Ms. G., a 39-year-old pregnant farmworker, presented as a new patient to a community health clinic. She told her new family physician, Dr. D., that she had already received an ultrasound, pelvic exam, and screenings for glucose tolerance and communicable diseases at another clinic in a nearby state, but no records had been forwarded. Ms. G. was a migrant berry picker who moved to a new farm every 3 to 6 weeks. Her five children lived with their grandmother in Mexico. She told Dr. D. that she had been feeling depressed since her 12-year-old daughter died by suicide in Mexico when she was away during the previous farm season.

As the primary breadwinner for her family, Ms. G. intended to work until the last days of her pregnancy and was preparing to move to a new region a week after this clinic visit. She lacked authorization to live in the United States and was not eligible for health insurance in the state where she presented for care. Dr. D. was concerned about the grave risks for pregnancy complications that Ms. G. faced as a grand multiparous woman of advanced maternal age who engaged in heavy physical labor daily, with depression, exposure to pesticides and heat, and uncertain nutritional and water intake. Dr. D. repeated the appropriate exams and screenings but wondered how their results would be conveyed to Ms. G. effectively, given that she needed to move for work before they would be available; she would also be gone before an appointment with a therapist could be arranged.
Social Analysis Concepts: Social Distance and Mobility

The services offered by clinics, hospitals, and health systems are built around a concept of a typical patient. Actual patients, however, often diverge from the type imagined. One way to understand this differential involves the concept of “social distance” — the gap created by marked cultural, socioeconomic, linguistic, or other differences between groups of people, even groups that may inhabit overlapping geographic areas. A classic cause of social distance is race: people of different races may traverse the same physical space throughout the day (neighborhoods, offices, transportation, public spaces) but never interact across a line of difference; thus, in some ways they inhabit different worlds (see box).

In a clinical context, the concept of social distance can help us to articulate the difference between certain patients’ social worlds and those of institutions’ imagined typical patients, which tend to reflect the world of the professionals who design health care systems, who often come disproportionately from dominant groups. When this social distance is great, the services provided may be ineffective or even harmful. Multiple health systems pro-
provided Ms. G. with services that had been designed under the assumption that patients were tied to a fixed location. But Ms. G.’s life was instead organized around movement, and this mismatch resulted in fragmented and sometimes either redundant or inadequate care.

Mobility is one especially pervasive basis for social distance between health systems’ imagined target patients and actual patients’ diverse lives and living conditions. Social scientists use the term “mobility” because societies do not consist entirely of geographically static people, as many social structures erroneously assume. The design of contemporary health systems does not capture the full range of mobile people, who also include those living on the streets, “snowbirds” who winter in warmer climes and summer in cooler ones, day laborers who cross international borders for work, college students who return home for summers, truck drivers who are on the road for weeks at a time, and professionals — in Europe, for example — who may temporarily reside in neighboring countries. Indeed, social scientists have shown that in most places and social worlds, mobility is very common, and in some places it is the rule rather than the exception.

Clinical Implications: Recognizing and Engaging with Social Distance

We recommend a few key steps for clinicians caring for patients who come from social worlds distant from the one their health care system envisioned.

1. Identify and address social distance. Social distance can be used as a conceptual tool for identifying mismatches between the life of an imagined typical patient and actual patients’ lives. Such recognition is especially important for the care of marginalized people, whose voices and concerns are rarely factored into the design of health systems. Once social distance has been identified, clinicians can work to bridge these gaps.

For example, most U.S.-based clinics consider patients to be “no-shows” if they arrive more than 15 minutes late for an appointment. This practice may penalize certain subpopulations, such as those with limited transportation options or limited control over their work schedules. Incorporating a walk-in option could lead to better outcomes. Similarly, a clinic serving many patients who have recently been incarcerated could create systems to address the risks associated with reintegration into society and transfer of health care. Such initiatives could include, for example, increasing appointment frequency to stabilize patients’ access to medications, food, housing, and safe living environments.

