitioner to view participants as amenable to change and enlightenment, to utilize strategic reasoning, to adopt a practitioner model compatible with his/her personality, and to be sensitive to ethical issues and able to resolve them (Cousins, 1985).

The more generic term "health broker" includes these and other roles for clinical sociologists. The term "broker" is advantageous because the act of brokering is necessary in situations in which inquiry is a goal, as it is in sociology. The term "health broker" is appropriate for the clinical sociologist who is concerned with problems of health and disease in the broadest sense; it incorporates a unified conceptual view of health and disease that is not fragmented by nosology or diagnostic labels (Engel, 1960). In addition, brokering conveys an active, innovative role for the clinical sociologist in health promotion and community health planning (Rogers, 1968; Rice, 1985).

Figure 1 shows the interrelationships of various aspects of the broker role with different levels of social interaction in which the clinical sociologist may act as a broker. The figure shows how a broker may perform several different aspects of brokering which cut across more than one level of interaction at any given time.

Brokering—Levels of Interaction

Figure 2 provides examples of possible broker involvement at different levels of social interaction.

	Individual	Group	Organization	Community	Social Institution
Individual	<ul style="list-style-type: none"> • Marital counseling • Divorce arbitration 	<ul style="list-style-type: none"> • Family therapy 	<ul style="list-style-type: none"> • Stress management • Employee assistance programs 	<ul style="list-style-type: none"> • Environmental design and planning 	<ul style="list-style-type: none"> • Health promotion programs
Group		<ul style="list-style-type: none"> • Understanding of role and function of new specialties in hospitals 	<ul style="list-style-type: none"> • Acceptance and use of PA's in hospitals and private practice 	<ul style="list-style-type: none"> • AIDS education and prevention programs 	<ul style="list-style-type: none"> • Health needs of refugees
Organization			<ul style="list-style-type: none"> • Interaction of community agencies with similar goals 	<ul style="list-style-type: none"> • Environmental protection groups 	<ul style="list-style-type: none"> • Mothers Against Drunk Drivers (MADD)
Community				<ul style="list-style-type: none"> • Area-wide emergency medical services • Joint disaster planning 	<ul style="list-style-type: none"> • Family planning, adolescent pregnancy, child abuse
Social Institution					<ul style="list-style-type: none"> • Programs to meet the needs of the poor, elderly, or homeless

Figure 2. Matrix Showing Examples of Possible Broker Involvement at Different Levels of Social Interaction

At the individual level, the broker commonly interacts with two people, together or separately. The purpose of brokering at this level is to decipher commonalities and differences which might be producing interpersonal conflict or obstructing progress in reaching an organizational goal. The broker seeks and gives information and, as such, is a facilitator, counselor, or coordinator. The two parties may be brought together to achieve reconciliation, to force confrontation, to correct misinformation, or to plan further steps. The recruitment of a broker at this level is usually initiated by the individuals concerned, their supervisors, or friends and peers. The broker is usually perceived as a “neutral” but helpful party.

Brokering at the individual level is often done either to “get people together” or to “keep people apart.” For example, a broker, who is a neutral party, might be asked by the leader of an organization to determine the barriers that are preventing a proposed policy change from being accepted, or to offer observations and advice as to why certain individuals in the organization are disenfranchised or isolate themselves. A broker at this level offers perspectives to individuals about barriers and potentials that they may not perceive or know about due to their position in an organization. Because brokers often have “nothing to lose,” they can be valuable resources to individuals in planning, problem resolution, thinking through the effects of proposed policies, examination of new markets, etc.

The group level involves brokering in two types of situations: between an individual and a group, and between groups. The former elicits the common example of family therapy in which an individual family member might be the

focus of concern or the precipitant for the family to meet as a group. Although brokering for groups involves some of the same types of approaches used in brokering for individuals, it is more complex due to the number of individuals involved. There are numerous examples in which brokers could be used to facilitate the formation of group coalitions, such as providing daycare services to the elderly, or assisting in accepting new groups into existing social institutions, such as the use and hiring of physician's assistants in hospitals. Brokering for groups is also complicated by the fact that group members may change. Hence, the broker may be the primary provider of continuity. One of the difficult aspects of performing the broker role under these circumstances is the need to avoid assuming a leadership position in the group, taking responsibility for group decisions or indecisiveness.

