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NEIGHBORHOOD HEALTH CENTERS: EVALUATION OF AN ENVIRONMENT FOR COMMUNITY HEALTH CARE

by

SIGRID REICH KIRSNERS

A dissertation submitted to the Graduate Faculty in Psychology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

1975

This manuscript has been read and accepted for the Graduate Faculty in Psychology in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

8/13/75
date

Maxine Wolfe, Ph.D.
Chairman of Examining Committee

8/18/75
date

Florence L. Denmark
Executive Officer

Maxine Wolfe, Ph. D.

Leanne G. Rivlin, Ph. D.

Patricia L. Kendall, Ph. D.
Supervisory Committee

The City University of New York

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TABLE OF CONTENTS

PART 1. INTRODUCTORY SECTION

		page
SYNOPSIS		2
Chapter		
I.	MODEL OF AN EVALUATION OF A COMMUNITY HEALTH CARE FACILITY	5
II.	NEIGHBORHOOD HEALTH CENTERS	11
III.	THE HEALTH CARE SYSTEM	16
	Structure of the American Health Care System	16
	Recommendations for Change	22
	Health Insurance	29
	Concrete Changes in the Health Care System	32
IV.	THE PHYSICAL ENVIRONMENT	38
	Density, Crowding and Congestion	47
	Noise	61
	Privacy	64
	Comfort and Ambience	68
	Site	82
	Summary	86
V.	COMMUNITY AND NEIGHBORHOOD: CONCEPTUAL DIFFERENTATION	91
	Working Definition of Neighborhood and Community	92
	Latent and Active Community	99
VI.	RELATIONSHIPS BETWEEN THE SYSTEMS: COMMUNITY PARTICIPATION	104
	The Non-Involved City Dweller.	108
	Community Participation: A Definition and Historical Overview	113
	Summary Statement and Foci of the Study	123
VII.	METHOD	127
	Participant Observation	128
	Interviews	139

Chapter		Page
	Specific Incidents	149
	Pilot Studies	151
	Summary	153
	PART 2.. DESCRIPTION OF FINDINGS	
VIII.	THE NORTH-WEST HEALTH CENTER--ITS SETTING, OPERATION, AND STAFF	156
	Financial Support	158
	The Physical Environment of NWHC	163
	Center Staff	171
IX.	NWHC PATIENT POPULATION	204
	Utilization Study	207
	Data on NWHC's Patient Population and the Samples for Interviews I, II, and III	210
X.	THE NORTH-WEST NEIGHBORHOOD HEALTH COUNCIL	230
XI.	NWHC AND ITS PLACE IN THE HEALTH CARE SYSTEM	241
	Patients	243
	Staff	284
	Summary	349
XII.	NWHC'S PHYSICAL ENVIRONMENT: HOW IT WAS PERCEIVED BY AND INFLUENCED THE INDIVIDUALS IN IT	354
	Effects of the Physical Environment on Patients' Perception of Care	356
	How Did the Center's Physical Environment Appear to Staff--and How Were They Affected by It?	373
	Significance of NWHC's Location	394
	Summary	399
XIII.	HOW PEOPLE INVOLVED WITH NWHC FELT ABOUT NEIGHBORHOOD, COMMUNITY, AND COMMUNITY PARTICIPATION	407
	Community Participation	408
	Neighborhood and Community	444
	Summary	467

PART 3. DISCUSSION AND CONCLUSIONS

Chapter		Page
XIV.	RECAPITULATION, IMPLICATIONS, AND RECOMMENDATIONS	472
	Implications of the Findings	475
	Recommendations	515
	Conclusion	523
APPENDICES		527
BIBLIOGRAPHY		636

LIST OF TABLES

Table		Page
8.1	Comparison of Recent NWHC Budgets	162
8.2	Economic Characteristics of Families Living Within the Catchment Area of NWHC	164
8.3	Composition of Center Staff (Spring 1973) . . .	172
8.4	Significance of Difference Between Proportions in Various Job Categories	173
8.5	Provider-Patient Encounters (July-September, 1973)	188-9
8.6	Sample of Staff Respondents by Department and Ethnicity	203
9.1	NWHC Patient Population	204
9.2	Sliding-Fee Scale in Operation at NWHC	206
9.3	Patient Population of NWHC (March 1973)	212
9.4	Age and Sex Distribution of NWHC Patients (March 1973)	212
9.5	Size and Ethnic Distribution of Samples for Patient Interviews I, II, and III	213
9.6	Sex Distribution of Samples for Patient Interviews	215
9.7	Ethnicity, Sex, and Age Distribution of All Respondents for the Three Patient Studies . . .	216
9.8	Respondents' Education (Int. I)	219
9.9	Place of Birth, Length of Residence in City, and Family Status of Respondents (Int. I) . . .	220
9.10	Average Reported Use of Center Services by Respondents and Their Families for One Year (Summer 1972--Summer 1973; Int. I)	222

Table		Page
9.11	Utilization of Health Care Facilities by Respondents and Their Families	224
9.12	Average, Median, and Range of Distances Between Int. I Respondents' Homes and NWHC . .	225
9.13	Reported Utilization Patterns of Center Services by Int. III Respondents (Fall 1972--Fall 1973)	228
10.1	Composition of 1972 Candidates and Elected Members of the N-W Council	236
11.1	Health Care Facilities Utilized by Int. I Respondents' Families of Procreation and Their Attitudes Toward Physicians and Hospitals . . .	244
11.2	Respondents' Preference Regarding Decision-Making Power in Choosing Health Care Facilities (Int. I)	246
11.3	Reasons for Preferring to Choose One's Health Care Facility or for Being Told Which to Use (Int. I)	247
11.4	Agents Which are Thought to Affect One's Health (Int. I)	249
11.5	Medical Facilities Used by Int. I Respondents Before They Became Center Patients (Int. I) . .	252
11.6	Perceived Reasons for the Creation of Neighborhood Health Centers (Int. I)	253
11.7	Main Reasons Offered for Thinking the Center More Convenient Than Other Facilities (Int. I).	256
11.8	Comparing NWHC Care to That Rendered by Private Physicians and Hospital Clinics (Int. I)	262
11.9	Suggestions for Improving Services at NWHC (Int. I)	266
11.10	Reasons for Liking NWHC (Int. I)	267
11.11	Respondents Who Were Assigned FHCs (Int. I) . .	270
11.12	Awareness of, and Agreement with, a Program to Train Community Residents for Center Jobs .	273

Table		Page
11.13	Type of Center Personnel Encountered by Int. III Respondents	278
12.1	Perceived Adequacy of Space at NWHC (Int. I)	357
12.2	Perceived Crowdedness of NWHC (Int. I)	358
12.3	Perceived Noise Level at NWHC (Int. I)	359
12.4	Perceived Comfort at NWHC (Int. I)	360
12.5	Scores of Overall Dissatisfaction with the Physical Environment of NWHC (Int. I)	364
12.6	Knowledge about Existence of Playroom at NWHC Among Int. I Respondents	369
12.7	Reasons Offered by Int. I Respondents for Thinking a Playroom at NWHC Desirable	370
12.8	Staff Comments About NWHC's Physical Environment Which Emerged During Focused Interviews	376
12.9	Perceived Ability to Change Conditions at NWHC/the Back-Up Hospital (Int. I)	397
12.10	Relationship Between Distance of Respondents' Homes to NWHC and Intensity of Use of Center Services (Int. III)	400
13.1	NWHC Staff Opinions Regarding Community Participation in Health Care	410
13.2	Staff Opinions Concerning the Council's Functions in Hiring and Firing Center Personnel	418
13.3	Staff Opinions Concerning the Quality of Council Performance	420
13.4	Ideal Functions of the Council, as Perceived by Center Staff	423
13.5	Incidence of Expressing Any Opinion About Community Health Councils (Int. I)	434
13.6	Feelings About the Existence of Health Councils and Reasons for These Feelings (Int. I)	434

Table		Page
13.7	Social Space Scores of Int. I Respondents . . .	436
13.8	Reported Membership in Voluntary Organizations and General Voting Activities (Int. I)	438
13.9	Perception of Community Influence (Int. I) . .	439
13.10	Definitions of the Term Community Participation and Control (Int. I)	441
13.11	Conceptualization of the Term "Neighborhood" (Int. I)	445
13.12	Ability to Identify Photographs of 11 Sites Within NWHC's Catchment Area (Int. I)	446
13.13	Identification of Photographs of Locations Within the Center's Catchment Area (Int. I) . .	447
13.14	Negative Aspects About Their Neighborhood Mentioned by Int. I Respondents	449
13.15	Work Necessitating Travel in the City (Int. I).	451
13.16	Measures of Central Tendency for Int. I Respondents' "Neighborhood"	453
13.17	Number of City Blocks Outlines by Respondents as "Their Neighborhood" (Int. I)	453
13.18	Criteria for Considering an Area One's Neighborhood (Int. I)	455
13.19	Positive Aspects of Respondents' Neighborhood (Int. I)	457
13.20	Definition of "Community" (Int. I)	458
13.21	Definitions of "Neighborhood" and "Community" Offered by NWHC Staff and Members of the N-W Council	459
13.22	Extent to Which Definitions of Neighborhood and Community Offered by Respondents Coincided with Those Hypothesized in This Study	466

LIST OF ILLUSTRATIONS

Fig.		Page
1	Location of the North-West Health Center within Its Catchment Area	14
2	Floor Plan of the North-West Health Center (Main Floor Only) . . . . . (Appendix A)	529
3	Time Frame of the Methods Utilized in the Study of the North-West Health Center	154
4	Age and Ethnic Distribution of Respondents for Interview I	217
5	Relationship between Distance from Patients' Homes and Frequency of Utilization of NWHC During Year Preceding Int. III.	402

LIST OF TABLES CONTAINED IN APPENDIX N

Table		Page
1	Analysis of Variance for Reported Number of Visits to NWHC During the Year Preceding Int. I	598
2	Age and Utilization Patterns of NWHC Services by Int. I Users (Summer 1971--Summer 1972)	599
3	Analysis of Variance for the Average Distance of Int. I Respondents' Homes from NWHC	600
4	Age and Utilization Patterns of NWHC Services by Int. III Users (Summer 1972--Summer 1973)	601
5	Attitudes Toward the Center, Its Back-up Hospital, Doctors and Nurses (Int. I)	602
6	Further Indicators of Satisfaction or Dissatisfaction with NWHC (Int. I)	603
7	Mode of Transportation and Time Required to Reach the Center and Other Health Care Facilities (Int. I)	604
8	Comparison Between NWHC and Private Physicians Based on Familiarity with the Latter (Int. I)	605
9	Assessment of Center Qualities as Compared to Other Facilities (Int. I)	606
10	Sources of Advise Sought on Various Problems--Including Non-Medical Ones, and Tests for the Significance of Differences Between the Three Ethnic Groups (Int. I)	607
11	Reasons for Seeking or Shunning Advise of Various NWHC Personnel (Int. I)	608
12	Attitudes of Interview I Patients Regarding the Training Program	609
13	Comparison of Int. I Respondents' Preferences for Dealing with Staff of Either NWHC or the Back-up Hospital, and Recurrence of Respondents' Contact with Them	610

Table		Page
14	Personal Acquaintance with Staff Members of NWHC and the Back-up Hospital	611
15	Type of Personnel at NWHC and the Back-up Hospital with Whom Acquaintance Was Reported (Int. I)	612-3
16	Locations and Occasions Named by Int. I Respondents in Relation to Their Perception of Space, Crowding, Noise and Comfort at NWHC	614-5
17	Overall Satisfaction with NWHC by Perception of Its Space, Crowdedness, Noise and Comfort (Int. I)	616-7
18	Relationship Between Dissatisfaction with NWHC's Physical Environment, Some Indicators of Satisfaction with Center Services, and Respondents' Ages (Int. I)	618
19	Perceived Privacy in Dealing with NWHC's Staff Members (Int. I)	619
20	Affect Expressed by Respondents Regarding the Perceived Degree of Privacy During Encounters with NWHC Staff (Int. I)	620
21	Correspondence Between Overall Satisfaction with Center Services and Perception of Privacy at the Center (Int. I)	621
22	Attribution of Responsibility for Unsatisfactory Conditions, and Feelings of Ability/Disability to Change These Conditions (Int. I)	622
23	Relationship Between Frequency of Utilization of Center Services, Age, Distance of Home from Center, and Being Accompanied by Children (Int. III)	623
24	Relationship Between Knowledge about the N-W Council and Respondents' Ages, Education, Length of Residence in the City, Family Status, and Social Space (Int. I)	624-5
25	Same as No. 24; Hispanic Int. I Respondents Only	626
26	Same as No. 24; Black Int. I Respondents Only . .	627

Table		Page
27	Same as No. 24; White Int. I Respondents Only . . .	628
28	Perceived Extent of Community Influence on the Operation of NWHC and of the Back-up Hospital (Int. I)	629
29	Feelings About Community Influence in Health Care Facilities Based on Comments About Such Influence	630
30	Feelings About Community Participation and Control by Perceived Effectiveness in Respondents' Own Part of the City (Int. I)	631
31	Analysis of Variance for Area Reported as Respondents' Neighborhood (Int. I)	632
32	Relationship of Area Claimed as One's Neighborhood to Yearly Use of NWHC, Knowledge Regarding the N-W Council, Perceived Influence of the Community in the Operation of NWHC, and Respondents' Social Space (Int. I)	633

PART I

INTRODUCTORY SECTION

SYNOPSIS

The past decades have witnessed an increase in public services for the underprivileged. The bases for the planning of these services, for the design of their facilities, and the determination of their client populations have, however, been largely on a trial-and-error model. There is little systematic study of understanding of what constitutes a "public service," which services are utilized and why these are used while others are not. Preventive medicine, for example, has not been overly successful so far. It is, therefore, necessary to learn why people seek health care, whom they approach for such care, under what circumstances and in which places. There is, in short, need for an increase in theory and evaluative research regarding public services to enable us, in the future, to provide those services which do, in fact, meet the needs of their potential users and will be utilized by them. It is hoped that the results of this study will add to the growing body of knowledge concerning urban health care delivery systems by providing empirical data on one such service.

The focus of this study is community health care as viewed through the model of a systems approach. More specifically.

a neighborhood health care center is regarded as part of a total social system which includes the neighborhood, the people in it, and their health care. This health center is studied in order to determine whether it is currently perceived as, and functions as a viable instrument of improved health care in an urban neighborhood. The interaction between community systems and health care systems--the two integral components of any neighborhood health center--are examined. The concept of community participation is considered as a possible link between the two systems because community participants are both part of the community--they live there and, by virtue of their government mandated role in the operation of the neighborhood health center, they are also part of the health care system.

Methods used in this study are: Participant observation of the center, extended interviews with samples of various relevant groups, and a specific incident analysis of patients' experiences in the use of the neighborhood health care facility.

Presentation of the study is organized in the following manner: After a brief examination of the concept of systems theory and its application as a model here, a general overview of neighborhood health centers and the American health care system are presented. This is followed by a theoretical

consideration of possible symbolic and practical influences of the physical environment on the system under investigation. The concepts of community and neighborhood are examined; and the possibility of linking the health care system, including neighborhood health centers, and the community system through the concept of community participation is then probed. The last part of the introductory section describes the research methods used and the rationale for their utilization, as well as two pilot studies--one of which led to this project.

The results of the research are offered in Part II which consists of a description of the research site, respondents samples, and a presentation of the data which were collected.

Part III comprises a discussion of the theoretical and practical implications of this study.

CHAPTER I

A SYSTEMS MODEL FOR AN EVALUATION OF A COMMUNITY HEALTH CARE FACILITY

Community health care facilities, like all institutions, can be conceptualized as part of a larger environment; there is a continuous interchange of inputs and outputs between environment and institution which influences the function of both. It is the conceptual approach, or holistic model, of systems theory which is utilized in the present study.

A systems approach entails the study of the dynamic relationship between the component parts of any specific phenomenon. Utilization of such an holistic model encourages examination of interaction patterns within and between various systems. Not enough is known about the health care system to make it amenable to a quantitative systems analysis; we lack the necessary quantifiable information regarding relevant variables, structure, and functioning of health services--any attempt to construct a mathematical model would, therefore, be premature (Anderson, 1972). We do have enough knowledge, however, to allow a qualitative study of a whole through examination of its component parts.

There are obviously many variables which influence the existence of a person in any given environment. One could investigate all these variables separately--but they cluster to form a number of sub-social structures of sub-systems, each with their own component parts. Thus all the variables that influence and are influenced by people in a given neighborhood, including their individual goals, expectations, feelings about the area--and the actual physical condition of the area, available services and other people, constitute a neighborhood system. All the variables which impinge upon the individual in terms of health care, where it is received, how it is rendered and by whom constitute the health care system. But the neighborhood system and the health care system, while complete social structures or systems in themselves are, in turn, parts of sub-systems of our larger social system and interaction is ubiquitous. In order to understand one relatively small social structure such as a neighborhood health center one cannot study it separately from all the phenomena it is part of and which impinge upon it since these form a variety of systems rather than a variety of independent variables.

Such an holistic approach essentially necessitates the determination of (a) the major systems impinging upon the phenomenon which is being investigated, (b) the sub-systems comprising the relevant systems, (c) the typical patterns of functioning of these components, (d) the method of their

interaction, and (e) the relative importance and influence of each in the formation of the situation confronting the investigator. This concept should be broadened to include (f) the extent to which the systems share purpose, function, and interdependence (Haberstroh, 1965), and (g) those aspects of the physical environment which are related to the function and development of the systems (Rapoport, 1968). Thus in examining a neighborhood health center, the following points can be made:

1. The major systems impinging upon the neighborhood health center system under investigation are the community system (the individuals, institutions, and organizations within a given area) and the health care system (the way in which medicine is organized, funded, and practiced in a given society).

2. Sub-systems of these three systems on which the study concentrates are (a) the roles, behaviors, perceptions, norms, and values of those people in the systems who are directly relevant to the neighborhood health center; (b) the internal organization of this center; and (c) external variables such as federal, state, and city legislation and policies, and funding--as far as these influence the system under investigation.

3. Typical patterns of functioning are explored by examining how the neighborhood health center operates, and how those aspects of the community and health care systems

which impinge upon the center operate. For example, how active are community residents in the affairs of the center and other community organizations? Medicaid and, to a much smaller extent, Medicare, are important sources of revenue--how does this affect the center's operation?

4. Interaction between the three systems under investigation is inevitable because the neighborhood health center, by virtue of its geographic location and the goals it espouses, is functionally linked with both the community and health care systems. It is, for example, governed jointly by a community board and a voluntary hospital; its patients and some staff are community people; its physicians are part of at least two and, if they live in the community, all three interlocking systems. How do they and other individuals occupying positions in two or three of these systems deal with any role conflicts which might arise?

5. The purpose of this study is to determine the relative effects of different variables on the dynamics of the neighborhood health center. How does the clinic differ from more traditional ambulatory health care facilities such as Emergency Rooms and Outpatient Clinics of hospitals? What are the goals of this center and how much do external and internal political, social, and environmental factors influence achievement of these goals. How does the fact that the center serves only neighborhood residents and is administerd with community participation influence the use and perception of the center by

its patients and staff? How is the presence of indigenous paraprofessionals regarded by patients and health system professionals? What influence do changes in government policies regarding funding of the center (e.g. threatened reduction of grants) have on the morale of staff and patients?

6. The extent to which neighborhood health center, community, and health care systems share purpose and function become apparent as the relationships between these systems and their sub-systems are investigated. How, for example, does staff's commitment (or lack thereof) to the ideals of neighborhood health centers affect the kind of care they give? How does the care they give affect utilization of the clinic by neighborhood residents? How does utilization affect perception of "community"?

7. Inclusion of the physical environment in a systems approach permits the examination of real and symbolic input of physical factors. The importance of this lies in the fact that, as Rapoport (1968) noted, any change in the attributes of the environment may affect the structure and behavior of the systems; any change in the system might affect the environment. Demarcation of the center's catchment area is a physical factor--is this demarcation perceived as furthering segregation or as offering added opportunities for better health care by the different groups involved in the various systems? The building

which houses the health center system and its location are physical factors--how do crowded quarters affect staff functioning and the perception of care rendered to patients? How does the distance to the center from patients' homes affect patterns of use?

The framework established by these points provides the conceptual base for the investigation presented here.

CHAPTER II

NEIGHBORHOOD HEALTH CENTERS

The idea of neighborhood health care facilities is not new. It existed in the early part of this century in immigrant ghettoes of several American cities. These facilities were sponsored by philanthropic agencies and generally attached to settlement houses. With very few exceptions, they were geared toward public health. The movement ceased when government became increasingly involved in welfare measures during the 1930s (Health/PAC, 1972a).

The concept was revived following the 1964 amendment to the Economic Opportunities Act, when Comprehensive Health Service Projects (CHSPs) were started across the nation. Some of these projects were associated with established group practices which served both publicly-assisted and private patients; others took the form of neighborhood health centers serving low-income populations almost exclusively (Strauss & Sparer, 1971).[1] The Office of Economic Opportunity (OEO) provided guidelines regarding cost, type, and quality of services. All CHSPs were expected

---

[1]As will be shown later, this, at least in theory, has changed since the Strauss & Sparer data appeared.

to offer ambulatory comprehensive health care to residents of a given geographical area. Those considered neighborhood health centers were, in addition, required to have community participation--both in planning and in operation--as a prerequisite for funding by OEO. Centers had to be located within the boundaries of the community, be linked to a hospital, and aim at increasing utilization of health services by their client population (Sparer, et. al., 1970). The concept underlying neighborhood health centers stressed that such facilities, like all poverty programs which originated at that time, were for the community, shaped according to community wishes, and staffed--at least at paraprofessional and clerical levels--by community residents (Moynihan, 1970). Although the policy-makers involved in drafting this 1964 OEO legislation were concerned that programs for the poor should be planned and administered with the input of the poor rather than be mandated for them, the terms of the act regarding community participation were, unfortunately, left somewhat vague (Moynihan, 1970). As a result the roles of many community councils remained hazy (Mid-Westside Neighborhood Health Council, 1973). Funding and supervision of neighborhood health centers now in existence have gradually been transferred from OEO to the Department of Health, Education and Welfare (HEW) under Section 314-e of the Public Health Service

Act. Funds are disbursed through Health Services and Mental Health Administration (HSMHA) project grants. A 1973 HEW policy statement decreed that neighborhood health centers, among other federally funded health service delivery projects, institute sliding-fee scales and become "self-sustaining" at the earliest possible date--without, however, refusing service to any individual unable to pay or not covered by some form of health insurance (Federal Register, 1973). At the same time, HSMHA operating grants were cut an average of 20% (National Association of Neighborhood Health Centers, 1973). The edict for self-sufficiency was modified by the Secretary of HEW during a hearing before the Subcommittee on Health of the Committee on Labor and Public Welfare in the summer of 1973 (personal communication). At present it does not appear as though client-or-third party reimbursements will be able to provide all operating costs for neighborhood health centers in the near future, if ever. Many of the services comprising comprehensive care (such as preventive medicine, counseling or helping patients in their dealings with landlords, schools, or various city and federal agencies) are not covered by such insurance plans; not all states have Medicaid programs and, finally, Medicaid payments are very low in several states. At best, only about 50% of the operating budgets of the centers are covered by third-party

payments, with government funds making up the deficit (Association of New York Neighborhood Health Centers, 1973).

To date there are about 147 such centers, located in 44 states, the District of Columbia and Puerto Rico, serving approximately 2 million patients (Association of New York Neighborhood Health Centers, 1973).

The center which was the subject of the present study was one of several such facilities established in

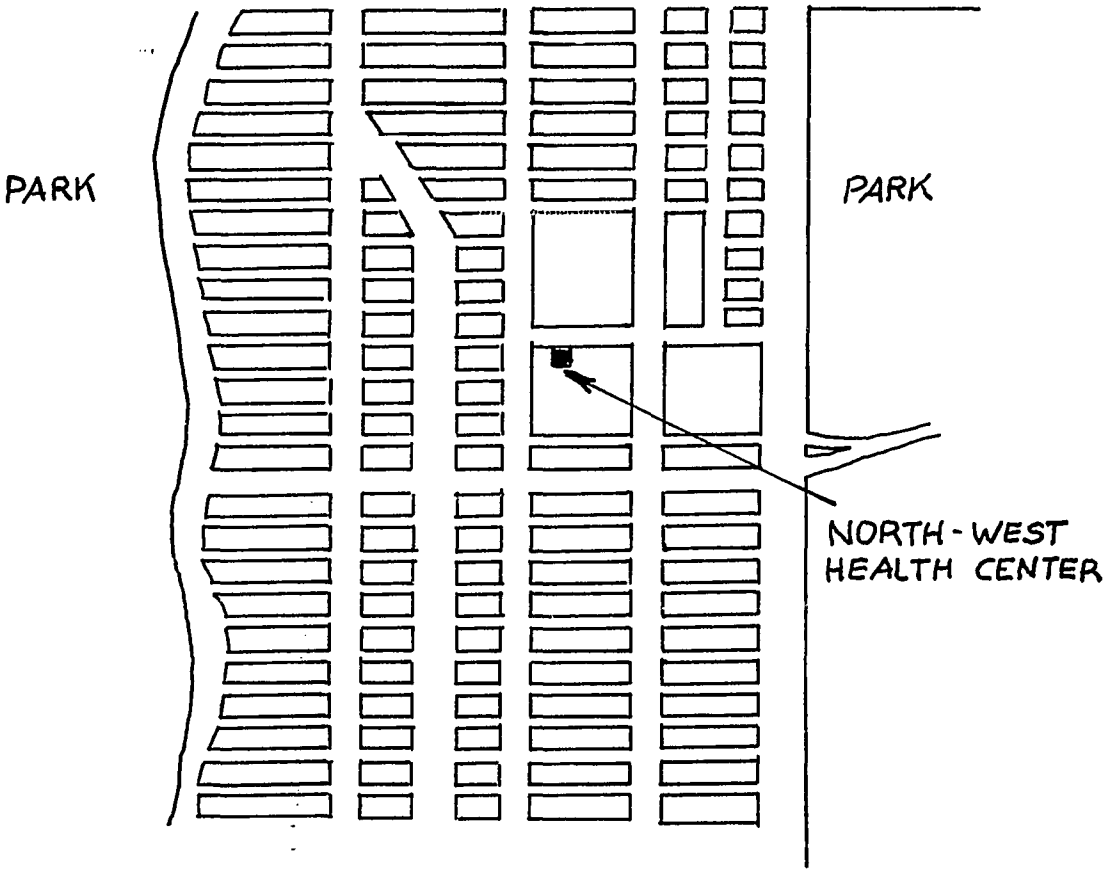

Fig. 1. Catchment area for the North-West Health Center.

one of our large metropolitan areas. Its catchment area comprised 120 city blocks (see Fig. 1) with a population of 31,757 families (U.S. Bureau of Census, 1972). This center will here be called the North-West Health Center, or NWHC for short. Created in 1967, NWHC was, throughout the period of this study, administered jointly by a voluntary hospital and a community council. This council, the North-West Neighborhood Health Council (N-W council), was formed by interested community people specifically to help administer the center in compliance with the OEO mandate regarding community participation.

Thus, the delivery of health care on one hand, and neighborhood/community on the other can be seen as the major systems influencing neighborhood health centers. The following sections will investigate theories and philosophies regarding these entities, their functions and possible impacts on health centers.

CHAPTER III

THE HEALTH CARE SYSTEM

> The ideal goal of medicine is to help man function successfully in his environment.
>
> Dubos, 1965

The World Health Organization defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity (Knowles, 1969)." It seems fairly evident that there is an intimate connection between the philosophical, social, political, and economic bases of any culture at a given time and the medicine which is practiced at that point (Ackerknecht, 1955; Anderson, 1969; Sigerist, 1943). Ackerknecht (1955) considered the medical behavior of each era and society as a "projective test" indicating its total culture.

Structure of the American health care system

Our health care system is comprised of two elements: (a) the health delivery, education, and financing institutions, and the industries which furnish plants, equipment, and supplies (Health/PAC, 1971a, 1972b); and (b) the public, which constitutes the system's real or potential client population.

Health/PAC (1971a) classified American health delivery institutions by ownership and function. Ownership can be either public or private. In the former category we find city, county, state, and federal institutions which are financed entirely by public funds. They may be operated directly by the public entity in question, through specially created agencies (e.g. the New York City Health and Hospitals Corporation), or through contractual arrangements and affiliation with voluntary hospitals. Institutions which are privately owned can be either voluntary (non-profit) or proprietary (profit-making). Voluntary institutions, while relying partly on donations and endowments, receive a large share of their funds from fees which are largely covered by third-party reimbursement, government subsidies and grants. Function can be divided into acute, chronic, or extended care institutions, nursing home facilities, specialty hospitals, outpatient departments of hospitals dispensing ambulatory care, and such decentralized clinics as neighborhood health centers, community mental health centers, and free clinics.

Interdependence and interaction between all segments of the health care system is common (Health/PAC, 1972b). It has been suggested, however, that the present structure of the health care system in the United States does not come

close to achieving the goal of health although over 60 billion dollars were spent on health care in 1969--double the amount of 1960 (e.g. Bernstein, 1970; Brown, 1961, 1962, 1964; Bullough & Bullogh, 1972; Citizens Board, 1971; Conant, 1968; Demchak, 1972; Freidson, 1970; Ginzberg, 1969; Glasgow, 1972; Graham, 1964; Greenberg, 1965; Harris, 1969; National Commission on Community Health Services, 1966; Strauss, 1970), and an expenditure of about 125 billion dollars was projected for 1975 (Lyons, 1975). Despite the ever-increasing outlay for medical costs and despite the fact that the United States devoted a larger percentage of its Gross National Product to health than any other nation, we lag behind many other countries in important health indices such as infant and maternal mortality, morbidity rates, and life expentancy (e.g. Anderson, 1969; Glasgow, 1972; Health/PAC, 1972b).

There can be little doubt by now that a large spectrum of Americans have good reason to be dissatisfied with available health care. The existing health care delivery system is characterized by high cost, fragmentation of care, and depersonalization of the patient--this applies to all Americans (Brown, 1964; Citizens Board, 1971; Glasgow, 1972; Greenberg, 1965). In addition, certain segments of our population receive care which is also inadequate from qualitative, quantitative,

and psychosocial perspectives. Among these groups are the poor, the old, the poorly educated, the non-white, the ghetto dwellers, the unemployed or underemployed, migrant labor, and residents of many small or outlying communities--in other words, mainly those individuals who do not usually utilize private physicians (Bullough & Bullough, 1972; Citizens Board, 1971; Glasgow, 1972; Graham, 1964; D. Schorr, 1970; Strauss, 1970). Richardson (1969) provided many statistics which showed that coexistence of two or more of these demographic characteristics aggravated the situation.

One of the aims of the study presented here was to determine whether neighborhood health centers have the potential of alleviating some of the dysfunctional aspects of the existing health care system in the United States. The crisis in this system has caused the following charges to be leveled against it:

1. It lacks overall planning and coordination with other social systems and goals (Bullough & Bullough, 1972; Goodman & Freund, 1968).

2. It has become a business and as such operates largely like other private enterprise establishments (Health/PAC, 1972b).

3. It utilizes a market model in spite of the fact that medical services are unlike other services in either their characteristics or the attitudes they elicit (Fein, 1969).

4. It is tightly controlled by the medical profession, though not always for the benefit of the public. The medical profession is completely autonomous and self-directing. In addition to all technical aspects, it determines social and economic aspects of the system; it controls the training and number of available physicians; it directs and limits the activities of all supporting occupations; it defines the division of labor between these supporting occupations and physicians (Freidson, 1970, 1971).

5. It is not really committed to the view that medical care is a collective responsibility (Abel-Smith, 1969).

6. It is beset by conflict between the medical profession and the public at large regarding "the rights and responsibilities of individuals, the proper scope of the role of government, and the relation of government to corporations, the professions, and consumers of health services (Brown, 1969, p.6)."

7. It does not have optimal organization and lacks efficient assignment of priorities--the large sums expended can, therefore, not be utilized most effectively (Ginzberg, 1969; Glasgow, 1972).

8. It does not invest enough effort to insure that individuals will utilize the services which are provided (Bullough & Bullough, 1972; Paul, 1955).

9. It permits the lack of individualization of the patient (Levine, 1957).

10. It does not exert itself sufficiently to assure a better doctor-patient relationship; for example, the need to understand the patient as an individual rather than a disease entity is seldom stressed; patients are not routinely provided with explanations regarding their illness and the necessary procedures to be followed (Hollender, 1958).

11. It encourages medicine to model itself on the natural sciences more than on the social sciences (Dubos, 1965; Henderson, 1935; Marti-Ibañez, 1960).

12. It resists change; gives priority to interests of institutions over the interests of the public (Conant, 1968).

13. It pays little attention to social factors which contribute to disease; there is little coordination of communication with other caring institutions. Medical centers deal only with acute, curative, scientific, and technical aspects of medicine--there is little effective social service. Outpatient departments are poorly developed; there is little effort to provide continuity of care or extension of service

to community or home (Knowles, 1969).

Recommendations for change

Both theoretical and practical suggestions and factual attempts have been made to alleviate these perceived shortcomings of the health care system. Foremost among the theoretical positions is the call to institutionalize the consideration of psychological, sociological, and environmental factors along with those of a purely medical nature. Henderson (1935) offered a paradigm for the doctor-patient relationship based on Pareto's social systems theory. Sigerist (1943) reiterated the fact that the goal of medicine was the maintenance of individuals as useful members of society--this could only be accomplished by paying attention to psychosocial factors as well as to physiological ones (see also Mari-Ibañez, 1960). It has been documented that cultural and ethnic background and socioeconomic status (SES) played a vital role in the way medical facilities and personnel were perceived and utilized; in the attitude toward preventive medicine, non-medical practitioners, and home remedies; in the reaction to pain and the need for nurturance; in labeling given conditions as pathological and in the ability and willingness to follow a prescribed regimen (e.g. Bullough & Bullough, 1972; Graham, 1964; Paul,

1955; Saunders, 1954; Zborowski, 1969). Health care personnel have been cautioned to be continuously alert to the importance of effective communication among themselves and with their patients; to the existence of sources of role strain in their own case as well as among their patients; to the fact that the assumptions and expectations patients and medical personnel bring to a medical encounter will color their perception of the encounter and that this, in turn, will influence behavior (King, 1962).

Hyman (1967) documented the influence of social factors on both the prevalence of disease and the extent to which one seeks medical care. Thus, for example, there is more illness among non-Whites and/or the poorer classes (as compared to Whites and/or members of the middle classes) yet less contact with the medical establishment (see also Richardson, 1969; Saunders, 1954; and Suchman, 1964, 1965 cited by Hyman, 1964). Hyman (1964) pointed to an evolution in interpreting these findings over the years: At first, the reason for the differences in morbidity rates was sought in physical variables such as housing and nutrition; this was followed by a belief that psychosocial factors of differential stress were primarily responsible. Explanations then focused on cultural differences

in relating to medical care and in seeking preventive as well as therapeutic care. Hyman mentioned the enactment of housing standards, food programs and, in recent years, the array of "Great Society" programs as attempts to deal with the problem. He suggested that improved interaction between health care providers and their public could be achieved through training the former in the social sciences, thus making them more aware of the role which cultural and psychosocial factors play in the delivery, utilization, and effectiveness of health care services.

There is recognition on the part of some physicians that their medical training did not equip them with adequate communication skills to establish the degree of rapport with their patients which is necessary to further comprehensive care (Chez, et. al., 1974; Contemporary Ob/Gyn, 1974). Many medical schools have incorporated some social science courses in their academic curriculum (Bloom, 1963). Others have, in addition, instituted comprehensive care programs in their clinical training (e.g. Merton, et. al., 1957; Levine, 1957). Some physicians now receive training in both obstetrics/gynecology and psychiatry and hold academic appointments in both departments (Contemporary Ob/Gyn, 1974).

Strauss (1970) maintained that one reason why the poor

do not get better care or even utilize existing facilities fully is the fact that the American health care system is not designed to fit their life style. He characterized the poor as oriented to the present; used to living with uncertainty and crises; believing that a breakdown of the "body-machine" must be expected; having low self-esteem; and often lacking the energy and money to seek medical help. Nothing but a complete revamping of the health care system to a form which would make it more relevant to the lower classes would be effective in raising their health indices.

Balint (1957) called the physician the most potent "drug" in medical practice because his understanding of his patient's social and psychological situation, and the whole atmosphere of the doctor-patient encounter, has as much effect as the medical treatment he prescribes. When a patient consults a physician, the latter has two options: he can diagnose the illness which is brought to his attention, prescribe a treatment, and an improvement of this condition will hopefully occur. Alternately, he can view this illness as a possible "presenting symptom"--one which the patient (consciously or subconsciously) uses in order to seek help with other problems.

In this case the physician would strive for a more comprehensive diagnosis, one which entails looking at the whole person and his social situation, attempting to locate or rule out possible emotional causal factors. Balint noted, however, that physicians capable of this approach are often constrained by the disapproval of their colleagues--this is particularly true of specialists who depend largely on referrals from other physicians for their clientele.

Freidson (1970, 1971) argued that this constraint is partly responsible for the type of medicine which is practiced. He maintained that the structure of the medical system determines the behavior of all individuals in the system. Thus, certain characteristics of the American health care system reinforce certain behaviors and suppress or extinguish others. These characteristics are: (a) fee-for-service practice; (b) self-regulation of the profession; (c) lack of observability (this is particularly true for solo practitioners as opposed to group practitioners); (d) possible sanctioning through boycott by the peer group (this applies especially to physicians who rely largely on colleague referrals); (e) the assumption by the professional associations of control over education and licensure, and therefore, supply. Freidson (1970) suggested that the medical system might be improved by limiting

the professional autonomy of physicians. In his words, this autonomy

> by allowing and encouraging the development of self-sufficient institutions. . . . develops and maintains in the profession a self-deceiving view of the objectivity and reliability of its knowledge and of the virtues of its members. Furthermore, it encourages the profession to see itself as the sole possessor of knowledge and virtue, to be somewhat suspicious of the technical and moral capacity of other occupations, and to be at best patronizing and at worst contemptuous of its clientele. Protecting the profession from the demands of interaction on a free and equal basis with those in the world outside, its autonomy leads the profession to so distinguish its own virtues from those outside as to be unable to even perceive the need for, let along undertake, the self-regulation it promises. . . . <u>While the profession's autonomy seems to have facilitated the improvement of scientific knowledge about disease and its treatment, it seems to have impeded the improvement of the social modes of applying that knowledge</u> (pp. 369-371). Italics in original.

The artificially limited supply of physicians impinges upon the freedom of choice of people in need of medical attention. This, coupled with the profession's overall autonomy has resulted in the practice of regulating or ruling patients rather than responding to the needs as they are perceived by these patients. In this connection Balint (1957) talked about "the apostolic mission or function" of the physician--a set idea of what the patient role entails, and a need to convert all patients to this view. Every doctor has "firm convictions about what a patient is entitled to expect from

his doctor. Moreover, the aim--and very often the effect--. . . . is to induce the patient to adopt the doctor's standards. . . . (p. 217)."

Freidson (1970) offered the following recommendations to improve the American health care system:

1. Step up recruitment of students from non-professional backgrounds; this will lessen the chance of prior socialization into the professional mystique.

2. Decrease the domination of medical education by the medical profession with its limited perspective.

3. Foster integration and interaction of various practitioners, including academicians and community physicians (see also Kendall, 1965 in this connection), so as to discourage isolation; make physicians more answerable to the users of their services.

4. Increase the role that the lay public assumes in determining the non-technical aspects of medical practice.

5. Establish more effective control mechanisms--including regular, mutual review of technical performance, and of economic and social practices according to the standards of both the profession and the public; finally, sanctions for deviance must be much more rigidly applied, even to the point of loss of the right to practice.

The Professional Standards Review Organizations (PSROs), legislated for Medicare and Medicaid by the 1972 Amendments to the Social Security Act could, theoretically, be a first step toward the establishment of more control over the health care system (Lander, 1974). However, Lander pointed out that PSROs or the Quality Assurance Program, the in-hospital committees which could be delegated to operate under the PSRO legislation, would--once they started operating--be concerned only with institutional care; in addition, they will be composed only of doctors and do not provide for direct consumer input.

Health insurance

Attempts have been made to improve health care, through the institution of insurance plans. One such plan was the 1965 legislation initiating Medicare and Medicaid. However, since no cost controls were provided, the enactment of these programs was followed by immediate escalation of physicians' fees and hospital costs (Bernstein, 1970; Bullough & Bullough, 1972; Spencer, 1971).

The United States is the only industrialized country without some form of national health service or insurance. Since 1970, many proposals for national health insurance have been introduced.

Some of these proposals would utilize tax incentives to encourage purchase of private insurance; others proposed benefit incentives whereby purchase of given private insurance coverage would make one eligible for additional coverage provided through tax funds. Yet another would split insurance cost between employer and employee, with the government paying for the poor and near-poor.[2] Most of the proposed bills suggested some kind of group organization for the delivery of health care services such as Health Maintenance Organizations (HMOs) or Health Care Corporations (HCCs; Olson, 1971; Eilers, 1971). At the time this report is being prepared (Fall, 1974 - Summer, 1975) various compromise measures have been proposed.

Health insurance plans become a significant aspect of the health care system because the method of third-party payment defines the users of a given facility. The type of clientele may influence the relationship between health care providers and consumers, quality of care, perception of the facility and

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[2]U.S. Social Security criteria for "poverty" and "near-poverty" for a family of four in fiscal 1969 were

	Poor	Near-Poor
Non-farm	$3,300	$5,300
Farm	2,300	4,300

Families of four with yearly incomes exceeding these figures were classified as non-poor (Sparer & Okada, 1971). With the rising cost of living these figures have been raised to where, by May 1975, farm families of four with a yearly income of $4,300 and city families earning $5,050 were designated "poor" (U.S. Department of Labor).

utilization of the services. NWHC, for example, until fairly recently, was allowed first by OEO and then by HEW to accept not only the very poor, with or without Medicaid, but also people with incomes which were somewhat higher than those prescribed by Medicaid, yet not high enough to permit the comfortable use of private practitioners (e.g. a family of five was confined to an income of $5,000 or less to be eligible). In fact, these individuals had fewer options than either Medicaid recipients or those with higher incomes.[3] An insurance plan such as the original Kennedy or Griffith bills would, on the other hand, afford every American an equal range of options.

It has been charged that none of the proposed health insurance schemes would result in much improvement for the patient because the power structure of the delivery system would remain basically unaltered (Ehrenreich & Fein, 1971). Eilers (1971) argued that the problems inherent in our present health care system--many of which affect the non-poor as well as the poor--will not be automatically removed through the mere enactment of a national insurance scheme, be it voluntary of compulsory. To represent a real improvement, such an insurance program would have to eliminate the present fragmentation of care, delays in

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[3]Following an HEW mandate, NWHC instituted a sliding-fee scale in the Spring of 1973 (see chapter 9).

receiving care, difficulties in finding primary care, rising costs, lack of medical manpower (especially in urban ghetto and rural communities), inefficient management, lack of accountability by providers, and improper utilization of facilities. It would also have to find some mechanism which would assure high quality care, as judged by both professionals and consumers, and objective means to assess this quality. Although certain of the proposed programs take care of some of these problems, none deal with all of them. Glasgow (1972) warned that the expanded use of group practice (featured by many of the suggested plans) need not rationalize the delivery system. The claims that it is more economical and provides a more efficient division of labor, greater productivity and quality of care than solo practice might prove unfounded.

Concrete changes in the health care system

Various practical steps have been taken in an attempt to alleviate the deficiencies in the health care system. In addition to OEO-funded Comprehensive Health Services Projects, decentralized facilities have also been sponsored by individual hospitals and medical centers (Ingraham & Lear, 1970; Schumaker, 1972). Sponsorship by agencies other than OEO often meant that financial eligibility requirements did not apply, that a sliding fee

scale may have been in operation from the start; that the extent and breadth of community participation varied; and that only seed money was provided.

All enabling legislation in the health field (e.g. The 1964 Amendment to the Economic Opportunity Act, The Migrant Health Act; Health Programs of Model Cities; Comprehensive Health Services for Children and Youth) has been created in recognition that health care for the disadvantaged segment of our population was inadequate. Renthal (1971, pp. 324-325) indicated that all prescribe the following elements for this new type of ambulatory care: it is for a defined population; it should be made as accessible and as complete (preventive, diagnostic, therapeutic, and rehabilitative care) as possible; it should strive for a personal relationship between provider and user; reorganization of the functions of various health professionals should make services more efficient and productive; each facility must be linked to a back-up hospital; continuity of care must be assured through efficient communication between all facilities which a given patient utilizes.

As a direct response to the shortage of physicians a variety of new types of physician support personnel have emerged such as Physician Associate, Physician Assistant, Family Nurse Practitioner, Medex, etc. (e.g. Health/PAC, 1972c; Hospitals, 6/1/71;

New England Journal of Medicine, 2/11/71). These new statuses require various levels of prior schooling and different degrees of formal training (offered mainly by medical schools and hospitals). There is no agreement as yet regarding licensure for this new type of paramedical personnel or the functions they should be permitted to carry out. Some neighborhood health centers have started to utilize paramedicals, but most have from the start concentrated on the training of paraprofessionals, such as medical assistants and family health coordinators (various terms are used by different facilities). Their training was not as formal or extensive as that required for paramedical personnel mentioned above. OEO's aims in creating these paraprofessional categories were to provide employment and career opportunities for poor residents of the centers' catchment areas and to find a means of better communication between patients and medical personnel. These individuals were assumed to understand the needs of center patients better than the largely middle class professionals and to be able to alert the centers to the special needs of their client population. It was also hypothesized that patients would feel more comfortable with indigenous personnel than with professionals who often are of different ethnic and socioeconomic background (Cowen, 1970; Hatch, 1969, 1970; Lashof, 1969; Newman, 1969).

Neighborhood health centers, if they function as they are meant to, could incorporate many of the suggested improvements in health care for the poor. They could do away with the inconveniences, indignities, and the depersonalization of large hospital clinics, and could therby perhaps influence the poor to seek medical advice more often. If they utilize the team concept which OEO mandated, centers could provide each family unit with continuous and comprehensive care by the same interdisciplinary team of practitioners. This care is to encompass the medical, dental, and psychosocial needs of the patients (Eddison & Farmer, n.d.; Parker, 1972). Freidson (1961), in a study of prepaid group practice, found that patients did respond more favorably to a demonstration project which offered truly comprehensive care by an interprofessional team than to regular group practice. Patients used two major criteria to judge care--personal interest and competence--and felt that the demonstration project provided much more of the former. Freidson noted, however, that some patients were critical of both forms of delivery; these individuals usually belonged to a higher SES and had extensive experience with private care.