Health Network, a program that provides case management, transfer of medical records, and follow-up services for mobile patients, is one example of an intervention for addressing social distance between mobile patients and health systems oriented toward geographically stable people. Ms. G.’s care providers drew on this program to create continuity in her prenatal care. Migrant Clinicians Network (where four of us work) developed Health Network in response to patients’ feedback that the barriers to obtaining continuous care on the road kept them from completing treatments for acute and chronic illnesses. When such patient feedback drives design, rather than merely contributing to or responding to it, health systems have a greater chance of succeeding in addressing patients’ needs.

2. Treat mobility as the norm. Mobility is common enough that we believe it should be considered in all clinical practice. Some patients may visit the same clinic year after year, when they return to the area for seasonal work; others may visit a particular clinic only once; still others may sometimes leave a service area briefly. Intake processes and medical records can be adjusted to indicate a patient’s degree of mobility — for example, by identifying secondary living locations, establishing connections with patients’ other or previous clinical care sites, and flagging patients with highly mobile lives for connection to “bridge case managers” (see step 3). Many mental health practitioners have begun to offer therapy sessions using video-chat technology to allow mobile patients to avoid breaks in care. Such approaches can accommodate patients’ mobility and avert many of the poor outcomes associated with fragmentation of care.

3. Utilize bridge case management. Although Ms. G. kept changing locations, her prenatal care did not completely slip through the cracks of the fractured health care system. The implementation of a geographically unbound system of case management that bridges locations and health systems can improve the ability to
construct a patient's medical history and contribute to consistent, cost-effective health management after the patient has left a given service area.

Similar tools can be applied to solve problems arising from causes of social distance other than mobility. If health care leaders recognize the assumptions embedded in the design of a health care system or clinic, they can design services that better accommodate or address the social conditions of actual, diverse patient populations. (For additional readings on social distance and mobility, see the Supplementary Appendix, available at NEJM.org.)

Case Follow-up

Dr. D. enrolled Ms. G. in Health Network's bridge case-management system for mobile patients. Ms. C., a Health Network associate, called Ms. G. shortly after her enrollment, identified a clinic at Ms. G.'s new location, forwarded her medical records there, and scheduled a prenatal appointment.

Ms. G. then moved every 3 weeks to work at three different in-state farms. Each time, Ms. C. contacted a new clinic, moved Ms. G.'s medical records, and communicated with her. This frequent communication helped build trust, reinforced the importance of continuity in medical care, and made such continuity possible.

In her sixth month of pregnancy, Ms. G. called Ms. C., fearing that her baby wasn't moving. With Ms. C.'s help, Ms. G. saw a clinician who examined her and confirmed the baby's good health. Ms. C. suggested to Ms. G. that her fear might have surfaced because of ongoing depression after the loss of her daughter, and she recommended that Ms. G. see a mental health specialist. Ms. G. attended a single visit, which was unsatisfying, and refused further appointments, but she was made aware that depression both during pregnancy and post partum might cause difficulties for her and her child.

After seven moves in 7 months, and despite inconsistent care, Ms. G. gave birth to a healthy boy at 38 weeks' gestation. Health Network contacted her five times over 4 months to help manage her postpartum care until she returned to Mexico to live with her mother and children 5 months after delivery. Ms. G. reported to Ms. C. that her depression had lessened after she had ceased migrating and returned to her community and support system. Ms. C. transferred her records to a local clinic in Mexico, forwarded all records to Dr. D., and closed her case in Health Network. Dr. D. reviewed the complete medical records from the multiple clinics Ms. G. had attended.

The editors of the Case Studies in Social Medicine are Scott D. Stonington, M.D., Ph.D., Seth M. Holmes, Ph.D., M.D., Helena Hansen, M.D., Ph.D., Jeremy A. Greene, M.D., Ph.D., Keith A. Walloo, Ph.D., Debra Malina, Ph.D., Stephen Morrissey, Ph.D., Paul E. Farmer, M.D., Ph.D., and Michael G. Marmot, M.B., B.S., Ph.D.

Disclosure forms provided by the authors are available at NEJM.org.

From Migrant Clinicians Network, Austin, TX (L.M., C.H.S., D.G., E.Z.); Penn State College of Medicine, Hershey, PA (L.M.); the University of Michigan, Ann Arbor (S.S.); and Johns Hopkins School of Medicine, Baltimore (E.Z.).


Copyright © 2019 Massachusetts Medical Society.