An example of dependence upon the broker-consultant for solving problems was experienced by the author. The "outsider" (broker) was asked to meet with two groups of health workers in a medicine outpatient clinic—clerks and professional nurses—who were at odds with each other. Clerks controlled the patient flow through appointments, and sometimes more patients were scheduled than could be seen by available physicians. The control clerks had over patient appointments was often interrupted by "no-shows," walk-ins, or patients who came on the wrong day or at the wrong time. Physicians were not always available even to see scheduled patients on time due to emergencies, meetings which ran overtime, etc. Nurses, who were the link between the patients and the physicians, caught the wrath of the clerks if the patients who could not be seen were asked to rebook an appointment or were given a return appointment without the clerk's knowledge. Nurses felt ineffective in controlling the availability of physicians, especially to see unscheduled patients. The clerks and nurses actively sabotaged each other's functions, and the patients were often the victims of the clerks' and nurses' angry outbursts and rudeness. The broker was asked to meet with the clerks and nurses together to see if they could work out their differences. Open discussion occurred when the two groups met with the broker, but the broker's suggestion that these groups meet directly with their clinic supervisors was rejected. Members of both groups did not want to risk their jobs by confronting their supervisors with complaints or suggested solutions. The level of distrust between clerks and nurses was such that anyone seen talking with a supervisor was thought to be either "feathering his/her own nest" or complaining about certain individuals. Short- and long-range solutions were only possible when the broker insisted that the supervisors become part of weekly group meetings with the broker. When paranoia lessened, tension lessened, and the groups began to work together for the benefit of the patients.

The broker may be involved in several different types of situations when working with organizations. The broker may interface between an individual and an organization (usually management), between a group or groups inside or

outside of the organization and representatives of the organization, or between organizations. Perhaps one of the more frustrating aspects of brokering at the organizational level is the usual delay in decision making, although this will vary with style of management. Communication channels and established lines of power and authority may complicate the broker's role, especially if one of the groups or organizations did not support the involvement of a broker.

Committees, especially in universities, are a way of life (Bruhn, 1981). Committees often function as brokers themselves between the administration, the community and alumni; between administration, faculty, and students; between faculty groups; or between faculty and students. Committees can facilitate or obstruct progress. A broker, especially one outside of the organization, can often provide advice about whether a committee is necessary in accomplishing an objective, and suggest a workable committee structure. When committees bog down, the problems are not always obvious to the involved parties. A broker may be valuable in facilitating compromise, especially if factions have ceased communication with each other. Brokers often perform their role best as listeners and reporters of observations. It is not the broker's job to make a committee work effectively or to accomplish its goal. It is the broker's role, when asked, to comment on behavior and offer suggestions.

Brokering at the community level is a comfortable role for the sociologist as a researcher; however, as an innovator or change agent, the clinical sociologist may become a focal point for individuals, groups, or organizations who might feel threatened by what they perceive the broker's role to be. There may be many different perceptions of the broker's role and, as these create misunderstanding, the perceived threat of a broker may become more real. A broker at the community level requires a variety of skills. He must have the broad perspective of a systems analyst, observing norms and values, interpreting groups dynamics, and facilitating individuals and groups having different attitudes. The broker must have a sensitivity to timing when working at the community level, especially when acting as an innovator or change agent. Often, a broker is employed as a consultant, so personal involvement in community change is limited. The broker can become the focus of anger for community groups, and his/her advice can be used as an excuse should the community fail to achieve its objective.

The current epidemic of Acquired Immune Deficiency Syndrome (AIDS) offered the opportunity for brokering in the author's community. While Texas ranks fourth in the total number of diagnosed AIDS cases in the United States, Galveston (City and County) has only 25 cases. Yet, the university hospital, as a multicategorical referral center, receives AIDS patients from across Texas, especially those without financial resources. This created a community problem and the opportunity for a broker. AIDS patients who could be discharged to outpatient status had no place to go in the community. Apartment owners would not rent to AIDS patients; therefore, patients were kept in the hospital, further

escalating hospital costs. The broker, with the assistance of a university administrator, met with the mayor and county judge to inform them of this problem and its likelihood of increasing as the number of AIDS patients grows. The broker first had to educate the officials about AIDS, which was seen by the officials as a problem of larger cities. The officials also resented the idea that the local community should have to cope with housing problems and resultant costs created by patients who were not residents of Galveston County. Both officials finally agreed to appoint a task force to examine the problem and to suggest immediate and long-range solutions, one of which was a half-way house for AIDS patients. The broker, in this example, was able to educate, initiate action toward solving a community problem, and emphasize prevention and planning rather than wait until the problem reached a crisis.