Neighborhood health centers could also provide their patients, through their representatives on the governing boards of such centers, with a voice in the decision-making process. This could

lead to greater accountability to the lay public by the centers' medical personnel than is usually the case in our health care system. It should also mean that services could be shaped to suit the cultural and psychosocial needs and values of the centers' patients. It has been shown that there is a much better chance that services will be utilized if treatment and preventive measures are not antithetic to these needs and values (Graham, 1964; Paul, 1955; Saunders, 1954). Since all non-professional personnel must live in the neighborhood, patients would know at least some of them personally as neighbors--this might make for a more comfortable relationship between personnel and patients. Ross (1970) reminded us that listening to a patient, using his language, and permitting him to keep needed defenses is an art which every physician must master. The same could be said for all health personnel. Some points should, however, be considered: Is this learning simpler for individuals of the same or similar cultural and socioeconomic backgrounds? People may talk the same language, but they may be less adept at preserving patients' need for self-defense. Do patients fear that confidential communications, recorded in the medical chart, become public knowledge in the neighborhood if their neighbors work at the clinic?

Since neighborhood health centers are decentralized facilities,

they are fairly close to their patients' homes. Easy accessibility could lead to greater utilization. In addition, it is possible that a health facility located in the neighborhood will come to be regarded as a community facility. The people in the area might feel more comfortable there and, therefore, use it more frequently--not only for health care but also as a focal point from which joint action could originate when such action is deemed necessary. There are two components to the concept of decentralization: (a) political, in terms of a certain degree of autonomy from larger institutions and bureaucracies, and (b) physical environmental, in terms of the location of the facility, its physical plant, its proposed function and the use to which it is actually put, and its symbolic meaning. The building in which NWHC was located was a representation of both the health care system and the community; it formed an integral part of the relationship between the two systems, with possible functional and symbolic significance for both of them.

To probe the feasibility of these ideas, the concepts of (a) the physical environment and its role in behavior and (b) community and neighborhood will be examined in the following two chapters. The possibility that community participation in the operation of the center might help make this a "community" health care facility will then be considered.

CHAPTER IV

THE PHYSICAL ENVIRONMENT

One of the focal points of this study concerns the role the physical environment plays in the functioning of a social system and in the perceptions, attitudes and behaviors of individuals and groups. Specifically, the physical setting of NWHC will here be considered as a variable which affects the perception and delivery of health care, and its location as playing a role in the utilization patterns of NWHC patients. It is suggested that

1. the location of any service facility can encourage use by potential clients if it is easily accessible. If these clients associate either site, building, or experience in it with some negative affect, the effects of accessibility might, however, be cancelled out.

2. as a component of the total environment, a physical plant can either further or hinder the function of its users. The extent of these effects might depend, among other things, on the nature of the functions carried out in it, on one's cultural background, past experience, present expectations, available options,

and the amount of time the individual must spend in this space.

It could be hypothesized that adverse effects of a physical setting--either immediate ones such as tension which actually interferes with one's goal achievement or is perceived as doing so, or long-term attitudinal effects may be influenced by the following factors: (a) being used to poorly designed space; (b) having low expectations; (c) the perceived freedom to leave if necessary; and (d) the amount of time one must spend in this space.

It must, however, be stressed that the social and physical environments are considered as an almost inseparable totality; that any observed effects are part of the social system as well as of the physical environment. The above formulation is merely a conceptual tool to evaluate the part played by the physical environment component of the total environment.

3. Any given physical setting symbolizes certain things to those who experience it. The provision of a clinic for the poor, for example, could be regarded as either charity or a basic human right. A shabby, functionally inadequate setting might signal the former instead of the latter and could, therefore, repel rather than attract potential users. The setting can thus be significant along dimensions other than just as facilitating or inhibiting certain functions; it can affect the

achievement of basic organizational and personal goals if people with health care needs might stay away from the clinic whose goal it is to fill these needs.

As will be described in detail in Chapter VIII, NWHC's physical plant appeared cramped, inadequately lit and ventilated, and rather poorly furnished. It was periodically overcrowded because a large number of individuals often had to be accommodated in a relatively small space. To give just one example: The main waiting area of 272 square feet (Fig. 2, Appendix A) contained up to 30 chairs, yet as many as 40 patients, including several children of all ages were at times observed to be waiting for treatment, in addition to patients and staff in transit through this area. The overflow of patients stood in the passages and hovered near the desks of personnel. Did this setting influence staff functions and/or patients' perceptions of the quality of care they received at the center? Staff members spent more time at NWHC than did patients, and the former were engaged in more complex activities. Did staff, therefore, express greater awareness of the environment, in turn, have a greater effect on them as compared to patients?

NWHC occupied space in a City Department of Health building which was located in the center of the clinic's

catchment area. This building was opposite a police and fire station, adjacent to a public library, church and school, and surrounded by lower and middle class housing projects. Did this location affect utilization or perception of the center as a community facility?

The physical environment forms one of the foci of the research presented here because of a belief that:

> a major task of any attempt to conceptualize the human environment must include the relationship between the person's physical world and the world he "contructs" from it, as well as between the latter and human behavior and experience (Proshansky, et. al., 1970b, p. 28).

There is much evidence that (a) behavior and environment are linked, that therefore (b) different environments may elicit distinct behaviors in the same individual, or (c) the same environment may bring out different behavior in people of various types (e.g. Craik, 1970; Ittelson, et. al., 1970 a; Osmond, 1970; Rivlin, et. al., 1973; Wolfe & Proshansky, 1974).

It is Barker's (e.g. 1965) position that the environment compels behavior in accordance with its own dynamic patterns. Barker found less versatility in the behavior of individuals within a given behavior setting than was apparent when these people were observed in different settings. Change of individuals within a setting did not necessarily alter the character of the setting, although change of behaviors modified

this setting. According to Barker, this meant that one could predict behavior better through knowledge of the behavior characteristics of a given setting than from knowledge of the behavior tendencies of the individuals in the setting.

Barker's focus was less on the interactions of people, and more on behaviors and the settings in which they took place. The conceptualizations of the authors cited above, on the other hand, stressed a pervasive interaction between man and environment. Wolfe & Proshansky (1974) carried the interactional model one step further to suggest that the person is a component of an environment, and has environmental as well as psychological properties. In addition, the environment is linked to a social system, and the two affect each other continuously. Finally, Ittelson (1973) proposed that the man/environment relationship be characterized as <u>transactional</u> rather than interactional because:

> Man is never concretely encountered independently of the situation through which he acts, nor is the environment ever encountered independent of the encountering individual. It is meaningless to speak of either as existing apart from the situation in which it is encountered (p. 18).

The concept of a transactional relationship thus implies a dynamic process in which the identities of both man and environment are altered through this very process. Interaction does not necessarily entail such continuing effects beyond situational adjustments.

Only a few examples of the unboundedness and complexity of the transactional relationship can be offered here: Aesthetics, which vary with cultures and eras, influence building styles which, in turn, have an intricate relationship to life styles. Allocation and use of space, too, change with civilization and time--they also serve a symbolic function (Madge, 1950). Madge noted that the Victorian British tolerated exterior surfaces which the French would consider ugly, yet the insides of most French homes would have been considered inferior by the inhabitants of Great Britain of similar SES. Madge also maintained that the difference between the large, fortified home of the feudal lord and the crude, often inadequate houses of his dependents symbolized the difference in both social status and function of these two strata of feudal society.

It could be postulated that the ghetto[4] and the slum[5] of

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[4]The term "ghetto" originated in Venice during the early seventeenth century (Oxford Dictionary, 1964) to denote the quarter of the city to which Jews were confined. In the United States it has been associated largely with residential areas of cities which are occupied primarily by Blacks. It is used here to describe any area in which individuals who share at least one characteristic (e.g. income, ethnicity, religion, et.) are segregated--either by choice or by society.

[5]There has been much discussion regarding the meaning of the term "slum" (Boelen, 1972). I shall use the criteria proposed by Boelen, namely high density, poor quality of housing and facilities, low income population, and social disorganization.

our urban society serve a similar symbolic function. Thus the upper middle class Crestwood Heights resident, as portrayed by Seeley, et. al. (1956) differed from Gans' (1967) Levittowner, and neither can be compared to a slum dweller as described by Clark (1965), Handlin (1962), Rainwater (1966, 1970), or Schorr (1963, 1968, 1970). The areas inhabited by these people of different SES were progressively less exclusive and the quality and density of their dwellings decreased in desirability. On a less tangible though not less important level, self-image and the view of society at large about groups and individuals is influenced by the neighborhood and home they live in. These help symbolize their respective worth to themselves and to others. In our society this worth is diminished by poverty.

Schorr (1963) defined poverty as a "syndrome of mutually reinforcing handicaps (p. 2)"--it is more than just lack of money. He maintained that advance in any one variable brings with it changes in others, and enhances the possibility to deal with the total problem. He speculated, for example, on a progression from better housing for slum dwellers to more stable families, from that to a more optimistic world view and, therefore, greater ability on the part of the indigent individual to better his position in life, which would then, in turn, help improve his self-perception, reduce stress, and better his health.

While the relationship between man and his environment applies to all physical environments and all people, different classes of settings and different individuals or groups will present different constellations. NWHC falls into the general class of institutional environments, created for and used by a special segment of the population. In this respect it is similar to other institutions, e.g., schools and hospitals, and its design will exhibit certain institutional characteristics such as given lay-outs, floor and wall coverings, etc. The people who use these institutions have been socialized to expect these physical characteristics and to recognize certain proscribed, prescribed and permitted behaviors.

Finally, NWHC is a decentralized ambulatory health care facility serving an ethnically heterogeneous, low SES population. Past experience as well as my initial exposure to this and other clinic settings (O'Mara & Kirsners, 1972) indicated that

1. size and density, noise, privacy, overall comfort and ambience (including the existence of a playroom, the organization of space, ventilation and general appearance) and the location of the facility, are the most salient environmental variables in ambulatory clinics;[6]

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[6]Cleanliness was not included in this conceptualization. It is now impossible to reconstruct whether I expected a clinic to be clean and therefore, did not include this variable or if it was left out because NWHC appeared clean to me on first acquaintance. As will become apparent when the result of this research are presented, cleanliness was spontaneously mentioned by many staff members, though not by patients.

2. ethnicity, especially that of patients, would contribute to different perceptions of these factors; and

3. staff and patients would be affected to different degrees by these variables.

A review of the literature on ambulatory clinics revealed a scarcity of evaluative studies of the relationship between the design of such facilities, specific environmental variables, and their effects on given needs and goals of clinic, staff, and patients. This was confirmed by Olsen (1974) who noted that critiques and evaluations were usually based on assumptions and often represented rationales for given designs by linking them to specific theoretical environmental constructs. The environmental variables which are considered critical in the context of the present research have, however, been investigated in other settings and some experimental studies. While generalizations from office or home environments, for example, should not be applied indiscriminately to an ambulatory clinic such as NWHC, use of existing studies can at least indicate if (a) given environmental variables appear to have an effect on human behavior and/or physical and emotional well-being; (b) which variables have greater, and which lesser importance; and (c) whether their effects are cumulative and interacting or not.

Density, crowding, and congestion

Conceptual differences between these three terms are made: density is thought of in terms of the numbers of individuals per census tract, acre of land, or number of square feet per person; crowding as the number of persons in excess of that which is comfortable or functional for a dwelling unit (or any given enclosed space): and congestion as the condition where the number or magnitude of activities exceeds the capacity of the space in which they take place (Ittelson, et. al., 1974). These distinctions are, however, not always held separate in the literature or observed in the context of given studies. For simplicity's sake, the term "crowding" will be used here although, as will emerge from the context of the discussion, one or the other term might, technically, be more properly applied.

The term "crowding" encompasses many meanings and phenomena; it has many concomitants:

1. Crowding can be thought of as a physical phenomenon: it can be measured objectively; definite standards are set for the optimal number of persons in a given space. This number will vary with culture and function of the area (e.g. Ittelson, et. al., 1974; Manning, 1965).

2. The perception of crowding is a cultural and social phenomenon: not only do various cultures and social strata define it differently, they react to it in diverse ways. There are cultural expectations, and within each culture, various groups will feel crowded in some conditions but not in others. Dore (1958) and Schmitt (1963) showed, for example, that the Japanese and Hong Kong Chinese, respectively, showed a greater tolerance for crowding than did Americans. Yet it is probably reasonable to assume that more tradition-minded families among the Japanese and Chinese both in Asia and the United States will differ in this respect from those who are further removed from traditional kinship structures. The reason for this is that the primary group which lives together is the extended family for the former and the nuclear family for the latter.

3. Crowding is an economic and political phenomenon: in any society individuals of higher SES and more power have a better chance to avoid being crowded, unless it is by choice (Esser, 1972); they generally command greater control over space and freedom of movement in it.

4. Crowding is a psychological phenomenon: some individuals might feel uncomfortably crowded in a space which others would consider sparsely populated. This means that

why or when one feels crowded is, in addition to being culturally and socially defined, also a function of personality variables. In this context, past experience, present expectations, and the perception that the presence of others interferes with the achievement of one's goal-directed activities and freedom of choice will all contribute to the feeling of crowdedness (Proshanksky, et. al., 1970b).

5. Crowding has physiological effects: Various pathologies, often leading to the death of animals, have been attributed to crowding (Calhoun, 1970; Christian & Davis, 1964; Hall, 1969). Man alone among animals can survive in crowded conditions for more than one generation. He does this through various adaptive mechanisms (e.g. the shutting out of excessive stimuli from consciousness) which might be more or less pathological (Esser, 1972).

It appears, then, that crowding is not a clearly defined concept, and that its effects on human behavior are poorly understood (Zlutnik & Altman, 1972). The conceptualization offered by these authors

> involves a multi-dimensional set of interlocked properties, such as (a) situational/environmental characteristics of high density of people per unit of space for long periods of time, in environments where resources are limited; (b) certain interpersonal events where persons are unable to adequately control their interactions with others,

> and/or where the psychological and physiological costs controlling interactions are high; and (c) personal/subjective events where there is a network of personal and subjective feelings reflecting an inability to control interpersonal exchange, discrepancies in expectations, and incongruities with past experience (p. 50).

Saegert (1973) noted that, while operational definitions of crowding employed by various researchers differed, all included high density. She suggested, however, that this variable be considered in terms of two separable components: the number of people in a given space, and the amount of space available to each person. Either of these two components will make different demands on, and necessitate different strategies by the individuals in the crowded situation: Increasing the number of people in a given space brings with it greater cognitive complexity for indivuduals because they must sort out stimuli (e.g. acoustical) relevant to themselves from a larger number of such stimuli. Decreasing the amount of space per person creates a constriction of movement and greater need for the coordination of activities of people in this space. Interaction of these effects is possible.

NWHC employed and treated individuals of different socioeconomic and cultural backgrounds. Like any large group, they could be expected to represent a wide range of personalities. Their roles at NWHC differed, as did the extent of exposure to

the clinic under crowded conditions. If, as the studies reviewed here seem to indicate, perception of and reaction to crowding do, indeed, vary with culture, personality, past experience, expectations and functions, then differences between and within the various groups involved with the clinic should appear. As the preceding theoretical discussion of crowding indicates, it is difficult to separate the influence of any given phenomenon or variable on the occupants of a specific environment. However, if one conceptualizes the setting of NWHC in terms of its being an heterogeneously populated work/health-service environment with waiting and traffic as part of it, then (a) goal achievement, (b) expectations, and (c) possible physiological and psychological effects of lack of space and crowding could be considered as the most salient points for this environment.

Goal achievement--can be thought of in terms of

1. the institutional goals of rendering health care to individuals who need such care, and training local residents for positions in the health care system;

2. the goals of staff, i.e. the ability to carry out their assigned tasks and, in some cases, learning new skills; and

3. the patients' goals to receive competent care.

Frequent crowding at NWHC could subvert the institutional

goals in several ways. First, crowding has been found to blur authority patterns (Schorr, 1970; Suttles, 1968). Although these findings come from housing studies, it seems reasonable to assume that the same might hold true for work environments. As will be shown later, lack of privacy--although not necessarily due to crowding--does have such effects (Schwartz, 1972). It could be postulated that efficiency at the clinic could be impaired without clearly defined authority patterns.

Second, patients who cannot find a seat while waiting for service, or who are kept waiting too long might leave before seeing any health care provider (Roth, 1972), or may not even bother to come to the clinic at all, except in real emergencies (Neutra, et. al. 1969). In either case, NWHC could not fulfill its stated goal of rendering comprehensive health care. Neutra and his coworkers, in designing clinics, worked on the assumption that people are more likely to seek preventive care--one important part of comprehensive care--in pleasant surroundings which permit maximal freedom of movement and utilization of waiting time in a manner most meaningful to them.

There is, however, another component of crowding which might be salient in this context: The view of a crowded waiting room as reinforcing the value of the services provided--it offers a kind of social affirmation of quality through competition for services. This is probably operative when one views the crowded waiting rooms of private practitioners

Arranging chairs or benches in tightly packed rows in the manner of most clinic waiting rooms, on the other hand, may do less to reiterate the value of these services. It thus appears that the ambience of waiting rooms is not only a function of crowding per se, but rather crowding coupled with the way the room is furnished and seating is arranged.

Finally, the training of paraprofessionals could well suffer through a lack of space. In the absence of studies regarding the effects of scarcity of space on the training of health-care personnel, I shall work on the assumption that such training may be hampered because a lack of space makes it convenient for physicians who are not committed to the concept of meaningful roles for paraprofessional or paramedical personnel in health care to avoid sharing their functions with these new professionals. It is probable that physicians who are strongly in favor of these new roles will find means to offer medical assistants [MAs] or nurse practitioners [NPs] an opportunity to utilize their training. Similarly, those doctors very much opposed to these innovations in health care delivery will find a way to circumvent these innovations, regardless of the physical setting. Space could, however, influence the middle group to go in one direction or the other. In the absence of sufficient space the training of new health care personnel will be impeded because

there simply is no place in which to practice new skills. Thus the MA might have received training in taking weights, temperatures, blood pressures and medical histories, but she needed an office to carry out these functions. All treatment rooms at NWHC were occupied by physicians, there was no space for MAs to function as paramedics (see Fig. 2, Appendix A). In the absence of practice, training could be forgotten and, therefore, wasted. This meant, then, that one goal of these staff members as well as of the organization will have been undercut.

There is evidence that the other staff goal, that of task performance, can be hindered by crowded conditions. Manning (1965) noted that the basic requirement for offices was sufficient space for employees to carry out their functions in a satisfactory manner. He observed, however, a positive correlation between increasing space beyond this minimum requirement and (a) the status of its occupants (see also Rosengren & DeVault's 1970 Hospital Study) and (b) the perception of an enhanced aesthetic quality of the space itself, as well as of the work performed in it. This last point could be important both in terms of NWHC staff perception regarding the worth of their work and patient perception about the quality of this work.

One laboratory study (Freedman, et.al., 1971) found no effects of density on the performance of various tasks. Since their subjects were simply seated in a room, performed their tasks, and left again, without any need to move about or get in each other's way these findings might, as the authors point out, only fit this particular situation. In a setting like NWHC, on the other hand, there is continuous movement, constant traffic of staff and patients across areas in which patients wait and many staff members perform tasks of varying complexity, question patients and convey information to them. If staff performance suffers, it would interfere with both the staff goal of task performance and patients' goal to receive adequate care.

Achievement of this patient goal is also made more difficult because large numbers of waiting patients have been reported to induce physicians to hurry their examinations (Roth, 1972). This point also illustrates that separation of goals into those of institution, staff and patients can be no more than a conceptual tool: If physicians do not examine patients properly, they do not perform their task in an approved manner, patients' health might suffer, and the most important goal of any health care facility can, therefore, not be met.

Expectations--have been shown to be important in one

laboratory study. Baum & Greenberg (1975) reported that subjects who expected a crowded condition sought social isolation, rated others in the room and the room itself more negatively, and expressed feelings of discomfort more often than did subjects who expected a non-crowded condition, although room size and the number of occupants remained constant in both conditions. Saegert, et.al., (1975) reported that expectations appeared to influence their subjects' reactions in field settings.

In general, one could postulate that rising expectations accompany improving living standards and the virtual disappearance of really pathological work environments (although not living quarters) in industrial nations. This would mean that greater importance is now assigned to various elements of the physical environment which would have been considered luxuries in the past. Manning (1965) reported, for example, that adequate, attractive washrooms were considered exceedingly important in the work environments he studied; this was especially true of women. It could also be assumed that newly trained staff members at NWHC might expect their work environment to reflect their upgraded professional status. A poor environment could feed into self-doubt.

On the other hand, the expectations of individuals, both patients and staff, who are used to environments of hospital

emergency and outpatient clinics may not be too high (Kirsners & Waters, 1972; O'Mara & Kirsners, 1972). McLaughlin (1975) who did not report on the SES of his respondents, did find, however, that most of these individuals voiced dislike of small waiting rooms or having to wait in hallways. It is possible that NWHC's patients were used to overcrowded conditions in other settings too. Most of them probably lived in crowded housing because they were poor. While this has been shown not to be very important or detrimental for some groups as long as they had their extended families around them (e.g. Gans, 1962; Schmitt, 1966; Whyte, 1955; Young & Willmott, 1957), other investigators associated psychosocial and/or physical pathology with crowded and deteriorated housing (e.g. Bullough & Bullough, 1972; Clark, 1965; Loring, 1956; Rainwater, 1966; Schorr, 1963, 1970; Sigerist, 1943; Suttles, 1968; Wilner & Walkley, 1963). It is difficult to hypothesize whether these observed ill effects of crowded living conditions are accompanied by apathy and low expectations regarding other environments and services they can expect or are entitled to on the part of these people. But at least some such effect is possible.

Four points could be noted in this context. First, Cassel (1972) postulated that if people are prepared for a situation and remain in it long enough they adapt, and the situation,

e.g. crowding, therefore becomes less harmful. Wohlwill (1972), on the other hand, argued the possibility that, despite adaptation, prolonged exposure to physical settings with extremes in given environmental variables may cause long-term ill effects. He mentioned as one example the subway commuter who seemingly adapts to crowds, heat, noise, and discomfort. But noted that we do now know whether years of using the subway does not bring about a lower frustration tolerance or a higher arousal threshold in these individuals. He cited Dubos (1965), who offered physiological evidence for limits in human adaptability, and Wolpert's (1966) theory that the migratory behavior of man could be a response to stress emanating from both the social and physical environments.

Second, it has been suggested (e.g. Loring, 1956; Wolfe, 1975) that both cultural differences and the social roles which are enacted in a given space should be included when one examines the degree and effects of crowdedness. In this context Loring mentioned that Americans of various SES and cultural backgrounds tolerate density quite well in emergencies or on such special occasions as vacations. Perhaps clinic settings are another such occasion?

Third, congruence between expectations and beliefs on the one hand, and experience on the other hand is important. Michelson (1970) differentiated two types of congruence: mental con-

gruence and experiential congruence:

> Mental congruence exists if an individual thinks that particular spatial patterns will successfully accommodate his personal characteristics, values, and styles of life. . . .
>
> Experiential congruence, on the other hand, deals with how well the environment actually accommodates the characteristics and behavior of people (p. 31). [Italics are mine.]

What did the occupants of NWHC expect and believe about their environmental needs in the clinic, what did they actually experience, how did they behave, and how did expectations influence experience and behavior?

Finally, the individuals involved with NWHC differed on various dimensions: Their cultural backgrounds differed, as did their roles, SES, and ages. These differences might, in turn, create different perceptions and expectations regarding such environmental variables as crowding, noise, privacy, and comfort. Yet these people were in close spatial proximity. Some health care providers may not hesitate to discuss intimate details of a patient's physical or mental condition in the presence of others; some patients may converse loudly right next to a staff member trying to do some work; in each case one can assume that the people perceive only their own need without regard for the needs of others--this could easily be a cause of conflict between patients and staff or between various staff members.

Physiological and psychological effects of crowding--have been shown to be dysfunctional in many animal studies (e.g. Calhoun, 1970; Christian & Davis, 1964; Hall, 1969; Marsden, 1972). The evidence for man is much less clear-cut (e.g. Ittelson, et.al., 1974; Saegert, 1973; Saegert, et.al., 1975). Ittelson, et.al. (1974) and Saegert, et.al. (1975) cited empirical evidence of altered behavior in human response to crowding which included greater hostility, aggressiveness, withdrawal, anxiety, feelings of inadequacy, skepticism, sadness, less social affection, and disruption of ongoing activities with increased crowding. Indications are that the character and extent of altered behavior within given cultures and social groups might depend on such factors as sex, age, mental health, as well as one's needs, moods, and goals at a given time. It also appears that there are psychological aspects to space and number that are non-mathematical: Four people in a room which is four times the basic size and one person in a room of the basic size present problems of a different nature since four people must now interact and set up a social system--none of this is required in the one-person room (Wolfe, 1975).

It should be noted, however, that these effects emerged from different studies--no universal crowding reaction has, in fact, as yet been uncovered. Any reaction noted in studies

so far has been situational. All that can be stated with any degree of certainty at this stage is that crowding is a multi-dimensional variable. Perception of crowding and tolerance for it differ with cultural, social and personality factors, as well as the situation in which it occurs. The actors' past experience, present expectations, perceived freedom of choice and ability to pursue goal directed activities also play an important role. Crowding is thus a significant variable for the present study. While crowding can be looked at in a variety of ways, the most useful one from the transactional point of view are the perceptions and expectations of crowding, as these relate to the way people use and perceive the space at NWHC and the health care they render and receive in this space.

Noise

Wohlwill (1972) and Ittelson, et. al. (1974) commented on the scarcity of systematic research on the effects of noise other than in industrial environments. The industrial studies reviewed by Bell (1966) indicated that noise, other than the excessively loud sounds which can cause hearing impairment, had apparently no lasting effects on the performance of simple and routine non-auditory tasks in industry; efficiency in more in-

tricate work could, however, be lessened. While habituation and adaptation can diminish negative effects of noise, fatigue caused by the need to process noise for possible meaning will increase these effects. Finally, different sources of noise will be perceived as annoying at home, at work, and outdoors.

Farr (1972) defined noise as "unwanted sound"--it is, therefore, inherently subjective. He noted that the absence of certain expected sounds can be as unsettling and annoying as the presence of unwanted sounds. The annoyance value of sound has been characterized by Kryter (1950, as quoted in Farr, 1972) as possessing five qualities: unexpectedness, interference, inappropriateness, intermittency, and reverberation. To these Farr added origin. Thus, sound made by oneself is less annoying than that which comes from another person. Farr, a physician, maintained that noise, even if not loud enough to impair hearing acuity, can increase the effects of certain infectious diseases, cause psychosomatic illness, and bring about such psychological reactions as anxiety and nervous tension because it is unwanted sound.

Our social norms prescribe a quiet environment for health care facilities. The implicit assumptions are that noise interferes with patients' rest and relaxation, adds stress to the pain

and anxiety with which a sick person might have to cope--all of which could retard recuperation. The often complex activities of staff, too, would seem to require an absence of noise.

If noise is unwanted sound, then NWHC's clients and staff, because of its cramped quarters, can be assumed to be exposed to more noise than an objective decibel measure of sound would indicate: The tension of patients waiting for service in crowded noisy surroundings can be heightened by the need to be vigilant in order not to miss hearing one's name being called and, therefore, one's turn to see an health care provider (Neutra, et.al., 1969). A question asked by a patient of a staff member might intrude upon the thought process of another worker seated nearby (Manning, 1965). The sounds of telephones, fans, typewriters, conversations, children, etc. could elicit adverse emotional reactions in patients. As a result, the noise level of NWHC might (qualitatively) be perceived in a negative fashion. This agrees with Klausner's (1971) suggestion that reaction to noise is socially determined because it depends on (a) perceived function and usefulness, i.e. the meaning attributed to it, (b) controllability, and (c) intrusion upon ongoing social activities or aural privacy. To the extent that the individuals involved with NWHC differed in these respects, the annoyance value of noise at the clinic would vary. Klausner

maintained that this annoyance value does not yield to habituation. Only redefinition of the meaning of any given noise can lessen the amount of annoyance.

Privacy

Privacy is not the antonym of crowding; neither is it the same as isolation, unless this isolation is by choice in search of privacy (Ittelson, et al., 1974). Privacy has been defined as:

> The status or condition of being withdrawn from the society of others, or from public interest (Oxford Dictionary, 1964, p. 1586).
>
> The individual's freedom to choose what he will communicate about himself and to whom he will communicate it in a given circumstance (Ittelson, et al., 1974, p. 152).
>
> . . . the claim of individuals, groups or institutions to determine for themselves when, how and to what extent information about themselves is communicated to others. Viewed in terms of the relation of the individual to social participation, privacy is the voluntary and temporary withdrawal of a person from the general society through physical or psychological means, or, when among larger groups, in a condition of anonymity or reserve (Westin, 1967, p. 7; as quoted in Ittelson, et al., 1974, p. 154).

Hall (1969) talked about the privacy of the ego in addition to, or as part of, physical, social and sensory (visual, olfactory, auditory, tactile) pricacy. Intrusion into any of these is possible; various cultures regarded different behaviors as intrusive, but most held certain parts of the self and/or their

immediate environment as inviolable. Intrapsychic balance and interpersonal relationships required the right amalgam of privacy and companionship (see also Ittelson, et.al., 1974; Westin, 1967; Wolfe & Laufer, 1974). Norms to assure privacy for individuals, the family or any other social group therefore develop in most societies and social organizations. Where the style of living (family structure, type of housing, or institutionalization) makes physical privacy hard to achieve, means to provide escape from continuous interaction through physical and/or psychological withdrawal usually evolve (Glaser, 1972; Goffman, 1961; Hall, 1969; Ittelson, et. al., 1970a; Sommer, 1969; Rivlin, et. al., 1973).

Schwartz (1972) suggested that opportunity for periodic privacy serves to reinforce selfhood and helps preserve social systems because continued interaction is unbearable for most people. All stable social systems must develop norms regarding privacy, otherwise withdrawal brings with it intrusion and espionage. Where structural provisions to afford privacy are lacking in a work setting, any withdrawal will be considered as "hiding", and therefore suspect. One is penalized for withdrawal by others, and one feels guilty about having withdrawn. The physical plant helps regulate interaction; it represents a physical institutionalization of norms. Ideally, it should

afford opportunity for both interaction and withdrawal; it also reflects and preserves hierarchial order of the organization.

NWHC offered no place for withdrawal to seek the periodic privacy which is said to help maintain such a well-balanced social system and to strengthen the ego. With very few exceptions, it was impossible for either patients or staff to achieve physical, social, or sensory privacy. Did the individuals involved with NWHC perceive this lack of privacy? How did they react to it? Were there any differences based on ethnic background, status, and perceived control over the environment? Did the absence of private spaces for staff, which would permit evasion of organizational rules without subverting them actually lead to the subversion postulated by Schwartz (1972) and Merton (1964, as cited by Schwartz)? If so, what were the effects of this on the NWHC system? Privacy can thus be seen to be of paramount concern in this work/health-care setting.

Laufer, et. al. (1973) suggested that privacy is multidimensional. They postulated nine dimensions for viewing privacy, several of which appear to be particularly salient for a study of NWHC: First, certain tasks are better performed in private, either because of the nature of the task which might require freedom from distraction, or due to personal preference (task-oriented dimension). Second, some places are more conducive

to privacy and come to be associated with it because of activities, such as physical examinations which, in our culture, are meant to be carried on there (ecological-cultural dimension; ritual-privacy dimension; in this context see also Kira, 1970 and Madge, 1950). Finally, past experience helps the individual to gauge the consequences of his behavior for both the present and the future. It helps determine how much of oneself one can safely reveal, in what form and to whom. NWHC patients had to divulge information about themselves to some staff members, they may not have wished other individuals to hear this information--yet the physical setting did not usually permit the patient control in this respect (biography-history dimension; control dimension).

This absence of auditory and visual privacy could also interfere with patients' and staff's sense of self-integrity. Schwartz (1972) stated that this integrity could only be maintained if one is able to close a door between oneself and the rest of the group because only thus can one escape the group-imposed role (and, thereby, group identity) for a while. Doors also serve as boundaries between the self and others--violation of this boundary symbolizes a violation of the self. Norms regarding intrusion vary with interpersonal relationships. Yet NWHC provided few doors which could be effectively interposed

between the individual or a self-chosen group and the rest of the people. It should be noted here that Schwartz's comments regarding the importance of doors were at some variance with those of Hall (1969) who maintained that the need for doors, especially closed doors, is culturally determined. Since both NWHC patients and staff were composed of individuals with a variety of cultural backgrounds, it would be interesting to see how they reacted to the scarcity of private spaces, equipped with doors, at the center.

Comfort and ambience

For the purpose of the present study, "comfort" is defined as the perceived effects of the following interacting environmental factors at NWHC: The organization of space, the existence of a playroom, lighting, temperature, ventilation, and the aesthetic quality of the enclosed space. This definition is, to some extent, arbitrary; it is, however, also based on the findings of Vielhauer (1965, cited by Kasmar, et. al., 1968) and a conceptualization by Fitch (1970).

Vielhauer (1965) found that physical organization, size, light, temperature, ventilation, and aesthetic appeal were the significant factors when subjects rated pairs of architectural adjectives for the construction of an Environmental Description Scale (EDC).

Fitch (1970) suggested that (a) light, access to windows, temperature, and ventilation cannot be separated from man's metabolic processes and, therefore, well-being. (b) Metabolic processes influence perception which, in turn, forms the material and experiential base for aesthetic reactions. (c) While the human body has definite physiological limits for given light intensities, temperatures, etc., ranges which are considered comfortable or even bearable differ with cultures and individuals. Finally, (d) stressful intensities of these variables preclude aesthetic reaction to the physical environment. Barring excessive stimulation (or lack thereof) however, these characteristics of the physical environment, modified by individual propensities and cultural background, will influence aesthetic processes.

Evidence regarding the aesthetic needs of users of various environments, or the effects of aesthetic variables on functions, moods, perception, etc. are meager indeed (Gutman, 1972). Maslow & Mintz (1972) found that college students were significantly more apt to see well-being and energy reflected in faces on photographs if these were presented to them in a beautiful rather than an ugly room. These effects did not decrease over time--there was no adaptation. In addition, experimenters expressed dislike, complained of tiredness and headaches, and finished testing their subjects more quickly when working in the

ugly room (Mintz, 1972).

While, as Gutman (1972) pointed out, one cannot be sure that either the assessment of beauty and ugliness or the effects of the different aesthetic surroundings can be generalized to different segments of the population (e.g. architects, blue collar workers), these two studies appear to demonstrate that judgments of aesthetic qualities in one's surroundings affect perception of, and reaction to, individuals and activities in these surroundings.

Kasmar, et. al. (1968), on the other hand, failed to find any clear-cut effects of the environment's appearance on either person-perception or on the mood of their respondents who had come to a psychiatric outpatient facility for the first time. It appeared that the degree to which perception of the qualities of the psychiatrists were influenced by the environment depended on the behavior of the physician as well as on respondents' age and sex. Thus some interaction effects for room by age and/or sex were found, but no main effect of the rooms alone. These authors suggested the following possible explanations for the differences in their findings and those reported by Maslow & Mintz (1972) and Mintz (1972): Different reactions when encountering a person and a photograph; the effects of age; and possible differences in priorities, and therefore reactions, of individuals

who sought psychiatric help and students who participated in an experiment. Yet Holahan & Saegert (1973) found some indications that a more attractive psychiatric ward generated an improved atmosphere which could lead to positive therapeutic effects, if only because a dismal environment has depressing effects. As for non-psychiatric patients, visitors and users of hospital emergency room (ER) and other OPD clinics expressed a desire for cheerful and warm interiors and objected to shabby looking furniture (McLaughlin, 1975).

In summary it can only be said that we simply do not know enough about the effects of aesthetically pleasing or displeasing environments on emotions and behavior--nor have we established what is considered beautiful by different people. Anthropology and history tell us that the concept of beauty is perhaps among the most culturally and socially determined concepts. Yet it is probably permissible to advance the proposition that few segments of our population today would consider a cramped, dismal looking waiting room of a clinic as aesthetically pleasing, or that such an environment might not, at the very least, dampen their spirits somewhat and affect the ambience of the place in a negative manner.

But even if aesthetic qualities of a work/health-care setting should prove to be of relatively little importance, the

same will probably not be true for the organization of space in such an environment. In a setting like NWHC, the questions one might wish to ask are: How does the physical layout influence the organizational functions of the system's actors? How does it affect their emotional well-being and assessment of both the clinic's and their own functions and realization of goals? What do staff and patients expect from a neighborhood health center, how does the spatial reality of NWHC affect these expectations, and how do they cope with these realities?

Once again, not much empirical evidence for ambulatory health care facilities could be found to help answer these questions. There is some indication that the organization of space at hospital ERs and other OPDs is one factor which helps staff control patients by placing them in treatment rooms where they can be "forgotten" or by deliberately overlooking them in crowded waiting rooms (Roth, 1972).

McLaughlin (1975) reported that his respondents expressed a need for information and direction when entering hospital clinics. These individuals also felt that waiting areas should vary with the size, anxiety level, and kind or degree of illness of their populations, as well as with anticipated waiting time. Lighting and materials should help create a relaxing and reassuring atmosphere. Such areas should offer opportunities for both interaction and privacy. Their furniture should be geared

to the age and physical status of the people using it. The furniture must remain comfortable regardless of how long people have to use it, and it should have shapes which do not look disarrayed when moved around. Finally, a desire for easy access to telephones, food and drink was voiced.

Spatial organization has been hypothesized to possess therapeutic qualities and to help furnish positive or negative associations which feed into perceptions of the activities being carried out in these spaces (Field, 1971; Neutra et. al., 1969; Sivadon, 1970). The experience reported by people who had been hospitalized in acute care facilities (Kirsners & Waters, 1972) confirmed this to some extent; it also reaffirmed the inherent need to look at the man/environment system in an holistic transactional manner.

These former hospital patients reported, first, that hospitals had been "known" to them even if they had no prior personal experience with any such institution; they therefore had certain expectations before they entered the hospital. Some expected and wanted large, impersonal, and aseptic looking buildings--they equated this with progress in medicine. Others preferred the smaller, older, more intimate hospitals which seemed to promise more personalized care. Second, a given hospital began to transmit cues for many incoming patients as soon

as it came into view. Its looks, location, the streets around it, its grounds--all influenced perceptions and confirmed or altered expectations. The process continued from the minute they set foot into the hospital to the time they left it. They somehow felt that interactions between appearance and lay-out of given hospitals on the one hand and their reactions to their hospital stay continued to operate although it was usually quite impossible to find simple cause-and-effect progressions. Third, most respondents complained about the interminable waiting hospital patients encounter: Waiting for somebody to answer your bell, waiting for treatment, waiting on a stretcher or in a wheelchair in front of X-ray or some other laboratory, waiting to be prepped for OR, etc. Waiting exaggerated feelings of anxiety about their illness; it also engendered a feeling of helplessness, of having been forgotten, of a lack of control over things--and none of it was helped by the environment. Fourth, many respondents reported the need for orienting cues from the environment. This was somehow tied in with experiencing a sense of insecurity and difficulty in maintaining one's identity. It was as though being able to orient oneself in a given space, to determine possible routes of mobility and (perhaps subconsciously) even of escape, to know who and what unfamiliar people and places were, would

increase one's sense of security and reality. Finally, the physical setting was reported to contribute strongly to feelings of de-individuation among many of these people.

De-individuation, which was defined by Festinger, et. al. (1952) as the condition where "individuals are not seen or paid attention to as individuals (p. 382)" is nowhere more marked than in large waiting rooms of any kind, and is perhaps most damaging among anxious individuals in the waiting rooms of clinics. One of the repondents in the study by Kirsners & Waters (1972) related an incident which serves to illustrate this: She had been waiting for hours in a crowded waiting room of a hospital emergency room without anybody taking any notice of her. In a fit of impatience she got up to leave, but thought immediately better of it and turned back to her seat--only to find it gone. The line of waiting patients had simply moved up--"it was as though she had never been there, and nobody cared (p. 36)." She felt infinitely replaceable. This incident would really seem to objectify the meaning of a "line of chairs" or a "line of people"--they are all the same.

Observing the waiting rooms of various hospital outpatient departments in connection with a preliminary study of NWHC (O'Mara & Kirsners, 1972) we had the following, purely subjective

impressions:[7] We noted that the only waiting room which had an arrangement of low tables with benches and chairs around them presented a much more relaxed, friendly and less anxiety-provoking atmosphere than waiting rooms with the usual tightly packed rows of chairs. In the former people looked around them and smiled at children and each other, they talked to one another and got up periodically to stretch their legs, look at wall decorations and signs. We were struck by the inherently constricting effects in both physical movement and social interaction when patients must sit in rows of chairs. They simply did not look at each other or got off their seats unless their turn for treatment had arrived or they wanted to leave for some other reason. On the day we visited it there were fewer people in the waiting room with the tables; many of the benches and chairs were empty. At this point I cannot translate the space into the number of straight chairs arranged in rows it would accommodate because this was not what we were then looking at. This waiting room simply "felt" more spacious and less constricting.

Osmond's (1970) characterization of buildings as having

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[7]During the periods of observation we each made notes of our impressions independently. These notes were compared only after completion of all observations. It then became apparent that our impressions were, on the whole, very similar.

sociofugal or sociopetal qualities comes to mind in connection with these observations. Sociofugality--the qualities of the physical environment which hinder the formation of interpersonal relationships, and sociopetality--the environmental properties which encourage such relationships, are inherent in the design of space and arrangement of furnishings. Thus Olsen (n.d.), for example, noted that dialysis patients whose chairs and artificial kidney apparatus were placed in long rows experienced psychological discomfort because this arrangement did not permit easy interaction. Sommer (1969) related that both brief and sustained social interactions of inhabitants of a geriatric ward increased drastically when chairs were arranged around small tables in the day-room instead of being placed along the walls. Other highly sociofugal buildings listed by Sommer (1974) were mental hospitals, prisons, and airports. To these one should add hospital OPDs and other clinics.

In addition to sociofugal or sociopetal qualities of a work/health-care setting the functional requirements of its inhabitants must be considered. Waiting rooms without adequate seating facilities, an inadequate number of treatment rooms and offices, or offices which do not provide auditory privacy to keep communications confidential are all probably dysfunctional

from a systemic, social, and individual perspective. I should like to suggest that this last point is of particular importance in a comprehensive health care facility where the need for confidentiality and privacy is often acute. Roth (1972) offered some conformation in reporting that ER personnel often complained of a lack of secluded space in which to notify relatives or friends that the person they had brought to the ER had died. Wells (1972) suggested that a building can be regarded as a catalyst, but one which --in contrast to chemical catalysts--can bring about many rather than one specific reaction between substances (in this case, people). Thus, certain staff members of NWHC interacted with patients closely but had no office space at all. This might affect the feelings, social behavior, self-concepts, and attitudes toward NWHC of both these employees and patients.

Parts of NWHC--especially the clinic area (see Fig. 2, Appendix A) can be conceptualized as an open-plan office. Such a lay-out might, according to Manning (1965) be more efficient because it permits better ventilation, lighting, and communication between various sections. This latter affords greater opportunity to form relationships with members of organizational units other than one's own. It also requires less space per person. Small work areas, on the other hand, lead to greater

cohesiveness of the group and a feeling of belonging which, in turn engenders greater satisfaction with work and, therefore, efficiency. But, Manning warned, the advantages and disadvantages of these two types of office lay-outs probably depend on what the individuals in these spaces are used to, as well as on their functions. Manning's formulations lead to the question whether an open-plan office is the most suitable one for a health care facility, especially if some of the advantages mentioned by him, such as better lighting and ventilation, are absent.

We know little about the optimal intensities of light, ventilation, and temperature outside the industrial context (Wohlwill, 1972). Rapoport & Watson (1972) examined the standards set by a number of nations for certain within-building environmental factors. They found both inter-and intra-cultural differences in these "hard," i.e. objective, measurable requirements. Preferences regarding room temperature and amount of light, how people moved about and used space were all influenced by cultural background, personality factors, values, adaptation, and by the activities carried out in the given space. In addition, individuals were often found to sacrifice a given environmental requirement in order to fulfill another. These authors, as well as Denton, et. al. (1973) did not believe it profitable to conceptualize the physical environment,

environmental needs and evaluations in terms of the "average man." Instead, Denton and his co-workers suggested that it is more useful to concentrate on the variety of needs of a building's users.

In discussing the visual and thermal environment of offices, Manning (1965) listed the following basic requirements:

1. Good lighting--this is both objective and subjective. While one can determine the former (e.g. the amount of light necessary to facilitate given functions; the absence of glare), we lack the tools to investigate the latter.

2. A view, a place where the eyes of the office worker can get some rest from the task at hand by focusing on a more distant view. An outside view is usually considered preferable in this respect since there is an expressed need to be able to look out-doors. In addition, most people believe they can see better by daylight than with aritificial illumination. This belief has been found to be based on prejudgment rather than actual response to an existing environment. Windowless environments do, however, need more exacting standards of lighting and ventilation.

3. Good color--this, too, has objective and subjective aspects. The extent to which given colors reflect light and thereby contribute to the illumination of an area can be

objectively measured; personal taste is a subjective variable.

4. A comfortable thermal environment depends on the combined effects of temperature, humidity, air movement, and ventilation.

Griffitt & Veitch (1971) reported that, during a laboratory experiment, social relations and perception deteriorated under conditions of high density and temperatures. Subjects were less likely to express attraction for individuals of the same sex if the room was hot and crowded than under more comfortable conditions. A hot and crowded environment also elicited more negative responses on a semantic differential scale. It is possible that the frequently hot and crowded clinic area at NWHC could cause staff and patients to be irritable and rude--not the most conducive behaviors for fostering comprehensive health care.

Depending on their particular illness and probably age, the temperature requirements of patients might vary, these could also differ from the requirements of staff (in this context see Olsen, n.d.) It is reasonable to assume that poor ventilation made many occupants of NWHC uncomfortable. If it contributed to headaches and inertia among staff, it may also have interfered with their work.

Lack of comfort and a generally dismal appearance could

thus be postulated to be dysfunctional for a clinic like NWHC. But here, as with other environmental variables, reactions and preferences might be greatly influenced by cultural background, role, etc. Manning (1965) commented, in connection with his study of offices that, generally (a) people have a tendency to "prefer" that with which they are most familiar; (b) inhabitants of a given environment are not necessarily the most qualified judges of what is best or most efficient for them; (c) age, sex, status, and past work experience influence an individual's reaction to a given work environment; and (d) the general trend in offices is for higher standard in comfort.

Site

The location of NWHC is relevant in the context of a discussion of the physical environment because location of a given building is, by definition, a variable of the physical environment. In addition, location, utilization, and symbolic aspects must be incorporated in any holistic treatment of the man/environment relationship.

Jehlik & McNamara (1952) found that rural residents who lived closer to medical facilities used these more often and reported fewer days of illness requiring bedrest than did respondents with less easy access to medical help. The authors

noted that greater distance made it more likely for preventive care to be neglected; care was usually only sought when acute illness occurred.

Similar points were stressed by Endicott (1975) in relation to health care facilities for the urban masses, especially the inner-city poor. These poor suffer more chronic illness, spend more sickdays in bed, are hospitalized more often, and remain in the hosptial longer than do residents of higher SES. Endicott, therefore, believed that offering decentralized and comprehensive health care facilities, such as neighborhood health centers, to this segment of the population is not only important from a medical and humanitarian point of view; it is also a sound economic practice on the part of government. A second important function of neighborhood health centers which Endicott mentioned is their service as liaison agents between the community, the health care system, and the political system.

Weiss, et. al. (1971) observed that organization of the medical care system interacted with the distance of patients' homes from care providers to produce a distinct relationship between distance and utilization. Thus a majority of users of a prepaid comprehensive care program in a metropolitan area (especially those under 18 years of age) used the one of three available clinics which was closest to their homes. This

relationship between proximity to one's home and utilization of a health care facility did not, however, hold true for visits to private practitioners.

Examining use of neighborhood health centers in urban areas, Borkow (1973), Hillman & Charney (1972), and Salber, et. al. (1972) all reported that easy access to the center was one important factor in its utilization. Other significant elements noted by these authors were:

*The presence of a hospital near the center caused patients to use the hospital's OPD as well as the center; patients who lived further away from the hospital, however, were more likely to use the center only (Borkow, 1973).

*Good quality of care and attitudes of center personnel increased satisfaction with, and use of, the center (Hillman & Charney, 1972).

*A center located in a predominantly Black housing project was assumed by many people to serve Blacks only; some eligible Whites living in the area therefore did not register for services (Salber, et. al., 1972).

The comments by Salber, et. al. (1972) and Endicott (1975) raise the question of the symbolic value of a given facility. Dubos (1973) reminded us that

> scientists and technologists are inclined to focus . . .

> attention on the quantitative, so-called objective aspects of reality, and to neglect the world of personal experience, which is qualitative and subjective (p. 379).

Did the Whites in Salber's study stay away from the clinic because they thought only Blacks were eligible, or did placement of the clinic in a predominantly Black housing project symbolize the type of facility with which they did not wish to be associated? Did residents of communities alluded to by Endicott recognize the potential liaison function of their neighborhood health centers? If so, what did this imply to them as community residents?

NWHC occupied space in a city Health Department (HD) building. This existed long before the clinic came into being and has a much larger catchment area. HD might still have negative associations in the minds of residents because of some of its public health functions: Older people may remember that it was HD which frequently removed family members with TB from their homes; all residents could associate it with treatment of VD--something dreaded and shameful. While conscious reasoning will admit that treatment of the above diseases, as well as pre-natal care, inoculation of children, and other services rendered by HD are important for the well-being of the community, subconscious negative feelings could still operate. This might mean that the building itself does have symbolic

value--unfortunately not the one desired from NWHC's point of view.

In conclusion: A health care facility could be regarded as a "monument" to the community in which it is placed. Its mere existence has symbolic value over and above its functional value. What did the existence of NWHC symbolize to its users and staff, to the health care and community systems? Did its symbolic value and/or distance of the clinic from patients' homes influence utilization patterns?

Summary

Design standards and building codes regarding site, minimum space per person, noise level, ventilation, bathroom facilities, etc. do exist; they are, however, inadequate because (a) conceptualization regarding the influence of environmental factors on health are too narrow (Gutman, 1972); and (b) focusing on quantitative, objective factors without regard to qualitative, subjective, experiential ones can never encompass all of reality. It seems clear that such standards must take the following into consideration:

1. No single environmental variable can be studied in isolation--each interacts with other environmental variables, as well as with functional, social, and psychological ones.

2. Cultural, social, and personality differences; past experience and present expectations; the actual use to which a given space is put; freedom of choice, control over one's environment and movements in it; and, finally, the ability to pursue one's goals all influence perception and evaluation of environmental variables.

3. While a given level of density, noise, comfort, privacy, etc. need not have measurable physiological effects on the occupants of a given setting, it can influence the psychological well-being of these individuals, their work and social behavior, in more or less subtle ways--all of which can affect the system's functions. They might also have cumulative and interactive effects.

4. The symbolic message transmitted by a facility could influence attitudes, perceptions, and utilization.

5. It is meaningless to look at setting and occupants as other than a totally intermingling entity; the relationship is indeed transactional.

These points have important implications for a study of NWHC. What did patients and staff expect a neighborhood health care facility to look like? Did the physical environment of the clinic influence perception of the care rendered there; did it affect the emotional and functional well-being of individuals

in it? If so, how? And were there different reactions among the various groups, such as patients and staff, various categories of staff, different ethnic groups, etc. Both mental and experiential congruence are of importance--and if expressed preferences often involve judgments based on hearsay (which included societal standards), they are no less important since this hearsay helps judgment of the situation as it is in reality encountered by the individual.

Crowding was stressed in the review of the literature because it is the one characteristic of NWHC which strikes one most forcefully on both first and prolonged acquaintance with the clinic. In addition, it either brings about or accentuates less than optimal conditions in the other variables. Thus, with larger numbers, there is more noise, less chance for privacy; inadequacies of ventilation and toilet facilities become more noticeable. But it appears that there is continuous interaction between <u>all</u> the variables considered in the preceding pages. And all could affect every user of NWHC, i.e. staff, patients, visitors. Each of these groups had their own attitudes, viewpoints, characteristics, and varying degrees of power to influence conditions--all these must be taken into consideration when evaluating a building (Rivlin, n.d.).

In addition to its purely functional organization of space,

NWHC conveys a message to its users. If, for example, it does not always afford the degree of privacy demanded for certain tasks and/or by social norms, does this imply a lack of regard for the functional and emotional well-being of staff and patients?

NWHC is a large-scale environment--perception of it is, therefore, through all sense modalities, influenced by expectations, and appears to be organized around a number of interacting levels of analysis (Ittelson, 1973). All of which results in a continued cycle of expectations, perceptions, emotional and behavioral reactions which, in turn, alter expectations, perceptions, reactions . . . . But, as seems clear from much of the evidence reviewed in this report, perceptions, expectations, and reactions are modified by cultural and social background, personality factors, past experience, and goals. These factors, then, must be assumed to play a role in the perception of large-scale environments.

Staff members spent more time at NWHC and were engaged in more complex activities. They might be expected to have a greater awareness of the environment and certain aspects of this environment (e.g., size) could have more effect on them than on patients. On the other hand, they could also become more habituated. Patients, however, might be more anxious, in greater need of support.

It is, therefore, hypothesized that the physical plant of NWHC--or any medical facility

1. can convey a symbolic message to the patient regarding the care he or she can expect;

2. helps structure both the role perception and actual functioning of staff. Working in a poorly equipped and crowded environment could influence attitudes and behaviors vis-a-vis patients and fellow workers.

3. The direct effects of the physical and psychosocial environment are greater on staff than on patients, and affect lower-level staff most because they wield least organizational power.

4. Staff members will engage in manipulative activities, such as maneuvering secretly for more office space for oneself and one's department, because such space might make one's function easier and is perceived as a status symbol.

CHAPTER V

COMMUNITY AND NEIGHBORHOOD: A CONCEPTUAL DIFFERENTIATION

Clarification of the concepts of community and neighborhood is important for this study because its subject is a neighborhood health center which, by OEO mandate, must be operated with community participation. Before one can determine how this mandate is being carried out it should be clarified which entities are supposed to participate--and participate in what?

Utilization of a systems approach can help avoid the reification of the concept "community" to which Suttles (1972) objected, while permitting a flexible treatment of this concept. Before any attempt is made to arrive at an operational definition of community, it would be helpful to distinguish between the terms "neighborhood" and "community". Although such a distinction is not always made (e.g. Jacobs, 1961; Keller, 1968; Lee, 1970; Michelson, 1970; Suttles, 1968) it can be of definite heuristic value when examining the interaction and interdependdence of human behavior and the environment because any attempt to understand interaction is helped by clarification of the characteristics of the interacting parts.

Working definitions of neighborhood and community

For the purpose of this study the term "neighborhood" will be used when no reference is made to the social-psychological aspects of individuals' behavior but rather to

1. physical aspects such as boundaries, land use, type and condition of buildings;

2. the existence of given institutions within a given region;

3. demographic factors such as density, SES, ethnicity, length of residence; and

4. the characteristics attributed to a given region by residents and outsiders.

A definition of "community," on the other hand, concentrates more on interactions, feelings, attitudes, perceptions, and behavior of individuals, who also happen to be located within a given physical boundary. The way in which Coleman (1966) defined community came close to this concept. For him

> the term "community" concerns things held in common. Some of these "things" may be tangible objects, such as . . . common property . . . . Others are less tangible: common ideas, beliefs, and values, common customs and norms held by all, and finally, common or joint action of the community as a whole (p. 671).

The important variables in the formation and maintenance of a community are (a) the present interests of the people involved (these may be similar, or dissimilar but complementary), (b) the

ability to act in concert to achieve a goal, and (c) the effects of these actions on the individuals in the groups which initiated action (Coleman, 1966).

The Middle English (1100-1500) meaning of "community" is given by the Oxford Dictionary (1964) as "a body of people organized into a political, municipal, or social unity," and this reflects the structure of life during this period. "No individual could stand alone; he had to be part of a community, and the community of a village or of a town influenced and controlled the lives of its members to a far greater extent than it does today (Strayer, 1951, p.33)." The cohesiveness of religious, economic and social systems meant that people of the Middle Ages formed a unit; the individual was subsumed under the group. "Community" would seem to have been perceived and used in a manner analogous to that attributed by Gans (1962) to sociologists, namely "in a combined social and spatial sense, referring to an aggregate of people who occupy a common and bounded territory within which they establish and particpate in common institutions (p. 104)."

The Renaissance, the Philosophes and the modern American ethos stress individualism over dependence on community. The Philosophes, for example, envisioned a world led by intellectuals, in which individuals used the power of reason and science

to free themselves and destroy the social, religious, and political institutions which bound them (e.g., Condorcet, 1955).

Many sociologists of the twentieth century have repudiated the gradual weakening of institutions which mediate between the individual and the state. Toennies (1957) compared the traditional close-knit community (i.e., a "folk culture" of Gemeinschaft) with the modern, industrial, urban society (i.e., "civilization of state" or Gesellschaft), and found more positive aspects in the former. Gemeinschaft is characterized by the consensus of wills, the "natural will" of the community members which is shaped by habits and sentiments rooted in family life, land ownership, and the common good. Values emphasize the collectivity; they derive from and are sanctioned by religion. Social relationships are guided by mores and folkways, both of which are relatively stable and salient to the society. Toennies perceived Gesellschaft, on the other hand, to be characterized by a union of the rational wills of the individual members of society, where the choice of means to given ends is made solely on rational grounds as perceived by the interested parties. Values emphasize the individual; they derive from and are maintained by public opinion. Social relationships are guided by conventions and/or law.

Public opinion, conventions, and law are less stable

and often less salient to a given social group than are mores, folkways and religion. Since cohesion of a group depends on the degree to which people subscribe to its values and norms, Gesellschaft is less stable, more disorganized than Gemeinschaft. Where members of a Gemeinschaft have a sense of relationship to one another which is continuously reinforced by family, guild, and village, those of Gesellschaft experience isolation, except where interaction and cooperation are necessary to further one's own interests.[8]

Toennies regarded the trend from Gemeinschaft to Gesellschaft as irreversible and did not try to find alternatives for the positive aspects of the former. Nisbet (1971), on the other hand, called for the establishment of communities analogous to those of the Middle Ages, but relevant to modern urbanized life. Like Toennies, he maintained that institutions such as the extended family, guild, local community, and church functioned as arbiters of values and as vehicles through which individuals could relate to one another and to society at large. As these institutions lost function and influence, large-scale

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[8]Dr. Z. Zuckerman (Columbia University) noted that Toennies did not make it clear whether he considered Gemeinschaft and Gesellschaft as ideal types or as opposite poles of a continuum; nor did he say whether the characteristics he ascribed to these two constructs were those of societies or of social relationships (personal communication).

organizations, with the state at the apex, stepped in to fill the void. Whereas the older organizations were built around primary associations, the newer ones are organized around offices. The older forms, almost by definition, could guard the individual against the intolerable states of alienation, dislocation, and anomie, but the present ones are unable to do so, and modern man is, therefore, "in quest of community."

Nisbet regarded social function and social authority as the two basic props of any community. Once these props are removed, the term "community" becomes meaningless--individuals "exist in a spiritual and moral void (p. 17)." Community is the product of group action; it exists to allow the achievement of common goals and to provide the spiritual and symbolic shelter which individuals need--this is part of the great appeal of totalitarian political parties. Alienation, on the other hand, is seen as the state of mind in which the individual not only does not feel part of the social order--he has lost interest in being a part of it because he finds it remote or fraudulent, inviting apathy, boredom, or even hostility (p. ix).

But is alienation inevitable in modern society and especially in large urban centers? Are organizations built on primary associations the only ones capable of providing the psychological,

normative, and political shelter which individuals apparently require? Perhaps groups based on community of interest, shared aspirations, ethnic identification, profession, or even a shared deviance from the norms of the wider society could partly replace the functions of the extended family, traditional guild, church, and local community. Perhaps the American Medical Association or the International Typographers Union (modern forms of guilds) are as efficient guardians of values and norms, as capable of marshalling the forces of their members, as able to protect and provide a sense of belonging, as successful intermediaries between the individual and the larger society as were the traditional groups. It may be that any kind of association, as long as it is important to the individual for psychological, emotional, political, or material reasons can serve the necessary function because it can command the individual's commitment. Considered this way, community is still a viable concept.[9]

Commitment, as defined by Kanter (1968) is

> The process through which individual interests become attached to the carrying out of socially organized patterns of behavior which are seen as fulfilling those interests, as expressing the nature and needs of the person (p. 500).

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[9]Confirmation for this view can be found in Becker (1963, 1964); Clark (1965); Cook (1963); Duhl (1963); Durkheim (1951); Harris (1969); Whyte (1955); and in several of the empirical studies and social psychology theories dealt with by Jones and Gerard (1967).

The commitment of actors in a social system helps solve the problems of group cohesion, continued participation of the actors in the group, and social control of the group over its members. Commitment is made possible through the individual's cathectic, cognitive, and evaluative orientations. Thus the actor's cathectic orientation will determine his cohesion commitment, cognitive orientation will determine continuance commitment, just as evaluative orientation will determine control commitment. These commitments and orientations are attached to social relationships, roles, and norms respectively. Which of these three predominates determines the strength of a given system--it is strongest if all three are present to a large extent. It is therefore in the interest of any social system which depends for its optimal function on the commitment of its participants to employ arrangements which will foster all three of these commitments.

As has been mentioned above, the question of community participation makes it imperative to clarify just what it is we mean by the term "community." The following operational definitions are suggested:

In the present study, an "urban community system" is taken to represent the functioning totality of all component groupings within the larger system (i.e., the metropolitan area). This includes

such entities as the metropolitan and city bureaucracies, institutions, professional groups, interest groups, organizations, and local communities.

The term "local community" is here defined as a sizable group of families and individuals who reside in a given location. It is a subset of the urban community and, therefore, smaller in scale. Here again there is interdependence of and interaction by organizations, institutions, groups, and individuals. Since it is an open system, it will include old established residents and their institutions as well as newcomers and it is possible that the backgrounds and customs of the two might--though they need not--clash.

Latent and active community

A major assumption of this study is that a local community can be dormant or active, latent or manifest. Interaction (occasioned by the structural requirements of neighborhood organizations and institutions, or by the fact that one occupies adjacent apartments, uses the same stores, schools, or clinics) does not yet constitue an active community. It is, rather a latent or dormant community which is conceptually only one step removed from "neighborhood" as defined on p. 92. Although

the people reside in a given location, their use of its facilities and institutions, their recognition of the boundaries and other characteristics of this location are now specifically included in the concept. These people do not, however, form a cohesive entity. In contrast, a manifest or active community requires social unity and communal action, due to a certain degree of commitment to the neighborhood and to definite goals for it.

This is made difficult in cities where the catchment areas for various services and political activities differ. NWHC's catchment area was not the same as that for City Health Department services; the school districts for NWHC patients differed from both these catchment areas, from the police district, the sanitation district, the assembly district, etc. If all these catchment areas or districts were the same, residents would have more opportunities to get to know each other and work together on a variety of issues on a regular basis. As matters stand now in many American cities, there is little such opportunity for sustained interaction. There is much less chance for people to organize; there is less chance that the same people are going to get involved and are going to maintain links so that they are always an active community. The lack of geographic overlap of catchment areas and districts for various social

and political activities precludes consistent interpersonal relationships by the same people on a variety of issues. It means that different people are going to be involved in different issues--it means, in effect, the predominance of latent communities.

It is, therefore, further assumed that the transformation from dormant to active community will generally occur only in the presence of certain conditions: the existence of a nucleus of voluntary organizations (which may be inactive until roused by an issue) and/or individuals capable of leadership and--most importantly--an issue which is important enough to a large number of individuals and groups to act as an ad hoc cohesive force. Examples of such conversions are offered by past events in Hunterdon County, New Jersey (Westcott, 1970); a 500 square mile area in Bolivar County, Mississippi (Hatch, 1969, 1970); and the mid-Westside of Manhattan (Lyford, 1966). In the New Jersey case, a population of about 45,000 created an integrated, county-wide health service over a period of about 25 years which, in 1970, was still expanding. In Bolivar County, about 16,000 residents assumed the initiative in determining just what services they wanted; with the help of OEO funds they managed to create viable cooperative and service systems. In the mid-Westside a very effective community committee was organized in 1959 to fight for more low-income housing in the Westside urban

renewal area. On the other hand, a threat to the continued existence of NWHC due, for example, to excessive federal budget cuts, might not have enough impact to create an active community in its catchment area because its patients have other health care facilities at their disposal and may not be committed enough to the idea of the center as a community facility to fight for it.

Decentralization has become a credo of reform in health care--the concepts of neighborhood and community are thus relevant. Distinguishing between latent and active communities might help in the formulation of plans for effective decentralized health care facilities which are operated with community input. A more limited approach to this problem was provided by the National Commission on Community Health Services (1966) which proposes a "community of solution" as a functional concept to deal with health matters. Such a community would be "established by the boundaries within which a problem can be defined, dealt with, and solved (p. 2)." An active community, as discussed above, would encompass this community of solution. It is, however, a broader concept because it includes the commitment and action of community members, and can be applied to any issue concerning the community. It also implies the recognition of the existence

of an issue by the members of the community. Both concepts submit that the boundaries of a given community can shrink or expand, depending on the issue which is acting as an agent for cohesion at a particular moment in time.

Using the concepts developed in this chapter, we now see that NWHC is a neighborhood facility because its catchment area is geographically bounded, with given physical aspects, institutions, demographic characteristics, and attributes. The designation "neighborhood health center" per se does not infer any cohesiveness on the part of patients due to shared norms, values, or action for common goals. Community participation, on the other hand does. It implies both the existence of individuals who share certain goals and commitments, and also their willingness to act upon these--in other words, an active community.

The theoretical construct of active vs dormant community will be further explicated in the following chapter on community participation, where the relationship between the community system and the health care system is dealt with by looking at it in terms of neighborhood health centers.

CHAPTER VI

RELATIONSHIP BETWEEN THE SYSTEMS: COMMUNITY PARTICIPATION

Many of the reforms which have been proposed for the health care system incorporate some plan for decentralized facilities (e.g. neighborhood health centers, health maintenance organizations). There was, however, much less agreement on the political factor--namely the desirability and degree of client input in the decision-making process of health delivery systems. With few exceptions, this input was non-existent in the city in which this study took place. There was, for example, no community representative on the board of the City agency responsible for the operation of all municipal hospitals (Badillo, 1970); a major city-wide health insurance scheme only started planning for consumer councils (for the purpose of providing "meaningful discussion") in 1971--14 years after this organization was established (Health Almanac, 1971). None of the proposed national health insurance bills seem to require grassroot community participation (Eilers, 1971; Olson, 1971), although the Kennedy bill did provide for the appointment of some consumers to the advisory

council which would participate in policy decisions (Congressional Record, 1970). OEO's neighborhood health center legislation mandated community participation, but failed to provide explicit prescriptions for the extent of this participation, or mechanisms to assure that untrained members of the community receive the necessary effective training, so that they would not be overpowered by the professionals with whom they must work. Just how meaningful community participation is in the operation of neighborhood health centers depends on the willingness of the professionals to cede some of their responsibility for planning and implementing programs, and the willingness of the members of the community to assume these responsibilities.

The catchment area of NWHC had the reputation of being over-organized because of the existence of a large number of voluntary organizations; most of these, however, were organized and manned by a small number of mainly middle class residents--few low-income people participated (Lyford, 1966). Although many of the poor come to service-oriented voluntary organizations for help and advice, generally

> People become active in a community because they have hope, a goal in view, and a sense of permanent status in a community. To the transient poor condemned to be moved about for a lifetime, discussion about community improvement such as one would hear at a council meeting would be taken simply as a warning that the time was

> approaching when they would have to be deported again to make way for other, more comfortably situated members of society (Lyford, 1966, p. 133).

The findings of Gans (1962) would indicate that even stable working class populations were not overly attracted to organizational participation.

Although no specific studies on the representativeness and effectiveness of health councils could be found, data regarding grassroot participation in the management of Community Action Programs (CAP) are applicable to some extent and would seem to support Lyford's statement regarding the non-involvement of the poor in community organizations. Moynihan (1970) summarized the opinions and findings of various authors: While CAP might prove to have been instrumental in creating a core of minority group leadership in urban areas this group was recruited largely among professionals who were Black or Spanish-speaking; those of the lowest SES apparently did not participate to any great extent in the actual operation of poverty programs. Why?

It is possible that, as Lyford (1966) implied, the poor lack a sense of community. Alternately it could be argued, as Moynihan (1970) seemed to do, that the poor lack the experience and, therefore, the ability to become active, act in concert, and govern. Perhaps the mistrust of institutions

and their expressed altruistic intentions exhibited by so many of the poor (Waldron, 1970) extends to disbelief that they would really be permitted to participate in any government-sponsored program in a meaningful way. Rainwater (1966) contended that the poor face real and symbolic threats from human and non-human sources both inside and outside their homes, and that these threats cause alienation from the peer group and society at large. The symbolic message of these threats causes lowered self-esteem and this, in turn, might preclude a belief in one's ability to participate in community affairs in a constructive manner. Wilson (1968) suggested that in contrast to the middle class's "community regarding" ethos, the poor are more "private regarding" because of their "preoccupation with the personal and immediate, and they have few (if any) attachments to organizations of any kind with the possible exception of churches (p. 50)." Another possibility is that the community, as defined by OEO, is not the community as defined by residents. Or perhaps non-participation was due to the lack of geographical overlap of service catchment areas mentioned in the previous chapter. As things stand now, there would have to be so many "communities" that it would be impossible to participate in them all. Probably a combination of these and other factors

would come nearer the truth.

It is a contention of the present study that a majority of urban dwellers--not only the poor--will not participate in community activities and programs unless an issue which is vital to their interests is involved (although middle-class people do seem more organization-prone than those of lower SES, e.g. Lyford, 1966). For community participation to become viable, a local, latent community must be transformed into an active community through such an issue. Otherwise, non-involvement is the norm which is supported by existing districting in many cities. If the poor refrain from participating in programs which are seemingly central to their interests it could be because (a) they do not regard these programs as important because of the availability of alternatives or a difference in norms and values, and/or (b) they do not identify these programs as "theirs," and/or (c) they simply do not have the strength to get involved in various programs.

The non-involved city dweller

In any large metropolitan area, fairly homogeneous and stable residential enclaves--urban villages, to use Gans' (1962) term--still exist, but the general picture presented by the city in which NWHC was located was one of

great heterogeneity, mobility, and an apparent lack of any desire to collaborate. Explanations for the non-involvement of city dwellers can be found in the formulation of Simmel (1950), Wirth (1938), and Milgram (1970). Simmel (1950) described life in the metropolis as being characterized by a surfeit of stimuli impinging upon the individual, and by rational relationships with people and things. Emotional involvement is shunned by metropolitan man because it cannot be governed by logic or by an (economic) exchange value. There is no room for impulsive behavior because all interaction is governed by contract. Modern man has to fight for autonomy and individuality or become submerged by the superindividual contexts of life. He adopts a blasé and reserved stance as a self-protective device. Simmel also believed that privacy, the opportunity to keep certain aspects of oneself secret, was essential for adequate social functioning, especially in modern life where the individual is in many respects regarded as a cipher. Finally, Simmel's concept of the "potential wanderer" or "permanent stranger"--the individual with whom interaction is a mixture of nearness and remoteness--can be applied to a majority of city dwellers. They have fairly abstract relationships with a variety of groups, based on shared general qualities (e.g. occupation,

residence) while they are more active members of other groups.

Wirth (1938) maintained that because of the size, density, and heterogeneity of city populations, human relationships tend to be utilitarian and segmentalized, and social bonds are often transitory. He agreed with Simmel that these characteristics should be regarded as protective devices.

Milgram (1970) utilized the above treatments of Simmel and Wirth and carried them a step further. The concept of "overload" was explicitly offered as the linking variable between the individual's experience and the demographic factors stressed by Wirth: The excessive sensory input to which city dwellers are exposed by these demographic factors necessitates such adaptive responses as the filtering out of inputs judged to be of low priority; the evolution of social norms, role performance and cognitive functioning; and the creation of impersonal institutions to assume part of the individual's responsibilities. While these devices protect, they also isolate and estrange; they restrict moral and social involvement among city dwellers and foster norms of non-involvement.

These concepts and arguments can all be valid despite the existence of community. Man and his society are more flexible than any of the above formulations imply. One can

retain privacy and protect oneself from stimulus overload while joining with others in the pursuit of a common goal. Heterogeneity of the residents of a circumscribed geographic area need not preclude their cooperating (as was shown in Chicago's Douglas Park Community Area, Suttles, 1972; or the Back-of-the-Yards area, Wilson, 1968).[10] Conversely, one could ask if homogeneity and close personal and social relationships necessarily ensure such cooperation (it did not among Boston's to-be-relocated Italian West-Enders, Gans, 1962).

Perhaps communal interaction is more likely in an "encapsulated" area, that is in a well-bounded sector of the city, one with well-defined edges (Lynch, 1960) which separate this area from the rest of the city. Or it may be that such interaction will be fostered once the artificial assignment of the same group of people to different service and political districts ceases. Possibly, cities laid out in the grid system make communal action more difficult or, conversely, the existence of one core facility--such as a playground--may foster it. The conditions for arousing

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[10]Besides, there is a limit to heterogeneity. It is suggested here that in densely populated regions anyone can find similarities to other individuals on a number of dimensions.

latent potentials for communal action and identification remain to be investigated.

NWHC's catchment area did not fit any of the classical community or neighborhood studies well. It was not the kind of ethnic ghetto area dealt with by Gans (1962), Glazer and Moynihan (1970), Suttles (1968), or Whyte (1955). It apparantly did not contain the type of pathological public housing complexes described by Rainwater (1970) and Suttles (1968). It did not fall into the category of a predominantly working-class tract such as Fried and Gleicher (1970), Gans (1962), Whyte (1955), and Young and Willmott (1962) investigated. Yet it contained some ingredients of all these aspects. It was a varied, multi-ethnic, multi-SES area which was unusual, though probably not unique. People did not think of themselves as living in a slum. They had a vision of variety which might have been important in terms of perceived options. This could also have been increased by the existence of a large urban renewal project which included subsidized housing for the poor in middle-income apartment buildings. This area illustrated most clearly a need voiced by Izumi (cited by Michelson, 1970) in connection with housing--namely, that the urban physical environments be broken down into meaningful concepts. The operational definitions

of neighborhood and dormant vs. active community are an attempt to arrive at such concepts because existing ones, such as ghetto area, working-class district, slum housing, etc. are found to be too constricting for relating community systems to health care systems.

In the case of neighborhood health centers the existence of this relationship can be exemplified through three factors: the physical entity of the center which belongs to each of these systems; the concept of career ladders which involves training and employment of residents at the center and, finally, community participation in the operation of the center.

Community participation--a definition and historical overview

Various meanings have been ascribed to the terms "community participation" or "citizen participation" (Chisholm, 1970). Here they will be used in the sense delimited by Spiegel (1968), that is, as the efforts by residents of a given region to improve their community and individual conditions through political action in the broadest sense, i.e., by organizing to achieve given ends. This definition is adopted because it best fits the concept of "active community" formulated for this study.

To participate means to share--ideas, plans, work, responsibilities, power--to share, not to control or be controlled. However, the rhetoric of many meetings and

pamphlets of community groups, and even of symposia such as that organized by the New York Academy of Medicine (1970) continuously alternates between the terms "participation" and "control." And yet, it is meaningless to talk about control of any given institution or program unless one also has control over resources and the systems that affect that program. For example, the governing board of the Lee County (Arkansas) Cooperative Clinic (see Neal, 1970) could not be said to control the operation of the clinic as long as it was unable to prevail upon the county hospital to accept the clinic's patients. Community health boards cannot be said to be in control unless they are given complete fiscal, policy, and administrative control over their programs, are free to contract with any hospital for back-up services, and have an adequate supply of medical personnel to choose from for positions at their centers (see, for example, Cowen, 1970; Waldron, 1970; Wise, 1971).

A continuum appears to exist for the concept and fact of community participation from complete lack of input, through advisory committees, to meaningful participation.

Until fairly recently, complete lack of input by any segment of the population except those directly in charge was

the norm for such systems as health, education, and welfare. (e.g. Cox Commission, 1968; Moynihan, 1970; National Advisory Commission on Civil Disorder, 1968; Rogatz & Rogatz, 1971).

Advisory committees were first legislated with the Federal Housing Act of 1949. Since they still form the model for much of what is termed community participation, these groups will be used as illustrations. The Housing Act of 1949 and those following it required that any urban renewal program utilizing federal funds had to provide for input by the affected citizens during the planning stage (Chisholm, 1970; Lyford, 1966; Spiegel, 1968). Directives by the Department of Urban Development (HUD) showed an evolution regarding the meaning of this input from the earlier "Workable Program" requirements to those applying to the 1966 Model Cities program. The former "encouraged" resident participation through a committee appointed by the city administration. This committee--meant to represent various interests, including those of minority groups--should, however, where possible, be drawn from the leadership of community organizations (Spiegel, 1968). In practice this directive usually meant that civic leaders who were appointed to these committees did not represent the segment of the population most affected by urban renewal (Chisholm, 1970; Lyford, 1966). In contrast, the Model Cities program requirements

were geared more toward involvement of a wider range of residents in both planning and implementing the program. The HUD directive stated that no improvement of the quality of life in model neighborhoods could be achieved without the full cooperation of residents (Spiegel, 1968).

It has been argued that this type of participation, in addition to being more democratic, would also assure easier passage of urban renewal plans. This has been countered by the contention that it would only serve as a lobby for vested interests, would hinder coordination of planning for the whole city, and would prolong the planning process; the claim that it is democratic was called misleading because only a small proportion of citizens participate and they have no authority to force compliance with their recommendations (Goldblatt, 1968). The same arguments and counter-arguments have been offered regarding community participation in post-1964 poverty programs. With the passage of time, community participation in urban renewal areas was much more likely to take the form of organized community resistance because of resentment at being designated "slum dwellers" and as it became increasingly apparent that slum clearance, perversely, usually meant the clearing out of minority groups, the replacement of low-cost housing by high-priced housing, disruption of

old-established neighborhoods, and failure of relocation programs (Wilson, 1968). This is an example of presumably dormant communities becoming active.

The third position in the continuum--community participation--was first called for (under the equivocal term of "maximum feasible participation") in the 1964 OEO legislation. One could suggest that ideally the concept should imply an equal share of responsibility in planning and management of programs by elected community representatives and professionals. Community residents were assumed to know the needs of their community and its population better than officials of government or service agencies; they should, therefore, be able to set priorities of goals. If they were truly equal partners with government or agency, no proposal could be implemented against their wishes--the wording "maximum feasible participation," however, left the extent of their equality open to different interpretations.[11]

Examples of effective community participation were provided by the Tufts-Delta Health Center (Mississippi) and in a Chicago Health Center. The former was, according to Hatch

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[11]Some of these ideas were indicated at the New York Academy of Medicine 1970 Health Conference.

(1969, 1970), operated by the community with a high degree of autonomy and self-determination. Great care was expended by Tufts personnel to gain acceptance among the people they wished to serve; to inform residents about the proposed health services; to recruit and train local staff; and to help set up and train community committees. Since the area served by Tufts-Delta covered about 500 square miles, several such committees were formed, and these were then incorporated into an association. Community organizations reportedly proved so viable that they soon were able to convince Tufts University that nutrition, sanitation, water supply, clothing, etc. were all part of any comprehensive health program. Health center funds (which Tufts administered as grantee) were therefore often used to help solve these problems. What started as a health center project evolved into an overall community development program which the service agency (Tufts) did not in any way dominate.

The establishment of a neighborhood health care program in Chicago's Mile Square area was planned from the start with the cooperation of an already existing community organization. Community representatives helped in determining priorities, selecting the site for the center, and recruiting and screening non-professional personnel (Lashof, 1969). One purpose of the

present study was to determine the extent of community participation at NWHC.

How well did community participation operate in neighborhood health centers in general? An OEO site appraisal of 27 neighborhood health centers revealed that the better the organization of the consumer group, the more effectively they functioned (Sparer, et al., 1970). Although few of these consumer groups had developed adequate election mechanisms or by-laws, strong leadership (either within the consumer group or among a community-oriented center staff) did exist in some, and helped make the group more efficient. There was no difference in the quality of function whether the community organization was an advisory group or a board--although the latter was the preferred form. There was no evidence of really disruptive conflict--it was difficult to determine whether existing conflicts were due to center organization or to the employment of community residents.

The study also found that while the concept of community participation was widely accepted, this did not necessarily imply agreement regarding its goals or the form it should take. In general, professionals did not find it difficult to work with the consumers.

One reason for this last point may be that many of these community boards were appendages to their health center, and the boards were still searching for a function (Wise, 1971, p. 37). They lacked the technical expertise to make policy decisions regarding health care. Because of their ambiguous position, endless negotiations between board members and administration often hampered maximal function of the centers. The health centers cannot exist without medical personnel--and given the existing shortages (especially among physicians willing to work in salaried positions in often "undesirable" neighborhoods), community boards are not in an enviable negotiating position vis-a-vis the medical staff.

Most reports on neighborhood health centers agree that one important function of community boards is the hiring of non-medical personnel. There is little disagreement with the premise that given adequate job descriptions by the center's administration, representatives of the community are well suited to decide whether a given applicant has the requisite qualifications for the position as well as the required attitudes toward the program. The question of firing, however, is more controversial. Should community board members have absolute veto power in dismissing an employee for such reasons as incompetence, refusal to perform one's job adequately, or because

a given position is no longer considered necessary? Might they prove reluctant to dismiss members of the community because they fear adverse personal publicity and do not take the dysfunctional effect on the center's operation into consideration? Wise (1971) believed that each community board should have the power to hire and fire the project director for its respective health center, but must then cede all further employment responsibilities to this individual.

In reviewing the literature on the effectiveness of community participation in a variety of poverty programs, Brieland (1971) discovered that community groups often were so busy scrambling for funds that they had no time left to seek meaningful social change. Other dangers were presented by the apathy of many members of the community; possible cooptation by established community leaders of inexperienced, non-radical community board members; and domination by special interest groups who could make sure that their members voted in elections.[12] The same individuals were often found on

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[12]Moynihan (1970) pointed out, for example, that in several communities extremely militant Blacks took over poverty agencies although Black citizens only represented a small minority of the population (he did not say what percentage of the poor they represented) and the militant group did not even represent, and was not responsive to, the views of most of their ethnic group. Several

several boards--being on boards may have changed their outlook so that they ceased to represent community viewpoints. Some boards acquiesced to all proposals, especially in fields such as health care, where they felt incompetent to judge the merits of a case. Interest in the programs and in board activities sometimes dwindled with time. High mobility rates made continuity difficult.

None of these need be insurmountable problems. Brieland (1971) suggested, however, that the true intent of community participation must be clarified, there must be provision for ongoing training of leadership within the community so that already trained individuals are available for service on boards. Boards must have effective input on issues involving members of their communities; they should perform true liaison functions between community and agency or program; they must represent various groups (e.g. various age groups, SES, etc.). They should--in terms of the present study--mediate

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writers (e.g. Aronowitz, 1970; Chisholm, 1970) seem to equate "community control" with "Black Power"--what about all the other disadvantaged minority groups in the United States, and what about WASPs or other non-minority Whites who fall below the poverty line? How much good can be accomplished if the poor align themselves against each other according to ethnic demarcations?

between the community and health care systems.

Summary statement and foci of the study

Neighborhood health centers in general, and NWHC in particular, were uniquely suited to examine several issues concerning the interplay of community and health care systems, and the role of community participation. Such centers were, by definition, community institutions: They were physically located within given boundaries, drew their client population and at least their paraprofessional staff from this area, and were partly administered by local residents. Their salaried physicians were outside the fee-for-service structure which depends on client or colleague referrals. The mandated existence of a community board allowed for (but did not insure) communication of community wishes and examination of the center's operation by lay people.

NWHC was chosen for this study because its administration welcomed the proposed research project and the community board did not oppose it. It was located in an extremely heterogeneous area; if indications of active community could be found here, it would go far toward dispelling the notion that the concept of community has no place in the modern metropolis. If its community board should prove to be an effectively operating body, the idea that the poor are unable or unwilling to assume

responsibilities for affairs concerning them would be weakened.

Approaching the in-depth study of NWHC from a holistic point of view, and guided by the literature survey as well as the preliminary work done at the center, this investigation endeavored to answer three main questions:

1. To what extent was NWHC perceived as a satisfactory health care facility by individuals involved with it? The individuals in question were the patients, staff and community board members of NWHC. It was expected that ethnicity and age of patients would influence perceptions and attitudes, while the roles of staff and board members--rather than demographic variables--were thought to be of greater importance. The groups were, therefore, studied and analyzed primarily from these different perspectives.

2. To what extent was this decentralized health care facility perceived as a community facility by its users, staff, and community council? This question was addressed by examining the attitudes of individuals connected with the center regarding community participation, and whether they differentiated conceptually between neighborhood and community. Here too, ethnicity was considered of primary importance in analyzing patient data, and roles for staff and board members.

3. To what extent did the North-West Neighborhood Health Council function as a liaison between the center and the community? The attempt to answer this question centered primarily around board members' relationships to both patients (representatives of the community system) and staff (representatives of both the community and health care systems).

When the subject of a neighborhood health center was considered in terms of interaction between various systems--center and community, center and the medical establishment and government, center function and its physical setting--a number of related, more specific questions emerged:

4. Did patients actually use NWHC for comprehensive care?

5. What did this center offer to the community which other health care facilities failed to provide?

6. How was the physical plant of the center regarded by patients, staff, and council members?

7. How did the physical environment affect staff's work?

8. How were the functions of the council viewed by patients, staff, and council members?

9. What kinds of conditions were perceived as furthering or retarding the formation of an active community among people connected with the center?

The methods used to find answers for the above nine questions are discussed in the following chapter.

CHAPTER VII

METHOD

This in-depth participant observation field study of an ongoing system was supplemented by interviews and a specific incident analysis to be described later. Structured interviews were conducted with one sample of patients of NWHC; these were complemented by unstructured interviews with a second sample of patients. Focused interviews were carried out with samples of center employees and the N-W Health Council. The specific incident study concentrated on reports by patients leaving the center after an encounter with health care providers.

The utilization of varied research approaches served to:

1. Permit an understanding of the center's organization, purpose and function as these were perceived by its patients, staff, and council members, as well as by the researcher;

2. Describe existing discrepancies among these viewpoints; and

3. Clarify the relationship between the neighborhood health center, community, and health care systems.

Participant observation

This method was considered by Bruyn (1966) to be uniquely suited for the study of the dynamics and subtleties of attitudes, beliefs, and behavior of individuals and groups since Verstehen--the "personal understanding . . . of their position (p. 7)" is possible only through "entering" the life situation of the people one studies (Weber, 1949, cited by Bruyn, 1966). "The intent of the participant observer is to 'catch the process as it occurs in the experience' of those he studies (p. 13)," "and to understand people from their own frame of reference (p. 22)." Participant observation, a method used by anthropologists and sociologists, represents a more complex type of empiricism which is necessary to achieve understanding of subjective knowledge and subjective categories (e.g., need, community, well-being). Without this understanding the nature of social systems cannot be fully explained. It is only through observation of and interaction with the individuals he studies that the researcher is led to comprehension of the symbolic meanings attached by participants of the system to things, words, and actions. This procedure requires extended exposure to a group.

Such exposure teaches the participant observer when to question, when not to question, what questions to ask and of whom; the observer will eventually arrive at a point where he

frequently will not need to ask any questions (Whyte, 1971). Schwartz (1971) pointed to the fact that the participant observer needs time to learn to distinguish individuals, recognize events which might be important, and observe the orderly process of phenomena; to learn how to feel secure in his role which, in turn, leads to the ability to "absorb emotional cross currents (p. 92)." Whyte (1971) mentioned the need to learn the norms of the site and how not to transgreww them; and how to achieve the maximum possible degree of acceptance and trust by the various segments of the system. Finally, participant observation allows the researcher to watch change over time. Becker (1958) noted that extended exposure to a social situation permits the field worker to assess the credibility and possible biases of given informants; to recognize when volunteered statements are different from those elicited in answer to a question; and to be alert to the fact that people might respond and act differently when they are alone with the researcher as compared to what they will do or say when in a group. Schwartz & Schwartz (1955) warned, however, that the participant observer must be aware of his or her sociocultural biases, emotional needs, anxieties, assumptions, and expectations. All of these can influence the manner in which the observer perceives and interprets data.

The field worker will assume a role determined by his ability to fit into the environment and by the norms of

this environment. Assuming this role in the group will permit him to share in the activities of the group and to take the group's interests into consideration when designing the study. It will teach him to look at a given situation from the point of view of the group; he will come to share some of their sentiments. Both the field worker and the social situation will change through his presence (e.g. Bruyn, 1966; Festinger, et al., 1956; Schwartz & Schwartz, 1955). Schwartz & Schwartz (1955 noted that

> the participant observer is an integral part of the situation he is observing. He is linked with the observed in a reciprocal process of mutual modification (p. 346. Italics are mine.)

Festinger, et al. (1956) found that field workers could not always resist pressures to act which were exerted upon them by the observed group--it was sometimes impossible not to affect the situation at least minimally.

It thus becomes clear that caution is needed when interpreting findings and drawing conclusions: The participant observer changes as his knowledge about ahd involvement with the organization and social situation he studies increases; the social situation changes by engulfing him in its fold sufficiently to permit this knowledge and involvement--both will be different. In addition to these continuing changes over the duration of the study, it should also be recognized that the situation the field worker participates in will be a different one from the situation as it was before he entered it, and again different from what it

will be after he leaves. The effects of the researcher's role must be recognized and accepted as one factor which will influence both what people do and say in his presence as well as his interpretation of this information.

Although a part of him must remain detached to fulfill his scientific role, there is complete interdependence of his social and scientific roles in the research setting. Tensions and difficulties might result when the participant observer becomes personally involved, receives confidences, and makes commitments. However, the belief that these can be handled without compromising either scientific standards or the interests of the people studied is implicit in utilization of the participant observation method (Bruyn, 1966).

Use of this method was indicated for the present research project because it fit the demands of the research site and the theoretical interest of the study (namely, the interaction of several systems and the influence of its physical environment on one of these). The majority of the center's personnel, patients and council members, belonged to ethnic and socioeconomic groups which differed from mine. In addition to the real language barrier which was created by my inability to speak Spanish, there was reserve toward me as an outsider. I felt that only extended mutual exposure could help lessen this. This exposure not only helped lower barriers--it also confirmed several points regarding participant observation which were made in the essays

collected by Vidich, et al., (1971). Like Schwartz, I needed to learn how to look and describe, and how to formulate my role. I found, like Whyte, that it was possible to learn about the social structure of the system by observing its actors; that acceptance depended on the development of personal relationships rather than on formal explanations of the research project; and that it was important to be flexible enough to accommodate unforeseen events in one's research design. I saw that Stein was correct in stating that the best data are often the result of interaction rather than formal interviews. With some individuals friendly ties must be established before cooperation for the research project can be obtained.

In my role of "observer as participant" (Junker, 1960 cited by Bruyn, 1966)[13] I made it a rule not to become an active participant in any of the meetings I attended. On the other hand, my services in taking notes during meetings, or my help in designing a utilization study were freely asked and given. Being an outsider to the organization

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[13]Junker described four roles which the field researcher can assume: (a) the complete participant is a member of the group, and research activities are concealed from the group. (b) The participant as observer participates in many of the activities of the group; research activities, although not kept secret, are not publicized. (c) The observer as participant is accepted as a researcher by the group; active participation in group activities is kept to a minimum. (d) The complete observer may carry out his or her research activities with or without the group's knowledge; there is no participation in group activities.

caused initial reserve and some distrust. In some cases this was never entirely overcome and certain individuals always remained on guard. But with many others the fact that I was an outsider slowly became an asset: They talked more freely about center affairs than they would to a staff member on a level different than their own. This offered a rich lode of insight into personality and group systems, and the causes of cooperation or friction between them. It also furnished the basis for several of the areas which were explored during the focused interviews with staff and council members.

In addition to gaining cooperation from the individuals I observed, the method of participant observation also allowed me to investigate theimportance of (a) varying extents of control over one's environment, (b) the symbolic value of the man-ordered environment, and (c) its effects on the function and interpersonal relationships of staff. For example: some variables, such as density, can be objectively measured; this does not tell us, however, how the individuals in a crowded environment react to it. Items on a questionnaire regarding this property of the environment will elicit some information; observation of individuals' actions, reaction, and interactions will add another facet to our knowledge. It will show how being a person acting in a crowded situation might differ from being a person in a non-crowded situation. To use another example, supervisors of individual sections who had been promoted from the ranks will express their

feelings towards their status in many ways. The participant observer can pick up the fine nuances in their attitudes and behaviors which might indicate that they are aware of the ambivalence of their status, i.e., that of supervisor for a given number of workers, yet not recognized as such by much of the rest of staff. This ambivalence could help shape their self-image and sense of dignity and control; this may come out in an interview or through observing them during supervisors' meetings (where they are low man on the totem pole) and in interaction with their supervisees.

The recognition of such nuances became increasingly possible through my "observer as participant" role. The holistic approach, inherent in this method, permitted an examination of the dynamics of a health care delivery system, by focusing on the effects of the center's physical setting, its operation, and its staff. Whereas staff was quite cooperative, there was much more observation than participation as far as patients and council members were concerned. I had little occasion to interact with patients in a sustained manner; and council members, with very few exceptions, remained somewhat suspicious of me.