Perhaps the most difficult situation in which to act as a broker is that which might occur at the level of the social institution. This may involve one or more individuals, groups, organizations, or communities in interaction with a social institution. The most common examples are the issues surrounding busing in the public schools, drug use and law enforcement, abortion and religious institutions, and mentally ill transients and mental health institutions. Brokering at the social institutional level undoubtedly involved politics and special interest groups. Social institutions are not easily changed. They usually have a public image based on long-standing traditions and are sources of support and stability for their members and advocates. Usually, it is not possible for one person to serve as a broker between institutions because of the complexity of the situation. A team of colleagues would provide a more effective approach to brokering at this level.

Brokers at the institutional level are more likely to be perceived as advocates or change agents, especially if they have an active and visible association with individuals and groups who are known for creating change. While brokering for change can occur within a social institution, the area of change must be viewed as a high priority by gatekeepers or it will not be permitted to be addressed. A well-known technique for stalling change in social institutions is the appointment of a study committee. The nature of the problem or issue may change substantially by the time a committee drafts its findings and recommendations, or the problem may have resolved itself.

Brokering to create change in social institutions is, perhaps, most timely when an institution is experiencing change. Universities provide an example of a social institution that generally undergoes little change except, perhaps, when a new president is appointed. If the appointee is an outsider, considerable anxiety may be created among insiders, whose jobs may be altered or eliminated. Yet, new leadership also provides an opportunity to advocate and help create change. Brokers are often used by new administrative appointees to "sense the environment" and assemble facts about relevant information from components of the institution. In this way, brokers can be especially helpful in program develop-

ment. This has been done in many universities in developing, for example, health promotion and gerontology programs. A distinguished professor might be recruited to provide leadership in getting a program off the ground. The professor serves as a broker in coalescing divergent components that could not get the program moving without an outside stimulus. Brokers are of key importance in developing most interdisciplinary programs.

The Health Broker as a Lifecycle Interventionist

Another way in which to view the health broker is as a lifestyle interventionist. All organisms have lifecycles and undergo change. Change, or the lack of it, creates dysfunctions in systems at various points in their development and, often, creates the need to seek special advice, direction, or support. A broker can help to alleviate problems in adjusting to change that occur in the process of growth and development, whether it be that of an individual, group, organization, community, or institution. One cannot intervene in a situation without considering the interaction between the demands on a system and its resources for coping at any point in time. French et al. (1974) refer to this as "person-environment fit." The person-environment fit framework considers the consequences of interaction in terms of growth and dysfunction. Much of the initial empirical work using this framework has been in the domain of organizational stress and studies of the effect of the work environment. The person-environment fit concept has the advantage of simultaneously considering individual differences, environmental factors, and their interaction in the development of dysfunction. In this view, a broker could help to predict and, hence, to prevent problems in changing systems.

If we view organizations as entities that are never static, but are experiencing various degrees of decline or growth at any point in time, it is reasonable to expect that there will always be parts of an organization that are not in complete synchrony with other parts. In the same manner, individuals only rarely achieve a state of homeostasis. The ability of an organization to predict problems related to its growth or decline, and thereby minimize the problems associated with decline and maximize the opportunities associated with growth, may be enhanced by the services of a broker. A broker who is concerned with the total health of an organization, and not only with its problems or ills, may call upon colleagues in other disciplines to add to the skills needed to deal comprehensively with organizational health (Coelho et al., 1974).

Table 1 shows various types of needs organizations often have during periods of growth: the needs to reorganize, redevelop, and/or resocialize its employees. These needs may affect the entire structure of the organization, require modifications in its philosophy, or involve role redefinition among employees. A clinical sociologist has several tools or skills to assist the organization's leadership

Table 1
BROKERING IN ORGANIZATIONS:
SOME NEEDS, APPROACHES AND METHODS

Brokering Needs	Level of Intervention	Brokering Methods*
<i>For Organizations Experiencing Growth</i>		
Reorganization and Redevelopment	Structure and organization Employees	Role redefinition New skills training program Reward system Problem-solving groups
Resocialization	Philosophy of organization	Value clarification (individual and organizational)
<i>For Organizations Experiencing Decline</i>		
Revitalization	Financial structure External relationships Product or service	New markets Create new demands Public relations program Involvement in local community organizations
Rehabilitation	Physical and social environment or organization	Quality circles Incentive programs Health maintenance program Involvement in local community organizations

*These methods may be applicable in more than one area.

in coping with needed readjustments. Methods include: organizing problem-solving groups; discussing and clarifying issues related to power, authority, delegation, and reward systems with management and employees; and individual and group counseling.