The field work at NWHC. 1971-1973. This work started with occasional visits in November 1971. The research began in earnest in February 1972, when I visited the center from one to three times weekly, often for the whole day, until November 1973. During this period I attended all weekly

supervisors' meetings, as well as city and regional conferences and workshops of the Neighborhood Health Center Associations. I also tried to be present at as many general staff and open Health Council meetings as possible. The bulk of my time, however, was spent in informal talks with staff members, observing their interactions and activities, and watching patients--in effect, observing the center in operation. In addition, I carried out focused interviews with a sample of staff and health council members during the last three months of my stay at the center. The last two days of the fieldwork were spent in talks with the project director and supervisors, singly or in groups, at which time I acquainted them with some of my findings and made suggestions when asked for them. At their invitation we jointly attempted to find remedies for some malfunctioning parts of the system. To assure distance from the subject, I did not visit the center for several months after completion of the research.

It was not always possible to observe certain staff members in sustained contact with patients because of the limited space of the center. Thus, the corridor in which Medical Assistants (MAs) had their desks was so narrow that it was impossible to take up any permanent station there (see Fig. 2, Appendix A). Instead, I gathered impressions while making trips for coffee through this corridor, and while drinking it standing in the doorway of the adjacent coffee room. Physicians were only rarely observed in prolonged interaction with

patients since their work is naturally carried out in private. However, glimpses of MDs interacting with patients or other staff members helped round out the picture gathered through talks.

During March, 1972 I carried out some systematic observations of the waiting room: Copies of a sketch of this area--similar to the waiting room section of the floor plan (Fig. 2, Appendix A) were used. These showed patients' chairs, the desks of appointment clerks and receptionists, and the aisles between. The number of patients, their sex, approximate age, and seating or standing arrangements were noted on these sheets at ten-minute intervals on several mornings and afternoons of different days during the week. I wanted to see if certain seating patterns emerged, to recognize which people belonged together, if and how strangers interacted, when people were most likely to take up space in the aisles--and whether any or all of these were affected by specific factors, such as the weather or the total number of people in this space.[14] These were later abandoned because the restricted space did not permit patients much freedom of movement, and thus significant variations were not present. General observation of this area continued throughout my stay at the center, with particular attention to the ambience

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[14]Although the idea was borrowed from behavioral mapping (Ittelson, et al., 1970b), the actual study of the waiting area did not progress beyond the initial phase and categories of behavior relevant to this setting were, therefore, never isolated on the basis of empirical study.

of the place as conveyed through interactions, crowdedness and noise. Here too, it was necessary to obtain frequent glimpses during the day rather than to take up much needed space for any prolonged period of time.

There is no lounge for staff. However, the offices of some of the supervisors with whom I first became friendly were centrally located and tended to attract a great deal of traffic. When visiting these supervisors I had the chance to meet and chat with a great many people, hear problems and complaints, witness instances of cooperation or arguments. I made it a point never to stay in anybody's office unless invited to do so; whenever my host received a phone call or somebody else entered I offered to leave. But after a few months people only rarely minded my presence. The hallways offered another opportunity for frequent encounters and a few words with most of the staff.

Organization of participant observation data. I took copious notes during all meetings I attended. In all other cases I recorded any pertinent observations or information at the end of the day. I also tried to collect whatever data and documents (such as the center's attendance figures or HEW directives) administration would let me have. In order to make the masses of notes, tapes, minutes, and other supporting materials more manageable, a variant of Whyte's (1971) indexing system was utilized. Given pieces of data were entered on a sheet which con-

tained its date, subject, technique, and highlights. These were filed according to subject (individuals, supervisors' meetings, etc.) and date. Other materials were filed according to source (e.g. HEW, National Association of Neighborhood Health Centers, etc.). No quantitative analyses of these data were attempted; rather, they were used to assess the quality of the social and physical environment of the health center, and to supplement the information received in more formal interviews.

Limitations of participant observation. Several dangers are inherent in field work using participant observation: If the researcher is identified with one of two or more antagonistic parties, he will not be able to get the cooperation of all the members of the system; hostility by an individual or group may spread throughout the system and jeopardize the project; finally, the most informative individuals may constitute a self-selected, not necessarily representative sample (Merton, 1947). The possibility of over-identification, an overly subjective interpretation, and a vision which becomes too selective due to one's sympathies and biases, are inherent in participant observation (Vidich, et. al., 1971). I encountered all of the above to some extent. In addition, some of these dangers were aggravated by the anxiety and mistrust caused by possible drastic cuts in government funds.

In most instances it was possible, however, to alleviate these dangers by a proper mixture of detachment and involvement, and by a clear recognition of the extent of identification with subjects and their causes (Stein, 1971). Nevertheless, in order to gain a greater degree of objectivity, impressions and findings of the participant observations were compared with findings of the interview and specific incident studies.

Interviews

This technique can be used to elicit factual data as well as information regarding attitudes, feelings, behaviors, etc. Interviews can range in type from a highly structured format which consists entirely of fixed-alternative questions where the responses are limited to stated alternatives (Selltiz, et. al., 1964), to a completely unstructured interview containing a checklist of the main areas to be explored rather than any standard questions (Kendall, 1965). Midway between these two extremes are interviews utilizing open-ended questions which do not supply a fixed set of answers for respondents to choose from (Selltiz, et. al., 1964).

Interviews may, of course, combine several of these forms, each of which has advantages and disadvantages. Thus, for example, fixed alternative questions are easy to administer, can be standardized, and analyzed quickly and inexpensively. They

may, however, force the respondent to express an opinion when he has none; they do not allow for qualifications, or for the recognition that researcher and respondent may utilize different frames of reference (Selltiz, et. al., 1964). Open-ended questions, on the other hand, can deal with many of these shortcomings. They can clarify the meaning of an answer, help identify factors which might have influenced respondent's opinion, and generally allow insight into attitudes and motivations (Lazarsfeld, 1944). The same factors which make open-ended interviews so valuable for gaining insight also make statistical analysis of these interviews much more difficult. In addition, this type of interview is a slow and expensive procedure; it is therefore difficult to use with large samples. Selltiz, et. al., (1964) warn, however, that concern over quantification is often allowed to overshadow concern with a unique quality of communication. Quantification, though preferable, is not always feasible. And Kendall (1965) documents that it might be just as profitable to examine the range of existing opinions, attitudes and behaviors as their frequencies.

The third type of interview, the nondirective approach

> gives the subject an opportunity to express himself about matters of central significance to him rather than those presumed to be important by the interviewer . . . . Furthermore, it permits subject's responses to be placed in their proper context rather than forced into a

> framework which the interviewer considers appropriate, and finally, the informant is ordinarily far more articulate and expressive than in the directed interview (Merton & Kendall, 1946, p. 545-46).

The authors believe that unanticipated consequences and subjective definitions of stimulus situations can only be elicited with a nondirective approach; any direct question will structure responses to some extent, if only by forcing the respondent to concentrate on given items or situations. The "focused interview" is a special variant of the nondirective interview in that it concentrates on individuals with known past or present involvement in a specific situation. The investigator, through familiarity with the situation, has made a content analysis of hypothetically significant variables and their interaction and incorporates these in hypotheses; the interview guide is fashioned to seek confirmation for these hypotheses; the focus of the interview, however, is on "the subjective experience of persons exposed to the pre-analyzed situation (p. 541)." An interview guide is needed to assure that major topics are covered; without this it would be difficult to compare results. One must, however, be careful not to fall into the habit of using this guide as a questionnaire, or to arrest the spontaneous flow of information because of possible premature judgment of irrelevance. The danger of digression into irrelevant sphere is not too likely with the focused interview; where it does occur it can easily be terminated by a nondirective reference to the situation at hand.

Interview techniques used for the study of NWHC. Three types of interviews were utilized to answer the questions posed by this research project:

1. An interview (Patient Interview I) consisting of a mixture of fixed-alternative and open-ended questions was used with a sample of Hispanic, Black and White center patients.

2. An unstructured interview (Patient Interview II) was conducted with a second sample of Spanish-speaking center patients. Only Hispanics were interviewed here because they represented the majority of the center population.

3. A focused interview was carried out with samples of staff and members of the center's governing board.

Patient Interview I--was conducted during the summer and fall of 1972.

Design of the instrument was guided by information received in the course of the two pilot studies (to be described at the end of this chapter) and participant observation.

The aim of this interview (Appendix E) was to find out how respondents felt about the center, its physical setting and personnel, the care they received, and their patterns of use. Another objective was to determine whether the use of some community people to staff the center and in dedision-making positions influenced perception of the center. Questions were directed at eliciting comparisons between the center and other health care facilities, attitudes toward

the neighborhood and community, familiarity with various community organizations, and respondents' extent of mobility around the city.

At one point during the interview respondents were shown a simple street map of NWHC's catchment area with major thoroughfares and boundaries clearly marked (Appendix K). This map was kept simple and explicit because Lansing, et al., (1970) reported that a fairly large number of their relatively high SES respondents experienced difficulties when presented with maps of their planned communities. Since NWHC patients were of lower SES it was feared that they might have even greater difficulties with maps. Interview I respondents were asked to (a) locate their apartment building on this map, and (b) mark the area they considered to be "their" neighborhood.

These respondents were also shown 11 photographs of various sites in the catchment area (Appendix L). These were taken explicitly for the purpose of this study and depicted main shopping area, urban renewal projects, playgrounds and churches which were located on main traffic arteries.

The purpose of the map and photograph tasks was to help determine the extent of both respondents' familiarity with the area they lived in and their social space. Social space is here defined as that part of the city in which the individual spends most of his time, which he traverses most often, where he feels most comfortable and where most of his interactions take place

(Buttimer, 1969, 1972; Nahemov & Kogan, 1971).

A starting sample of 90 respondents--evenly divided between Hispanic, Black and White individuals--was picked with the help of a table of random numbers and NWHC's Family Registration Numbers. Assigned in consecutive order to each newly registering family or single individual, these numbers began at 0001 in August 1969 (the date this system was instituted) and had reached 06521 in April 1972, the arbitrary cut-off date for my sampling. The table of random numbers was, therefore, entered three times at every drawing--once each for two, three and four digit numbers. This was done to assure an even distribution among long-term and newer patients.

A total of 788 names were selected in six drawings over a period of three months. This was necessary because

1. almost 70% of the center's patient population was Hispanic; it was therefore difficult to find the required number of Black and White respondents;

2. many of the addresses on the center's books appeared to be inaccurate. In addition, many of the older patients--largely White--were either in hospitals, nursing homes, or no longer alive; and

3. some patients (7%) refused to be interviewed.

Two letters (in the appropriate language) were sent to prospective respondents. The first, on center stationery and signed by the Medical Director, expalined the purpose of the study and was meant to show the recipient that the research

was carried out with the center's permission (Appendix C). The second letter, which was written on plain stationery and signed by the interviewer, served to introduce him or her and was also meant to reassure the recipients that this was not a center-sponsored study (Appendix D). If neither of the two letters were returned, they were followed by a phone call from the interviewer to make an appointment or, if respondent had no telephone, by a visit to the address which appeared on the patient's clinic file. In spite of these steps, many individuals simply could not be located, even though the letters had not been returned.

When, in spite of frequent drawings, it was found impossible to reach the full complement of Black and White respondents through random sampling, it was decided to find the 11 White and 7 Black respondents needed to complete the sample by approaching patients at the clinic and asking them for appointments at some later date. A few refused this, but were willing to be interviewed while waiting to see the doctor.

Although the population of the catchment area is heterogeneous, the center's patient population is ethnically heavily skewed (see Tables 9.3 and 9.4). Truly random sampling of the patients would have resulted in very small numbers of Black and White groups, and therefore a probable loss of valuable information. One of the concerns of this study was the differences which cultural background might make in how one views one's health care, and it therefore seemed important

to sample an equal number of all three ethnic groups.

A bilingual interviewer had a Spanish form of Interview I at his disposal for use with Hispanic respondents who preferred to converse in that language. All interviews, with the few exceptions noted above, were conducted at respondents' homes and lasted anywhere from one half to three hours.

Interview II, an unstructured interview--was conducted with Hispanic patients during the summer and fall of 1973.

Decisions regarding topics to be covered during this interview were influenced mainly by the insights gained through participant observation and the results of Int. I.

The aim of this interview (Appendix F) was to probe the degree of satisfaction with the services rendered by the center; perceptions of the physical environment of the center; concepts of neighborhood, community, and community participation; and whether the center was thought of as a community facility or as "just another" health care facility.

A sample of 25 was chosen by using the names of Hispanic patients who had been drawn but were not needed for Interview I: 64 families or individuals were contacted before the necessary 25 respondents were found. The refusal rate was 11%. This time only the letter on center stationery (Appendix C) was sent before the interviewer contacted respondents directly to ask for an appointment.

Interviews were conducted in respondents' homes by two bilingual interviewers. They lasted from one to three hours.

Focused interviews--with center staff and council members were conducted by me during the summer and fall of 1973. They dealt with respondents' concepts of neighborhood and community; their aims and hopes for the center; their attitudes toward patients, medical care, community participation in the affairs of the center; and their perception of the quality of care rendered by NWHC.

Interviews with staff (Appendix H) also sought to determine whether recognition of the partial failure of career ladders (Pearl & Riessman, 1969) influenced the attitudes of indigenous personnel toward their work. Further, the interviews probed the interaction between the physical environment of the center and the functional and psychological well-being of staff. Another issue broached with staff concerned the effect which the concept of team care had on the formulation of personnel roles along non-traditional lines. The issue of the quality of supervision and administration was not part of the initial guide but was included later since it emerged as a concern in the first staff interviews.

Interviews with council members (Appendix I) centered

around perceptions of their responsibilities toward community and center.

A lack of community involvement had been indicated in staff interviews, my observations, and past elections for the council. Elections sometimes drew as little as 2% of the eligible voters. In the last election for council members, during the summer of 1972, about 3.5% voted--this was considered a good turn-out (Council meeting, 1972). Figures such as these were not restricted to this particular council (Sparer, et. al., 1970), or to neighborhood health council elections in general: Brieland (1971) and Moynihan (1970) pointed to similar results in all poverty program elections. The poor turn-out for the school board elections which took place in New York City in May of 1973 and 1975 indicates that such results are also not idiosyncratic to poverty program elections.

Focused interviews were deemed suitable for interviews with staff and members of the health council because these interviews dealt solely with their involvement with the center. By the time the guide for these interviews was drafted, the situation at the center had become familiar through participant observation; it was therefore possible to determine the significant variables with some degree of certainty.

The original plan was to talk to all members of the administration and community council, all supervisors, full-time

physicians and dentists. Samples for the rest of the center's employees were drawn by picking every second name of an alphabetical list for the staff of each department. The results of this sample selection are reported in detail in Chapters VIII and X.

Interviews took place at the center or the council offices and lasted from one to four hours. Most of them were taped.

Specific incidents

This method derived conceptually from the "critical incident technique" developed by the World War II Aviation Psychology Program and the American Institute for Research (Flanagan, 1954). "Essentially a procedure for gathering certain important facts concerning behavior in defined situations (p. 355)," it entails either observation or self-report to determine factors which further or hinder a given activity. The technique has been utilized mainly for military and industrial purposes to (a) determine the critical criteria for a given occupation or activity, (b) measure and/or evaluate performance, (c) develop training programs, (d) develop tests to predict performance, (e) describe and classify occupations, and (f) improve efficiency of operations and equipment.

The purpose of the critical incident technique is to determine the variables which are essential to the effective performance of a given activity. In the prsent study a somewhat

related procedure was utilized in order to determine which variables make given interactions satisfactory to one of the actors. Specifically, what factors must be present for a patient to be satisfied with the outcome of his visit to the center. "Satisfaction" in this context was defined as "getting the service one came for." The unit of analysis was one specific visit to the center, one particular encounter with one or more providers of care, as perceived by the recipient of this care--hence the term specific incident analysis. Personnel performance as such was not the focus of this part of the investigation; neither was there any intent to establish a series of objective criteria for "good" service. The object of this procedure was, rather, to get the subjective reactions of the recipients of this service while these impressions were still fresh in their minds. It probed the aims of the patient in coming to the center that day and whether they thought that these aims had been met.

The data were gathered in the fall of 1973 on the following days and hours:

Wednesday, 9/12.....1:30 p.m. to 8:30 p.m. (closing time)
Thursday, 9/13.....8:30 a.m. to 1:45 p.m.
Friday, 9/14.....10:30 a.m. to 5:00 p.m. (closing time)
Saturday, 9/15.....9:00 a.m. to 1:00 p.m. (total work day)
Monday, 9/17.....1:30 p.m. to 8:30 p.m.
Tuesday, 9/18.....8:30 a.m. to 1:45 p.m.

Two bilingual interviewers (one female, one male) were used at all times. All patients were approached as they left the center and were asked a few very simple questions, requiring only short answers (Appendix J). The refusal rate was 5%.

Pilot studies

One pilot study (O'Mara & Kirsners, 1972) was conducted in December 1971. It focused on patients' perception of the medical care offered by NWHC. This information was gathered through open-ended interviews which were guided by a small number of questions (Appendix B). We preceded our interviews by periods of observation of the waiting room at NWHC as well as waiting rooms in many clinics of its back-up hospital and one other large metropolitan medical center. The reasons for this were twofold: Our interest in the behavior of people in given types of physical environments, and a desire to have some base of comparison for assessing the physical set-up at NWHC.

The interviews for this study were conducted on three separate occasions with 31 patients who happened to be in the waiting room of the center. Evening hours were not sampled, and Hispanic patients who did not speak English could not be interviewed. No notes were taken during the interviews, but the information was summarized immediately following each talk.

Results revealed that most of those interviewed were satisfied with the services they received. They gave accessibility, speed of service, and opportunity to be treated by the same physician as the main reasons for their satisfaction. The quality of care offered by the outpatient department (OPD) of the center's back-up hospital was perceived as being generally as good as that rendered by NWHC, except that continuity of care with the same provider was usually not possible in the hospital clinics, and waiting times were much longer there. We noted that none of the patients seemed to regard the center as <u>their</u> community's project--it was just another health care facility.

This study pointed to the need for a more thorough interview schedule, a random sample of patients, and a Spanish-speaking interviewer for some of the respondents.

A second pilot study, consisting of unstructured interviews with the center's supervisory personnel, was geared toward learning their aims for the center and gathering information about their attitudes regarding neighborhood health centers, career ladders, and community participation (Appendix F). As these interviews were conducted by me in the spring of 1972--that is after I had begun participant observation--they also served as a means for becoming acquainted with the supervisors, so as to solicit their approval and cooperation for the research project.

These interviews left the impression that, although there was on-the-job training and quite a bit of occupational mobility of paraprofessi-nal and clerical personnel within the center, they had difficulty utilizing their acquired skills in other health care facilities because they still lacked official credentials. Some of these employees, realizing this, had started to attend city colleges on their own. Although this might eventually ensure upward mobility for a few individuals, it is hardly in the spirit of alternate routes to mobility (Pearl & Riesman, 1969).

Most of these supervisors appeared to have a high degree of commitment to the aims of the center and to community participation. All seemed quite happy to have the study carried out.

Summary

Fig. 3 shows a time-frame, spanning the entire period of the study. It is hoped that by entering the dates and duration of each of the research methods, a sense of coordination between the methods can be gained.

As can be seen on Fig. 3, participant observation was carried out throughout this study. The insights gained through this method guided formulation of questions to be covered with patients, staff, and council members. Results of earlier interviews, in turn, helped shape topic areas for later ones.

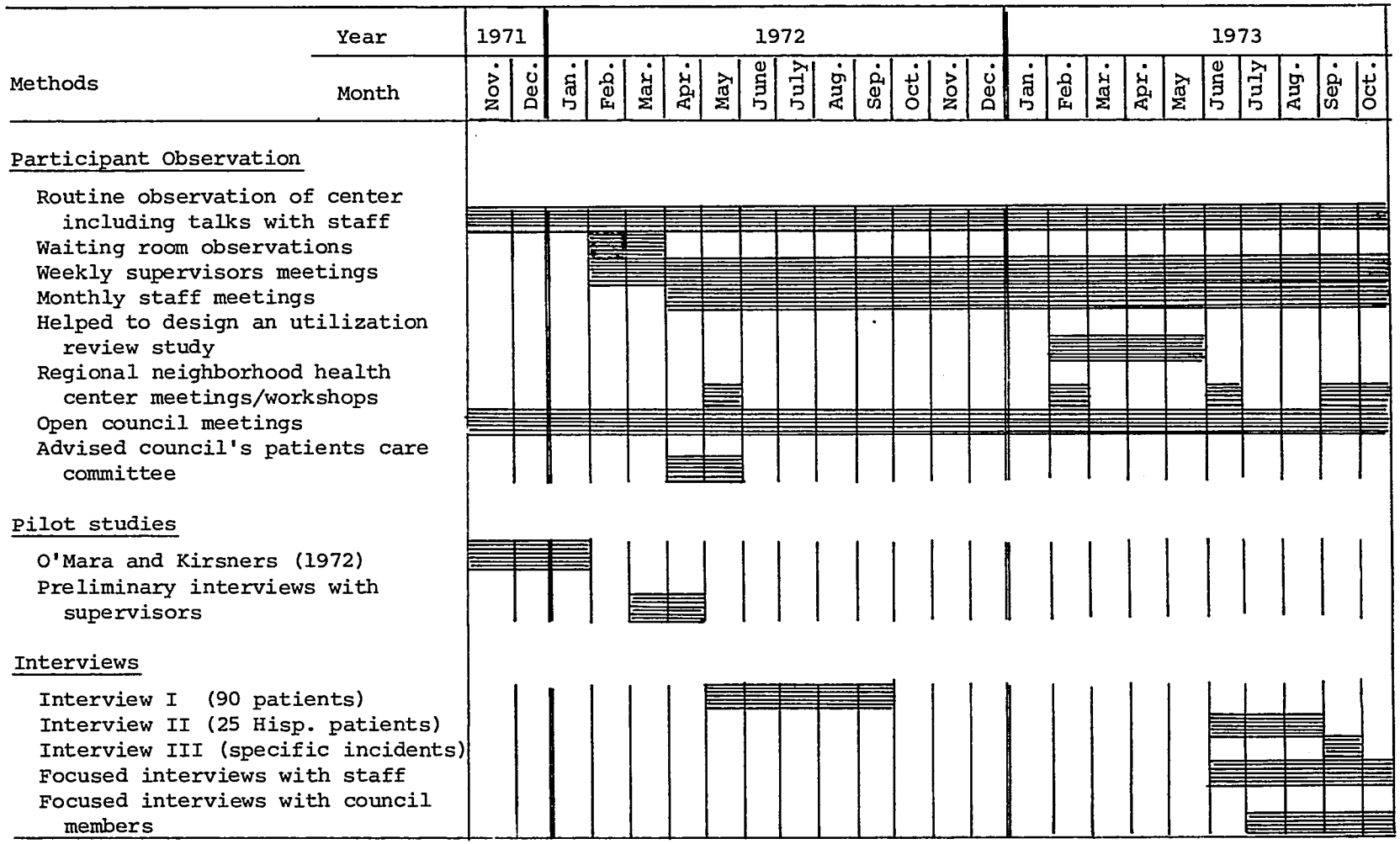

FIG. 2. Time frame of methods for the study of the North-West Health Center.

PART II

DESCRIPTION OF FINDINGS

CHAPTER VIII

THE NORTH-WEST HEALTH CENTER--ITS SETTING, OPERATION, AND STAFF

The objectives of NWHC, as stated in the original proposal to OEO (St. Luke's, 1967) stressed

1. good, comprehensive, continuing team care for the poor of the catchment area who had previously received inadequate care;

2. opportunities for poor residents of the area to receive on-the-job training at the center. This would not only provide immediate work for these individuals, but was also meant to open career opportunities in the health care field in general. The concept of career ladders was meant to alleviate the difficulties presented by prevailing accreditation systems in various service professions.

3. The last objective was to find a viable procedure for working with the community.

It was anticipated that these objectives would be facilitated by placing the clinic near the geographic center of the catchment area and, therefore, within easy reach. It was hoped that the patients would feel more comfortable with non-professional staff from the same cultural and socioeconomic backgrounds and that these

community people, in turn, would be more attuned than predominantly White, middle-class professionals to the special needs of the patients. The system would provide indigenous personnel with avenues for careers in the health care field; and that these individuals would serve as disseminators of health care knowledge in the community.

NWHC was open to its patients four evenings a week and on Saturday mornings, in addition to the usual five-day business week. Approximately 200 patients visited it during an 11 1/2-hour day, and 138 people were employed there (see table 8.2; the number of employees fluctuated somewhat over the two-year period of this study). The clinic provided ambulatory medical, dental, psychiatric and social services. Some laboratory and X-ray work was carried out on the premises; patients went to NWHC's back-up hospital for more complicated tests. This hospital, a voluntary teaching institution, which was located four blocks from one boundary of the center's catchment area, also provided center patients with in-house and specialty clinic services. With the exception of hospitalization, NWHC reimbursed the hospital for all services rendered to center patients.

NWHC was administered jointly by the North-West Neighborhood Health Council (N-W council) with offices near-by and by the back-up hospital. The center's administrative personnel was wholly responsible for the

operation of the facility and was accountable to the N-W council, the back-up hospital and, ultimately, HEW. They could not institute organizational and/or procedural changes without the approval of these bodies. In practice, freedom from council interference or veto depended largely on the administration's relationship with the council at any given time; this relationship has varied with changes in each. The back-up hospital, on the other hand, routinely allowed the center a large degree of autonomy unless hospital interests were involved, as for example, in the question of the amount of time spent by NWHC physicians in the hospital's outpatient department (OPD) clinics; granting clinic physicians admitting privileges at the hospital; or the setting of fees paid by the center to the hospital for services rendered to center patients.

Financial support

Funds for the center's operation come from HEW and from such third-party payment agencies as Medicaid and Medicare. Since the hospital was the grantee, it administered the federal grant funds. Thus, for example, center employees were paid through the hospital and this institution--after submitting its bills to the center's fiscal administrator--deducted its own charges from the federal funds. The center was responsible for collecting its own third-party reimbursements and finding such

additional sources of revenue as training grants or money to launch pilot projects. NWHC was not allowed to operate at a deficit, and budget surplusses usually reverted back to HEW. Under OEO sponsorship, this agency made up any operating deficits. With HEW sponsorship, NWHC could apply for additional funds during any year when a deficit loomed. No such emergency arose during the two years of this study. If and when the council assumes granteeship, a mutually acceptable contractual agreement between the back-up hospital and center will be worked out regarding back-up services, their financing, and admitting privileges for center physicians.

The center paid the back-up hospital for all of its outpatient services to center patients. Under both the OEO contract and the beginning of HEW sponsorship, until mid-1972, the hospital charged the center's grant-money account the published rates for all ancillary services (a different price for each procedure) and the prevailing Medicaid reimbursement rate for every emergency room and specialty clinic service to any center patient, regardless of the patient's Medicaid status. This meant that the center paid $31.92 per patient visit in 1967, progressively more over the years as the Medicaid rate rose, until it reached $37.92 in 1973. If a patient needed more than one service on a given day, the center paid multiple charges.

This fee seems high since all center patients

qualified for Ghetto Medicine support. Ghetto Medicine was a 1968 State Public Health Law Amendment whereby the state undertook to reimburse approved clinics for the deficits which remained from their treatment of the poor after the clinic had collected from all possible sources such as Medicaid, Medicare, patient fees, etc. (Bernstein, 1970). The fees charged the patient by various clinics--mainly OPDs of voluntary hospitals, differed, but were usually around $4.00-5.00 per visit. Thus, if a center patient did not show his center card, the hospital collected $4.00 from him and the rest from Ghetto Medicine; if he showed his card, the hospital collected over $30.00 from the NWHC account.

In April 1972, a new center administration, feeling they were being overcharged by the hospital, alerted the N-W council to these practices. After pressure, the hospital agreed in July 1972 to charge the center Ghetto Medicine fees for all hospital clinics used by center patients, and in October 1972 it agreed to a 35% discount for ancillary services. Though the charges here remained extremely high, the hospital refused to consider any further reduction. The probable reason is that ancillary services present a profit factor in the budget of any voluntary hospital, helping to defray some of the OPD and in-house deficits. In the budget period of November 1, 1969 through October 31, 1972 the center paid the hospital

$637,051 in fees for services rendered its patients; 59% of this amount (or $378,062) was for ancillary services.[15]

The amount the center saved with the new agreement has increased since October 1972 because

1. Medicaid reimbursement rose from $37.72 per visit in 1973 to $39.23 on January 1, 1974, and

2. the Ghetto Medicine fee was reduced from $4.00 per visit to $3.00 in August 1973.

While this study was in progress NWHC operated with yearly budgets of approximately $2.4 million for 1971-72 and $2.8 million for 1972-73 (see table 8.1). The budget, ostensibly a joint effort of hospital, council, and center has--during the period of this study been worked out by the center's administration, especially its fiscal administrator.

The generally higher figures shown for 1972-73 were in line with rising costs in the health care field. Savings shown for "patient care" were due to the above mentioned lowered charges by the back-up hospital. It should be noted that collection of third-party reimbursement had increased. Whereas the center collected $1,007,364 (or 43% of the total budget) from such sources in 1971-72, the amount rose to $1,319,137 (or 47%) in 1973-73. The percentage covered by the HEW grant has therefore declined

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[15]Personal communication from center staff.

TABLE 8.1

COMPARISON OF RECENT NWHC BUDGETS[a]

	1971-72	1972-73	$ amount of change	% of change
Source of Funds				
HEW	$1,400,000	$1,477,000	$ + 77,000	% + 5.50
Title XVIII (Medicare)	10,000	82,000	72,000	720.00
Title XIX (Medicaid)	952,364	1,191,774	+239,410	+ 25.13
Other	45,000	45,000	-	-
Total	$2,407,364	$2,796,137	$+388,410	% + 16.14
Disposition of Funds				
Administration	$ 68,409	$ 66,137	$ - 2,274	% - 3.32
Business office	67,279	85,602	+ 18,323	+ 27.23
Information systems	150,588	200,238	+ 49,650	+ 32.97
General services	96,131	110,338	+ 14,207	+ 14.77
Training	33,278	34,523	+ 1,245	+ 3.74
Medical	494,935	502,362	+ 7,427	+ 1.50
Laboratory	28,375	29,021	+ 646	+ 2.27
X-Ray	21,427	38,942	+ 17,470	+ 81.36
Pharmacy	-	41,604	+ 41,604	-
Mental health	135,318	193,578	+ 58,259	+ 43.05
Dental	202,322	235,727	+ 33,405	+ 15.51
Clinic	161,902	165,831	+ 3,929	+ 2.42
Outreach	246,810	305,841	+ 59,031	+ 23.91
Fringe benefits	200,090	225,585	+ 25,495	+ 12.74
Miscellaneous[b]	-	111,156	+111,156	-
Total personnel costs	$1,906,910	$2,346,483	$ +439,573	% + 23.05
Patient care[c]	203,320	143,000	- 60,320	- 29.66[c]
Equipment	26,199	11,100	- 15,099	- 57.63
Construction	50,000	45,000	- 5,000	- 10.00
Health council	35,000	46,854	+ 11,854	+ 33.86
Other[d]	135,935	203,700	+ 67,765	+ 49.85
Total budget	$2,357,364	$2,796,137	$ +438,773	$ + 18.61

[a]Adapted from figures received through fiscal administrator.

[b]Covers estimated salary increases per union negotiations.

[c]An approximate estimate of cost per patient could be obtained by setting up a ratio of budget/total number of patients. This would, however, be misleading because utilization of the facilities varies drastically among patients. It was, therefore, not used here.

[d]This category covers supplies, communication costs. etc.

from 59% to 53% respectively.[16]

The physical environment of NWHC

The catchment area of NWHC was one of the most densely populated in the world (Lyford, 1966). Its multi-ethnic, multi-lingual population covered a wide spectrum of socioeconomic levels (see table 8.2). Housing ranged from elegantly restored brownstones, to recently completed urban renewal buildings, to an ever increasing number of run-down and overcrowded dwellings (Planning Commission, 1969). Population turnover, especially among the poor, was great (Lyford, 1966). A mixture of residential and commercial land-use, large park areas, and a good network of public transportation made this neighborhood convenient and attractive. An influx of society's dispossessed, however added fear of crime in the street to the ambience of the area.

NWHC was housed in a City Department of Health (HD) building, part of which was occupied by a public library which had its own entrance. Grass, shrubs, and a few trees filled the space between the two wings of this low-rise, U-shaped building--the site looking inviting. NWHC's presence was indicated by a fairly large sign on the fence which separated this space from the sidewalk.

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[16]Percentages throughout this report are rounded off to the nearest whole figure.

TABLE 8.2

ECONOMIC CHARACTERISTICS OF FAMILIES LIVING IN THE CATCHMENT AREA OF NWHC

Family income	Total population		Black population		P.R. population	
	% of families	No. of families	% of families	No. of families	% of families	No. of families
Below $1000	3.13	933	5.55	305	6.31	264
$1000-1999	2.30	730	4.02	221	4.11	172
2000-2999	4.21	1336	4.28	235	7.08	296
3000-3999	4.69	1490	6.32	347	10.55	441
4000-4999	5.43	1725	7.96	437	9.26	387
5000-5999	6.61	2098	9.40	516	13.32	557
6000-6999	5.99	1902	8.59	472	10.33	432
7000-7999	6.24	1982	9.07	498	7.70	322
8000-8999	5.52	1754	7.43	408	6.46	270
9000-9999	4.40	1396	5.08	279	4.52	189
over $10000	51.49	16351	32.30	1774	20.35	851
Total	100.01[a]	31757	100.00	5492	99.99[a]	4181
Other economic characteristics						
Below poverty level	10.04	3190	16.66	915	24.25	1014
Receiving public welfare[b]	9.42	2992	- - - no information - - -			
Receiving public assist. income[c]	32.07	10185	30.1	1653	51.52	2154
With female heads	4.96	1575	10.32	567	13.99	585

Note: This table is adapted from information which appears in the 1970 Census of Population and Housing (U.S. Government Printing Office, 1972); the figures for the fourteen census tracts which comprise the centers' catchment area are combined.

[a]Percentages do not add up to 100% because of rounding of figures to the nearest two decimals.

[b]This includes such programs as Aid to Dependent Children (ADC) or Home Relief (HR).

[c]This is the Social Supplemental Income (SSI) program for the old and/or disabled (Old Age Assistance or OAA, and Aid to Disabled or AD).

The entrance to the HD building led up a few broad steps and through a large, double glass door. This brought one into a big, well lit, clean hall in which there was only one counter and switchboard, manned by one HD employee. This hall was used by HD as additional waiting space a few hours during the week.

The dental department of NWHC occupied 700 square feet adjoining this hall. It had a relatively large waiting room which it shared with HD's dental services, but the treatment rooms were extremely small--there was hardly room enough for chair, dentist, and dental assistant (DA). The fact that this department was located on the main floor and the rest of NWHC on the second floor seemed to set the dental department apart from the rest of the clinic. Interviews showed, for example, that dentists (with the exception of the director of the department) were less well informed about center affairs than were other doctors; some patients did not know that this department was part of NWHC; and physicians did not always refer patients for routine dental check-ups as part of the initial health assessment. The spatial separation tended to hamper communication and prevented some of the dental department employees from feeling and acting as part of the center.

The main part of NWHC occupied 10,600 square feet on the second floor which could be reached either by elevator

or a staircase; there were no very visible signs directing patients to NWHC.

If the HD entrance hall and the stairwell appeared large, cold, bare, and clean, entering the second floor was like stepping through one of C. S. Lewis's magic doors into another world. Here one encountered constant movement of NWHC's staff, patients--some with baby carriages or in wheelchairs--and, not infrequently, outsiders such as repairmen, salesmen, etc. . . . or researchers. There was incessant low-level noise, augmented in summer by the whirring of fans and window air conditioners.

The entrance and some hallway walls were covered with very pale pink ceramic tiles. All the walls and ceilings in corridors and the clinic area, and nearly all the offices, were painted dull yellow or beige, grayed by time and in need of redecorating. Doors and metal office partitions were bright orange enamel with black trim which emphasized the small size of the clinic because of continuous breaks in wall-surfaces. Physicians' offices (i.e. examining rooms), the playroom, coffee room [which also served as the locker room for medical assistants (MAs)], and the X-ray department formed the outer perimeter of the clinic area (see fig. 2, appendix A). Appointment and intake departments were partitioned off within this area; the waiting room was enclosed on two sides by additional low partitions. Off-white, acoustic tiles,

some of which were broken, lowered the ceiling to 8 1/2 feet in the windowless hallway leading to the clinic area and in the inner core of this area which was, of course, without windows too. NWHC had no central airconditioning. Most offices, however, had window airconditioning units installed over the years. While these did not offer relief to individuals outside these offices, they did cause occasional power failures because of overloaded electrical circuits.

Ventilation in the clinic area was often bad and lighting poor. Existing overhead fixtures in most of NWHC were quite inadequate when first installed; with age they became even less efficient because their diffusers had become dusty and yellowed. Chairs in the waiting room, despite brightly colored plastic seats and backs, did little to enliven the area because they were placed in straight rows with little space between the rows. The small, brown wooden desks of MAs in front of each doctor's office were scuffed and scarred. A profusion of improvised signs cluttered much of the wall-space.

The second floor part of NWHC had only one toilet each for men and women. This was inadequate because these toilets had multiple uses: They were for adults and children; for staff, visitors, and patients; they also had to serve as the place where patients provided their urine specimens and staff members could seek a few moments privacy. Most

employees tried to utilize washroom facilities on other floors of the building.

NWHC was too small for an operation of its scope. During peak hours--weekdays from about 9:30-11:30 a.m. and 1:30-3:00 p.m.--the central clinic area of approximately 1600 square feet (not including the offices surrounding it on three sides) could hold as many as 40 patients, about 10 MAs, and 10-12 members of the appointment and intake staff. This did not take into account physicians leaving their offices, patients entering or leaving these offices or sitting at the MAs' desks, FHCs bringing patients, or any other staff member who might be in this area temporarily. Patients could not always find seats while waiting; passages, offices, and the playroom were crowded; there was an impression of constant movement and unrest. Despite this periodic crowding the noise, though steady, was usually not great compared to hospital OPDs--this appeared to be at least partly due to the absence of the usual public address and paging systems, as well as to the presence of vinyl tile floors throughout the clinic.

Except for the examining rooms, there were no places in which patients could be assured of privacy--the information they gave to intake personnel, the family problems they discussed with family health coordinators (FHCs) or MAs could often be overheard by others sharing the same space.

Staff members had no space in which to take a break in comparative privacy. FHCs, nurses, and clerical personnel shared offices into which the maximum number of desks, chairs, and office equipment had been squeezed. Whatever was said in the office of the fiscal administrator or the director of information systems could be overheard in the adjoining office, unless one kept one's voice low. The project director had one of the few offices which was comparatively private and comfortable, though not really soundproof. It was also somewhat separated from the clinic, since it was located in one of the corner offices on the floor. Because of this, the project director did not appear as easily accessible to most of the staff as her professed open-door policy should have promoted. The layout of the clinic generally seemed to hinder easy communication among various staff members.

The Mental Health and Social Service Unit (MHSS) was separated from the main clinic area. It did not have an office for each provider, it had no waiting room--their waiting patients occupied chairs ranged along the walls of two hallways. If people felt self-conscious about having to seek psychiatric or social service aid, this arrangement could cause embarrassment. Privacy in consultation, apart from therapy sessions, could not always be assured because of the lack of office space. Privacy for therapy sessions could often only be obtained

by displacing some MHSS staff members from the office space allotted them, or by such stratagems as meeting patients on a parkbench when the weather permitted.

With the exception of the project director, medical director, and fiscal administrator, no supervisor or line supervisor had a private office. This could prove awkward when disciplinary measures had to be discussed with some staff member. Space was at a premium in all departments, particularly in the medical records room, laboratory, business office, appointment and intake departments. There was no meeting room--meetings had to be held in HD's auditorium, which meant that they could only take place when HD did not need it.

The clinic was cleaned every day after closing, and members of the housekeeping department cleaned the washrooms and hallways several times during the day. The facility nevertheless looked somewhat messy by mid-morning due to the large number of people in it--this was much worse on rainy days.

Some of the above, and the following concluding comments represent subjective impressions--the way NWHC struck me, both on first acquaintance and after two years. As will be shown later, many of these impressions were confirmed during interviews with staff and, to a much smaller extent, patients. Neither the original floor plan nor subsequent subdivisions seemed to fill the needs of an

outpatient facility. Partitions appeared to be makeshift and often did not really serve the purpose they were meant to achieve, such as auditory privacy. Attempts at redecorating the place did not dispel its basic drabness. Signs, posters, and cartoons pasted over much of the wallspace were intended to add a personal touch, but they only served to increase a sense of clutter and untidiness. Above all--the place simply was too small.

Center staff

Changes in center staff (as well as in council membership) occurred while this study was in progress (November, 1971-October, 1973), and since then. Data which are offered here and later regarding these two groups refer to the spring of 1973, the time shortly before interviews with samples of these groups were undertaken.

Of the 138 people employed at the center in the spring of 1973, 124 (90%) worked full time and 14 (10%) worked part time; there were representatives of various ethnic groups, with Hispanics constituting the single largest one (see table 8.3). Most staff members were assigned to one of the five teams serving center patients.[17] Table 8.3 shows a rather heavy concentration of Whites among medical personnel and of Hispanics among para-professionals; more generally, it points to a somewhat

[17] A more detailed discussion of the teams is presented in chapter XI.

TABLE 8.3

COMPOSITION OF CENTER STAFF (SPRING 1973)

Job category	Employment			Sex		Ethnic Group				
	Full time	Part time	Total	Male	Fem.	Hisp.	Black	White	Haitian	Other
Administration[a]	4	-	4	1	3	1	2	1	-	-
Physician[b]	12	5	17	11	6	1	1	13	-	2
Dentist	4	2	6	6	-	-	2	4	-	-
Mental Health and Social Services (MHSS)										
Psychiatrist	2	-	2	1	1	-	1	1	-	-
Psychologist	-	1	1	1	-	1	-	-	-	-
Other professional	2	-	2	-	2	-	-	2	-	-
Paraprofessional	4	-	4	-	4	2	1	1	-	-
Clerical	1	-	1	-	1	-	-	-	1	-
Nursing Department										
Outreach:										
Public Health Nurse	4	1	5	1	4	1	3	1	-	-
Paraprofessional	15	-	15	3	12	7	5	1	2	-
In-house:										
Registered Nurse[c]	3	1	4	-	4	1	2	1	-	-
Paraprofessional[d]	21	2	23	-	23	16	5	-	2	-
Laboratory and X-Ray										
Technician	4	2	6	4	2	1	3	-	-	2
Paraprofessional	1	-	1	-	1	1	-	-	-	-
Clerical	1	-	1	-	1	1	-	-	-	-
Training Department	2	-	2	1	1	-	-	2	-	-
Clerical[e]	36	-	36	5	31	22	11	1	2	-
Housekeeping	6	-	6	5	1	5	1	-	-	-
Security	2	-	2	2	-	2	-	-	-	-
Total	124	14	138	41	97	62	37	28	7	4

Note: Most departments have supervisors who perform line duties in addition to their supervisory functions; these individuals are tabulated according to their regular job category--not separately.

[a]This includes one project director and three supervisors in charge of more than one department who perform solely supervisory and administrative functions.

[b]Psychiatrists are listed with the Mental Health Services.

[c]This job title at the center is "Family Health Coordinator".

[d]This job title is "Medical Assistant" or "Dental Assistant".

[e]Included here are: business office, medical records, appointments, intake, receptionists, telephone operators, secretaries--not mental health or laboratory clerks.

uneven distribution of various job categories among the different ethnic groups (see also table 8.4).

TABLE 8.4

SIGNIFICANCE OF DIFFERENCE BETWEEN PROPORTIONS IN VARIOUS JOB CATEGORIES

Job Category	Ethnic Group				Total
	Hisp.	Black	White	Haitian/ Other	
Physician, dentist	1	4	18	2	25
Administration, nurse social worker, technician, training dept., psychologist	5	10	7	2	24
Paraprofessional, housekeeping[a]	33	12	2	4	51
Clerical	23	11	1	3	38
Total	62	37	28	11	138

$\chi^2 = 69.41$, df = 9, $p < .001$

NOTE: The minimum expected frequency for the above table is 1.9. Although, according to McNemar (1969) a minimum expected frequency of 2 is acceptable where the degrees of freedom are not small, a Chi-square without the "Haitian/Other" category was calculated. This yielded a minimum expected frequency of 4.85, N = 127, $\chi^2 = 68.83$, df = 6, $p < .001$. The dropped category was, therefore, retained.

[a]This group was included with the paraprofessionals to avoid a minimum expected frequency of less than 1.0.

In describing the functions of the groups depicted on Table 8.3, an historical approach is necessary. This is especially true of administration: First, because practices of the previous administrations still greatly

affected the work of administrations in office since mid-1972 and second, because most of the drastic changes in composition, function, and style took place in this group over the duration of this study.

Impressions

Following are my subjective impressions regarding center staff. Where possible, these will be substantiated by examples which led to these impressions. Beginning with material on p. 178, more concrete data regarding staff's functions will be offered.

At the time research was started, center administration--then consisting of a non-medical project director responsible for the whole operation, a medical director and an administrator--and supervisory personnel were two very distinct entities. The latter group was then comprised of two nurses in charge of in-house and out-reach nursing services; one business manager; one training director; and one person in charge of data processing, intake, medical records, and appointments (by the fall of 1971 he was in the process of training one staff member in each of these departments to assume line-supervisory responsibilities). A dentist and a psychiatrist doubled as supervisors of the dental and MHSS departments respectively. By the time the field work was completed several of these individuals had left center employment,

the roles of some others had changed, and the relationship between the new administration and some of the supervisors was quite different.

Under the old regime the level and degree of communication between administration, supervisors, and the rest of staff appeared less than optimal. There was no provision for regular staff meetings. Weekly supervisors' meetings, while seemingly inviting an open exchange of opinions, left much to be desired regarding the completeness of information imparted by the project director on the one hand, and the adoption of suggestions coming from staff or supervisors on the other. Thus, implementation of teams was often debated, but no concrete steps were taken to make them operative throughout the center--nor was any explanation given why there was a seeming reluctance to proceed with the teams.

The project director, a forceful, charismatic, and intelligent individual with power in the community, gave the impression of playing politics 24 hours a day, on and off the job. This eventually caused friction among staff. FHCs as a group, for example, were favored (higher salaries, less stringently supervised functions) over MAs. A number of people voiced the opinion that FHCs were favored because their work actually took them into the community and they could thus serve as the director's emissaries in the community. It is, of course, impossible to assess the

veracity of this allegation now. Another cause of friction was misleading information which was allowed to circulate. When, for example, one of the secretaries was dismissed because of personality clashes with a member of the administration, the latter made unsubstantiated allegations about financial irregularities by the former, instead of giving the real reason for the dismissal. This affair was permitted to get out of hand until both center staff and council members were divided into feuding factions. The preoccupation with community-based support often precluded initiation and follow-up of innovative ideas: It was felt that nothing should be done without the consent of the community, yet few steps were taken to obtain this consent. Situations such as these were responsible for continuing difficulties at the center throughout the period of this study.

In the spring of 1971 differences between the project director and the N-W council culminated in the resignation of the former. The council appointed one of the nursing supervisors as interim project director as of mid-March 1972 and the appointment of this person was made permanent a few months later.

This new project director established good relations with the council, instituted regular monthly staff meetings at which staff received detailed and, as far as I could ascertain, accurate reports on all matters concerning the

center, and invited a truly open exchange of opinions. I was able to verify the information given to staff on many occasions because records, HEW directives, etc. were made available to me by the administration, and I attended staff meetings at which the information was made public. Thus, for example, I saw the budget which had been approved by HEW and heard it discussed with staff. Many plans continued to bog down in the planning phase for various reasons, usually because there was not enough follow-up by administration. Communication remained bad. These points will be discussed at greater length in chapter XI.

The new director's old supervisory duties were assumed by the other nursing supervisor. The functions and influence of the business manager (who later became fiscal administrator) and the data processing supervisor (or director of information services) were also augmented. The administrator, nursing supervisor, fiscal administrator, and director of information services formed an inner circle which helped the project director run the center. When the administrator resigned in the beginning of 1973 he was not replaced. His functions were absorbed by the other four people. Since they, in fact, administered center affairs at least until the end of this study, they are

here referred to as the "center administration."

The medical director never became part of this inner circle. A basic mistrust between him and the others had possibly been fostered and nurtured by the former project director. There were, in addition, personality difficulties. Although sincerely interested in community health and participation, he gave the impression of having a sense of mission to "do for" people. Much of lower-level staff felt that his manner was condescending--a counterproductive approach when dealing with people who mistrust the medical establishment as such. The fact that he often appeared to "negotiate" on the behalf of physicians vis-à-vis administration (e.g. he fought against their having to reduce the hours spent at the back-up hospital for which the center paid them) did not help his position with this group or with most of the others who attended supervisors' meetings. It is ironic that it was the center physicians who forced his resignation in the spring of 1973. When this study was completed he still had not been replaced. Several of the staff physicians successively filled this role in addition to their regular duties.[18]

Relations between the new administration and the N-W council were continually strengthened through mutual trust,

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[18]A new medical director was appointed as of May 1974.

good communication, and tact on the part of administration--necessary because, according to some council members, this group sometimes abdicated responsibility and often had to be guided in the decision-making process. The relationship remained very good for about one year. Then, according to informants at both the council and NWHC, a new member on the council staff started to question the project director's role at the council, her right--as an employee--to participate in Executive Committee decisions. This weakened the position of the project director and the other members of the administration. Although this council staff member only stayed on the job for a few months, he succeeded in destroying all trust. Unfortunately it was never fully re-established.

The project director's policy of honesty and open channels of communication had a varied effect: it worked best with the small group at supervisors' meetings, less well with the rest of staff. Supervisors' meetings were attended by the administration, the medical director (as long as he was in office), supervisors of the dental, MHSS, and training departments, all line supervisors, representatives of paraprofessional personnel, laboratories, and physicians. As is the case in all groups, some of those who attended were more vocal than others. Although it was often paraprofessionals and line-supervisors who were the silent ones, I did not get the feeling that this was due

to mistrust, ill-will, or discomfort, but rather because of some remaining diffidence. Whatever feelings of insecurity may have existed to start with were alleviated by open discussion. Most group members, regardless of status, worked hard and well-especially in emergencies. While some individuals disliked and/or mistrusted some others, such feelings never became generalized, and did not interfere with group functioning.

The picture was entirely different as far as the rest of staff was concerned. General staff meetings were, by their very nature, more unwieldy. These meetings were held once a month, always on the same day, during the lunch break. Half the staff attended while the other half was on duty, and 45 minutes later they changed place. Since the available time was very short, and the groups large, the project director delivered a condensed report on all important issues concerning the center (the same to both groups) and then invited comments and discussion. Unfortunately, these issues were often of a financial nature because of an ever-present threat of reductions in grant money.[19]

I observed the following phenomenon at every meeting dealing with finances which I attended: The director would start her report; there was silence and faces were

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[19]See chapter 2,

attentive; after a few minutes there was a sudden withdrawal of attention which was almost palpable. Everyone still pretended to be attentive, but did not seem to absorb much of what was being said. Talking with people after these meetings showed that many left the meetings as ill-informed as they had been when they came to them. In addition, this impression was confirmed first by the rumors which circulated continuously throughout the center, and later in my interviews with staff. A few reasons for this withdrawal of attention and suspension of belief soon became obvious:

1. Staff had been misinformed too often in the past to be willing to accept an administrator's word.

2. Their jobs seemed to be threatened. As will be seen later, most non-professionals at the center feared, quite realistically, that they would not be able to find another job with the same pay and working conditions. They did not want to face a threat to the status quo.

3. Attempts to unionize all non-professional staff except guards had started in February 1973; the union was voted in overwhelmingly at the end of April, and contract negotiations started around June. A handful of staff members who were actively promoting the union had been circulating rumors about tremendous budget surplusses, hidden money, and excessive salaries for administration and supervisors since the beginning of the year. The

charge that the center had money hidden was made during union negotiations.

4. The panic button was pressed too often. Why pay attention to repeated dire predictions if they never materialize? The following randomly selected excerpts from my notes taken during meetings--and confirmed by the official minutes of these meetings--will serve as examples.

Feb. 24, 1972 -- "The program is in a precarious financial state."

March 9, 1972 -- "A 100 million dollar allocation for 314-e programs is proposed for 1973, 80 million of this is for neighborhood health centers--this means a 9 million deficit as matters stand now. But OEO is still in the process of transferring centers to HEW--this deficit will therefore get bigger because more centers will have to share the 80 million. We must anticipate a cut from our present 1.4 million grant."

June 22, 1972 -- "We are facing a serious money shortage . . . must consider discontinuation of free prescriptions for patients without Medicaid."

(This proposal was never implemented.)

Nov. 9, 1972 -- "The situation is bleak. There is a trend to do away with all categorical grants. There is no constituency for health legislation, the budget for health can therefore be cut drastically--in fact, Nixon has now vetoed all HEW funds, except one."

Feb. 1, 1973 -- "The transfer of all OEO centers to HEW will be completed within 4-6 weeks, all will face a budget cut of 14-18%--we are all in financial trouble, all fighting for survival."

March 31, 1973 -- "The shortage of money forces us to stop all, except the most urgent overtime."

May 31, 1973 -- "The requirement that neighborhood health centers become financially self-sufficient by July 31, 1973 has now been published in the Federal Register. This means that, theoretically, we could be left without grant money next year."

(The Secretary of HEW rescinded the edict for self-sufficiency later; see chapter II.)

June 28, 1973 -- "We expect a further cut from HEW, despite the fact that 314-e has been extended for another year."

Sept. 13, 1973 -- "We have no money to fill vacancies on any line except physicians."

Most staff members did not listen to the explanations of why the worst had not taken place after all (the fiscal administrator had made third-party payment collection much more efficient; she had managed to reduce the fees charged by the back-up hospital; one politician had succeeded in getting some threatened Medicaid funds reinstated; administration had managed to convince HEW not to carry out anticipated budget cuts). All staff perceived each month was that the threatened doomsday never arrived.

5. In her attempt to be completely honest with staff, the new project director erred in the opposite direction by presenting overly detailed financial reports. Most staff members were rather uneducated in political and financial matters, so they found budget figures reaching into the millions difficult to comprehend, and the

Washington alphabet agencies confusing. The director might have appeared to exhibit her superiority in reporting these matters, since she obviously was at home with them.

Feelings of insecurity soon degenerated into a generalized sense of dissatisfaction and poor morale, which apparent lack of supervision did nothing to alleviate. This lack was due in part to the fact that the workload of administration was too large. Perhaps more important was the style of supervision of some of these individuals. Believing that all staff members should be imbued with a sense of mission and responsibility, the project director and supervisors cum administrators felt everyone would be able to carry out their duties with a minimum of direct supervision. Unfortunately the work ethos of many of their supervisees did not warrant such an assumption; this was no less true of physicians and department supervisors than of non-professional staff. It was perhaps unrealistic to run an organization like the center with an administration of four (three of whom doubled as supervisors of multiple departments) and, later, without a medical director. This was especially true during a period of change and insecurity regarding the future of the center.

With the above as background, it is now possible to give a brief outline of the duties of each of the groups listed on table 8.3.

Staff categories and sampling procedures for focused interviews

Administration. This group carried out policies which it formulated in cooperation with the N-W council. The three supervisors were each responsible for two to five departments. The project director and at least two of these supervisors also dealt with fiscal matters (including recurring crises), attended several council meetings weekly, attended regional and national neighborhood health center organization meetings and seminars several times each year, kept abreast of and implemented changes in government policies, and contacted local and national political figures whenever help for the center was needed.

All administration members were interviewed several times. In addition, frequent informal contacts were possible.

Physicians. Until July 1972, physicians were supposed to spend 28 hours per week at the center and 7 hours per week at the back-up hospital for duty in OPD clinics and for educational rounds. This arrangement was perceived as less than equitable by most of the non-medical staff. This was due at least in part to the fact that released time for educational purposes had been severely restricted for the rest of staff with successive budget crises. It was also claimed that many physicians came late and left early and, therefore, were not even putting in 28 hours a week. The back-up hospital rarely turned

over to the center money it received from such agencies as Medicaid or Ghetto Medicine for patients seen by NWHC physicians in its ER or SCS. Whether this was due to clerical problems or because center physicians failed to sign in was difficult to establish. The hospital did not pay its own physicians for educational rounds, yet the center made such payment to NWHC doctors.

NWHC's administration and the N-W council came to an agreement with the back-up hospital whereby the center paid its physicians for only three hours weekly for OPD duty as of July 1, 1972. Pay for educational rounds at the hospital was discontinued--physicians were, of course, free to attend these rounds on their own time. At the time this study was concluded, the fiscal administrator was trying to work out a mechanism which would allow center physicians to be clearly identified when working at the hospital OPDs so that the center could receive part of whatever third-party payment the hospital collected.

Most of the center's physicians were not granted attending privileges at the back-up hospital although all were board certified or eligible. Several physicians mentioned that this reflected poorly upon their professional competence--they therefore perceived this lack of admitting privileges as a blow to their self-esteem. But many of them also felt that it made continuity of care by one physician impossible. Since it is necessary to know the

history of a patient to make the most appropriate treatment possible, these doctors believed that center patients could not always be assured of the most efficacious care when they had to be admitted to the hospital.

Another factor which obviated continuity of care was physician turn-over at the center. Lack of attending privileges was thought by some physicians to have contributed to the large turn-over of internists; most pediatricians had these privileges, and they seemed to have greater longevity at the center.

For all practical purposes, center physicians worked without supervision during the time of this study. Although there was a medical director for part of this time, he appeared to lack strength and authority. This may have been one reason for the low morale evident through observation and in conversations; it may also have contributed to a productivity rate which HEW considered less than optimal. Neither morale nor productivity appeared to change when this group forced the medical director out.

Physicians recorded more time spent in direct patient encounters than any other group of providers (see table 8.5).[20] Yet questions regarding the utilization of physician time remain to be answered. It is possible that

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[20]This table derives from computerized data which was compiled from the encounter forms filled out by all employees who provided primary services to patients.

TABLE 8.5

PROVIDER-PATIENT ENCOUNTERS (JULY-SEPTEMBER 1973)[a]

	Provider	15-minute encounter	45-minute encounter	Standard hours (SH)[b]	% of work hours[c]	Range of SH	Aver. SH per provider[d]	% hrs. spent by av. prov. in enc.[e]
M.D.	D.O.	1,020	76	312.00	75.00			
	R.B.[f]	1,074	2	270.00	64.90			
	A.K.	734	32	207.50	49.88			
	A.E.	644	11	169.25	40.69			
	T.A.	591	11	156.00	37.50			
	N.L.	423	63	153.00	36.78			
	N.T.	550	13	147.25	35.40			
	A.B.	456	38	142.50	34.25			
	D.H.	435	20	123.75	29.75			
	B.S.	447	14	122.25	29.39			
	E.N.	414	15	114.75	27.58			
	A.S.	359	15	101.00	24.28			
Total		7,147	310	2,019.25		101.0-312.0	168.27	40.45
DDS	H.R.	389	0	97.25	23.38			
	A.A.	377	0	94.25	22.66			
	A.W.	358	0	89.50	21.50			
	L.J.	291	0	72.75	17.49			
Total		1,415	0	353.75		72.75-97.25	88.26	21.22
MHSS	E.M.	199	42	81.25	19.53			
	G.G.	318	0	79.50	17.47			
	A.D.	295	0	73.75	16.21			
	G.A.	131	46	67.25	16.17			
	J.T.	231	0	57.75	12.69			
	B.T.	203	0	50.75	11.15			
	M.P.	87	0	21.75	4.78			
Total		1,464	88	432.00		21.75 81.25	61.71	14.83 psych. 13.56 oth.
PHN	E.A.	345	1	86.25	18.96			
	K.A.	320	0	80.00	17.58			
	M.D.	232	0	58.00	12.75			
	W.S.	128	0	32.00	7.03			
Total		1,025	1	256.25		32.00-86.25	64.06	14.08

(continued)

	Provider	15-minute encounter	45-minute encounter	Standard hours (SH)[b]	% of work hours[c]	Range of SH	Aver. SH per provider[d]	% hrs. spent by av. prov. in encoun.[e]
FHC	M.M.	191	0	47.75	10.49			
	A.S.	155	0	38.75	8.55			
	A.S.	146	0	36.50	8.02			
	E.N.	135	0	33.75	7.42			
	C.R.	126	0	31.50	6.92			
	W.C.	126	0	31.50	6.92			
	J.F.	114	0	28.50	6.26			
	B.S.	92	0	23.00	5.05			
	T.M.	81	0	20.25	4.45			
	D.D.	61	0	15.25	3.35			
	M.N.	52	0	13.00	2.87			
	N.R.	34	0	8.50	1.87			
Total		1,313	0	328.25		8.50-47.75	27.75	6.00

[a]This includes all full-time employees who provide a primary service to patients--e.g. physicians and dentists, but not their medical or dental assistants.

[b]One standard hour (SH) consists of one 45-minute encounter plus one 15-minute encounter--thus the SH in the first row is computed in the following manner: [(1,020 x 15) + (76 x 45)] ÷ 60.

[c]Work hours for the quarter are computed by multiplying 13 (the number of weeks in a three-month period) by 32 for MDs and DDSs (the number of hours spent by these staff members at the center per week) and by 35 (the number of hours in a work week for all other staff). Thus MDs and DDSs are supposed to spend 416 hours each quarter at the center, other staff 455 hours. (Physicians and dentists spend the remaining 39 hours each quarter at the back-up hospital.) This does not take holidays or overtime into account.

[d]Computation: Sum of SH for given department ÷ number of full-time providers in this department.

[e]Computation: Average SH per full-time provider in given department ÷ work hours per quarter for given staff category.

[f]This physician, whose employment was temporary, saw only walk-in patients.

one should not use the same index on health care providers with different duties. It is also probable that not all encounters with patients were recorded. But working with existing figures, one sees that 12 out of 14 physicians recorded less than half their work-time as being spent with patients.

The amount of time spent by physicians on paper work and at meetings could not be estimated accurately, but at most they attended one team meeting and one doctor's meeting (each lasting about one hour) per week. Each MD and DDS had the service of a medical or dental assistant who took care of much of the paper work; appointment clerks dealt with referrals and appointments. The doctor was responsible for making entries in patients' charts, reading EKGs and laboratory reports, writing prescriptions, and filling out the encounter forms which were required in order to collect third-party payment for their services. Missed appointments were one obvious reason for wasted physician time; excessive overscheduling in order to reduce this slack has obvious disadvantages--e.g. long waiting times if all patients keep their appointments.

All full-time physicians (with the exception of those who started working at the center after June 1973) were interviewed. Talks with the medical director took place both prior to the start of research and before he left the center.

Dentists. This group showed much less variability in patient encounters than physicians, but their overall average was lower (see table 8.5). The department was supervised by one of the working dentists. I observed and was told that the man who was director of the dental department when I first came to the center had not managed to establish any rapport with his staff or most of the center's administrative or supervisory personnel. He resigned when put on probation for serious infringements of the rules. One of the other dentists was appointed director in September 1972. Better liked, a hard worker, and genuinely interested in community health, this individual was able to improve the morale of the department, although its productivity did not increase.

All full-time dentists were interviewed.

Mental Health and Social Service. This department offered individual and group therapy for adults and children. It helped patients in their dealings with various city and federal agencies. It also worked with tenants of a Single Room Occupancy (SRO) building in an attempt to get the residents to help each other. Some psychological testing was done by a part-time psychologist. One MHSS para-professional ran the center's playroom where parents could leave their children while waiting and/or while receiving care. The department had its own secretary.

It was not possible to determine what proportion of time the department's care providers (two psychiatrists, one psychiatric nurse, one psychiatric social worker, and four paraprofessionals trained for such service) was taken up by therapy/consultation, or by direct services. Accompanying a patient to a court hearing or to the Department of Social Services could easily take up a social worker's day. This might partially explain the department's low productivity rates (see table 8.5); it also raises two questions: (a) is this the most profitable utilization of a professional's time; and (b) are standard hours spent in patient encounters the best index of productivity for a department such as MHSS? It may not be--though I do not know of a better one which would fit all providers and thereby offer a tool for comparisons. In general, the length of patient encounters at MHSS, may vary from a few minutes to several hours; many involve travel throughout the city and/or telephone contacts with other agencies. The department was supervised by one of the psychiatrists and appeared to work harmoniously.

Sampling procedure--for this and all remaining departments was as follows: The business office had provided me with a list of all employees, arranged by department and with staff in each department listed in alphabetical order. The supervisor of each department was asked for an interview. For the rest, starting with the

first name on the list for the given department, every other individual was approached for an interview. If he or she was for some reason unavailable (e.g. refusal, sick-leave) the next person on the list was asked. This procedure resulted in talks at MHSS with the four full-time professionals and two of the paraprofessionals. One paraprofessional refused to be interviewed.

Nursing. The department was divided into in-house and outreach divisions and was, during most of this study, supervised by one registered nurse who was a member of the administration.[21]

The outreach department--consisted of public health nurses (PHN) and family health coordinators (FHC). Each PHN supervised several FHCs in addition to making home visits to patients in need of professional care. This group consisted of both registered and practical nurses. During the summer of 1973 two of these registered nurses (they are not included in table 8.5) were among a group of four center nurses who received training as nurse practitioners at one of the city's medical schools. They started work in their new role after this study was

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[21]When she went on maternity leave shortly after I left the center, the duties of this position were altered somewhat and divided among two nurses; when she decided not to return to the center, a full-time director was hired for the nursing department in the spring of 1974.

completed.[22]

FHCs were community people who were trained by the center for their job. This training took place both at the center and at such OEO institutions as Mobilization for Youth (MFY) and the School for Human Resources. A few FHCs apparently managed to retain their jobs although they refused to seek formal training at an outside agency. Depending on training and personality factors, FHCs saw their function as akin to either those of a social worker or a nurse. Although they all performed basically the same services for their clients (i.e. made home visits when requested by physician or patient, accompanied non-ambulatory patients to the center or back-up hospital, and served as patient advocate vis-á-vis school or government agency) some of the FHCs stressed the physical, care-taking aspects of their job, while others considered the social aspects as more important. Each PHN and FHC had a caseload of patients.

Failure to terminate a given outreach service once it was no longer required was one of the problems of this department; productivity was another (see table 8.5). However, here--even more than in MHSS--the estimated fifteen minutes per patient encounter was totally unrealistic

[22]One of these has since left the center for family reasons. The other three spent part of their workday in seeing patients--especially the chronically ill and new registrants for their initial health assessment before they were seen by a physician.

since it took a worker this long even to reach the patient's home. An FHC could be tied up for several hours in bathing a patient, straightening out the apartment, cashing a welfare check, shopping; the best part of a day might be spent with a patient at the back-up hospital clinic or at the department of social service. Granted that it was difficult to estimate just how long any given patient encounter should take, outreach personnel still did not seem to have enough contacts and did not record all contacts they had. According to the charts, the most productive of them would seem to have seen less than one patient in two days. Supervision in this department, as in others, was less than optimal; observation indicated that some PHNs supervised their FHCs more successfully than others, but higher-level supervision was minimal.

One PHN and two FHCs refused to be interviewed. Sampling resulted in talks with two PHNs and ten FHCs, two-thirds of out-reach paraprofessionals. It was hoped that this overrepresentation would make up for the relative large number of refusals from MAs, the second largest body of paraprofessionals employed at the center.

The in-house segment--of the nursing department consisted of registered nurses (RN), medical assistants (MA), and dental assistants (DA). Some of the nurses were employed in screening walk-in patients to determine what service they required. During the period of this study

both RNs and the paraprofessionals were under the direct supervision of the nursing department supervisor.

Each MA was assigned to one MD; she got the charts for his appointments, made out whatever forms were necessary (e.g. requests for laboratory work), and served as interpreter if the patient did not speak English. Although trained to carry out such functions as taking temperature, weight, blood pressure, or electrocardiograms, very few MAs were, in fact, asked by their MD to do these things. In practice their job was mainly clerical, although physicians varied in the role they assigned their MAs. Pediatric MAs were allowed to take histories on a prepared form; toward the end of my stay a few received training from the pediatric nurse practitioner to carry out certain audio-visual tests on children. Some doctors did treat their MAs as a team member and expected her to assist with the patient in a meaningful way. Since each MA worked with one doctor only, she was idle when either the physician or the patient did not come to the center at the appointed time.[23] On the other hand, most MAs automatically covered for their colleagues who were absent. Depending on when they started to work at the center, MAs received from four to nine months training. For those who were not allowed to utilize all their skills, part of this training has been wasted.

[23]This system has been changed while this report was in preparation.

A larger proportion of MAs, as compared to other groups at the center, refused to be interviewed. This was due to an interaction of three factors: To start with, MAs were generally dissatisfied with the treatment accorded them over the past few years. They did not understand why their salaries were lower than those of FHCs with the same length of service and the same as those of the cleaning personnel.[24] They expressed a feeling that more was expected of them than of other non-professionals at the center since they were the only ones to serve and be on view in the clinic area. FHCs, in contrast, were perceived by MAs to be comparatively free agents. Much of the disaffection voiced to me dealt with their perception that the N-W council had reacted to their complaints in a manner which the MAs considered shoddy and disrespectful. The whole group voted for the union although most according to many informants, had not favored unionization before. Quite apart from the merits of their financial complaints (and it was difficult to find a rationale for the differential treatment) it was true that this was one of the few groups which were always in spotless uniform; they were fairly unobtrusive--not easy to achieve in their work-location (see fig. 2, appendix A); and they consistently arranged matters so that no physician was left without an

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[24]Salary inequities may have been adjusted with the coming of the union.

assistant, regardless of how many MAs were absent.

Secondly, several MAs told me that one of the group's leaders, who strongly favored unionization, could not be convinced that I was not a spy for HEW, the council, the back-up hospital, the administration, or all four and therefore, almost by definition, an enemy of the workers.

Finally, and perhaps most important--the fact that I had had least contact with MAs during my stay at the center. This was due partly to the nature of their work, but mainly to the physical lay-out of the center. The work schedules of MAs was matched for the most part to those of their doctors. While the physician was in his office, the MA had to help with the patient, or hold herself in readiness should need for her service arise. The time physicians spent at the back-up hospital was taken up with getting charts, supplies, etc. or filling in for a colleague. Theoretically at least, there was little time available for talking. In practice, of course, there was quite a lot of free time, but there was no place in which to talk--at least not with me. Since the center lacked space for socializing, my contacts with all other personnel took place in their offices or hallways. As figure 2 (appendix A) shows, however, the desks of MAs were in corridors which were very narrow and saw much traffic in and out of examining rooms, playroom, and coffee room. For me to take up space in order to pass the time of day with an MA was

simply out of the question. Some of them never got to know me or my project, and the fear engendered by threatened budget cuts and their disadvantaged feeling could therefore not be overcome. I did get to know a few of them and they, in turn, persuaded some of their colleagues to talk to me; but the fact remained that while seven (47%) agreed to be interviewed, eight (53%) refused. Since all MAs were approached, this must be considered a self-selected sample of respondents.

Dental assistants were technically members of the nursing department, but were, for all practical purposes, autonomous under the supervision of the director of the dental department. They assisted dentists at the chair and took X-rays. The usual sampling techniques were followed in this department; no refusals were encountered.

Laboratory and X-ray. Each of these departments was supervised by one of the technicians. They performed routine tests; patients went to the back-up hospital for more complicated procedures. One paraprofessional in the X-ray department had been trained to develop plates which were then sent to the hospital for interpretation. The only person to refuse to be interviewed was the clerk.

Training. During the period of this study the department did not have much of a function, since there was little turn-over of non-professional personnel. Both

members of the training department contributed to the functioning of the center by participating, for example, in the design of an evaluation study and the creation of the nurse practitioner program. However, their activities did not--as originally planned--primarily benefit non-professional personnel. The director of the training department had certain ideas about what the role of this department should be: To provide or arrange for the on-the-job training of non-professional personnel, as had been stipulated in the original proposal to OEO. By the time I came to the center this need was limited because most non-professional jobs had been filled. There was apparently little attempt to innovate creative, ongoing in-service training programs for all staff. The department did not appear to encourage non-professionals to better their education by offering practical suggestions to do so (e.g. GI bill).

When the director of the department resigned in the summer of 1973, the training department, as such, ceased to exist. The other member trained individuals who were hired as FHCs and MAs and kept informed regarding educational possibilities for members of the staff. In addition, she took over part of the supervision of the nursing department, gave extensive orientation to each new staff member, and functioned as a nurse practitioner. Both members of the training department were interviewed.

The job descriptions of clerical, housekeeping, and security personnel are no different from those in any organization.

It should be noted, however, that 50% (3) of the appointment staff, including their supervisor, refused to be interviewed. The supervisor told me quite frankly that she did not want to talk to me because, to use her words, she "was turned off" due to difficulties with her immediate supervisor. Since she considered this supervisor to be a friend of mine she wanted nothing to do with me. I don't believe that she told her staff not to talk to me, but she definitely did not encourage them to grant me interviews. As the people in this department worked closely with each other and admired their supervisor, her disaffection probably contributed to the other two refusals.

This is one example of possible difficulties in participant observation. By the spring of 1973 I had established personal relationships with quite a number of people who occupied various jobs at the center--the supervisor of this line supervisor was one of them. As far as I could determine, this was the only case where such relationships prevented me from getting information. It is, of course, possible that some of the other refusals to be interviewed were for similar reasons, although I feel fairly certain that people I was friendly with would have mentioned it. We often talked about why some of their

colleagues would not speak to me, and the usual reasons given were that they did not know me, felt too insecure to talk, and could not really believe that I would spend so much time at the center without getting paid by someone for passing on whatever I could find out there.

To sum up, focused interviews were carried out with 64% of all full-time personnel (see table 8.6). In all, 17 staff members (12% of all employees, or 14% of all full-time employees) refused to be interviewed. Four of these individuals either kept missing appointments or pleaded lack of time, while the other 13 simply said they would rather not talk. Among these 17 were 8 clerical workers, 7 paraprofessionals, 1 guard, and 1 licensed practical nurse. Finally, it should be noted that all staff representatives of the union negotiating committee were among those who refused to be interviewed.

TABLE 8.6

SAMPLE OF STAFF RESPONDENTS BY DEPARTMENT AND ETHNICITY

Department	Number of full-time employees[a]	Respondents		Ethnicity of Respondents				Total number interviewed	% of number in depts.[b]
		f	%[b]	Hisp.	Black	White	Haitian/ Other		
Administration	4	4	5	1	2	1	-	4	5
Medical[c]	16							13	16
Pediatric. & Internists	12	9	11	1	1	6	1		
Dentists	4	4	5	-	2	2	-		
MHSS	9							6	8
Psychiatrists	2	2	3	-	1	1	-		
Other prof.	2	2	3	-	-	2	-		
Paraprof. & clerical	5	2	3	1	-	1	-		
Nursing									
PHN Outr.	4	2	3	-	1	1	-		
Paraprof. Outr.	15	10	13	3	4	1	2		
RN In-h.	3	3	4	1	1	1	-		
Paraprof. In-h.	21	11	14	9	1	-	1		
Lab and X-ray	6							4	5
Technicians	4	3	4	-	3	-	-		
Paraprof. & clerical	2	1	1	1	-	-	-		
Training	2	2	3	-	-	2	-	2	3
Clerical[d]	36	20	25	12	6	1	1	20	25
Housekeeping & security	8	4	5	3	1	-	-	4	5
Total	124	79	99	32	23	19	5	79	99

[a]As was mentioned before it had been decided to interview only full-time staff members because observation showed that part-time employees are not in the mainstream of center affairs.

[b]Because of the sample sizes and the small numbers in various groups percentages are rounded throughout this report

[c]Excluding psychiatrists. The three full-time physicians who were not interviewed has just started to work at the center when the interviews were carried out.

[d]Other than NHSS and Lab or X-ray.

CHAPTER IX

NWHC PATIENT POPULATION

From its inception in 1967 until June 1973, NWHC's eligibility requirements for patient enrollment were residence within the catchment area and income ceilings. These ceilings were somewhat higher than the amended (1972) Medicaid limits (see table 9.1).

TABLE 9.1

FINANCIAL ELIGIBILITY REQUIREMENTS

Family size	Income N-W ceiling	Medicaid ceiling[a]
1	$2,200	$2,100
2	3,100	2,900
3	4,000	3,500
4	5,000	4,500
5	5,700	5,200
6	6,400	5,900
7	7,200	6,600
over 7	600 for each additional member of family	

[a]These figures were taken from a November 1972 report by the Community Health Law project, NYC.

NOTE: All individuals or families receiving Medicaid benefits were automatically eligible for service at the center.

Those entitled to treatment at the center received all ambulatory services entirely free of charge, including all tests and the use of specialists either at the center or the back-up hospital; medication; outreach (home visits by nurses and/or family health coordinators); and transportation where needed. Those people who found themselves between center and Medicaid ceilings were the ones who needed the center most. Definitely too poor for treatment by private physicians, yet not poor enough to receive Medicaid, their only alternative was Ghetto-Medicine subsidized clinic care for which the patient must pay his share.

Since June 1973 an HEW-mandated sliding fee scale has been in operation at the center (see table 9.2). However, no patients were refused service if they could not pay the fee; no payment was required from individuals enrolled in Medicaid; and one fee covered all services the patient received during a given visit to the center. By the time this study was concluded the income from fees paid by patients was approximately $2,000 monthly--just about equal to the costs incurred for the collection of these fees. As had been predicted by center administration, the fees were too high to attract middle-income people into what was, essentially, a clinic setting. Basic characteristics of the patient population remained unchanged. Patients were low-income individuals

TABLE 9.2

SLIDING-FEE SCALE IN OPERATION AT THE N-W CENTER

Family Size	Fee for given family size and income category							
	$3.00	$6.00	$9.00	$12.00	$15.00	$20.00	$25.00	Charge +
1	up to $3,199	3,200 3,899	3,900 4,599	4,600 5,299	5,300 5,899	5,900 6,499	6,500 7,399	over 7,400
2	up to $4,699	4,700 5,699	5,700 6,699	6,700 7,699	7,700 9,599	8,600 9,499	9,500 10,699	over 10,700
3	up to $6,599	6,600 7,999	8,000 9,399	9,400 10,699	10,700 11,999	12,000 13,299	13,300 14,999	over 15,000
4	up to $7,999	8,000 9,699	9,700 11,299	11,300 12,899	12,900 14,499	14,500 15,999		over 16,000
5	up to $9,699	9,700 11,199	11,200 12,699	12,700 14,199	14,200 15,999			over 16,000
6	up to 12,299	11,300 12,799	12,800 14,299	14,300 15,999				over 16,000

and families who belonged to several distinct ethnic groups (Hispanic, Black, White, Haitian) and a number of subcultural groups (Puerto Rican, Cuban, Jewish, etc.). Hispanic individuals comprised approximately 67% of the patient population.

Among these registered families, and within the families themselves, a variety of patterns of use existed; some people used the center on a regular basis, others came only for specific services, while some were registered with the center but did not utilize it at all.

Utilization study

During the summer of 1973 a research institute associated with one of the metropolitan medical centers investigated patients' utilization of the center at the invitation of its administration.[25] The following information comes from their initial (unpublished) report which was submitted to center personnel who had participated in the design of the study:

Review of a random sample of patients' charts led to the conclusion that 20.4% of the patients still carried on

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[25]The basic plan and overall design for this study came from a group of center staff; I participated in this planning at their request. When the Emergency and Primary Care Project team of the medical center group joined us, they helped crystallize the design, carried out the actual research, and wrote a report for NWHC. The material presented here comes from this report. This data, gathered by the Medical Center group, served as the basis for a paper by Gorman & Nelson (1974).

the center's computerized information system were, in fact, no longer active--an active patient being defined in the utilization study as one who had visited the center at least once during the 18 months preceding the chart review.[26] They estimated a patient population of approximately 14,000 rather than the 18,000 which appeared on the center's books for the third quarter of 1973. Of this group, 60.0% were of school age.

The sample of 472 patients whose charts were surveyed exhibited the following characteristics for the 12-months' period preceding the utilization study (July 1, 1972 to June 30, 1972):

Of the sample's total number of visits to the center 12.3% of the patients made 42.5% of all visits.

Among active patients at least one visit per year was made by 82.8%; 4 or more visits were made by 43.5% of all patients and by 60.0% of patients over 45.

The mean number of visits for males was 4.2;
for females 4.9; and
for patients over 45, 6.6.

The mean number of visits and frequency of visits was slightly lower for children under 15 than for other age groups.

Of all provider-patient contacts
99.0% took place at the center;
1.0% in the patients' homes.

Of all visits to the center
61.4% were by appointment;
38.6% were without appointment or "walk-in."

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[26]This is in contrast to the two-year period required in the present study for inclusion in the "active" category.

Appointments were broken
at least once during the year by 60.0% of all active patients;
3-9 times by 15.0%.

The ER of the back-up hospital was used inappropriately (i.e., for complaints which the center could have handled) by 10.0% of the patients.

Of the 1,276 visits studied
39.6% were to pediatricians
37.4% to internists
13.5% to dentists
5.8% to nurses
2.6% to specialists
1.1% to others

46.7% were for episodic care (i.e., treatment of an acute ailment)
23.9% for chronic care
10.3% for preventive care
13.6% for dental care
5.5% for tests and other uses.

Higher rates of utilization were shown by
individuals who kept house or were unemployed;
persons over 18 years of age with either less than 6 or more than 11 years of schooling;
those who had never been married; and
people who had completed their initial health assessment, especially if they had been examined within one month of being registered at the center.

Sex, ethnicity, command of the English language, Medicaid or marital status were reportedly not related to differences in utilization; but, as was mentioned above, the patients' initial health assessment was: Those patients who had completed this initial assessment (N = 325) were much more likely to remain active than patients who did not (N = 147).

Interviews with a sample of 97 patients, which were carried out as part of this utilization study during the summer of 1973, indicated that:

1. most of the patients were unaware of the wide range of services available to them at the center;

2. approximately half the sample sought care in from one to five other health care facilities, in addition to the center and its back-up hospital;

3. many respondents mentioned long waiting time at the center;

4. most found staff friendly and courteous; and

5. most rated the care at the center good to excellent.

As will become apparent later, these findings were congruent with information received in the course of my interviews with center patients.

Data on NWHC's patient population and the samples for Interviews I, II, and III

There were discrepancies in the patient population figures of the center's computerized data and those estimated by the utilization study cited above. The figures used here (tables 9.3 and 9.4) were the official center figures, adapted from the center report to HEW for the first quarter of 1973. This was the latest report to include a breakdown into ethnic groups--it was, therefore, chosen rather than the report for the second quarter which would have matched the collection of staff data; or the report for the third quarter, which would have coincided with the time at which all data collection for the study

was completed.

Tables 9.3 and 9.4 show that Hispanics and children under 14 years of age represented the largest proportion of the patient population. The division between male and female patients was 43% and 57% respectively. People over 64 comprised the smallest number; the White group was quite small. The center's computerized data did not cross-tabulate age and ethnic groups, but talks with center staff, samples drawn for interviews for the research, and my observations all tended to place the largest concentration of old people among Whites.

The sample of respondents for the interview which was conducted during the summer of 1972 (Int. I, see appendix E) consisted of an equal number of Hispanic, Black and White center patients.[27] Respondents for the open-ended interview (Int. II, see appendix F) were all Hispanic because they represented the largest group among patients; and the persons surveyed for the specific incident analysis (Int. III, see appendix J) should, because of the time sampling, represent the spectrum of the various groups served by the center (see table 9.5). As one can see by

[27]No Haitians were interviewed because this would have entailed the employment of a Haitian interviewer and translation of the questionnaire into French--this was beyond my means. Equal numbers of Hispanics, Blacks and Whites were used for Int. I despite the fact that Hispanics comprised 67% of the patient population. This was deemed necessary because the use of a stratified sample would have yielded very small numbers of Blacks and Whites and this could have resulted in the loss of valuable information.

TABLE 9.3

PATIENT POPULATION OF THE N-W HEALTH CENTER (MARCH, 1973)

Ethnic breakdown of patient population	f	%	Total f	Total %
Family units			7,729	100.00
Individuals			17,818	100.00
Puerto Rican	6,593	37.00		
Dominican	3,564	20.00		
Cuban	356	2.00		
Other Hispanic	1,425	8.00		
Total Hispanic			11,938	67.00
Black	4,340	24.36		
Haitian	891	5.00		
White	356	2.00		
Other	293	1.64		
Total Non-Hispanic			5,880	33.00

TABLE 9.4

AGE AND SEX DISTRIBUTION OF N-W HEALTH CENTER PATIENTS (MARCH, 1973)

Age group	Sex Male f	Sex Female f	Total for age group f	Total for age group %	Cumulative Total Male f	Cumulative Total Female f	Cumulative Total f	Cumulative Total %
1- 4	1113	1112	2225	13.00	1113	1112	2225	13.00
5-14	2348	2298	4646	27.00	3461	3410	6871	39.00
15-24	1282	1575	2857	16.00	4753	4985	9728	56.00
25-44	1439	2795	4234	24.00	6182	7780	13962	80.00
45-64	842	1463	2305	13.00	7024	9243	16267	93.00
over 64	392	789	1181	7.00	7416	10032	17448[a]	100.00

[a]This total does not match the total number of individual patients given in table 9.3 (i.e. 17,818). The discrepancy is due to inadequate information when computer data were compiled.

TABLE 9.5

SIZE AND ETHNIC DISTRIBUTION OF SAMPLES FOR PATIENT INTERVIEWS I, II AND III

Ethnic group	Int. I		Int. II		Int. III[a]		Total	
	f	%	f	%	f	%	f	%
Hispanic	30	33	25	100	336	69	391	65[c]
Black	30	33	--	--	84	17	114	19[c]
Other[b]	30	33	--	--	48	10	78	13
Not specified	--	--	--	--	19	4	19	3
Total	90	99	25	100	487	100	602	100

[a]510 patients were approached: 23 (or 5%) refused to respond; the total interviewed was therefore 487.

[b]Respondents for Interview I in this group were all White.

[c]These percentages approximated the distribution of these two groups in table 9.3.

comparing tables 9.3 and 9.5, the proportions of various ethnic groups in the patient samples did not diverge grossly from their proportions in the patient population.

Respondents for Int. I and Int. II were chosen by one random sampling of the registered patient population; the same Hispanic patients could therefore not have been interviewed twice. Since all patients leaving the center on designated days and at specified times were approached for Int. III, it is possible that some of the people who had been interviewed previously were in the Int. III sample.[28] Respondents in this study were not asked their names; it is therefore impossible to establish whether they had, in fact, been seen for Int. I or Int. II--nobody volunteered this information. The following figures are on the assumption that no duplication took place.

A total of 602 patients were interviewed in the course of the three studies, but as we lack some demographic information on 23 of these, the following percentages and ratios are based on a total of 579. Of this number 459 (79%) were female, and 120 (21%) male (see table 9.6). This represents a female:male ratio of 3.83:1 which differed from the ratio in the total patient population of 1.35:1. One probable reason is that, as table 9.4 indicates,

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[28]Approximately 30 to 40 patients visited the center more than once during the time these data were gathered. Interviewers collected information from these individuals only once.

there were fewer males in the patient population over 25 years of age than among children and young adults under 25. Another reason had to do with the sampling procedure which selected respondents according to their family registration number. Since either husband or wife was accepted as respondent in nuclear families, it is likely that women who were not employed outside their homes were more readily available for interviews.

TABLE 9.6

SEX DISTRIBUTION OF SAMPLES FOR PATIENT INTERVIEWS

Study	Sex					
	Female		Male		Total	
	f	%	f	%	f	%
Int. I	69	77	21	23	90	100
Int. II	22	88	3	12	25	100
Int. III[a]	368	79	96	21	464	100
Total	459	79	120	21	579	100

[a]A total of 487 patients were interviewed, but since some demographic data were lacking on 23 of these, percentages for Int. III and for the total were based on a group of 464.

A summary of demographic data of the three studies is offered in table 9.7.

The ages of respondents for Int. I ranged from 21 to 85, with White respondents showing a heavy concentration in the older age brackets (see fig. 4).

TABLE 9.7

ETHNICITY, SEX AND AGE DISTRIBUTION OF ALL RESPONDENTS FOR THE THREE PATIENT STUDIES

Study	Int. I							Int. II[b]			Int. III[c]									Grand Total
Ethnicity	Hisp.		Black		Other[a]		Total	Hisp.		Total	Hispanic			Black		Other		Not Known	Total	
Sex	F	M	F	M	F	M	-	F	M	-	F	M	Not Known	F	M	F	M	-	-	-
Age																				
under 20	-	-	-	-	-	-	-	-	-	-	17	5	1	4	3	1	-	-	31	31
20-29	4	1	3	1	1	1	11	4	1	5										
30-39	6	-	8	1	3	-	18	10	1	11	175	40	1	38	14	11	6	-	285	330
40-49	8	2	6	1	1	1	19	5	-	5										
50-59	6	1	2	1	2	-	12	1	-	1	63	10	1	12	7	13	2	-	108	145
over 59	1	1	5	2	13	8	30	2	1	3	21	2	1	4	1	8	6	1	44	77
not known	-	-	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	17	19	19
Total	25	5	24	6	20	10	90	22	3	25	276	57	5	59	25	33	14	18	487	602

Note: A "Not known" category was added for the Specific Incident Analysis (Int. III) because interviewers sometimes failed to enter demographic data.

[a] In Int. I category "Other" consists of Whites only.

[b] Int. II was with Hispanic respondents only.

[c] In Int. III the age of respondents was estimated by interviewers using 20-year intervals.

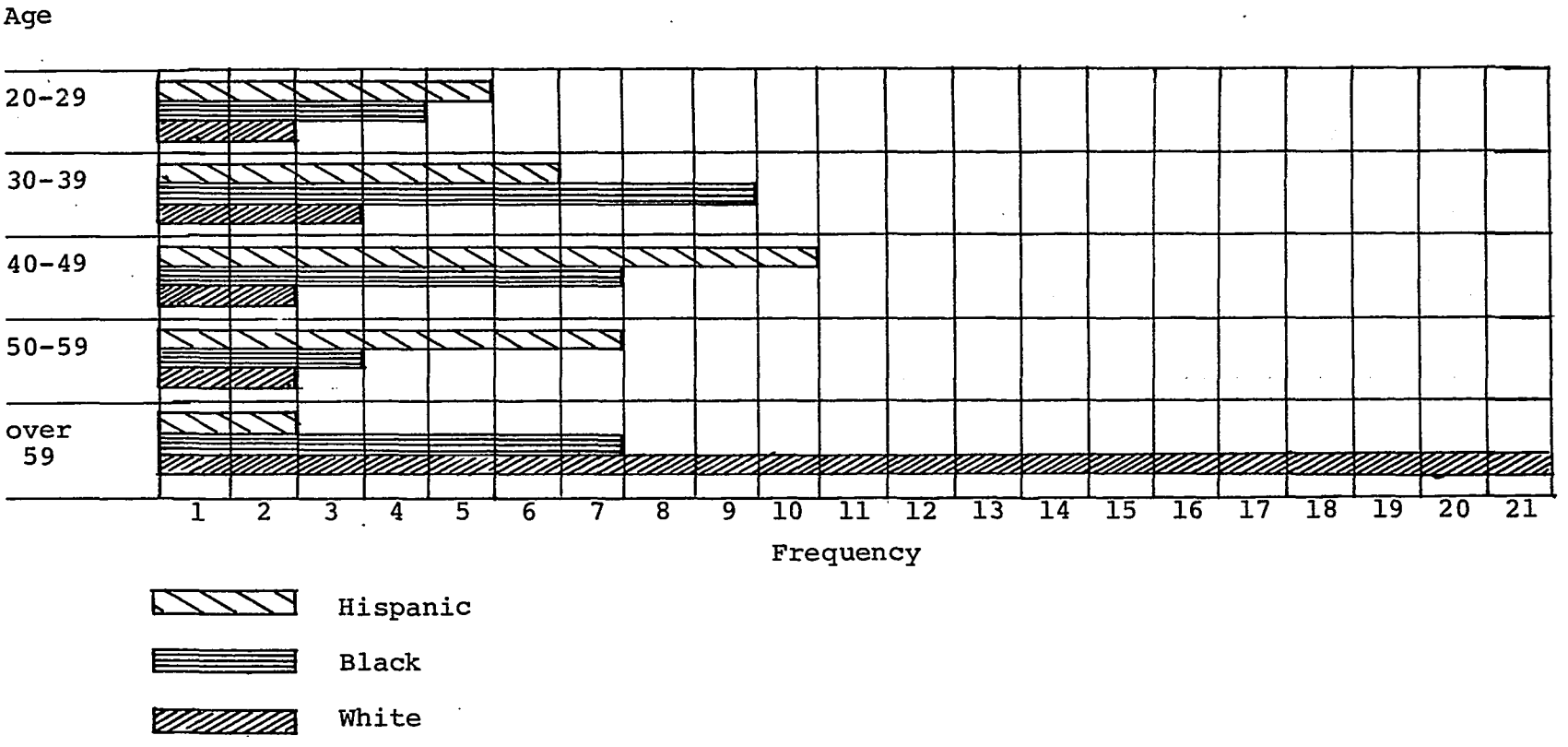

FIG. 4. Age and ethnic distribution of respondents for Int. I.

The average ages were 43.50 for Hispanics, 42.36 for Blacks, and 62.32 for Whites. The White sample was significantly older than the other two groups ($\chi^2 = 32.22$, $df = 8$, $p < .001$). This was confirmed when median ages were computed--they were 43.37, 46.37 and 62.43 years for Hispanics, Blacks, and Whites respectively.