When organizations undergo periods of decline, they need revitalization and rehabilitation. If an organization's survival is threatened, the basic structure of the organization—its financial system, external relationships, and even its product or service—may need to be reworked. Sometimes, an organization merely grows out of touch with its physical and social environment and its relationships with other organizations. The clinical sociologist can assist the organization in learning new or revamping old survival skills.

The Limitations of Health Brokering

The possible role of a health broker is very broad and, indeed, encompasses the spectrum of concerns in sociology. A health broker is a specialist with specialized interests and skills. A broker is not a universal problem solver, and must be aware of the limits of his/her knowledge and skills. A broker must be aware of, and willing to work with, other professionals who are also knowledgeable in human behavior in dealing with complex issues. Hence, the broker must be comfortable working in interdisciplinary teams. Finally, the broker must be willing to accept failure. Expectations of brokers and consultants are often excessive, especially when a broker is sought as a last resort. Brokers should be careful about setting forth what they can and cannot do at the onset in working with any social unit.

Conclusions

The role of the health broker provides an opportunity for clinical sociologists to play a significant part in coping with the effects of change in a variety of social units, ranging from individuals to social institutions. Brokering requires active involvement or intervention to enhance the health, and minimize the risks to health, among individuals, groups, and organizations. Health brokering is a positive, action-oriented, and futuristic role for clinical sociologists; it directly involves clinical sociology in such current health trends and issues as prevention and gerontology.

REFERENCES

- Alinsky, Saul
1984 "A sociological technique in clinical criminology." *Clinical Sociology Review* 2:12-24.
- Bruhn, John G.
1974 "The diagnosis of normality." *Texas Reports on Biology and Medicine* 32:241-248.
- Bruhn, John G.
1981 "On the care and feeding of committees." *Southern Medical Journal* 74:133-135.
- Bunker, John F., Guy S. Parcel, Billy U. Philips, and Denise Simons-Morton
1986 "Curricular implications of health promotion and disease prevention in allied health education." *Journal of Allied Health* 15:329-337.
- Church, Nathan
1984 "Sociotherapy with marital couples: incorporating dramaturgical and social constructionist elements of marital interaction." *Clinical Sociology Review* 3:116-128.
- Coelho, George V., David A. Hamburg, and John E. Adams, eds.
1974 *Coping and Adaptation*. New York: Basic Books.
- Cousins, Albert N.
1985 "The sociological practitioner: an adjunctive role model." *Sociological Spectrum* 5:361-379.

- Engel, George L.
1960 "A unified concept of health and disease." *Perspectives in Biology and Medicine*, Summer:459-485.
- Fine, Ruth B.
1982 "Health information brokers." *Nursing Management* 13:39-40.
- French, J.R.P., W. Rogers, and S. Cobb
1974 "Adjustment as person-environment fit." In George V. Coelho, David A. Hamburg and John E. Adams (eds.), *Coping and Adaptation*. New York: Basic Books.
- Gutknecht, Douglas B.
1984 "Organizational development: an assessment with implications for clinical sociology." *Clinical Sociology Review* 2:94-108.
- Miller, John S.
1985 "Sociologists as mediators: clinical sociology in action." *Clinical Sociology Review* 3:158-164.
- Newell, Lawrence
1984 "Brokered partnerships: a new way to cap health costs." *Business Insurance*, October 1:28.
- Pruger, Robert
1982 "The good bureaucrat." Pp. 385-392 in Hiasura Rubenstein and Mary Henry Block (eds.), *Things That Matter: Influences on Helping Relationships*. New York: Macmillan.
- Rice, Thomas J.
1985 "American public policy formation and implementation." Pp. 153-171 in Roger A. Straus (ed.), *Using Sociology*. Bayside, NY: General Hall.
- Rogers, Edward S.
1968 "Public health asks of sociology. . . ." *Science* 159:506-508.
- Rossi, Peter H. and William F. Whyte
1983 "The applied side of sociology." Pp. 5-31 in Howard E. Freeman, Russell R. Dynes, Peter H. Rossi and William Foote Whyte (eds.), *Applied Sociology*. San Francisco: Jossey-Bass.
- Voelkl, Gary M. and Kenneth Colburn, Jr.
1984 "The clinical sociologist as family therapist: utilizing the strategic communication approach." *Clinical Sociology Review* 2:64-77.