Originally, it had been planned to examine the effects of age and ethnicity on given dependent variables. But age and ethnicity were nested and could not be separated in this study because of insufficient numbers of older Hispanic and Black respondents or younger Whites. In analyzing the data I tried to pinpoint whether ethnicity or age appeared to be more significant for a given dependent variable, but it was not possible to do this with any degree of certainty.

Respondents in the three groups did not vary significantly in educational attainment (see table 9.8). Respondents did, however, show significant variety in place of birth, length of stay in the city, and family status (see table 9.9). White respondents differed from respondents in the other two groups in all three characteristics: more of them were born in the city, had resided there longest, and lived alone--this latter can probably be explained by their relatively higher ages. Generally, there could well be interaction of various factors. Thus length of residence, for example, may be a function of a combination of age, ethnicity, and historical

TABLE 9.8

RESPONDENTS' EDUCATION (INT. I)

Education	Ethnic Group							
	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
Less than elementary	4	14	6	21	3	10	13	15
Elementary	4	14	2	7	4	13	10	12
Some High School	13	45	5	18	11	37	29	33
High School graduate	5	17	9	32	2	7	16	18
Some college	2	7	3	11	4	13	9	10
BA/BS or better	1	3	3	11	6	20	10	12
Total	29	100	28	100	30	100	87	100

$\chi^2 = 14.53$, df = 10, $.10<p<.20$

Note: 1 Hispanic and 2 Black respondents did not answer this question; they were not included in the computation of χ^2.

TABLE 9.9

PLACE OF BIRTH, LENGTH OF RESIDENCE IN CITY AND FAMILY STATUS OF RESPONDENTS (INT. I)

Birthplace, residence in city, and family status	Ethnic Group							
	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Place of birth[a]								
City	6	20	2	7	12	40	20	22
Mainland U.S.A.	7	23	22	73	10	33	39	43
Other (incl. P.R.)	17	57	6	20	8	27	31	35
Total	30	100	30	100	30	100	90	100
Residence in City[b]								
Born in City	6	20	2	7	12	40	20	22
Arrived before 1939	-	-	5	16	11	37	16	18
Arrived 1940-1959	12	40	11	37	3	10	26	29
Arrived after 1959	2	7	10	33	3	10	15	17
N.R.	10	33	2	7	1	3	13	14
Total	30	100	30	100	30	100	90	100
Family status[c]								
Living with family	22	74	20	67	10	33	52	58
Living alone	7	23	10	33	20	67	37	41
N.R.	1	3	-	-	-	-	1	1
Total	30	100	30	100	30	100	90	100

[a] $\chi^2 = 23.95$, df = 4, $p<.001$

[b] $\chi^2 = 43.48$, df = 8, $p<.001$

[c] $\chi^2 = 12.19$, df = 2, $.001<p<.01$; to attain an acceptable minimum expected frequency, the "NR" category was not included in the computation of this χ^2.

Note: On this and all following tables "NR" denotes "No Response" and "DK" denotes "Don't Know."

events--mass immigration of Whites took place mainly in the late nineteenth and early twentieth century; Hispanics and Blacks immigrated to the City in large numbers at later dates.

The percentages of Int. I Hispanics (93%), Blacks (83%) and Whites (87%) who were "users" of center services did not differ greatly ($\chi^2 = 4.05$, df = 2, $.10 < p < .20$). A "user" was defined as someone who had utilized the center at least once during the two-year period preceding the summer of 1972, when these interviews were conducted. Among these users, White respondents reported the greatest and Hispanics the smallest average number of visits to the center during the one-year period preceding Int. I for both themselves and their families (see table 9.10). The differences between Hispanic, Black and White respondents were found to be significant ($F = 3.21$, df = 2,73, $.01 < p < .05$; see table 1 in appendix N for a summary of the Analysis of Variance).

Examination of the reported frequencies of visits by respondents (summarized in table 2, appendix N) led to the following explanation of the means appearing in row 1 of table 9.10: Hispanic respondents used the center consistently 2-11 times during that year. In the other two groups, on the other hand, some respondents utilized center services very heavily--this was particularly true among Whites and could probably be explained by their higher ages. The

TABLE 9.10

AVERAGE REPORTED USE OF CENTER SERVICES BY RESPONDENTS AND THEIR FAMILIES FOR ONE YEAR (SUMMER 1972-SUMMER 1973; INT.I)[a]

Visits by	Average Number of Visits		
	Hispanic	Black	White
Respondents only[a]	4.41 (N=27)	9.67 (N=24)	17.6 (N=25)
Respondents and members of their families[b]	5.67 (N=21)	15.33 (N=18)	15.56 (N=9)

[a] Q 1a: "About how often did you use the center during the past year?"
Figures in parentheses represent the number of users who answered this question.

[b] Q 6: "Please think of this past year and tell us how many times your family (i.e., respondent and family members) used the center?"
Figures in parentheses represent the users who lived with family members and who answered this question.

Black sample was about equally divided among those who used center services minimally (0-1 times), maximally (over 11 times), or 2-11 times. The standard deviations from the mean number of visits were, in fact, 2.1 for Hispanics, 12.63 for Blacks, and 30.36 for Whites.

A similar explanation might hold for respondents' families. Once again, the utilization pattern of Hispanics was more consistent--it ranged from 2-14 times during that year, while center visits by Black and White families ranged from 0-52 times. White respondents, because of their higher ages, were probably more likely to have shared their living quarters with a spouse who was also elderly and therefore needed a similar amount of care at the center. Black respondents could have had a larger number of children; one also reported use of union or Veteran Administration clinics by both parents, but not by the children--both these factors might help explain the relatively greater differences in the average number of visits between Black respondents and their families as compared to the much smaller differences between Hispanic and White respondents and their families.

In general, Hispanics reported more use of the center and less use of other health care facilities both by themselves and their families than the other two groups (see table 9.11). Since these Hispanic respondents (a) did not differ significantly from respondents in the other two

TABLE 9.11

UTILIZATION OF HEALTH CARE FACILITIES BY RESPONDENTS AND THEIR FAMILIES (INT. I)[a]

Utilization patterns	Hisp. f	Hisp. %	Black f	Black %	White f	White %	Total f	Total %
Respondents use NWHC only	13	43	2	7	3	10	18	20
Respondents use other facilities also	16	54	27	90	23	77	66	73
NR	1	3	1	3	4	13	6	7
Total	30	100	30	100	30	100	90	100

χ^2 =14.62; df=2 (to attain an acceptable minimum expected frequency, $\chi^2$was computed without the "NR" category); p<.001.

Family uses center only[b]	21	95	4	22	3	37	28	58
Family uses other facilities also	1	5	14	78	5	63	20	42
Total	22	100	18	100	8	100	48	100

χ^2=23.57; df=2; p<.001

[a]Q 1: "The first thing I would like to ask is if you, yourself, use the Neighborhood Health Center on...Street?" (Fixed alternative + probe)

Q 2: "Do you use any other places for health care?" (F.A.+probe)

Q 3: For respondents sharing quarters with other family members: "Do other members of your family use the Health Center?" (F.A. + probe)

Q 4: I'll mention other members of your family; will you tell me where do they go for their health care? (F.A.)

[b]The number of respondents who lived with family members were: 22 Hispanics, 20 Blacks, 10 Whites. (See table 9.9)

[c]The families of 2 Blacks and 2 Whites did not use the center at all.

groups in size of the area around their homes which they considered "their" neighborhood (see table 13.9), (b) reported a larger average and median social space (see table 13.17), and (c) reported a greater incidence of working outside their homes (see table 13.16) one cannot conclude that they came to the center because they were not accustomed to travel far. More likely reasons for preferring NWHC were the facts that the center employed a great number of Spanish-speaking people (see table 8.3) and that Hispanic respondents reported living a shorter distance from the center than either Blacks or Whites (see table 9.12).

TABLE 9.12

AVERAGE, MEDIAN AND RANGE OF DISTANCES BETWEEN INT. I RESPONDENTS' HOMES AND NWHC

Distance in city blocks	Hispanic	Black	White
Average[a]	5.07	5.53	7.07
Median	4.25	5.00	7.64
Range	1-13	1-12	1-17

[a] $F = 32.35$; $df = 87,2$; $.01 < p < .05$. See table 3, appendix N for a summary of the Analysis of Variance.

Many respondents (24 or 80% among the Hispanics, and 19 or 63% each among Blacks and Whites) claimed that this had been a typical year with respect to health matters for

themselves and their families.

In summary -- White Int. I respondents were significantly older than respondents in the other two groups; they were more likely to be native to the City or to have lived there a long time, and to be living alone. The average number of yearly visits by Hispanics was less than that of the other two groups, but this group used center services more consistently while the others showed both minimal and maximal use. Hispanics were also more likely than Blacks or Whites to use NWHC than other health care facilities.

The 25 Int. II respondents exhibited the following characteristics:

Ages ranged from 22 to 87, with a median age of 36.32; 21 (84%) were users of the center, 4 (16%) were not; 2 (8%) lived alone; of the remaining 23, the families of 18 (78%) utilized center services, while 5 (22%) did not.

Reported average use of the center by respondents and their families was 8.64 times for the year preceding the interviews (summer 1972-summer 1973). In addition, 16 (64%) reported use of other facilities.

While the largest single number of users (9 or 43%) reported visiting the center 2-6 times during the preceding year, almost as many (8 or 38%) came there 12 times or more, with the remaining 4 (19%) reporting 7-11 visits. This utilization pattern was more widely dispersed than that reported by Hispanic respondents of Int. I (see table 2,

appendix N). The two groups differed in other respects too: Int. II respondents (as compared to Hispanic respondents of Int. I) showed a lower median age, fewer of them used the center--but they visited it more often; more utilized other facilities. A smaller percentage lived alone and among the rest of Int. II respondents fewer families utilized center services.

Median ages of Int. III respondents were 32.94, 32.76 and 46.84 for Hispanic, Black and Others respectively.[29] Here, as in Int. I, Blacks showed the lowest median ages--although the median ages of Black and Hispanic respondents were very similar.

The three groups reported a not too dissimilar utilization pattern for the year preceding the specific incident analysis (Int. III) in the fall of 1973 (see table 9.13).

When ethnic groups were further broken down by age, it appeared that the reported number of visits in the 20 to 40 age range of Hispanics and Blacks was much larger than those reported by respondents of all other ages in all three ethnic groups. With the exception of respondents under 20 years of age, all age groups in the "Others" category reported a fairly even distribution of visits

[29]The category "Others" comprises all respondents who were not identified as Hispanic or English-speaking Blacks by the interviewers--i.e., Whites, Haitians, Asians, etc.

TABLE 9.13

REPORTED UTILIZATION PATTERNS OF CENTER SERVICES BY INT. III RESPONDENTS (FALL 1972 - FALL 1973)

Number of visits during past year	Hispanic		Black		Other		No Info.		Total	
	f	%	f	%	f	%	f	%	f	%
0 - 1	42	12	9	11	5	11	3	17	59	12
2 - 6	86	26	23	27	14	30	4	22	127	26
7 - 11	68	20	22	26	10	21	3	17	103	21
12 or more	141	42	31	36	18	38	8	44	198	41
Total	337	100	85	100	47	100	18	100	487	100

(see table 4, appendix N). In contrast to Int. I, the largest percentage of Hispanic Int. III respondents reported having visited the center 12 times or more during the preceding year; this was not too unlike the reports by Int. II respondents.

In summary—the ethnic distribution of the individuals approached for the specific incident analysis (Int. III) showed great similarity to the ethnic distribution of the center's patient population. In both Int. I and Int. III the median ages of Hispanics and Blacks were lower than those of others, especially Whites; as was noted before, this last group appeared to be heavily represented among elderly center patients.

Int. III Hispanic respondents reported a much larger number of visits to the center during the year preceding this survey than did Hispanic respondents of either Int. I or Int. II. A probable reason for this could lie in the fact that the individuals interviewed for the specific incident analysis were, by definition, at least one-time users since data were gathered as they left the center. Respondents for Int. I and Int. II, on the other hand, were randomly selected from all potential users, as this term was here defined. It seems reasonable to expect that people one actually sees on center premises would be more frequent users.

In all Int. III groups, the 20 to 40 year age group reported the largest percentage of visits; disregarding age, all groups reported a very similar utilization pattern during the preceding year.

CHAPTER X

THE NORTH-WEST NEIGHBORHOOD HEALTH COUNCIL

The N-W council is described in this chapter rather than with the preceding organizational material because, representing the community and being the governing body of NWHC, it forms a link between community and center.

This council came into being in 1967 before the center was established in the same year. Its original ten members helped back-up hospital personnel formulate plans for the center, and approved the final draft of the program proposal.

The council's functions, according to the original proposal, were to

1. assist in the formulation of policies for the center;
2. be responsible for its operation;
3. coordinate the center's services with those of other community agencies;
4. determine the community's health needs;
5. rouse community awareness of these needs and encourage use of health care facilities;
6. recruit paraprofessional personnel among the community's poor residents; and

7. serve as an agent of communication between community, center, other institutions and agencies, and the back-up hospital.

As will be shown in a later section of this report, some of these functions have been carried out by the various groups in office since the inception of council and center, while others have not.

The original draft called for a council consisting of 10-15 members, to be drawn from existing community agencies and organizations. This was soon modified to accommodate representatives of all local groups then functioning, and brought the membership up to 30 individuals. In 1971 the council's by-laws were altered to include consumers of center services.

The 1971 amendment provided for an overall council membership of no less than 25 and no more than 60 individuals. Half of these were to be center patients and the other half representatives of organizations with the added proviso that (a) the membership of at least two-thirds of these organizations consist mainly of low-income people and (b) delegates from these organizations either work or live in the center's catchment area. Patient council members would, ipso facto, be residents of the area.

All members were to be elected to the council upon application to the membership committee and a vote by the

whole council, with such voting to take place once a year. Council officers were to be one chairperson, two vice-chairpersons, and a secretary-treasurer. These officers, together with the chairpersons of all standing committees would form the executive committee. Monthly meetings by both the executive committee and the whole council were to be held, the latter to be open to the public. The NWHC's project director was expected to attend all executive committee meetings ex-officio; other center personnel would attend when requested to do so by the executive committee.

The 1971 constitution provided for four standing committees:

1. Personnel committee--to recruit, screen, and in some cases (e.g., project director) select staff; to formulate policies and practices regarding staff in cooperation with center administration; to review staff grivances which could not be settled within the center.

2. Membership committee--to recruit and screen applicants for council membership.

3. Patient care committee--to review services rendered by NWHC to its patients.

4. Hospital committee--to review services rendered to NWHC patients by the back-up hospital; to serve as liaison between center, council, and hospital.

The council had three paid, full-time employees: one community organizer whose function was primarily communication and coordination with other neighborhood organizations and the catchment area at large, one administrative assistant, and one secretary. Council members served without pay, although they were reimbursed for expenses incurred by virtue of their service on the council (e.g., baby sitters, lunch money, travel expenses, loss of pay from one's job).

Two factors contributed to a short life for the 1971 by-laws. One had to do with the manner of filling council seats, the other with personalities and community politics.

The by-laws stipulated an upper membership limit of 60. Once the 60 places were filled there was no room for new members (unless somebody vacated a seat) because the by-laws did not call for regular community-wide elections. According to several informants whom I have always found to be reliable and who had long been associated with NWHC and the N-W council, some protest began to be voiced against the council in office in 1971. It was thought to be self-perpetuating, stagnant, and non-representative of the community. It was, therefore, decided to drop those council members who frequently missed meetings--with vacant seats to be filled in the manner prescribed by the by-laws. Again according to my informants, the council members who were forced to resign were not necessarily the most ineffective individuals on the council.

When difficulties between the council and a high-ranking member of the center's administration developed,[30] a dissident community group accused the council of being unproductive and not truly representative of the "community." This group, more radical than the N-W council in that it advocated total community control of all funded poverty programs, called for community-wide elections to council membership and "meaningful" participation by the community in operating the center. It claimed that inaction by the present council permitted the back-up hospital to disregard community wishes.

Whether the dissidents actually influenced the HEW mandate calling for new election procedures and the reorganization of council membership is a moot point. Such reorganization was ordered and--with the help of an arbitration group specializing in community disputes--took place in the summer of 1972. This arbitration group proposed a new council, to be elected for two years, which would consist of at least 28 members and would guarantee a voice in policy decisions to all important segments of the target population. A minimum of 20 council members had to be eligible for service at NWHC; a maximum of 8 individuals could be from the non-eligible segment of the catchment

[30]It should be remembered that this was not the administration in office during most of this study (see chapter VIII).

area's population.[31] This area would be divided into four election districts--each to elect a minimum of seven members to the council--to insure that the electorate be familiar with candidates. If no representatives of given segments of the population (e.g., young adults or the old) were elected, two members of each of these groups could be appointed, provided their group comprised at least 5% of the center's patient population. First consideration for these appointments would be given to defeated election candidates belonging to the groups in question. All elections must be publicized well in advance, convenient voting places provided for each of the four election districts, and these biennial elections must be supervised by an accredited non-involved organization. All persons registered as patients with NWHC were eligible to vote; center employees were barred from voting or serving on the council. The structure of committees, executive board, open and closed meetings remained unaltered.

The first election under the new guidelines was held in June 1972 (see table 10.1). None of the dissidents ran for office because they disputed the legality of council

[31] This was, of course, before the sliding-fee scale was instituted. Once sliding fees became operative, financial eligibility ceased to exist.

and election.[32]

TABLE 10.1

COMPOSITION OF 1972 CANDIDATES AND ELECTED MEMBERS OF THE N-W COUNCIL[a]

	Candidates		Elected Members	
District	Consumers	Non-consumers	Consumers	Non-consumers
A	8	5	6	1
B	16	2	6	1
C	3	6	3	2
D	11	9	5	2

[a]The target figure was for 28 elected members--at least 20 consumers and no more than 8 non-consumers.

As this table indicates, not all districts managed to nominate a choice of candidates or, in some cases, even enough candidates. The elected council fell 2 members short of the membership of 28 stipulated by the 1972 by-laws.

Council members received periodic management training by a government-funded organization serving all the neighborhood health centers in the city. It was difficult to evaluate the effectiveness of this training because of

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[32]In fact, they instituted a lawsuit against the newly elected council which was dismissed by the court. This group did have a slate of candidates in the 1974 election--four of them were elected. Despite this, another lawsuit was started; its outcome was unknown at the time of this writing.

a large turn-over in council membership.[33]

At the time when interviews with council members were planned, only eight of the twenty-six elected in 1972 remained. The rest had either resigned or been dropped because of non-attendance. New members had been appointed upon application by interested individuals. Some of these had originally been defeated in the election, others had never run. The composition of the 20-member council in the spring of 1973 was: 35% male, 65% female; 35% Hispanic, 40% Black, and 25% White; the chairperson was Black, there was no vice-chairperson. Since the center population consisted of 67% Hispanics, 24% Blacks, and 2% Whites (see table 9.3) it would appear that Hispanics were under-represented on the council, while Blacks and Whites were over-represented. The former do occupy a larger proportion of staff positions at the center than either of the other two groups--although these positions tend to concentrate in nonprofessional categories (see tables 8.3 and 8.4).

All council members were asked for an interview. While none refused, four of them either could not be reached to settle on a time or asked for several

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[33]This turn-over coupled with the directive that all council seats be vacated for elections in June 1974 presented a problem for the assumption of granteeship. For this reason the council then in office held a referendum to permit twelve of its members to retain their seats. This was defeated. The 1974 elections left very few of the old council members in office, and HEW has postponed consideration of giving the council granteeship for another year.

postponements, and six kept missing appointments. The chairperson was among those not interviewed. The council sample of ten (four Hispanics, three Blacks, and three Whites) was, therefore, very much a self-selected one, more so than the staff sample. Whereas 50% of council members did not make themselves available for an interview, only 12% (17) of all employees (or 14% of all full-time employees) fell into that category. Any conclusions based on these figures alone would be invalid, since the entire council was approached while only a substantial sample of staff was. The feeling that council members were somewhat more reluctant to talk was, however, reinforced by several other indicators: First, with very few exceptions, council members volunteered much less information than staff members. The strength of the focused interview lies in the fact that respondents are free to bring up material of concern to them and to express affect more freely. While most staff members did just that--most were very honest, articulate and often emotional--very few council members showed the same behavior. Second, in most cases they talked in a manner which appeared somewhat stilted, "for the record"; whatever their power of expression, the answers were to some extent, stereotyped. Third, on some questions (e.g., the actual functions and effectiveness of the council, its role in formulating the yearly budget, its relationship to staff) the information offered by most

council members differed substantially from information given by staff, including administration, and my observations.

Some reasons for the differences in the reactions to the interview and interviewer immediately come to mind: Staff had much more opportunity to get to know and trust me than did council members. Not surprisingly, council members who had been in office longer were more open than newly appointed ones. The council as a whole must have felt particularly vulnerable because its application for the granteeship was being processed at that time. Perhaps most importantly, training had given most members the official language of health politics and management, but not yet the self-confidence of successful managers. Observation over the period of this study revealed that they did not feel comfortable unless appearing in and as a group; they permitted themselves to be led by strong individuals within (or outside) the membership; there was also a tendency for anger--or resolution--to wilt rapidly when faced with authority figures.

Perhaps the comment of one person closely connected with neighborhood health centers and their community boards explained the situation best: When asked why community councils apparently did less independent governing than was theoretically within their power, he replied that they have not been provided with enough tools to perform effectively. "At present," he said, "the situation is not

unlike one where you would put a five-year old behind the wheel of an Offenhauser and send him to drive in the Indy 500." He believed that sporadic, short training sessions could not accomplish very much, but that once the N-W council had true authority as the grantee agency, it would acquire the skills necessary to wield this authority effectively.

CHAPTER XI

NWHC AND ITS PLACE IN THE HEALTH CARE SYSTEM

In order to answer the various questions regarding respondents' satisfaction with NWHC services and its physical plant, as well as their ideas regarding community, neighborhood, and community participation which were raised in part I (see summary for chapter VI), data gathered through observation, interviews, and specific incidents will be offered here and in the following chapters. Answers will, to a large extent, be framed in terms of perceptions and attitudes on the part of patients and staff. My own observations will help round out the picture.

Most of the persons studied who were involved with NWHC--whether patients or staff[34]--considered this form of health care delivery system at least equal, and in many cases superior, to others. This was in accord with findings of studies that the care provided by neighborhood health centers appears to be satisfactory by both medical (Morehead, 1970) and consumer standards (Citizens Board,

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[34]No data are offered regarding the opinions of council members. All but one praised the quality of care in our talks; the one dissenting voice came from an individual who was not a patient.

1971; Health/PAC, 1972a; Hillman & Charney, 1972; Salber, et al., 1972).

Positive evaluation by NWHC patients was based mainly on convenience, continuity of care with one physician, low cost, personalized care and, among Hispanics, the presence of Spanish-speaking personnel. Staff agreed that the care patients received was more personal at the center than in other clinics (and my observations confirmed this), and that the center was at least striving to accomplish the goals of continuity and comprehensiveness of care. Physicians, nurses, and administrators were less likely to judge that these goals had, in fact, been met than were paraprofessional and clerical personnel.

Among patients there was little recognition of the role of ancillary personnel in comprehensive health care; there was, however, little indication that such care was considered inferior. Most physicians were not too unlike patients in their attitudes on this point.

The material in this and the next two chapters is organized into analyses of the perceptions, feelings, reactions, etc. of (a) patients and (b) staff because one of the expectations of this study was that these two categories of respondents would differ. Patient data, in turn, were often examined for differences among ethnic groups.

Patients

As the following quotes from Interviews I and II indicate, the reaction of patients toward NWHC was varied--it ranged from wholehearted acceptance to complete rejection.

> The first time I went to the center I thought of it as my clinic; I knew I would have a personal physician for myself and my family, and I didn't feel that the staff would think "oh, no, here they come again!" when we go there.
>
> C.B., Hispanic female, age 42

> They pay attention to you at the hospital and give you medication; at the center they only give you aspirin--won't give antibiotics or real medicine.
>
> A.L., White female, age 71

> If the center were to be closed, the people would drop like flies; they depend on health care from the center.
>
> D.C., Black female, age 33

Health care practices: past and present. Approximately one half (53%) of Int. I respondents grew up in families which had utilized the services of private physicians (see table 11.1). While the three groups hardly differed in this respect--the relevant figures were 16 each Hispanics and Blacks and 18 Whites--use of hospitals by their families was reported more often by Hispanic respondents. It would appear that none of these Hispanics did without some form of medical care in childhood. They also mentioned more positive evaluation of both physicians and hospitals by their parents than did individuals in the other two groups.

Despite, or perhaps because of, this generally more positive attitude in their family backgrounds, these Hispanic respondents were much less emphatic in insisting that they

TABLE 11.1

HEALTH CARE FACILITIES UTILIZED BY INT. I. RESPONDENTS' FAMILIES OF PROCREATION AND THEIR ATTITUDES TOWARD PHYSICIANS AND HOSPITALS[a]

Respondents' Report on their Parents	Ethnic Group							
	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
A. Facilities used								
Private physician	16	48	16	50	18	60	50	53
Hospital	14	42	8	25	3	10	25	27
Home remedies	3	10	-	-	-	-	3	3
No place (region without physician or hospital	-	-	2	7	4	13	6	6
Other[b]	-	-	3	9	4	13	7	7
DK, NR, Don't remember	-	-	3	9	1	3	4	4
Total	33	100	32	100	30	99	95	100
B. Attitudes								
Positive	23	72	12	37	17	45	52	51
Negative[c]	5	16	11	34	8	21	24	23
Neutral[d]	2	6	1	3	3	8	6	6
None[e]	-	-	4	13	4	10	8	8
DK, NR, Don't remember	2	6	4	13	6	16	12	12
Total	32	100	32	100	38	100	102	100

[a]Q. 81: "When you were a child, where did your parents go for help when someone in the family did not feel well?" (O.E.)
Q. 83: "How did your parents feel about doctors and hospitals?" (O.E.)

[b]Other: Don't remember/orphan (Black=2, White=3); midwife (Black=1); physician or nurse in family (White=1).

[c]This category is comprised of such answers as "Hated/feared/disliked them; skeptical about them; avoided them where possible; frightened of hospitals; little or no contact with hospitals."

[d]"Did not fear them" (Black=1, White=3); "Trusted in God" (Hisp.=2)."

[e]M.D. not available/little contact.

preferred to choose their health care facilities rather than being told where to go for health services (see table 11.2). But among those Hispanics who did say that they preferred to make a choice, about as many mentioned that it was a basic right, or important to exercise a choice as did Blacks and Whites (see Table 11.3). Fewer, however, seemed to believe that they knew what "was best" for themselves.

This could, perhaps, relate to the finding that Hispanic respondents reported much less use of home remedies than did Blacks and somewhat less than Whites--the figures were 5, 20, and 10 respectively ($\chi^2 = 16.38$, df = 2, $p < .001$). This seems to be contradicted by the existence of botánicas in Puerto Rican neighborhoods. The only remedies mentioned were rather orthodox ones like aspirin, fruit juices, teas (both regular and herbal), plasters--and prayers. White and Blacks also mentioned teas and plasters, but added more imaginative items such as spider webs for cuts, turpentine for worms, a bag with a foul-smelling substance around one's neck to cure a cold, molasses to guard against the effects of spring fever, and camphor oil rubs to keep boys' breasts flat.

White respondents might simply have used fewer home remedies than Blacks; this could fit the finding that Whites reported much more frequent use of the center than either Black or Hispanic respondents (see table 9.10 and table 2, appendix N). And it is possible that Hispanics were less

TABLE 11.2

RESPONDENTS' PREFERENCE REGARDING DECISION-MAKING POWER IN CHOOSING HEALTH CARE FACILITIES (INT. I)

Respondents' Preferences	Ethnic Group							
	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Own decision	13	43	23	77	25	83	61	68
To be told	1	3	5	17	3	10	9	10
D.K.	13	43	1	3	2	7	16	18
N.R.	3	10	1	3	-	-	4	4
Total	30	99	30	100	30	100	90	100

χ^2= 26.28, df 4 (combined "DK" and "NR"), p<.01

When respondents who voiced any preference (i.e. combined "own decision" and "to be told") were compared to those who did not (combined "DK" and "NR") the difference between the groups remained highly significant:

χ^2= 25.2, df=2, p<.001

[a]Q. 86: "Do you prefer to make your own decision about where to go for health services, or would you rather someone else told you where to go?" (F.A. + probe)

TABLE 11.3

REASONS FOR PREFERRING TO CHOOSE ONE'S HEALTH CARE FACILITY OR FOR BEING TOLD WHICH TO USE[a] (INT.I)

Reasons	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Own decision								
Basic right/freedom/my body	3	21	3	11	4	16	10	15
Important to exercise choice/ quality of service/convenience	8	58	12	43	9	36	29	43
Know what is best for family/ know when change is needed	3	21	8	28	10	40	21	32
Accept suggestions, but want own decisions	-	-	5	18	2	8	7	10
Total	14	100	28	100	25	100	67	100
Told								
Value doctor's opinion/like good advice	-	-	2	40	3	100	5	56
Not qualified to decide/ don't know where to go	1	100	3	60	-	-	4	44
Total	1	100	5	100	3	100	9	100
Not applicable								
DK or NR to Q. 86[b]	16		2		2		20	

[a]Probe on Q. 86 (see table 11.1)

[b]One of white respondents volunteered: "Have no choice."

willing to admit use of home remedies because of a wish to appear Americanized and a belief that Americans might consider such health practices primitive.

Hispanics also displayed less imagination and/or knowledge when they were asked what things could affect the health of individuals (see table 11.4). Respondents in this group named fewer agents in general, and these were distributed among only a portion of the categories mentioned. But more importantly, most of these people appeared to lack an understanding of the roles of properly balanced nutrition, exercise, and rest in the maintenance of health, as well as the possibly detrimental effects on health of some agents in the physical environment. Without such understanding, prevention of disease is made more difficult. It is now impossible to determine the reasons for this apparent lack of knowledge, but it might point to a failure on the part of center staff to educate their patients. This failure could be more detrimental to Spanish-speaking people who might be underexposed to health education in the English language mass media.

Some confirmation for assuming a connection between language and knowledge was found in the fact that six of the seven Hispanics who mentioned nutrition and/or the physical environment as agents which could affect one's health were rated by the interviewer as speaking excellent English. Since all interviews were conducted in the language of the

TABLE 11.4

AGENTS WHICH ARE THOUGHT TO AFFECT ONE'S HEALTH (INT. I)[a]

"What things can affect your health?"	Ethnic Group							
	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
Care[b]	1	3	1	2	1	1	3	2
Contagion/chance/accident	2	5	2	3	5	8	9	5
Age/disease	-	-	3	5	2	3	5	3
Exercise/rest	-	-	7	11	4	6	11	7
Nutrition[c]	4	11	18	30	13	20	35	22
Alcohol/smoking/drugs	-	-	3	5	3	5	6	4
Physical environment[d]	3	8	10	16	12	19	25	15
Poverty	-	-	4	7	2	3	6	4
Social environment[e]	-	-	2	3	5	8	7	5
Mental attitude[f]	5	14	8	13	11	17	24	14
Too many things to mention	3	8	-	-	-	-	3	2
Nothing	-	-	-	-	3	5	3	2
Sub-Total	18	49	58	95	61	95	137	85
DK/NR/irrelevant	19	51	3	5	3	5	25	15
Grand total	37	100	61	100	64	100	162	100

Note: Percentages were based on grand totals (i.e., 36, 61, 64 and 162).

[a]Q. 80: "What things can affect your health?" (Open ended)

[b]This category included: How to take care of yourself; vacations; way of life; quality of medical care; regular check-ups; medications.

[c]Included were: Appetite; diet; weight loss; vitamins.

[d]This included: Air pollution; climate; allergens; noise, dirt; weather; city environment; inadequate transportation.

[e]Not getting to know anybody; altercations with people; crime; muggers; such comments as: "People make me sick!"; "hassle at clinic".

[f]This category included: Tension; worry; anxiety; stress; depression; upset about children; financial problems; excessive excitement; how the day goes; excessive waiting.

respondents' choice by an interviewer fluent in both English and Spanish apparent lack of knowledge was probably not a function of the language used in the interview. Neither was it a function of age or birthplace since these six individuals ranged in age from 20 to 59; two were born in this city, one on Mainland U.S. and three outside this territory. All six did, however, have at least some high school education and one had completed college.

Respondents of all three groups reported about the same pattern of seeking treatment when feeling ill: 21 (70%) each Hispanics and Blacks and 22 (73%) Whites apparently did so immediately or fairly soon after noting symptoms, while the rest waited a while.

According to the information gathered in Int. I then, more Hispanic respondents, as compared to the other two groups, tended to

1. come from families where medical care was sought and regarded positively;

2. be somewhat passive in exercising their freedom of choice among health facilities;

3. use fewer home remedies; and

4. exhibit less knowledge concerning disease-causing agents.

Did these factors influence utilization of and satisfaction with NWHC? What facilities were utilized before the center opened?

Among Int. I respondents, Hispanics reported about equal use of the back-up hospital, other hospital clinics, and private physicians before becoming NWHC patients (see table 11.5). Blacks and Whites reported (a) more use of hospital clinics other than those of the back-up hospital; (b) more use of clinics than of private physicians; and (c) more clinic utilization in general than did Hispanics. As for utilization patterns since becoming NWHC patients, Hispanics reported more use of the center and less use of other facilities than did the others (see table 9.11).

When asked why they thought neighborhood health centers had been created, Hispanics--as compared to Blacks and Whites--were more likely to speak of decentralization or convenience; they were also the only ones to mention "quality care" specifically (see table 11.6). Yet only half of these eight respondents perceived the care rendered by NWHC as being better than that offered by any other health care facility or provider (see questions 11-15, footnote 38, p. 254). Blacks and Whites, on the other hand, stressed economic need and crowded conditions in hospital OPD clinics.

As was mentioned above, Hispanics reportedly did not do much choosing among available health care facilities when they started using the center. Several possible reasons for this come to mind. One has to do with economics: the 1970 Census Report (see table 8.2) listed Puerto Ricans in the center's catchment area as being poorer (in the aggregate)

TABLE 11.5

MEDICAL FACILITIES USED BY INT. I. RESPONDENTS BEFORE THEY BECAME CENTER PATIENTS [a]

Facility	Ethnic Group							
	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Hospital OPDs								
Back-up hospital	12	33	11	29	6	17	29	26
Other hospitals[b]	13	36	18	47	20	55	51	46
Private physician	11	31	8	21	6	17	25	23
No place; NR	-	-	1	3	4	11	5	5
Total	36	100	38	100	36	100	110	100

[a]Q.9: "Where did you get your medical treatment before you used this center?" (Open ended) Multiple answers were possible; therefore N≠90.

[b]These included both voluntary and city hospitals. The only respondent (Black) who reported use of both VA and Labor Union facilities was included in this category.

TABLE 11.6

PERCEIVED REASONS FOR THE CREATION OF NEIGHBORHOOD HEALTH CENTERS (INT. I)[a]

Reasons	Ethnic Group							
	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Provide quality care	8	23	-	-	-	-	8	8
Economic need	2	6	9	26	9	27	20	20
Provide decentralized care; convenience	15	43	6	18	3	9	24	24
Need existed; hospitals overcrowded	5	14	12	35	8	24	25	24
Other[b]	-	-	4	12	4	12	8	8
DK, NR, Irrelevant	5	14	3	9	9	27	17	16
Total	35	100	34	99	33	99	102	100

[a]Q. 69: "Why do you think clinics like the Neighborhood Health Center were started?" (open ended)

[b]This category included the following answers: "They provide more personal service," "they have a stabilizing effect on the community," "they improve health attitudes," "for political reasons."

than either Blacks or Whites.[35] Care at the center, even after the sliding-fee scale was instituted, was cheaper than that available in other places; besides, being near the homes of all patients, no carfare needed to be involved. Yet table 11.6 indicates that Hispanics were less likely to talk about economics. And while a majority of all Int. I respondents reported walking to the center, Hispanics were more likely to use public transportation (see table 7, appendix N), despite the fact that they tended to live closer to NWHC than Black or White respondents (see table 9.13).[36]

The reasons for this are not known. Among Hispanics, 77% (23) stated that there was nothing connected with transportation to influence their choice of treatment facilities, and only 1 (3%) listed carfare as an important consideration. In contrast 9 (30%) Blacks and 8 (27%) Whites did so, while 63% (19) and 60% (18), respectively, were not influenced by any considerations in connection with transportation. Several Int. II respondents (an all-Hispanic group)

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[35]Not all Hispanic center patients were Puerto Ricans, the only Hispanic group which appeared in the census. It is known that many Central and South Americans come to the North-Eastern part of the United States via Puerto Rico in order to avoid the necessity to obtain an entry permit; they may also have been listed as Puerto Ricans in the census.

[36]Table 7 also indicates that a minority of all respondents walked to other facilities--since some of the hospitals and private physicians which were visited by these patients were quite a distance from their homes, this finding is not surprising.

did, however, mention accessibility of the center on foot, or the fact that no carfare was needed to reach it among the reasons for thinking that it was important to have such a clinic within the community.

A second reason for the reportedly greater utilization by Hispanics of NWHC rather than other health care facilities might have had to do with language. The bilingual interviewer for Int. I rated the proficiency in English of his 30 respondents in the following manner: The knowledge of English of 14 (47%) was judged to be non-existent or poor, that of 6 (20%) as fair, and 10 (33%) spoke the language well or excellently. Out of the 16 Hispanics who reported use of other health care facilities 9 (56%) spoke English, 7 (44%) did not. Among the 12 Hispanics who reported no use of other places 5 (42%) spoke English and 7 (58%) did not.[37] These proportions do not offer more than a slight indication that language might have influenced the utilization of all available health care facilities.

Lastly, and perhaps bridging economics and language--both of which could have conceivably inhibited mobility--was a family background of positive evaluation of health care facilities and personnel, coupled with a relatively sparse knowledge concerning health matters and some passivity in taking advantage of one's freedom of choice among health care

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[37]Two individuals, both proficient in English, did not answer this question.

facilities. If such individuals were offered a conveniently located and inexpensive clinic which provided acceptable care by personnel, many of whom spoke Spanish, it should not be surprising that more Hispanics, as compared to respondents in the other two ethnic groups, used only this facility (see table 9.11) and voiced greater satisfaction with it (see table 11.8).

While respondents of all three groups were more likely to pick the center as the most convenient place for treatment (63%), they differed in the reasons for this choice (see table 11.7).

TABLE 11.7

MAIN REASONS OFFERED FOR THINKING THE CENTER MORE CONVENIENT THAN OTHER FACILITIES[a]

Respondents' reasons	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
NWHC gives appointments, asks patients' preferences	4	29	16	100	14	61	34	64
NWHC is accessible	9	64	-	-	6	26	15	28
NWHC allows walk-ins, has convenient hours	1	7	-	-	3	13	4	8
Total	14	100	16	100	23	100	53	100

Note: 37 respondents either did not answer this question or did not give a reason.

[a]Q 21: "Which of the places you use make it possible for you to go at a time most convenient for you and how do they do this?" (Open-ended)

Hispanics cited ease of access to the center most often, while Blacks and Whites mentioned the use of an appointment system. Taken in conjunction with the finding that they did not walk to NWHC as much as did members of the other two groups while expressing less concern with carfare, it is possible to speculate that these Hispanics were either more likely to be accompanied by small children on their visits to the center, and/or that they feared crime in the streets more than did the others. Some confirmation for this will be offered in chapter XIII where it will be shown that Hispanics expressed the greatest concern with muggings and insufficient police protection. They were also less able than the other two groups to identify photographs of locations in the neighborhood correctly. The fact that Black and White Int. I respondents were more likely to mention the center's appointment system is consistent with the finding that they were also more inclined to prefer making their own decisions on the question of where to seek health care (see table 11.2). Both preferences could indicate a greater sense of wanting control over one's environment and fate.

As for the use of Spanish-speaking staff at the center, 25 (83%) of the 30 Hispanic Int. I respondents thought that this affected health care for their group in a positive manner, 4 (13%) did not think so, and 1 (3%) was undecided (only individuals with good command of English were found in the last two groups). However, half of those who spoke

English well and all whose proficiency was judged as fair did think that the availability of Spanish-speaking staff was important. The reasons given by respondents who thought use of Spanish-speaking personnel important were:

1. many individuals "don't know enough English to explain their symptoms and illness, or to understand instructions" (14 or 47%); and

2. "one can relate better to, feel more comfortable with, people who speak one's own language" (11 or 37%).

Attitudes toward NWHC and other health care providers. A majority of all Int. I respondents expressed satisfaction with NWHC; the differences between the three ethnic groups were not significant (see table 5, appendix N). This table indicates that, while a greater proportion of all these respondents voiced satisfaction with physicians and nurses, Hispanics were significantly more likely to do so than Blacks or Whites. Finally, among users of back-up hospital services, Blacks were significantly more likely to voice dissatisfaction with this facility.

Most Int. I respondents could name one or more aspects of NWHC which they particularly liked, could not think of anything they really disliked, and had recommended the center to others (see table 6, appendix N). The three groups did not differ significantly regarding the question of recommendation; on the other two issues more Blacks tended to both like certain things about the center and dislike

others.

The most important information emerging from the probes for the questions appearing in tables 5 and 6 (appendix N) is that among all groups, quality of care, being treated in a personalized manner, and convenience were cited most frequently as reasons for satisfaction with the center: 83 out of 160 answers, i.e., 52% of all answers, fell into these three categories; the remaining 48% of answers were distributed among 11 other categories which included such things as provision of free transportation and medication, free or inexpensive service, the maintenance of a well-run community facility where one could meet one's friends, etc. The lack of specialty clinics was mentioned most often (26%) as a service unavailable at the center. This probe also revealed that some respondents were unaware of the availability of a few services (e.g., dental clinic, free medication). The rest of the probes yielded no definite trends.

The all-Hispanic Int. II respondents basically agreed with Int. I informants. Thus C.L. (a 50-year-old widow, living with two adult children) felt that while the clinic lacked the specialty equipment of the back-up hospital, its "employees are more sympathetic and affectionate. They are very attentive." D.C. (female, age 33, living with three children) approved of the presence of Spanish-speaking assistants which "make the center more community oriented,"

and C.B. (female, age 42, living with four children) liked the fact that "your personal doctor knows you and your family." On the other hand five (20%) of this group of 25 felt that the center essentially had nothing special to offer; as H.C. (female, age 35, living with two children) stated "it is medicines that cures one, not the doctors. Some places offer good medicine but other places do not." Another 20% of these respondents felt that they could not answer this question because they only knew the center and its back-up hospital. The fact that they did not compare these two facilities might indicate that they did not consider NWHC as an independent entity.

Only one respondent (4%) said that she would not recommend the center, but did not give any reason; five (20%) would just send neighbors over without trying to convince them or telling them anything special about it. On the other hand, 12 (48%) gave specific reasons (e.g., good, inexpensive service, good doctors) for recommending the center, and eight (32%) were concerned that their friends and neighbors should know certain facts about the center such as the need to bring one's Medicaid card along.

Int. I respondents did not appear quite as willing to recommend the center (see table 6, appendix N). Among those who did, competent, personalized, and inexpensive care were again cited as the main reasons. However, eight (27%) Hispanics, nine (30%) Blacks, and 13 (43%) Whites said they

had never recommended anybody to the center. Reasons here ranged from dissatisfaction with and/or lack of confidence in the service (six or 20% out of the 30 negative answers), through "no occasion to" (15 or 50%) and "don't know it well enough" (five or 17%) to no reason given (four or 13%).

When asked to compare the care rendered by NWHC and various other health care facilities,[38] a majority of all respondents (18 each Hispanics and Blacks and 17 Whites, or a total of 59%) perceived the clinic as being better than 1 or more of those other facilities and only 4 Hispanics and 6 Blacks and Whites each (or a total of 18%) thought it worse. Table 11.8 presents two of these comparisons.

While Hispanics showed a greater tendency to evaluate NWHC care as better than that rendered by the clinics of the back-up or other hospitals in the city, the differences between the three groups were not too significant. The only highly significant difference was found in the evaluation of private physicians' care--Blacks were much more likely to find this care superior to center care. The care by private physicians was, however, generally assessed more positively

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[38]Questions 11, 12, 13, 14 and 15: "Think about the center and the care doctors and nurses give you. Compare it with (Q 11) other places you know; (Q 12) private physicians; (Q 13) the clinics of . . . [the back-up hospital]; (Q 14) other . . . [Name of the city] hospital clinics; (Q 15) the medical care you think most . . . [residents of the city] usually get. Tell me how they compare. On the whole, would you say the care at NWHC is better, worse, or about the same as in these other places?" Each of these fixed alternative questions was followed by a probe about reasons for the answers.

TABLE 11.8

COMPARING NWHC CARE TO THAT RENDERED BY PRIVATE PHYSICIANS AND HOSPITAL CLINICS (INT. I)[a]

The care rendered by NWHC as compared to private physicians is:	Ethnic Group							
	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Better	3	14	6	24	6	31	15	22
Same	15	68	4	16	10	53	29	44
Worse	4	18	15	60	3	16	22	33
Total	22	100	25	100	19	100	66	100
χ^2= 17.75, df=4, .001<p<.01								
The care rendered by NWHC as compared to hospital[b] clinics is:								
Better	17	61	12	48	9	32	38	47
Same	11	39	10	40	14	50	35	43
Worse	-	-	3	12	5	18	8	10
Total	28	100	25	100	28	100	81	100

χ^2= 7.61, df=4, .10<p<.20

[a]For wording of questions see footnote #38, p. 170.

[b]Comparisons of "back-up hospital" and "other hospital clinics" were combined because the latter did not yield an acceptable minimum frequency. Duplicate answers were counted only once.

than any other. But in this context it should be noted that 32 out of 89 respondents (36%) made judgments without any apparent indication that they were familiar with care by private physicians (see table 8, appendix N). Among these 32 individuals, nine (28%) gave a better rating to the clinic, five (16%) to private physicians, and 18 (56%) thought the care available from these two types of providers comparable.

Of all 90 Int. I respondents 62 (69%) were unable to give any tangible reasons for preferring either the center or one or more of these other places. Altogether, these five questions elicited 205 (41%) of those non-specific answers and 292 (59%) definite reactions for a total of 497 answers (see table 9, appendix N).

Table 9 indicates that the most frequently cited reasons for assessing center care positively was the perception by patients that staff and service here were more personal and considerate--"you don't get herded like cattle"; and that the care was more competent and the service good. Other favorable comments concerned such factors as staff listening to patients and giving them information; the place was convenient, smaller, and less crowded than other clinics; one saw the same doctor every time; and, by and large, service was faster than in most other places. Taking only the 292 definite answers into account, 60% of these were favorable to the center, 18% unfavorable, and 22% did not fall into either of these classifications because their overall tenor was that "the

center's care was better than most clinics, but worse than that of private doctors," "one gets OK treatment everywhere," or "none are worth a damn." The answer that care and treatment were acceptable in most places was often coupled with comments that "doctors and nurses in all places are trained alike."

In this context it is interesting to note that many respondents related their judgment, be it positive or negative, to the attitudes and behaviors of health care personnel rather than just to being treated medically. Int. II respondents tended to confirm this. Thus "the kindness staff shows for its patients is what makes this center different from other clinics," and "the personnel is really together, they care and that counts." This would confirm the proposition that psychosocial variables must be taken into consideration if medical care is to be complete. The patient is indeed a total person rather than a collection of diseased organs.

Staff attributes: how they affect perception of care. Did the distribution of the various ethnic groups among staff affect patients' perception of and attitudes toward the center? As was shown on table 8.2, Whites were found mainly among professionals, Hispanics among paraprofessional and clerical staff, with Blacks occupying all levels. Did the various groups of patients react to this fact--and if

so, how?

When asked their opinion about ways to improve center services, Hispanic Int. I respondents offered fewer suggestions, but when they did these were more likely to deal with expansion of facility and services; Blacks and Whites, on the other hand, mentioned more and better qualified staff (see table 11.9).

Only two Hispanics said that they really disliked some aspects of the center (i.e., long waiting time; center is too small and noisy) while ten Blacks and seven Whites did so. Reasons given by the latter two groups ranged from inferior care and lack of respect for patients, through long waiting time and various aspects of the physical environment, to "everything." When asked what they really liked about the center no Hispanics, but several members of the other two groups, mentioned concern and consideration on the part of physicians (see table 11.10).

It should also be noted here that of the six Hispanics who mentioned quality of service or care in table 11.10, not one related this answer specifically to physicians, while two Blacks and three Whites did so. This by itself need not mean anything, but if one combines the answers in this category with those in the categories regarding "considerate/ concerned/own physician," the difference between Hispanics and the other two groups becomes more apparent: 7 Hispanics, 19 Blacks and 14 Whites made specific reference to physicians

TABLE 11.9

SUGGESTIONS FOR IMPROVING SERVICES AT NWHC (INT. I)[a]

Suggestions offered by Respondents	Ethnic Group							
	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
Expand facility, services[b]	6	67	5	23	9	43	20	38
Better qualified, more concerned staff, doctors[c]	-	-	7	32	4	19	11	21
Faster, more punctual service	2	22	5	23	4	19	11	21
Better organized, informed	-	-	3	13	3	14	6	12
More Spanish-speaking staff	1	11	-	-	-	-	1	2
More concern for community[e]	-	-	2	9	1	5	3	6
Total	9	100	22	100	21	100	52	100
Not applicable (DK or NR to Q. 79, see Table 11.9)	13		4		2		19	
Not applicable ("No" to Q. 79, see Table 11.9)	11		11		11		33	
DK, NR	-		-		1		1	
Grand Total	33		37		35		105	

[a]Probe to Q. 79: "Can you think of any way the center could give better service? If yes, how?"

Following are examples of answers included in the various categories:

[b]More space, equipment; specialty clinics; emergency unit; playroom; keep center open longer hours.

[c]More professional behavior of staff and doctors; give better explanations.

[d]Install a number system; clarify procedures; disseminate information on FHCs and assign where needed.

[e]One expects more from the center than from other places because it is established for the community; need physicians who are more community minded.

TABLE 11.10

REASONS FOR LIKING N.W.H.C. (INT. I)[a]

Reasons given by respondents	Ethnic Group							
	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
Quality of service/care[b]	6	14	8	14	6	10	20	13
Personal/individualized care[c]	11	25	8	14	13	23	32	20
Doctors concerned/ considerate	-	-	6	10	4	7	10	6
Always seen by same doctor[d]	1	2	5	9	4	7	10	6
Physical aspects[e]	3	7	1	2	-	-	4	3
Convenient[f]	11	25	10	17	10	17	31	19
Free/inexpensive service medications/dentist	1	2	7	12	7	12	15	9
Faster service than other clinics	1	2	3	5	2	3	6	4
Other[g]	-	-	7	12	4	7	11	7
NA (DK, NR to Q. 73)	8	18	2	3	3	5	13	8
NA ("No" to Q. 73)	2	5	1	2	5	9	8	5
Total	44	100	58	100	58	100	160	100

[a]Q. 73a, probe to Q. 73: "Is there anything you especially like about the center?"

Examples of answers in the various categories:

[b]Service and care; competent staff; doctors are good.

[c]Individualized care; people are friendly; concerned, congenial, courteous; give explanations; one can ask advice; warm atmosphere; do not feel like a number; coffee.

[d]Have own doctor; can call as if private physician.

[e]Small, comfortable, quiet; privacy in doctor's office.

[f]Decentralized; accessible; can choose own time; evening hours; area safe because opposite police station.

[g]Walk in when sick (1 W.); well maintained and run, modern equipment in dental clinic (1 B., 1 W.); cooperate with, refer to other clinics (3 B.): a community facility, it's ours (2 B).); meet people there (1 W.).

(χ^2 = 9.81, df = 4, .02 < p < .05). This becomes more noteworthy in view of the fact that 24 (80%) Hispanics, but only 16 (53%) Blacks and 9 (30%) whites expressed unqualified positive feelings about physicians in general (χ^2 = 15.12, df = 4, .001 < p < .01). Answers here were in the vein of "I trust/like/admire them; they are good/nice/friendly/ sincere in their desire to help." Twenty-four of the 30 Int. I Hispanic respondents trusted, liked, admired, etc. physicians in general, but only 7 of them mentioned doctors specifically among their reasons for liking NWHC. As will be shown shortly, few Hispanics named physicians' personal qualities or their sensitivity to patients' needs as reasons for seeking their advice in other than purely medical matters.

Given (a) the more unequivocal positive attitudes of Hispanics toward physicians in general, and (b) the fact that 87% of them expressed satisfaction with NWHC yet a rather small number singled out center physicians as a reason for this satisfaction--do Hispanics then have any reservations about NWHC physicians? One could hypothesize that this is due to the paucity of Hispanic physicians at the center. It is impossible to test this now, or even if Hispanics expected to find such doctors there.

Why did Black respondents not react in the same manner since there were only two representatives of their group among center MDs? The answer might lie in the fact that they saw

quite a few Blacks among other professional and administrative personnel and that, in addition, there is no language barrier, and perhaps less of a cultural barrier, between Black patient and White physician--both American-born--than between Hispanics who are relative newcomers to this country and these same physicians.

While a larger percentage in each group trusted NWHC doctors and nurses most for advice on various problems, including non-medical ones, Hispanics were more likely than members of the other two groups to accord such trust to MAs and FHCs too (see table 10, appendix N). This table also indicates that significantly more Hispanics reported going to sources outside the center--especially to family members--for such advice. This can probably be explained by the fact that the extended family plays a greater role among Hispanics than among Blacks or Whites.

The reasons respondents offered for either seeking or not seeking advice from center staff can offer some slight indications about possible effects on patients of the ethnic distribution of staff (see table 11, appendix N). Taking all respondents as one group, competence in their work was the most frequently cited reason for seeking the advice of various staff members; this was followed by their positive attitude toward patients. Hispanics and Whites, however, were much less likely to comment on these positive staff attitudes. As was mentioned before, fewer Hispanics were

likely to say that they sought advice from center physicians because they found the attitudes of these physicians supportive or sympathetic. Only Hispanics and Blacks felt that FHCs knew them and were sensitive to their needs. There was only one White FHC employed at the center, and only one White respondent reported being assigned an FHC (see table 11.11).[39] Finally, Whites (although only three of them) were the only ones who mentioned prejudice and incompetence in connection with all but doctors--i.e., non-medical, non-White staff was incompetent and prejudiced against White patients.

TABLE 11.11

RESPONDENTS WHO ARE ASSIGNED FHCs[a]

Assigned FHC	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Yes	10	33	5	17	1	3	16	18
No	12	40	25	83	20	67	57	63
DK, NR	8	27	-	-	9	30	17	19
Total	30	100	30	100	30	100	90	100

$\chi^2 = 11.24$, df = 2 (without DK, NR category), $.001 < p < .01$.

[a]Q 24: "Do you have a family health coordinator assigned to you at the center?" (F.A.)

[39]Considering that Whites account for the largest proportion of Int. I respondents who are 65 years of age or older (see figure 3, p. 132), and assuming that old people would be most in need of outreach services, this information comes as something of a surprise.

Of the patients who were assigned FHCs, all Hispanics, 3 Blacks (60%) and the 1 White reported receiving home visits from them. All the Hispanics in this group named FHCs as one category of center staff whose advice they valued; three Blacks with FHCs (and two without) did so; the fourth Black did not know and the fifth did not want such advice--neither did the White with FHC service, or any other White for that matter. All but one each of the Hispanics and Blacks with FHCs assessed their function positively; the one White did not.

It would be easy to put too much emphasis on the differences between attitudes of Hispanics and Whites concerning physicians and paraprofessionals and to take this as proof that the uneven ethnic distribution among staff did indeed affect patient perception and attitudes to an important extent. No such assumption is implied here. Even if the indications were more tangible, the question regarding overall satisfaction with the center would negate it. When asked "are you satisfied with the service at the center?" (Q 77), better than two-thirds of all users voiced satisfaction. The answer was "yes" from 26 (87%) Hispanics, 21 (70%) Blacks, and 25 (83%) Whites; "no" from 2 (7%) each Hispanics and Whites, and 6 (20%) Blacks, with the rest not giving any response. These differences are not significant ($\chi^2 = 3.6$, $df = 4$, $p > .30$).

But neither should one completely overlook indications of possible strain caused by ethnic factors in the social environment. Although shortages of Hispanic and Black physicians, White non-medical personnel, and Black and White patients, need not be sufficient cause for an expression (or even a conscious awareness) of dissatisfaction with the center, it could bring about some unease which, in turn, might tend to keep patients from coming to the center as often as necessary, from following a prescribed regimen, to cause other behavior detrimental to maximal health maintenance and care, or to keep them from considering the center as "their" community facility.

Attitudes toward non-medical health care providers. It was mentioned before that respondents often based their judgment of center services on the attitudes of health care personnel. It was also apparent that patients generally trusted the advice of physicians and nurses more than that of any other single category of staff (see table 10, appendix N). If this was so, how did they react to treatment by personnel other than physicians, or to the center's policy of training community people for health care professions?

Only a relatively small number of Int. I respondents was aware of this training program at the time the interviews were conducted, but a much larger number thought there should be such a program (see table 11.12).

TABLE 11.12

AWARENESS OF, AND AGREEMENT WITH, A PROGRAM TO TRAIN COMMUNITY RESIDENTS FOR CENTER JOBS (INT. I)[a]

	Ethnic Group							
	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Does NWHC train community residents?								
Yes	8	27	7	23	10	33	25	28
No	1	3	5	17	3	10	9	10
DK, NR	21	70	18	60	17	57	56	62
Total	30	100	30	100	30	100	90	100

χ^2= 3.69; df=4; p>.30 (with "DK, NR" category) χ^2= 2.58; df=2; .20<p<.30 (without "DK, NR")

Should there be such a program?								
Yes	21	70	27	90	24	80	72	80
No	-	-	1	3	1	3	2	2
DK, NR	9	30	2	7	5	17	16	18
Total	30	100	30	100	30	100	90	100

χ^2=36.9; df=2 (to reach an acceptable minimum expected frequency, the "No" and "DK, NR" categories were combined); p<.001

[a]Q. 53: "Does the center train people from this community for many of the jobs at the center?" (F.A. and probe)

Q. 54: "Do you think there should be such a program?" (F.A. and probe)

The three ethnic groups did not differ greatly on either of these questions; somewhat more difference was apparent when people were asked for the reasons behind their answers (see table 12, appendix N). Whites appeared less likely than either of the other two groups to mention benefits to the community--including the provision for training and jobs. Considering that they did not see many Whites in center-trained positions this was perhaps not surprising. Among the three categories of answers given by the largest number of respondents, the one dealing with the comfort of patients occurred least frequently. It is impossible to determine now whether the reason for this was that (a) the presence of community people did not add to patients' comfort; (b) whether it was simply a function of a realistic assessment of priorities--i.e., training and jobs for community people were considered more important; (c) if patients desire or idealize a sense of professionalism in all workers at health care facilities such as NWHC, perhaps it should not be unexpected that they de-emphasize comfort; or if a combination of all three factors was operating.

Paraprofessionals were mentioned as performing an important function by 5 (20%) of the 25 Int. II respondents. Thus C.B. (female, age 42) volunteered that "the doctor would be lost without them. They do so many odds and ends that they would be very much missed if they were eliminated

from the staff. They handle charts, handle blood reports, make calls for the doctor, serve as messengers, . . . get the [treatment] room ready. They are not just interpreters." P.C. (male, age 23) on the other hand, feared that "if they don't have the profession, they tend to gossip about it after you talk to them." It should be noted in this context that the fear of a lack of confidentiality due to the presence of paraprofessional and/or community personnel at the center was only mentioned by one Int. I respondent, a 38-year-old Black woman.

Asked whom they saw at the center besides physicians, Int. II respondents mentioned nurses, clerks, technicians, dentists, translators, MAs and FHCs. Among this group, 11 (44%) specifically mentioned that they now used or contemplated future use of the social service and mental health department for help with various problems in their daily lives.

Asked how they would react to receiving medical treatment and advice by staff members other than physicians, 13 (52%) expressed opposition to the idea; 6 (24%) said that they prefer a physician, but would permit treatment from other trained personnel under the supervision of an MD; and the remaining 24 appeared quite receptive to the idea of qualified paramedics--they felt that getting competent help was of primary importance, rather than who rendered this help.[40]

[40]This question was not asked of Int. I respondents.

Answers to this question ranged from "non-medical personnel should have nothing to do with administering treatment. They should not lay their hands on the ill. Their job is to observe and assist the doctor, but in no way should they be given other responsibilities dealing directly with the sick" (D.C., female, age 33); "only medically trained staff should treat medical problems" (E.M., male, age 31), or "it is not good to have non-medical persons administer care . . . . Other staff members should do their assigned jobs, whatever they may be, and not do the doctor's job" (J.C., female, age 37); through such reactions as "if they are specially trained--yes, but a person learning the trade should not be entrusted with someone else's life" (S.P., female, age 46); to wholehearted acceptance, such as was expressed by C.R. (male, age 60) "I don't believe the center would allow people to do the jobs for which they aren't qualified. My treatment has been good at the center, so I trust that the care from others on the staff would be consistent. I'm sure I would be directed to the proper person when I come with a medical problem."

In view of the fact that this question was put to patients before the nurse-practitioner program was instituted, it is a hopeful sign that the idea of personnel other than physicians rendering such medical care as they are trained for is not rejected out of hand by about half of the respondents. On the other hand, it also is apparent

that much reorientation of the public (and, as will be shown later, of physicians) is needed before use of paramedics could become a widely accepted practice.

Int. III indicates that the largest single group of patients surveyed for this specific incident analysis did, in fact, come to see physicians, although there were many encounters with other personnel (see table 11.13). As can be seen here, 285 of the 487 Int. III respondents (59%) were seen by physicians, dentists, or psychiatrists, the rest by a variety of other personnel.

A very large majority of all Int. III respondents--414 (85%) saw the person they came to see, 63 (13%) did not, and the answer of 10 (2%) was that "it does not matter." Again a majority--419 (86%) were satisfied with the result of their visit, 63 (13%) were not, and 5 (1%) did not answer this question. The preponderance of satisfaction is in accord with information elicited during Interviews I and II.

Interview I respondents were asked if there were some staff members both at NWHC and the back-up hospital with whom they preferred to deal. A majority stated that they had no preference in either facility (see table 13, appendix N). The groups did not differ significantly on either of these two questions. Asked whether they saw given staff members regularly, more reported doing so at the center than the hospital. As table 13 indicates, this question elicited larger differences between the groups: Blacks and Whites

TABLE 11.13

TYPE OF CENTER PERSONNEL ENCOUNTERED BY INT. III. RESPONDENTS

Staff member who took care of respondent	f	%	Total f	Total %
Doctor	195	40		
"My doctor"	16	3		
Walk-in doctor	7	1		
Psychiatrist	8	2		
Dentist	59	12	285	59
Technician	14	3		
Social service worker/social worker	39	8		
Nurse	15	3	68	14
Clerk/receptionist	88	18		
Other clerical	4	1	92	19
Nobody	8	2	8	2
More than one[a]	15	3	15	3
Don't know his job	17	3	17	3
NR, illegible	2	1	2	1
Grand total	487	100	487	100

[a]Intake and lab technician/physician and social worker.

reported significantly more such regular contacts at both the center and the back-up hospital than Hispanics.

Answers to the probes following these questions did not allow any conclusions regarding the type of personnel patients saw regularly, or the reasons why they preferred to deal with some more than with others. Of all those who reported that they saw given staff members at the center and the hospital regularly, "frequent use" of the facility was as likely a reason at the former place as "to see the doctor"; the latter did occur more frequently in connection with the hospital. Considering that NWHC patients were routinely sent to the back-up hospital for treatment at many specialty clinics and for more complicated tests, this was not surprising.

Int. I respondents did report knowing the names of more staff members--and being known by name in turn--at NWHC than at the back-up hospital (see tables 14 and 15, appendix N). This difference appeared particularly marked among Hispanics in the latter facility where 1 of the 12 respondents who reported use of this hospital claimed to know the name of 1 staff member--a physician; none were certain that they were known by anybody. Whites claimed the largest degree of personal acquaintance with back-up hospital personnel, and Blacks the second largest; in both cases doctors were the single staff category most likely to be named in response to either question. The same held true for the center as far as these two groups were concerned. Hispanics, on the other

hand, named FHCs and nurses more often than either physicians or any other single category. Once again, the question arises if ethnicity or--perhaps more specifically, language--of patients and staff played a role in forming a more personal relationship. The finding that Blacks and Whites were much more likely to claim a relationship with physicians than Hispanics might also have been due, at least in part, to the fact that the former two groups were raised in a culture which values the physician status very highly. The same might not be true for Hispanics.

In this context it is interesting to note that throughout Int. II, respondents very often referred to "service to the community," "taking care of our own (or neighborhood) people," when talking about the center. Thus, for example, when asked to summarize the general aim of the center the main factors mentioned were: Helping the community (12 or 48%), providing health care for the poor of the community (5 or 20%), and just generally providing health care (3 or 12%). Three others responded non-commitally that the aim of the center should be to "keep doing what it's doing now." The recognition of the clinic as a community facility will be referred to again later on.

My informal observations at NWHC over the two-year period, as well as the much more cursory observations of hospital OPD waiting rooms (O'Mara & Kirsners, 1972) led to the impression that the atmosphere of the center invited

greater ease. Patients seemed to be more relaxed at the NWHC waiting room as compared to the waiting rooms observed in other hospitals, although the former was smaller, often more crowded and shabbier. Patients were more likely to be seen talking to staff members, and children appeared less intimidated by their surroundings--they moved around freely and did not talk in hushed voices. It could be hypothesized that acquaintance with personnel of a health care facility, and feeling at ease there, might make it more appealing for people to seek care at this facility. If the aim of our health care system is to make sure that all Americans receive adequate preventive, acute, and chronic care, the fact that NWHC patients report even a minimal personal relationship is an important element in evaluating the viability of this form of health care. A small majority of Int. I respondents [17 (57%) each Hispanics and Whites, and 18 (60%) Blacks] did report that the fact that health workers knew them personally--and that respondents knew the workers--influenced their choice of where to seek health care.

Finally, more patients reportedly received help with non-medical problems (e.g., with schools, government agencies, landlords--or just talking) at the center than at other clinics although they had felt in need of such help at one time or another. The figures were small: 9 Hispanics, 10 Blacks and 13 Whites at the center; no Hispanics, 6 Blacks, and 4 Whites in other clinics; but they offered an indication

that the center provided more comprehensive care than other clinics, that at least some patients were aware of this, and liked it. On the other hand, both the present study and the Gorman & Nelson (1974) report (see chapter IX) make it clear that many patients either did not know about comprehensive care and/or were not ready to change their health care practices. This was indicated in several ways:

1. Of the 25 Int. I respondents only 5 (20%) could define the term "comprehensive care" correctly; 8 (32%) thought of it in terms of medical care only, and 12 (48%) did not know what it meant at all.

2. Not all patients were aware of the full range of services available to them at or through the center. When Int. I respondents were asked what services other health care facilities provided which were unavailable at NWHC, 12% of the answers were incorrect.

3. Many patients utilized other health care facilities either for themselves or for members of their families.

4. The ER of the back-up hospital was used even when the center was open, and for services which it could provide.

5. Patients very often broke appointments on the one hand, and walked in without appointments for episodic care on the other hand. When Int. I respondents, for example, were asked what they did when they found that they could not keep an appointment at the center, one-third said that they did nothing, "tried" to notify the center, or that they just

never made appointments. Among Int. III respondents, 76 (16%) identified themselves as "walk-ins."

In this context it should be noted that the utilization study reported on in chapter IX indicated a much larger number of walk-ins as well as a large amount of broken appointments. My information from center administration pointed to a missed appointment rate of about 40%. Center records did not differentiate between "missed" and "cancelled" appointments, but I was told that patients rarely cancelled. This high rate of missed appointments has, however, reportedly been reduced to approximately 20-25% since the start of a new system which was initiated toward the end of this study, whereby patients were reminded of their appointments by mail a few days before they were due at the center.

In summary, then, while most Int. I and Int. II respondents did shop around for health services to some extent, Hispanics apparently were least likely to do so; they also reported the greatest use of, and satisfaction with, the center. In general, personalization, quality, and easy accessibility of care were among the main reasons for liking the center; lack of specialty clinics, equipment, proper organization and--in a few cases--lack of competent personnel were reasons mentioned for dissatisfaction. Evaluation of health care facilities was quite often linked to mention of attitudes and behavior of health care personnel. There is some slight indication of possible strain in the social

environment caused by the uneven distribution of center staff (and perhaps even patients). The bulk of patient care still rested primarily with physicians. Finally, many patients appeared to lack understanding about the meaning of comprehensive care. Before most patients will be ready to (a) accept care by paramedical and paraprofessional personnel, and (b) will comprehend what comprehensive care entails on the part of health care providers as well as patients, much more patient education will have to take place.

Staff

NWHC staff, like its patients, voiced a variety of attitudes regarding the center--the following quotes from taped interviews will serve as examples.

> To work here, I really feel that you have to like people. I really do. Because, first of all, you are working in a low-income setting--the demands are great, there's just no getting around it, there are so many real problems. . . . and I think you have to be flexible and you have to be concerned . . . if you are just kind of coldly efficient you're not going to do any kind of a good job. . . . you've got to be able to relate to people. . . . and you've got to have a sense of humor. In a hospital it's possible to create artificial barriers behind efficiency, behind procedures, all of those things. Here you don't have those barriers, here you're right smack out there--with the persons--and I don't think that's bad. I really feel that you've got to reach out to people. Poeple have been so alienated by traditional structures, the kind of establishment-type procedures--that's why they don't relate. But if you really sit down and talk, and you're open, and you're not putting on a lot of airs and you're not speaking the sort of language that some of them cannot understand, or looking down your nose--they're going to come, they are going to use you.
>
> G.A. (MD)

> We are supposed to be a total health service for each family--the total family and the total person. But we don't have sufficient personnel to give such care.
>
> E.S. (FHC)

> The center offers delivery of services to people who have never before received them--the concept is beautiful.
>
> L.J. (DDS)

> I think that the goal of this center is to provide as comprehensive a care as it can, in a very, very private and dignified fashion, to people who have not had these services available to them before, to people who have gotten care in a helter-skelter fashion, in an episodic pattern, in one place or another. I think . . . [the center has not put] enough emphasis on educating people to the goals of the center . . . there is nothing concrete done to change the patterns that people have for care.
>
> H.N. (RN)

> [Patients] are treated differently here; they are less rushed. If a mother is worried, I sit with her, try to reassure her. At hospital clinics they wouldn't even give her a tissue to dry her tears.
>
> B.P. (MA)

My first contact with the North-West Health Center was in December 1971 (O'Mara & Kirsners, 1972). At that time we noted that, in our opinion, NWHC rated better than the other hospital clinics we had observed on several dimensions, and poorly on others. These latter points relate mainly to the physical environment, and they will therefore be referred to in the chapter dealing with this variable. As positive aspects we mentioned:

1. Relaxed atmosphere: staff gives information and guidance where needed . . . lack of aloofness on the part of staff; administrative difficulties [are] handled in a friendly fashion; children seem to feel at home.

2. Personalized environment: home-made Christmas decorations and cartoons; fewer uniforms, more

idiosyncratic apparel; lack of physical barriers between staff and patients; tri-lingual signs (English, Spanish, and French).

3. Awareness of individuals: clerical staff keeps track of patients' waiting time; brief, informal staff-patient encounters.

4. Relatively fast service (p. 4).

My subsequent two years' observation of the center and its staff did not cause any drastic alteration in this initial assessment. Most of the staff attempted to create a relaxed, personalized atmosphere. There were, of course, personal differences but, by and large, they apparently managed to make the patient feel less an object than is often the case in hospital OPDs. This was perceived by many patients, was obvious to an outside observer, and came up in talks with most staff members.

What had impressed us as "personalized environment" in 1971 came, however, to appear as adding to the clutter and feeling of crowdedness of the place after prolonged exposure.

Although patients did complain of long waiting periods, and Int. III revealed that 56 of the 487 respondents (12%) had waited for more than 2 hours for service, and 8 (2%) never got to see anybody, most respondents in all 3 sets of interviews mentioned that the waiting time in other clinics especially in ERs, was usually much longer.

As it is impossible to include all impressions and information gathered over a two-year period in this report,

I shall limit presentation of data to the following:

1. Staff perception of the quality of care rendered by NWHC, including evaluation of the attainment of comprehensive care and the team concept.

2. Communication between various departments, with the nurse-practitioner program as one example of the effects of poor communication.

3. Effects of new role concepts required by neighborhood health centers.

4. Relationship between paraprofessionals.

5. Career ladders.

6. The question of staff's ethnicity.

Administrative and supervisory styles at NWHC entered into almost all these points because of their effects on center operation as it was exemplified by them.

Quality of care

Staff on all levels largely agreed that the quality of care was at least as good as, and in many cases better than that rendered by hospital OPDs.

> Here there is a shorter waiting time, more personalized treatment, much better quality of service. Here you only see one doctor. Till now the service was completely free but even now, even with the three dollar fee, people will prefer to come here--people here are more friendly. . . . people are unfriendly at . . . [the back-up hospital]. They are even unfriendly to me, and I work for them. If they behave that way to their employees, I wonder what they do to regular patients.
>
> B.P. (MA)

> The care here is more personal than . . . [the back-up hospital], which is already better than . . . [a city

> hospital]; it is more dignified. Because people live in the neighborhood and keep coming back for care, we build up relationships, they know you and look for you, and bring their families to you for help. This leads to better health care, because when people know you, they tend to listen to what you say, pay attention to you. . . . The care is also much more comprehensive than in hospitals; when we see something wrong, or the patient tells us, we send the patient to the proper department . . . pediatrics, internal, social service, etc.
>
> R.A. (DA)

One psychiatric nurse stressed the fact that, through close cooperation with the various center departments, and by choosing physicians who fit a given patient's emotional needs, the mental health unit had been able to keep patients out of hospitals who would have been admitted to mental hospitals had they gone to a private physician or a hospital OPD:

> In this place you have the most options for keeping people out of being hospitalized. Initially, when I came here and met some of the patients I thought they were acutely ill, but there is very little pushing into the mental hospital--we tell them to come five days a week, give them the appropriate medical care. . . . so I see patients who are so pressured and anxious and worried and I initially think they should go right into the hospital, but they seem to do well . . . in three months I only had to hospitalize three patients, the others who seem pretty acute can be maintained with a minimum amount of medication. . . . we give individual, family and group therapy, whatever is necessary--all three modalities may be used in combination for one patient. . . . I am a nurse, but in this place you have to be extremely generic--social work, welfare--otherwise you're not really giving full service. The role of the psychiatric nurse in this kind of center is probably the freest--no traditional modes.
>
> G.G. (RN)

> This is different from OPDs--it's more personalized; some patients are followed actively, no place else would they get the interest and the care. A portion do get comprehensive care. It's also a matter of community education, you have to either teach them or talk to them and see what they want. If they are crisis oriented,

> you'll never get anywhere. If you can't get the people to follow comprehensive care, you have to think of what the next best thing for them would be. . . . Education is done on an individual basis; it entails more than handing out pamphlets. I know it goes on in the field, and MAs too try to explain. Preventive care is stressed in the field; we try to educate them to know exactly what is going on, "what pills did you take today, why are you taking them." This works much better here than in OPDs. We teach them to ask the doctors--they rarely tell them voluntarily. When I'm a patient in a hospital, I keep asking doctors what they are doing--they never offer information. Regular patients feel some sort of reverence toward the doctor "he's a busy man, so I can't bother him"; but they will ask the nurse. They should ask the doctor, should be given explanations.
>
> E.A. (PHN)

Of the 79 staff members who were interviewed, 49 (62%) viewed the quality of care offered by NWHC as excellent or good; 24 (30%) thought it varied with individual providers; only 2 (3%) judged it to be really poor, and the rest (4 or 5%) did not feel competent to voice an opinion. Many of the non-professional staff came to the center as patients before they started to work there, and their families still utilized center services at the time of this study; they could therefore judge these services both from a consumer and provider point of view. As will become apparent later, they were openly critical about many aspects of the center--yet their overall impression of center services was positive and there was no reason to doubt that this was their real opinion.

Many of the comments regarding this subject were coupled with references to the following:

1. The importance of attitudes of health care personnel, especially physicians.

2. The fact that lack of space often interfered with rendering the best possible care (e.g., there was no room for specialty clinics; crowding made patients and staff nervous; it was impossible to set up a really efficient operation).

3. The insecure position of the center due to the inability of the federal government to commit itself to a continuation of partial funding for as long as it should be necessary. Recurring budget crises interfered with morale which, in turn, affected staff performance.

4. The large turn-over of internists.

More will be said about each of these points in the remainder of the report. For now it need only be reiterated that the consensus was that center patients were better off now than they had been before the facility came into being.

> We render care to the family as a whole, with a primary provider, usually an intern [sic] for the adults and a pediatrician for the kids, according to the original proposal. The concept was developed in response to the lack of care people were receiving, especially in hospitals--the OPDs are so specialized that they are treating parts of the body, instead of the whole person, and even that is poorly done, due to long waiting times, indifference, lack of dignity. Comprehensive care is an attempt to deal with the whole individual, and to go beyond that, to deal with the family unit and to deal with the social and economic aspects as well--we're doing pretty well, but not well enough.
>
> J.B. (administration)

Comprehensive health care. Although no physician claimed that the goal of a comprehensive health care system

had been achieved, all averred that the center was striving to do so. To quote Dr. G.A.:

> I think theoretically we are on the right track, in terms of family-oriented care, in terms of the idea of comprehensive health care and trying to tie in the idea of prevention, of routine medical work-ups, of follow-ups, and so forth. I think that that makes sense in terms of providing for the health care of the country. The comprehensive care model of providing care for medical and psychiatric and social problems under one roof is a good one. I frankly feel that it is a better concept than, let's say, community mental health centers. I like the idea of integrated health care better, I really do. Well, they've shown that . . . [a large percentage] of people who come to a general practitioner really have psychiatric or psychological problems, or family problems --so I think it makes sense if you have a closer working relationship between doctors and mental health personnel. The traditional dichotomy is rather ridiculous and I don't think it really helps the patient very much. Similarly, in terms of the fragmentation that's happened in medical care with all the specialization is bad. It's good in terms of people becoming more expert in their field, but there has to be some funneling of that specialization when it comes down to patient care; there has to be some kind of general doctor that the person can relate to and be referred back to; there needs to be that old family practitioner concept and I think that this program strives to do that.

Even at NWHC not all physicians thought of psychosocial problems when talking about comprehensive care; some regretted the lack of many specialty services under the same roof, and many felt that communication between internists, pediatricians, dentists and the mental health unit could be improved. Most agreed that at least one of the reasons for this lack of communication lay with the failure to really implement the team concept. Lack of sufficient staff and--therefore, shortage of time on the part of staff--poor utilization of paraprofessionals, and patients' failure to grasp the meaning of comprehensive care--

and their share in the process if it is to succeed--were other reasons mentioned for partial failure to deliver such care. Finally, there was the fact that not all staff members were really clear about the meaning of the term "comprehensive care." Many thought it meant only complete health care.

> Comprehensive care means examinations, lab tests, people returning periodically, specialists. People shouldn't be deprived of these services just because they have little money.
>
> S.W. (technician)

When asked whether at the beginning of his work at the center anyone had given him a run-down of all available services and the main concepts of the program, S.W. answered that

> there was a brochure giving procedures, rules, history. There is an orientation program at . . . [the back-up hospital] which is also for staff here; you go to the payroll department there, get a physical, and they tell you about the orientation--but I didn't go, thinking it was basically for the hospital.[41]

If at least part of staff fell short of fully understanding the meaning of the concept, it should not be surprising that many patients were ill-informed. Missing appointments and walking in for treatment without an appointment might be considered as indicators of a crisis--rather than comprehensive care--orientation on the part of patients. It also made an orderly patient flow difficult, and often caused overcrowding of the facility and long

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[41]Since this study was completed, the center has initiated its own orientation program which is mandatory for every new employee, regardless of the position he is to assume.

waiting periods. Walk-ins, for some reason, usually appeared in shock-waves. Dr. T.A. felt that

> many of the people who use this center are not able, in terms of their culture and their education, to really use an appointment system . . . they do tend to come in when they're acutely ill . . . but the chronic illness is often neglected because the patient simply doesn't come in when told to, once the acute flare-up is over.

The same holds true for preventive care. Some physicians reported doing a complete physical on walk-ins: "You have to grab them when you can; they won't come for tests, etc. unless they are acutely ill" was a comment often heard at supervisors' meetings when doctors were asked why they could not process more patients.

But then, did all patients really want comprehensive care? According to R.A., a paraprofessional,

> I think, from living in the neighborhood, that most of the people come here for immediate results. They get referred for help they are not interested in getting. We're helping them--but I don't think that they want it or know it.

The apparent difficulties with an appointment system and with the concept of comprehensive care might support Strauss' (1970) contention that our health care system does not fit the life styles of the poor. But where old habits are dysfunctional to maximal health care it might be more productive to attempt some changes in life style through patient education in addition to changing the medical system, rather than concentrating only on the latter. Any other course would imply that the poor are unable to understand and learn better health habits. Patient education was,

however, one of the most neglected areas at NWHC, and of our health care system.

Individual professionals and paraprofessionals undoubtedly did give pointers regarding health care to their patients--many claimed to do so; some pamphlets were handed out periodically, and films were shown from time to time. But NWHC patients did not receive systematic orientation before entering the program, nor were they exposed to comprehensive, ongoing health education while they remained in it. And, although patients who received a complete initial examination soon after registering for services at the center were more likely to remain active (Gorman & Nelson, 1974), a large percentage either never completed this work-up or did so only months after becoming center patients.

During the course of this study there was periodic talk about (a) making sure that the initial health assessment of each new patient be completed within a given time; (b) offering health education by showing videotaped material on this subject in the waiting room; (c) showing films in the evening, and/or (d) making it mandatory for patients to attend orientation sessions before they could receive their clinic cards. Little ever came of these plans, primarily because administration did not follow them up.

Intake personnel was, theoretically, required to tell patients about all available services, the appointment system, and the importance of making and keeping appointments,

during the intake process. This was not done. I was told that patients at that point were simply not interested in anything beyond getting the formalities over with. Giving them anything but the most necessary information regarding the program would, therefore, be a waste of time. This is probably a correct observation. It is also questionable whether reeling off services, the importance of preventive and follow-up care, etc. would be an effective educational tool. That such a tool needed to be found and utilized was, however, beyond any doubt if the goal of comprehensive health care were to be furthered.

Another factor complicating the delivery of comprehensive and continued health care was the fact that many center physicians lacked admitting privileges at the back-up hospital. If one of their patients was hospitalized after a visit to the OPD, the center physician was, in fact, often unaware of this hospitalization until the patient's chart was examined on his or her next visit to the center. Since more adults, especially the elderly, were likely to need hospitalization, internists were particularly sensitive on this point. At the time interviews with physicians were conducted, only one internist had admitting privileges--and he was about to leave center service. The others complained about the lack of these privileges, a general dearth of communication between hospital and center physicians because of the former's refusal to cooperate, and disregard for the

opinions of center physicians by hospital physicians. It was suggested by several informants that this lack of admitting privileges was one of the reasons for the large turn-over of internists at the center. This turn-over, while not necessarily interfering with comprehensive health care, obviated continuity of care with one physician for adults. One internist commented that pediatricians had a lower turn-over rate because more of them had admitting privileges and, therefore, need not feel like second-class citizens vis-à-vis the back-up hospital. A pediatrician, while not disputing this assessment, also offered the opinion that longer service by pediatricians was due to the great cohesiveness of this segment of the staff which was attributed to the coordinating qualities of one of their group.

Finally, how comprehensive can care be where personnel lacks the power to affect the function of other agencies in any meaningful way? The term "comprehensive" implies that in addition to medical problems, psychological and social problems are dealt with effectively. NWHC was powerless to do this in many instances. Let us assume that one of the psychiatrists had been treating a man with emotional problems which were severe enough to prevent him from working, and so he lived on welfare. After a while the patient felt he would like to try to hold a job again, but knew that if he did secure work, his welfare payments would stop, and should

he find after a few weeks that he was not yet able to work, he would be without any kind of income for some time. Ideally, it should be possible for NWHC and the Welfare Department to have an agreement whereby such a patient is kept on a special list for a given number of weeks. If after that time he is still functioning effectively, he is taken off the list; if not, his welfare payments are reinstated automatically upon request of the psychiatrist as soon as his paychecks stop.

Or, to give another example, let me quote B.S., an outreach paraprofessional:

> A family comes in and we can handle their health problems, and then we go out to their home and see that it is not really fit to live in--there could be about eight people in one or two rooms, and no matter what we do here, you have to put them right back into the same apartment and it is just a continuation of the same thing. You can fill out forms for housing, go down there, but you know nothing is going to happen. . . . They get medicine to make them well but the apartment makes them sick again and there is nothing you can do about that, it's beyond our control.

Welfare or housing were not the only problems; many patients who were entitled to Medicaid never got their cards because they could not cope with the red tape and/or were afraid to go to the Medicaid office alone. Since it often took days to get through all the formalities, the center could not very well send an outreach worker with each of these people. NWHC suggested that one worker bring a group of applicants by appointment to the Medicaid office--the agency refused. NWHC then proposed that Medicaid put one of their own clerks

in the center to handle center patient applications--this too was refused. After months of negotiations, two of the center's clerical staff were finally permitted to spend some time at the Medicaid office to be shown how the forms should be filled out, what documentation was needed, etc. Medicaid promised to supply the center with all the necessary forms so that center staff could help their patients fill them out at the center, make sure they had all the necessary materials with them before sending them down to Medicaid. It has, however, proven rather difficult to get the promised forms from Medicaid.

The team concept. There was almost unanimous consent among administrative, professional, and paraprofessional staff that with the exception of one team this did not work too well. The center's catchment area was divided into four geographic sectors, each to be served by one team; a fifth team was handling SROs. It was my understanding that all staff members were assigned to a team--it was, however, impossible to determine whether this really applied to the total staff or only to professionals and paraprofessionals. Attendance at team meetings was obligatory--but not all teams held regular meetings, and not all members attended.

The team concept was instituted at the start of the program in 1967. It is difficult at this point to trace the history of teams at NWHC with any accuracy since accounts by various informants differed. But teams were apparently

unofficially permitted to cease operating. On first arriving at the center in 1971, I was told that one "experimental" team was in operation. As I later found out, all members on this team were volunteers, the PHN and FHCs belonging to it shared one office, separated from the other members of the outreach department; the whole team met regularly. All except one of its members whom I interviewed reported that this team worked well. They felt that being on a team permitted health care providers to render better care to their patients; there was continuous communication about them between staff members, and difficult cases were discussed at meetings.

In mid-1972 teams were reactivated throughout the center. Patients were assigned to the team serving the sector in which they lived; however, they had the option to stay with a given provider, even if this individual did not serve on the team to which the patient belonged. Since patients could, theoretically, desire to remain with an internist from Team I, a pediatrician from Team III, and an FHC from the SRO team, etc., effective implementation of teams became somewhat difficult. New registrants have generally accepted their assigned providers.[42]

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[42]Only 8 of the 90 Int. I respondents (9%) reported ever having requested transfer to another physician. This question was not asked about any other health care provider.

According to several informants and my observations during supervisors' meetings (e.g., March 2, 1972), the individual who was then project director held out against permitting more teams without first obtaining community input, though no steps were taken to get this input; other staff members felt at that time that teams should be formed first and then each could hold open meetings with the respective patient population to explain the concept and get feedback. The argument remained stalemated until the change of administration in the spring of 1972. The other four teams were then organized. A few open meetings of team members and their patients were held; they were poorly-attended, and this practice soon lapsed--and with it an important avenue of patient education was closed off. Many staff members told me that by that time the majority of patients had become used to their various providers and these staff members voiced objections regarding the geographic organization of teams in our talks, saying they feared that it would mean a change of patients for them. In practice, new patients were assigned to a team according to the location of their homes while old patients remained with their providers for as long as the latter stayed at the center.

Haphazard implementation of teams, and possible dispersion of given patients' health care providers among several teams were by no means the only reasons for a partial

failure of this concept at NWHC. Another very important one had to do with the role of administration in this whole question: there was no provision to insure that teams did--in fact--meet, that members attended, that meaningful subjects were discussed, or that staff members of different statuses learned to talk to one another without contraint. As Dr. E.M. put it:

> aside from the generic reasons, which would be the difficulties that health workers have in talking to one another, and in overcoming disciplinary barriers . . . the mission of the teams has not been clearly defined. . . . [the former medical director, who was also in charge of teams] had a number of possibilities but did not want to force any of them down our throats, and . . . [the present project director] has spoken publicly about the importance of teams. But I think there is . . . some gap between the formal pronouncement that "teams are good and important; attend and do good things," and the actualizing of that mission. I have felt that there hasn't been much scaffolding between the admonition to do good things in the teams and the teams' working. . . . I guess I'm a little tired of being the one to literally round up team members, write minutes and schedules, etc. . . . If there are going to be teams, it requires . . . a fairly consistent concern about team functioning, and I really haven't seen evidence that we've decided in any serious way to pursue team functioning. It's a rather different conception of health care delivery--it's one that would require a lot of energy and continued scrutiny, and working out obstacles, and trying out new things. I don't think there is one or even ten things that would have to be done. I think it would have to be a whole kind of ambience and a hell of a lot of work--and it just doesn't seem to be on the agenda.

And Dr. T.A. felt that perhaps administration needed to be a bit more authoritarian where teams were concerned:

> Unless you're going to give up that whole idea, you really don't have a choice--at least until people have tried the idea. Once they've tried and it doesn't work, perhaps we're barking up the wrong tree. I don't think that it is necessarily terrible to be authoritarian to the extent

> that people are told "you must attend, you can't just give up the teams, and you have to schedule time for meetings." But then you have to be a little bit more than authoritarian and say "now we have to have some machinery for actually getting you to go and work together" . . . I think that there is a resistance to being free and open with each other and the team approach is an aspect of this. . . . I don't think that there is a great deal of intimacy or friendship between physicians and non-physicians here. It doesn't exist. . . . I would suspect that there is a great deal of prejudice on both sides--I think that it is a mutual thing. It has not broken down primarily because the team concept has not been successfully implemented.

Several physicians felt that many paraprofessionals were afraid to expose possible ignorance or invite censure and, therefore, they kept quiet at meetings; others explicitly or implicitly alluded to the differences in status and knowledge. Some paraprofessionals told me that they did not attend meetings because they were bored since

> all they do is show us movies, they don't deal with real problems that we feel we can solve. So I never go.
> (A.G.)

Others felt that the subject matter and language of the meetings were too difficult for them to deal with; they could not understand what it was all about--so they, too, stayed away:

> I would have liked the meetings to teach me more about health care. I couldn't really learn anything from their viewpoints about this patient or that--when they went into a whole medical dialogue they lost a lot of people.
> (R.A.)

A few mentioned that once the physician or dentist has had his say, what is there left for the MA or DA to add? It is different for FHCs, these individuals maintained, since

they have much more independent contact with patients. It was a fact that FHCs I talked to, on the whole had a more positive attitude toward the team meetings as they then functioned than did other paraprofessionals (or many professionals, for that matter)--FHCs felt that there were important insights into patients which they could offer in-house staff.

As far as I could determine, many of the above observations were justified. At least at that time administration did not enforce its edict of regular meetings and compulsory attendance; there was nobody to check on what transpired at meetings or to suggest a format which would suit staff members of varied educational backgrounds. I was told that although at times interesting cases were discussed at team meetings, sometimes the whole hour was spent in trying to decide just what to discuss; members were only too glad to plead pressure of work as an excuse to cancel meetings. A few individuals appeared dedicated to the concept and worked hard to make it a success, but they--like Dr. E.M. --must eventually tire of fighting an uphill battle without help other than pious pronouncements. If administration fails to provide initiative, drive, and supervision--the necessary scaffolding will remain missing, teams won't really get off the ground for the center as a whole.

It is my belief, however, that in addition to administrative failings, mistrust between some physicians

and paraprofessionals, and perhaps a basic unwillingness to try something new, the center's physical layout also helped aggravate the situation. As figure 2 (appendix A) shows, the clinic area was separated from the mental health unit; and the dental department was on another floor. Physicians who were on the same team did not usually have adjacent offices. An internist, for example, with several patients waiting for him might have felt the need to have a word with the FHC handling a given patient, but he could be forgiven for not wanting to take the time to run the width of the clinic on the off-chance that the FHC would be at her desk. He might remember to contact her later, but he might also forget. He might make a note in the patient's chart, but there was no assurance that the FHC would see this note. Since not all team members could be reached by telephone, communication might have been easier if providers of each team had shared adjacent spaces, each with its own waiting section. They should also have had their own appointment staff and a secretary to ensure that messages would reach absent or occupied team members, and to send out reminders of appointments to patients. Although this would have required drastic alterations in the layout of the second floor, it need not have been an impossible task. There is no solution to the separation of the dental clinic from the rest of the center unless more space can be procured from the health department.

Despite shortcomings in the actualization of team work, most staff had gotten used to contact given colleagues (both professional and paraprofessional) in other departments, and did recognize that team care offers a chance for better communication and patient care. Informants among staff told me that most individuals did know who the internist, FHC, etc. of a given patient were and got in touch with these people in time of need, rather than selecting a worker randomly. Thus, one MA could say one minute that "teams won't work" since the patients of her physician would not want to change because of geographic redistribution, yet in the very next sentence she averred that teams were good because patients

> should always see the same people; your doctor knows your problem, your history. For some families we have very good communication [with other departments, e.g., outreach]. The team members know the families and their problems. The FHC visits regularly where necessary. For example, we have collected clothes for one family who did not have enough for the winter. You'd be surprised how many times, when I take the temperature, I see that the kid doesn't have any underwear on, even if it's cold outside.
>
> B.P.

So B.P. mentioned the fact at a team meeting, and team members brought clothes or made a money donation.

Dr. T.A., extremely conscious of the importance of psychosocial variables in medicine, was in constant touch with his team members in the outreach department and mental health unit. B.T., a psychiatric social worker, thought that although many people, at least to start with, could not see

the advantages of a team approach, she felt that this approach

> is absolutely a good way to give comprehensive care. I have to know what is going on medically with the patients and how that affects what I see. Doctors never had the time to communicate with us . . . [without teams].

Communication

Lack of communication was ubiquitous at NWHC. Indicators for this were many: misinformation which became apparent in many of the interviews; lack of knowledge about the training and duties of various staff members, new programs, and the functions of different departments; frequently rampant rumors; and a few respondents, of course, complained about it directly. Why should this condition exist in an organization whose administration honestly attempted to keep staff on all levels informed about developments concerning the center?

As was mentioned in chapter VIII, this administration inherited a certain amount of mistrust engendered by the previous one--staff had been lied to and manipulated so often in the past, they were unable to believe now, although many expressed an appreciation of the present project director's openness. Thus, from Dr. E.N.:

> I think there is a wondering about some of the practices of the administration vis-a-vis the others; I think there is a tendency, or at least there has been in the past, of a difference of opinion and a lack of information between the administrators . . . and [the rest of staff]. <u>But now I am very, very pleased with the way</u> . . . [the present project director] <u>is running the show</u>. . . . [There is] <u>a tremendous amount of lack of communication going on on all levels</u>; everyone stays in their little cubbyholes and writes little memoranda that set off a whole chain of

> events and other memoranda and confrontations that are unnecessary. . . . I think people have . . . a feeling of imminent doom here; things are put on the bulletin board making all sorts of threats--people are anxious about this, especially people with families who depend on their salaries. I think that it is an ill-advised tactic to frighten employees so. There is a schism between administrators and workers both paraprofessional and professional. I feel that they [administration] may be privy to more information than they give us and rumors have a way of finding their own level--and that's what I think has been happening here.

Note the difference between the first sentence which is italicized and the other two; the first has nothing but praise for the project director, yet quite soon after there is allusion to lack of communication and mistrust. C.A., a clerical worker, put it more succinctly when she offered the opinion that administration

> as far as giving out information, I guess they're pretty good, but I can't tell how much of it is true, how much they try to pass over my head.

During the first union negotiations it became very obvious that staff, or at least its representatives at the negotiations, believed that administration not only had more money at their disposal than appeared in the budget, but that they also paid themselves "under the table."[43]

But lack of communication, and the mistrust bred by it, went beyond the relationship of administration and the rest of staff. Time and again, opinions regarding various questions

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[43]Confidential communication from a number of people. When I asked where these hidden moneys come from the usual answer was "I don't know, but I know there is more money than they let on."

were prefaced by "of course, I don't know what goes on at the rest of the clinic." Why "of course?" The place was so small one couldn't help running into people from various departments, and observation showed that those who ran into each other did talk to one another. There were regular supervisors' and staff meetings; each department had non-supervisor representatives at the former and these individuals (as well as the supervisors) were supposed to report what transpired at the meetings to their department. Yet it was frequently apparent that people were either uninformed or misinformed, and so rumors did, indeed, find their own level.

Several staff members thought that rumors and gossip at the clinic were no worse than in any organization. It is also possible that at least part of this was a deliberate campaign by those staff members who wanted the clinic unionized; rumors did diminish once the first contract was signed in the summer of 1973.

Yet the impression of some neglect on the part of administration remained. It should be remembered that this body at that time consisted of the project director plus three supervisors, each in charge of several departments. It might be unrealistic to expect people who carried an extremely heavy load of administrative and supervisory duties to attend to a correct flow of information, but the fact remained that non-attention caused difficulties and disaffection which were often dysfunctional to maximal operation of the clinic.

I believe that it was at least partly responsible for permitting the nurse-practioner (N-P) program to start under less than optimal conditions; poor relationships between professional (especially MDs) and non-professional staff and within certain categories of paraprofessionals; and a general lack of knowledge about and respect for the functions of various staff categories.

But it should also be remembered that poor communication can be caused by--as well as cause--uncertainty with its attendant mistrust, rumors, jealousies, etc; especially where one's livelihood and/or ideals are concerned. As was mentioned in chapter VIII, about half of NWHC's budget at the time of this study came from a block-grant by HEW. This grant, however, had to be negotiated every year. This meant, in effect, the center (a) did not know how much money it would receive in the coming year, and (b) that, at least in theory, it could be left without any government aid at all. Since government supported health care was not one of the priorities of the Nixon administration such fears were not too unrealistic.

Fiscal uncertainty had three main effects while I was at NWHC:

1. Much of the efforts of the community council and the administration--especially those of the project director and the fiscal administrator--were taken up with lobbying for funds.

2. Staff constantly repeated to me that their jobs were in jeopardy. This was of particular importance to non-professionals because, as will become apparent later in this report, many of them did not feel equipped to find jobs outside the neighborhood health center system. This was the main reason why so many employees who had previously rejected unionization now voted overwhelmingly for union representation. Unionization brought up the running expenses of the center. The union did not seem interested in the actualities of funding. Neither did it (at least at that time) make any efforts to educate staff that greater discipline and productivity should accompany higher salaries. But probably most importantly, unionization brought about

3. a schism between non-professional personnel and administration, since the latter perceived the vote for the union as a personal rejection. Believing that <u>all</u> center employees and council members were engaged in a common struggle for a cause, administration had difficulty adjusting to a situation of "they" and "us" where "they" suddenly stood for administration and council rather than the federal government. It seemed to me then, and still does so in retrospect, that administration over-reacted. Incidental comments, a facial expression, a tone of voice, a whole series of little innuendoes all led me to feel that they found it difficult to identify in a meaningful way with the very real financial threat to non-professionals; on the other

hand, the charges of financial chicanery voiced by staff representatives at union negotiations did nothing to further such identification and understanding.

The result of these three interrelated issues was a drastic deterioration of real and perceived communication which, in turn, aggravated existing problems and caused new ones, such as the difficulties with the N-P program.

Nurse-Practitioner program. This program was started after the training department had obtained a small grant from a private foundation which enabled four center RNs (all volunteers) to receive N-P training at a medical school in the city. At the end of this training course they had to pass an examination before being allowed to start operating in their new role at the center.[44] As envisioned by the training department, N-Ps would do all routine screening of new patients, and be active in preventive care as well as in routine treatment and check-ups of chronic cases, thereby relieving physicians of much routine work and ensuring more comprehensive care for patients.

> We have to accept the fact that there are problems in certain areas. . . . As I see it, a person who comes in for a physical has a very poor chance of getting a complete physical and I'm saying "let's take this away

[44] One other nurse had previously taken a leave of absence from the center and gone for training as a pediatric nurse practitioner at her own expense. The center thus had five N-Ps by the end of the summer of 1973; one, however, left center service shortly after completion of her training.

> from the internists completely, let's systematize it" . . . I'm making that possible by getting money to train and thereby better prepare our nurses to do it . . . and by setting up the program and the protocols for them to follow. Therefore, within a month, a patient who comes for a physical will get a complete physical done by a nurse, one . . . who will always do the same thing to all patients, and by sheer doing it will not miss things; most things are missed because they are not looked at . . . and most physicians tend to leave out part of the examination because they do not consider certain things important to the problem of the day. . . . as I see it, that is [also] part of the way you teach a patient. If you teach him that it is important to have a complete physical done, then he has more respect for the system so that if you tell him to come back to follow up on one thing or the other, he will be more likely to do it. . . . in terms of my own role, I see it as formalizing a lot more comprehensive care, and as far as the areas of preventive and chronic care are concerned--the areas which I feel are most wanting--those are precisely the ones I see as attacking by getting the nurses additional training, setting up the system where they can do the work.
>
> H.N. (RN: Training Dept.)

Unfortunately, many physicians were outraged when they received referrals by N-Ps and found that tests had been ordered by them. It appeared that the role of the N-P had not been worked out in cooperation with physicians before their actual training started. Most physicians I talked to were unaware that nurses had received additional training, or did not know what the training consisted of; they did not know that N-Ps had started practicing at the clinic until after the fact.

> Some [people] want to do too much, more than they are trained for--this may even have legal implications. . . . I don't know if someone like a nurse-practitioner, who has not been to medical school, can examine patients or dispense medication. N-Ps are fine, but they should be instructed about their limitations. . . . There should be an outline of their duties and the extent of their work. For example, recently I received a bunch of EKGs

> to read which I had not ordered--they were ordered by an N-P. They should only be ordered by physicians. I also think it's wrong to order EKGs on a routine basis--it makes for extra work. I'm over forty and never had an EKG. Certain routine tests, that is CBC, urinalysis and chest X-rays are OK, but without special indication other tests should not be performed routinely.[45] . . . to administer medication is not something to be done without medical training. And a certain N-P has written a protocol which shows that they do not know their limitations. They even started referring patients to consultants--this is definitely wrong; they are overdoing things. I've worked in many institutions in the United States and I never heard or saw anybody other than a doctor prescribe or refer. . . . If non-medical people are to assume greater responsibilities then we must have an institution in this country to authorize these people--even doctors have to pass through all kinds of tests.
>
> N.T. (MD)

Even after I had explained[46] that these women were all RNs who had received special training and passed exams, that the center's insurance covered their activities, and that the American Medical Association (AMA) was presently trying to work out some format for licensure of paramedics, N-Ps, etc., he was not too happy about the whole idea, mentioned that it was an innovation which is difficult for older

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[45] It should be noted here that the center's protocol for initial health assessment and, if possible, regular check-ups of all patients has always called for many more procedures than CBC, urinalysis, and chest X-ray. In this case, at least, the N-P was correct and the physician incorrect.

[46] While it was not my usual procedure to feed information to individuals during the focused interviews, it seemed important in this case to find out whether this particular physician would retain his highly negative attitude if he knew that N-Ps were specially trained RNs, and that NWHC was not the only institution to utilize such paramedical personnel. Explanation was here used as a provocative devise --to see if this individual could be provoked to change his opinion.

physicians to accept, but mainly complained about lack of discussion, explanation and information concerning the question of N-Ps with physicians. Such a meeting did finally take place between N-Ps and physicians some time after the former had started to perform in their new role--the feedback I got was that a number of physicians were vehemently opposed to the whole idea if it involved the assumption of some of the physicians' functions by N-Ps. According to my informants they appeared to feel really threatened. Others, however, were quite willing to go along with the proposed reorganization.

> The building in of the N-P program makes the team better able to see more patients. I like the concept.
> J.S. (MD)

Dr. A.E. liked it too. When asked how patients would react, the answer was that

> they might resist it because these are women, just like some resist a woman physician--some people might think they would get inferior care from a woman. But I'm sure the problem could be overcome.

Especially if, according to Dr. J.S., these patients have

> a strong relationship with their primary physician and this physician introduces the patient to the N-P and explains how care will be divided between doctor and nurse.

A third group of physicians remained outwardly neutral but, as I found out later, really did not know much about either the training or the functions of N-Ps. Dr. E.N., for example, when talking about the training of MAs, offered the opinion that this training had fallen short of its goals,

thought that

> now that, for example, the N-P program has been brought into being, the MAs might feel that they should have had more training in this line rather than letting the nurses have it.

Apart from other problems, it is difficult to see how physicians who reject RNs in the role of N-Ps would accept individuals many of whom lack a high-school education. When pressed a little further regarding this point, Dr. E.N. appeared to envision the role of an N-P mainly in the area of immunization and such preventive measures, although he did say that it would probably be all right for her to do the initial screening and then refer the patient to a physician who, in turn, should advise on necessary referrals to consultants. But once again, the issue came down to communication.

> I don't think that the role of the N-P was well thought out beforehand. I don't think that people knew about it, I don't think that people knew what the guidelines would be. There was a lack of communication and it still hasn't been dealt with. With communication and with talking it out it could resolve itself into something operative.
>
> E.N. (MD)

H.N., the individual who was partly responsible for having some RNs trained as N-Ps, might have seen it as her function to "formalize" or "formulate" a more comprehensive program; many doctors questioned the legitimacy of her claim. The point here is not whether it was or was not within her purview to send out a memo to physicians which spelled out the functions of N-Ps. It is, rather, why the

respective roles of the two groups in the scheme of rendering comprehensive care were not clarified jointly by physicians, nurses, and administration before the nurses even went for training. Because of this neglect a number of physicians who might not otherwise have done so, reacted negatively to an innovation in medical practice which goes counter to the traditional roles of physician and nurse. This is particularly true in an organization in which some physicians tended to feel on the defensive in any case.

What makes neighborhood health centers different?

"Doctors walk around the halls with a tag in the back saying 'kick me' (Dr. A.S.)." This assessment might be a bit too drastic. It perhaps indicated as much about this particular physician as about staff relations at NWHC--it did, however, point to a problem which appeared to be real.

Health care facilities such as neighborhood health centers do represent some rather revolutionary concepts in the American health care system: where the physician held a position of absolute authority before, there is now much more involvement of lay people. Physicians at centers are accountable to both lay administrations and the community (represented by the community board or council). They are expected to look beyond the diseased organ to the patient's family, social, and emotional situation; they must learn to delegate part of their functions to non-medical

personnel and, finally, to work in close cooperation with paraprofessionals whom many regard as their social and intellectual inferiors. Instead of being private entrepreneurs, they are salaried employees who, at least in some centers, must punch a clock like everybody else. In the case of NWHC physicians, many had to cope with the problem of hospital admitting privileges. It was perhaps not surprising that at least a few exhibited some paranoia.

But non-physicians, too, must live with this new system. Nurses and paraprofessionals, community people and administration must all be prepared to accept greater responsibilities, to learn to hold their own in discussions with individuals whom most were used to hold in awe in the past. It is not an easy task to look beyond the mystique of the "all-knowing healer" to the person occupying this position--and not all non-physicians are equally well prepared for this change in perspective.

At the time of this study, the situation of physicians at NWHC was aggravated by the lack of a strong medical director. It is interesting to note that none of the physicians who dealt with this problem in our talks (and most of them did) saw the director's function as that of a supervisor for their group: doctors were assumed to be able to supervise themselves, and/or peer review was--at least theoretically--possible in a setting like the center. The need for a medical director was felt, rather, in terms

of having somebody to represent their interests vis-à-vis council and administration. It was also felt that it was wrong for a medical program to lack a powerful MD at its helm, with status at least equal to that of the project director. Even doctors who voiced least difficulties with the administrative structure of the center thought that a medical director should have complete power and authority in medical matters.

> We should have a medical director, but not the way this person has functioned here in the past. The kind of medical director that we had, and his functions as they have been defined--no, we don't need it because the medical director here has not really had any independent authority, and we don't need a superfluous administrative person who has no independent scope of authority. . . . The medical director should really have the full authority over a large amount of the professional programs, certainly the medical program. Of course this has to be in the hands of a person with some innovative ability who is able to function in a setting like this. . . . for a while we had, for example, a great deal of pressure [from the council and administration] to increase the number of patients each of us should see. . . . the medical director at that time really had no opinion of his own, he kept vacillating back and forth, depending on whether he talked to doctors or administration at that moment. And yet . . . the answer was very simple. He knew how busy people were . . . how efficient they were, what they were trying to do. While the number of patients per physician could have been increased it would have meant that we would have to stop showing an interest in social and nursing problems, anything but the most straight-forward, purely clinical symptoms would have had to be neglected. This would just not have been desirable for a program like ours. . . . [in effect] the administration and council wanted an increase of productivity which would have really defeated the entire purpose of the program. Now, I feel that this should really not have come up at all. If we would have had a medical director who was knowledgeable and who would have had the authority to say "look, this is the aim of the program, this is how it can run, I know what my people are doing, and this is the only way they can do it" we wouldn't have had

> this difficulty to start with. So there is one function for a medical director if, and only if, he has real authority.
>
> T.A. (MD)

Several facts should be pointed out here. First, by no means all physicians I talked to saw it as part of their function to concern themselves with anything but "the most straight-forward, purely clinical symptoms" of their patients. Second, the center at that time worked with less than a full complement of physicians, and those had to deal with the disruptive effects of missed appointments and walk-ins. Third, table 8.5 indicates that physicians, as a group, spent a much larger percentage of their working hours with patients than did other health care providers. There were, however, large differences within the physician group--the range went from 101 to 312 standard hours spent in patient encounters. But even those with the fewest number of patient encounters had more than members of any other provider category. Yet administration and many other workers at the center were convinced that physicians were the least productive staff members.

This was just one indication of a less than perfect relationship between medical and non-medical personnel. Another was that many physicians, although probably sincerely convinced that the community had a right to determine its health care delivery system and that they liked sharing responsibility with non-medical personnel, nevertheless could not avoid a somewhat elitist tone in their talks with

me. An underlying flavor of "they" and "us" crept in, and references to "them" were not always complimentary. Non-medical personnel, on the other hand, felt on the defensive and often imagined power play on the part of physicians. And then there remains, of course, the old belief that physicians are responsible for conditions in the medical system of our country, that they like to play God, and that they are unwilling to cede authority.

> Health care in the country, in this city, is very bad. This sounds terrible, but I'm beginning to think that poor people are beginning to get better care than working and middle class people, because of the availability of centers like this and because of Medicaid. Most people are crisis oriented, because of the cost of medical care and the mystery of medical care. The aura of the way physicians, especially, discuss you clinically, talk around you, never to you--you're put into the position of being afraid to ask a question, or they make you feel stupid if you do ask it. I think they go off into clinical terminology because they're afraid to tell you if they don't know, or if something is seriously wrong. They are playing God all the time. This mystique has an adverse effect on patients emotionally. I always tell my patients what I'm doing; I let a twenty-year-old listen to her heart and then to my heart so that she could hear the difference involved in having an enlarged heart. . . . I tell patients what medication they are getting and why. I think it's because of the training I've had [psychiatric nursing]. . . . most medical students don't look at people as people; there is too much book learning, too much atypicalness; they don't find out about the real world stuff until they get out, and then it's too late; they aren't concerned if the patient is comfortable or not. . . . Doctors aren't willing to face reality, even here. One doctor told a mother with four kids not to wash the dishes because of a dermatological problem, but her kids are too young, and maybe there is no man or friend or relative that can do it--then he can't understand why she can't follow his instructions. Some don't go past what is presented to find out the whole situation; others make unrealistic requests like asking an FHC to find a family an apartment--but there aren't any apartments.
>
> B.J. (RN)

This mistrust in the status of the physician--though not necessarily given individuals--resulted at times in actions which could be interpreted as somewhat hostile, such as the dismissal of a physician for behavior which would not have cost a paraprofessional his or her job. Result: paranoia on the part of some physicians; discomfort on the part of some non-medical staff.

Why did physicians, despite mistrust, difficulties, and loss of authority, work at NWHC? Some because they liked the fixed hours and the freedom from nightcalls:

> In private practice I'd feel as though I were on duty twenty-four hours a day; in working in a place like this I avoid that.
>
> A.E. (MD)

Others, because they did not like the idea of physicians as entrepreneurs:

> I work here because it fits in better with my idea of how to practice medicine. The fee-for-service setup is for businessmen--that's not my bag.
>
> J.S. (MD)

Several mentioned the fact that at the center they could order necessary tests without financial hardship for the patient:

> The patients I see here get better care than those I saw in private practice. Tests are no financial problem for them.
>
> J.S. (MD)

A few saw it as

> just a stepping stone. It offers a good salary for those preparing for their boards, especially among internists.
>
> A.K. (MD)

And finally, there were those who worked in the center for idealistic and/or political reasons:

> The doctors who stay here are the ones who are probably interested in good medical care for the poor population.
>
> A.K. (MD)

> Neighborhood health centers [have the capacity to offer] comprehensive, continuous, good medical care in an atmosphere which treats the patient with the dignity to which all patients are entitled. They can also expedite things in a manner which does not tax the patient's patience; things can move relatively quickly. . . . you have to go out of your way to be an ombudsman for the consumer . . . some problems are really very simply solved.
>
> D.O. (MD)

> If you look at our medical education . . . every doctor in America gets his skills off poor people--they learn to do brain operations, heart operations on poor people. But once they have completed their education they disappear--they don't pay back what they owe the poor. They don't consider themselves as having ever received--they are so removed, so aloof from the clinic patients, they don't even ever think about them--as students or as doctors. The system is designed to operate this way. . . . maybe some of the doctors here want to pay back some of that debt.
>
> H.R. (DDS)

> Neighborhood health centers can play a vital role in reorganizing the whole medical system. . . . [Centers] should be something that could be built upon and duplicated throughout the country. . . . The government didn't really plan well, it doesn't see itself as being in the health-care business, although it should be.
>
> L.J. (DDS)

> Neighborhood health centers have a definite place in the medical system, or perhaps in changing this system toward making it less of an alienating system. I think that is especially important in terms of poor people because of the massiveness of the problems, but also because they tend to be more shy in dealing with the establishment--but I think that's true for everybody. Even if you're loaded and you go to a doctor and he's very efficient but cold--alright, you might feel that you're getting good medical care, but you are not really going to feel that you can open up with that doctor, so I think that goes for everyone. I really feel that if

> you are in the business of trying to help people you've got first of all to like them, really. If you want to work in a lab someplace in a very cold and efficient way--fine, great; but unless you can make the transition to also working with people, stay in the lab!
>
> G.A. (MD)

The concept that the function of a health care facility and health care providers goes beyond strictly medical questions was shared by most of the NWHC employees I talked to:

> I find that people really develop a kind of . . . transference to the program, they really do. It kind of becomes a second home. It becomes a place where, when the establishment is harassing you--whether it is Welfare or the landlord--there is one place you can go and there are people there who will try to help you cut through the red tape, and that's just really been very prominent and very rewarding. . . . There are patients I have who I think would be very isolated from traditional medical care--they are the ones who distrust traditional medical care because they are the ones who are getting short shrift in traditional settings. . . . [Here] they know that the door is open, they know they can come--and they do come, and I think that that is important. . . . We have little old ladies who come and sit here all day and just talk to the staff, it's kind of a protected place to come to. . . . people get to know people on the staff. . . . there is more than one person they can relate to.
>
> G.A. (MD)

When talking about the importance of NWHC to its patients, most staff members, especially non-physicians, stressed staff attitudes, relationships with patients, and the center's multiplicity of functions.

> The clinic is important because it is convenient. . . . it is special because the attitude of staff is better, patients get to know you-- and that's very important. At . . . [the back-up hospital] the attitude is very bad, yet much of the staff there is also from the neighborhood, but they have forgotten where they came from; that's sad.
>
> C.A. (clerical)

> They holler about waiting, but they stick around. I think we have good doctors. . . . I think everybody does their job. Everybody who is in contact with the patient is important, they have to make the patient feel comfortable. They want to come here, they want to be listened to, to make a connection--to be understood. I listen, I feel for them, I feel I am one of them. Especially, I feel sorry for the Spanish people who can't make themselves understood; they feel like they're fighting a losing battle--you should take time for them. . . . they feel slighted if you walk away from them because you are busy; it would be good to take them to the person who can help--but you don't always have the time.
>
> L.P. (MA)

Not all employees took time for patients, even if they had it; and sometimes it appeared, at least to the outside observer, that a few of the staff who came from the community did, indeed, "forget where they come from." But, by and large, people did care and tried to let patients know that they did.

> The center is essential to the community. Before its existence people didn't know where to turn for health needs. Doctors here aren't like doctors in a big hospital--there is a more personal relationship here. . . . People that know that I work here tell me that they feel at home here, have people they can talk to--at the big hospital they are shy and nobody cares. Here they feel it is theirs. They feel more at ease here; they resent the fact that they are sent to . . . [the back-up hospital] specialty clinics. . . . The outreach department is a wonderful thing for people who cannot get around by themselves or do for themselves. . . . Patients get more personalized care here . . . staff cares.[47]
>
> R.G. (clerical)

[47] I should like to give one example of just how much at least some staff members cared: I had an appointment with one of the outreach department nurses. She had to cancel it because one of her old patients had died. She not only undertook to arrange for his funeral, and took care of all legal matters, but also attended the funeral because she could not bear the thought that the old gentleman would be buried without someone in attendance whom he knew and trusted.

Some staff members felt that she, he, or a specific group cared more than others. This is not an unusual phenomenon. It was, nonetheless, regrettable because it created friction which in such a confined space could not be kept either from patients or the rest of staff.

The relationship between paraprofessionals.

FHCs represented a special constituency and political tool for the former project director--they, therefore, received special treatment.

> There used to be complete lack of supervision of FHCs; democracy led to anarchy. There was always an open door to the project director's office for them; FHCs could take complaints to [the director] directly, without telling the supervisor first, or they could go straight to the council. The attitude was "just because you are a supervisor and have some initials after your name, MD, RN, whatever, who are you to tell me anything? We represent the community."
>
> B.J. (administration)

The present project director started work at the center as the supervisor of the outreach department. Even if she were not aware of it, there is still the possibility that she could have felt differently toward that department in contrast with others--although they were now subject to the same rules as the rest of staff. A second difficulty where FHCs were concerned was the very real problem of assessing the function of outreach workers. If a PHN or FHC said she or he had to spend half a day with one patient, how could one know that this was, indeed, what happened without checking with the patient, which would indicate mistrust of

the worker and, therefore, be undesirable? Finally, FHCs simply did not always fill out encounter forms or enter notes in patients' charts. It is difficult to determine now whether this was because of the fact that they had occupied a privileged position in the past, supervisory laxness, or an inate mistrust of the written word by largely undereducated people. The fact remained that filling out of forms was not the FHC's forte. Let me give just one example of this last point. T.M., a family health coordinator, was telling me about her work.

> Most of my cases are old people--you have to have a lot of patience, they're very concientious [sic] about what you're doing. . . . I feel I can handle some emergencies, but it would depend what kind; I would know when it is necessary to call a doctor. I gave an old patient my home telephone if she has any emergency. . . . One of my patients had a blackout, she called me when she came to, and I called an ambulance. . . . I feel I'm doing a necessary job. I have one family with six kids, the mother left the country, the father didn't want welfare's housekeeper. I pick them up from school when they have appointments at the clinic--it's a hard job, but they're nice kids, and affectionate with me because their mother's not around. Welfare wanted to take the kids away, but the father took it to court. . . . There are seventeen or twenty that I visit regularly on home visits and take care of . . . I go at least once a week, the others less often--but we can't let it go as long as a month. We check the charts and see if they've missed appointments, keep a list of when appointments are made, sometimes make the appointments. We take the old people to . . . [the back-up hospital], they are not very self-supportive [sic], they want you along, but it's good not to go every time because they begin to depend on you too much, are afraid of going alone.

Yet, as table 8.5 shows, T.M. recorded only 81 15-minute patient encounters during a three-month period. Even if she aggrandized her function in our talk, it is hard to

believe that she really only spent about 5% of her work-time with patients. The table also indicates that FHCs, as a group, recorded the lowest number of patient encounters for this three-month period. This was financially disastrous to the center because third-party reimbursement could only be collected if encounters were recorded; it also led to a general impression among staff that FHCs did not work.

> FHCs sit around--yet we have so many patients who need help. They say they work so much, but you can just see them sitting back there.
>
> A.T. (MA)

This was probably an overstatement, but it seemed to express the opinion of many staff members.

> [FHCs] are, for the most part, very immature. . . . they exhibit ambivalence and hostility toward the freedom that's been given them--that's my impression, that there has been so much freedom. Freedom of hours, of making phone calls, of time, of taking time off; freedom of scheduling when they're going to see patients and when they are not going to see them--and so little concrete demands placed on them. And they are very, very frightened by this. To some extent they are frightened, and to some extent they feel guilty . . . because they know that these people [the patients] are people like themselves.
>
> H.N. (RN)

H.N. felt that the poor performance of FHCs was due partly to personality factors, but mainly to poor supervision, for both outreach and in-house personnel.

> There is very little supervision and direction, as I see it, in a positive way--this tends to deprofessionalize their roles, and therefore a person will feel that they can get away with a lot and that leads to an irresponsible attitude toward your job and the end-result is that you don't have an overall good view of it. . . . [With FHCs] it is up the basic integrity of a few people who feel like doing what they do. I'll give you one example of what I mean. There is a completely different atmosphere

> with the FHCs that K. [a PHN] supervises than with the rest of the outreach people. You never see those women, they are always working so hard. . . . She is very devoted; she never socializes on the job at all, she never takes breaks; she is a very, very conscientious worker and as a result her professional attitude toward her job is picked up by the FHCs that work with her. . . . they all act in a completely professional manner . . . they don't seem to abuse the system, they don't seem to have gripes or complaints. . . . they all look a lot better--much more professional.

I should not like to associate myself with H.N.'s judgment regarding the maturity and/or hostility of FHCs. Like any group of individuals, these were of all types. Supervision was another matter: it was then, according to many informants and my own observation, rather poor--especially in the nursing department. As was mentioned in chapter VII, I had not planned to ask about supervision--I only started including the subject in the guideline for staff interviews after noting that the first few people I interviewed formally almost invariably complained about lack of supervision. This, as far as I could observe, was due as much to the supervisory philosophy of the individual in charge as to two other factors:

1. It has always been extremely difficult to discharge paraprofessional and clerical personnel because both council and administration were loath to deprive a member of the community of a job. And, in the case of council members, the fear of adverse reaction among their constituency in the community might also have been a factor.

2. There was also the question of what one could reasonably expect from one supervisor. In addition to

administrative functions, this nursing supervisor was in charge of fifty-one individuals--both outreach and in-house --consisting of professional, paraprofessional and some clerical personnel.[48] Professional demeanor and discipline were not always conspicuous.

> Some people don't act in a professional manner--people forget where they are. If they have something to say to another person, they should take them aside. If they start arguing in the open, it gives a bad impression to the patients: "what are we doing here if this is the kind of people taking care of us?" . . . Some girls just don't care enough.
>
> L.P. (MA)

It was true that many employees of all categories could, at times, be observed doing nothing. It was also true that they often stopped to talk to, or quarrel with, one another without lowering their voices. Finally, employees did, of course, move from one place to another. These forms of behavior are common to all organizations--at NWHC they appeared in a more negative light because of the lack of space. Except for those few fortunates with private offices, there was literally no place (not even a toilet) where one could argue, be idle, or private for a few minutes without being observed; there was no place where one could talk without adding to the noise level of the clinic. And if 100-200 people occupy and move about a small area at any one time, the impression of continuous

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[48]The function of this supervisor has since been divided among several individuals, none of whom had anything to do with administration.

movement, a lack of order and peace is inevitable. Unfortunately this might be the wrong impression for a health care facility.

It appeared to me that the individuals who suffered most from this condition were MAs who had no space to call their own (see fig. 2, appendix A). They were the most visible group of employees; they had more contact with patients than any other single group; if only because more patients simply had to walk by them than other staff they probably were on the receiving end of complaints meant for the physician or the center as a whole. Yet most appeared businesslike, though not all very friendly or especially outgoing to patients. All were always in spotless uniforms and seemed to take pride in their appearance. Most filled in for absent colleagues, and all apparently considered their function at the center at least as important as that of other paraprofessionals, and sometimes more difficult.

> Some patients are very nice, some are very nasty. Since I've been in training I've learned that some are mental, learned that you can't talk back because they are sick. Sometimes the patients here like to tell MAs everything, not the doctor; they feel more relaxed with us. Specially with Spanish people. Translating is hard. Sometimes I don't understand what they say, I go out and ask another girl because I want to translate correctly.
>
> T.J. (MA)

> Our patients trust their doctors and MAs--they will follow our advice. I remember one case where a woman was afraid to have a spinal done on her child--they were at the . . . [back-up hospital] ER because the child had had an accident--the hospital called here, I went over and talked to the woman, told her that it would help make the proper diagnosis if the child had

> the spinal, so she consented, but only under the condition that I could stay with the child. . . . The MAs talk with patients, we listen for as long as they want, many patients know our names . . . many patients think we are nurses, even if we tell them that we aren't, to them we are nurses.
>
> B.P. (MA)

> It's a good thing that patients see their neighbors working here, it gives them some security--they feel more free to talk; I know I would.
>
> L.A. (MA)

> If you let them [patients] talk to you like to a friend, they'll tell you things they won't tell the doctors. If you are not willing to listen, they don't feel good. No matter how they look or smell, Dr. A. and I treat them with respect, and they like it. I feel sorry for the patients. Some don't know English, some don't have anyone at home--we are the only people they can talk to. Some people think we waste time, but it is necessary to treat people right, not like animals--just prescribing medicines. Of course some doctors and MAs don't talk to patients, but that's people for you.
>
> A.T. (MA)

> If patients feel they can confide in you, you can help them or tell them where to go to get aid.
>
> L.P. (MA)

The recurring theme was pride in the MA's function, the fact that many patients wanted and needed to talk, and that most MAs felt it was necessary to take the time to listen because this was part of good medical care.

Another theme touched upon by most MAs in our talks dealt with their belief that they were treated unjustly by administration and council. They did, indeed, appear to be the group with most cause for complaints, and the greatest feeling of insecurity--this latter might have been partly responsible for the fact that a larger percentage of MAs, as compared to other groups except appointment clerks and

council members, refused to be interviewed.

> We feel we are getting the rotten end of the deal, we're not really appreciated. It's true sometimes we have some free time and we're not working, but we get the feeling that . . . [the project director] always walks by when we are not working, never when we are swamped. A few months ago three of us went to her to ask for a raise, she said there was no money, the most she could give us would be 2%; but we got the feeling that she really didn't want to help us. We went to the council and they told us the same thing--that's when we decided we had to have a union to help us, represent us. It's too bad it had to wind up this way, we already have good benefits, we didn't need the union for that. I think the union creates a bad feeling between supervisors and staff, they take it as a personal rejection. . . . but we knew we had to act as a group or they would step all over us.
>
> L.P. (MA)

Two factors seemed to hurt most: that FHCs earned more than MAs, although they "don't have to work nearly as much," and that MAs got the same salaries as janitors.[49] This latter point hurt pride at least as much as pocketbooks. It also did little to help interdepartmental relationships.

Another complaint often voiced by MAs had to do with the fact that most were unable to perform functions they had been trained for and, alternately, that their training did not really equip them to get jobs outside the health center system--this latter point will be discussed in the section on career ladders. Some physicians apparently encouraged their MAs to do as much as possible, others did

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[49]The first union contract was being negotiated at the time these interviews took place. It is possible that these negotiations may have resulted in a salary scale which was satisfactory to the various staff categories at NWHC.

not. Some MAs felt that they were capable of more than they were allowed to do, others were afraid. Once more the difficulty was due partly to a lack of firm guidelines (by OEO; the National Neighborhood Health Center system, and/or NWHC administration) regarding the functions of MAs and insistence that both MDs and MAs adhere to these; and partly to a lack of space. Even if an MA wanted to take temperatures, blood pressures, etc. while the physician saw another patient in the examining room, there was simply no place for her to do so. Finally, the relationship between MAs and their belief in the capabilities of their own group was somewhat strained due to the fact that not all had received the same training.

Career ladders.

> The whole theme of career ladders gave everyone here ambition to continue to study and do things. . . . The basic idea was for you to improve your skills to help you do a better job, but also the idea of <u>up and out</u> . . . if you improve your skills you could move on and get a job in other places. The idea was not for you to stay at the center.
>
> O.E. (clerical)

Since many formerly untrained individuals acquired clerical and paraprofessional health care skills, the concept of career ladders was to some extent honored at NWHC. But only very few of the community people went "up and out," although there was a lot of horizontal and some vertical movement within the center. The fact that employees did not vacate jobs at the center meant that there was no room

for new trainees. It also indicated that they had no desire to move. One reason which often emerged in our talks was that they liked their jobs and realized that these jobs were infinitely better than any other work they were qualified for before coming to NWHC. But it was also clear that they were afraid to do so, were unable to find other jobs, and/or felt unqualified to assume work outside this particular system. In effect, I found these possibilities closely interrelated--and all connected with a feeling of disappointment and unfulfilled promises, regarding employability outside the NWHC system.

Many of the clerical and paraprofessional employees told me that they knew it would be impossible for them to get the same working conditions (type of work, salary, fringe benefits, working hours, etc.) outside the city neighborhood health center system; and since all center jobs must be filled by residents of the community in which the given center is located, this meant, in effect, NWHC as the only source of employment for them. They, therefore, had no desire to change jobs. Among paraprofessionals (with, perhaps, the exception of dental assistants) there was also the recognition that they lacked the necessary credentials to assume positions other than as hospital aides--a status which they considered lower than their own.

> After I finished my training I got a certificate, but I don't know if it's valid anyplace else. I am not allowed to take blood, give injections or medication; therefore I couldn't work for private doctors. Hospitals

> don't have medical assistants, there they only have aides who do all the dirty work.
>
> B.P. (MA)

I do not know whether it could be made legal for the center to permit MAs to draw blood, give injections, etc. and if so, whether their insurance could be extended to cover these activities on the part of paraprofessionals. Since the original training staff was no longer at NWHC by the end of 1971, I also had no means of establishing exactly what non-professionals had been told about the skills they would acquire and whether these would be permanently usable outside the center. The original proposal to OEO (St. Luke's, 1967) did not refer to Pearl and Reissman's (1965) career ladder concept; it did not specify what training would be provided; it did, however, mention that it was hoped that the new trainees would be employable in hospitals all over the City--but it did not say in what capacities.

Interviews with non-professionals and professionals indicated that the former had been informed that they would be given skills which could be utilized in other health care facilities. Enough non-professional personnel assumed that these skills would include taking blood, giving injections, doing formal social work, keeping medical records, etc., to make their present disenchantment understandable. Whether based on realistic grounds or not, these employees had certain expectations about their work

at NWHC and future employment possibilities outside the center which were not met. The situation was aggravated by the fact that, as has been mentioned above, not all physicians permitted their MAs to perform duties that would be within their province of competence. Finally, matters were not helped by the fact that many non-professionals considered the center's training department (as it operated at the time of this study and for some time prior to it) as worthless.

Paraprofessionals had received systematic training of varying duration from OEO-funded organizations and/or in-house during the first years of the center's existence. This ceased when most of the jobs had been filled. Some non-professionals were given the opportunity to get their high-school equivalency diplomas; some clerical personnel were permitted to take pertinent courses (e.g., business English) at a near-by university which offered programs for the undereducated; two paraprofessionals earned an A.A. degree at an OEO institution. But, with very few exceptions, no training was paid for by the center by the time I arrived there. Those who were willing to continue their education on their own were not allowed to do it during working hours.[50]

> Many people are aware that they cannot really utilize the training they got here . . . if they were to go to

[50]This restriction has since been modified.

> work at a hospital, they would still have to take the same training all over again. . . . Some people had more initiative than others. In the beginning there were very many programs that you could go to on the outside, but very few who went finished them. . . . a lot of times it is not their fault, they have a family to take care of. I know, when I went at night, it was hard--at three o'clock in the morning I'd be asleep over the books . . . I did it, and I plan to do it in September again, and I'll do it until I get my degree in accounting. I would have gone to school wherever I worked, because I can't just sit at one thing, I have to go on. . . . I don't really think the career ladder thing worked so well in practice . . . but I think it could have if it were set up correctly; and also, if--when you are finished--you would be put in a position where you can use what you learned, both here and outside . . . if one person leaves, another can be brought in to be trained; and even here, some of the things people learned are permitted to go to waste. It's a standstill, you train, but you are still doing the same job. . . . Another thing I cannot understand is how, after six years, not one MA has made nursing school.
>
> K.S. (clerical)

Most of the complaints voiced to me over my two-year stay at the center were directed toward the training department: most non-professionals felt that it did not even attempt to keep them informed of possible avenues to better their positions. Coupled with the fact that RNs received N-P training paid for by the center (hardly anybody knew that there was a special grant for this) and on center time, and that physicians were permitted time at the back-up hospital, the whole question of career ladders added fuel to the fires of discontent.

> My feeling is that it is only professionals who go to school . . . the training department should at least get people involved. . . . Whether they go or not is up to the individuals, but at least they should open doors for us and give people a chance to refuse it. . . . I think it should help the non-professional . . .

> to get a better position, get some kind of degree--and for some other person to move into that slot. I feel let down with the career ladder thing. What is the training department here for? Whom are they training? Are they looking out for us? Are they getting schools, informing us?
>
> M.L. (clerical)

> He [the director of the training department] wouldn't help me to get money from the GI bill or to get a leave of absence at least to start going to college to see if I can do it. . . . The center has not kept its obligation to train employees, they have failed, no one encourages you; HEW never comes to see how things are going. There are a lot of staff people who are intelligent, I think it's unfair that you can't go any higher.
>
> I.O. (clerical)

> The whole career ladder thing is just on paper. I'm doing the same thing I was doing four years ago. But I can't go to a hospital as a medical records secretary because I lack knowledge of enough medical terminology. In four years here I should have had a chance to get it--they should have given me training. I always feel insecure about the job; and I probably could only get a clerk's job on the outside. MAs and FHCs don't think much of the training department either.
>
> R.G. (clerical)

This last point was largely confirmed in my talks with representatives of these two groups.

> The training I got inside the center and at . . . [an OEO-funded training institution]--health and social training--was good but not enough in either field. . . . And there are no other places that use FHCs; it's not a profession, but I feel happier with it than I did as a factory worker.
>
> E.N. (FHC)

> I could only use my training as FHC at another center--that bothers me sometimes because I had expected to be able to use it. . . . I failed twice in taking the high school equivalency test because I have difficulties with math; now I feel disgusted. To become a practical nurse you need a high school diploma and to pass another test to be accepted for training. Nobody helped me [with the math], nobody encouraged me; now I feel sick when other people are starting to go to school. I can't

> even go to the high school program at . . . [the near-by university] in the evening now because I have to have another job in addition to this one . . . I'm divorced and have a sick daughter.
>
> M.N. (FHC)

> We didn't get enough training--we need more. . . . there are so many things to learn. . . . that takes time, especially if you want to learn it good. Besides, the training department here doesn't do a thing--we need somebody who will really teach us. This is a place for poor people, to help people--if we know more, we can help better. We all have free time [during the work day] . . . we could use it to learn something. . . . We aren't really qualified for jobs outside. We are supposed to assist the doctor in every way, but we don't. I forgot how to take vital signs because I didn't learn it well enough in the first place. Now I do mostly paper work. . . . I don't ask Dr. A to give me a chance because I don't feel I learned it well enough to practice. I'm sure he'd let me, but I don't feel I know enough--I wouldn't want to do harm.
>
> A.T. (MA)

> I like my work as an MA, but I can't use all I learned. . . . I expected to be inside the office with the doctor most of the time, but that didn't happen. Now I do mostly clerical work or interpreting--it's boring. . . . I want to learn everything . . . but I'm disappointed not to be able to work with patients more. . . . Besides, I heard that doctors on the outside want more than we learned. And you forget what you learn if you don't use it.
>
> T.J. (MA)

Always the same refrain: we didn't learn enough; aren't allowed to use what we did learn; couldn't utilize our skills outside the center; don't get help/encouragement to learn more from the training department--general disappointment with career ladders. Oddly enough, only very few people asked for direct financial assistance (in the form of tuition, etc.)--they wanted, rather, guidelines, encouragement, more on-the-job training, practical help with such mundane problems as poor mathematical skills, and

paid time off during the day for those who wanted to go to school. Since most had children at home, and many were the sole providers for their families, it is not surprising that even the most ambitious could not quite face the prospect of evening classes.

Not all physicians at NWHC believed that MAs should do more than clerical work, and that FHCs should have other functions than as homemakers and/or just to take disabled patients to the clinic, hospital, etc. Other doctors gave lip service to the concept of career ladders, but could not really hide their low opinion of non-professionals. Thus, from Dr. L.J.

> Career ladders is a good concept on paper, but some people don't want to rise. The Peter Principle is very true: a man rises to level of his incompetence. Here people don't really want to better themselves. . . . there was one woman who just left [center employment] whom I really tried to help. She was street-wise, but coming to work was totally alien to her. I don't know of any worker whose position in life was bettered by working here--I've seen the opposite. I've seen a supervisor take a lesser position because she didn't want the responsibility--they want more money, certainly, but with less work, no responsibility, no effort. . . . I offered all my people the position of line supervisor, and all of them turned it down. . . . it might be their poor self-image, it might be my personality.

On checking further with the paraprofessionals in this department, it appeared that their lack of self-image was not the problem. It was much more a case of not wanting to undertake added responsibilities without commensurate respect, reimbursement and--perhaps most importantly--backing from the supervisor. In contrast to Dr. L.J.,

the (non-physician) supervisor who first introduced the concept of line supervisors in his various departments never failed to teach, encourage, and stand up for these individuals. He was consistently demanding, but also proud of their work. He truly believed in career ladders--perhaps because he was one of the few people at NWHC for whom the concept worked, because he started at a rather low level and became a member of the administration. He did, of course, recognize that not everybody wanted to advance. He voiced much less democratic philosophy than Dr. L.J. in day-to-day conversation, but I have never heard him generalize about the aims, ambitions, qualifications, characteristics, etc. of NWHC workers.

There were two other groups of physicians: one which simply deplored the inadequate training, and another (by far the minority) which recognized that no matter how good the training, the medical system of our country is not yet ready for the professionalization of individuals without the time-honored credentials of the university. One example of the former group is supplied by Dr. E.N.:

> The center has not fulfilled its mission as far as career ladders are concerned. I think what the [OEO] planned to do with these programs was to train people to enable them to go out and find jobs elsewhere. I don't think that our people can go out and work in doctors' offices nor do I think that they are trained to work in hospitals. I don't think that they are trained to provide medical assistance anywhere but here. I'm definitely sure there has been no malicious intent. I think that training just stopped short of its goals.

Dr. G.A. agreed with the assessment of the inadequacy of training, but went a step further to consider the question in a broader perspective:

> I guess I feel that in general they [paraprofessionals] should probably have more supervision, more informal and formal training than they presently get. I think some of them have a tremendous natural talent for relating to people. . . . They should get both on-the-job training and formal training . . . the academic [training] is important because it gives them more mobility . . . it gives them credentials that can be recognized. . . . I don't think it is fair to lock them in to a level that doesn't have very much marketability . . . and right now you're only marketable if you have various degrees. . . . I think that is damaging to their self-image. I think it also creates a lot of dissention on the staff between professionals and paraprofessionals, it makes things uncomfortable. I've seen this myself with some of the paraprofessionals that I've worked with--they are very doubtful about how they are handling patients . . . they are afraid of exposing themselves and as a consequence in some ways restrict their own opportunity to learn. . . . I know that there are problems with money and time . . . but in all fairness, training should be tied in with an academic program, it would help. Frankly, I think that a lot of academic knowledge is for the birds, I don't really believe that that is where you learn how to treat people, but unfortunately our society only recognizes the credentials for the most part.

What it amounts to, then, is that it is not enough to propound an idea of "new careers for the poor" (Pearl & Reissman, 1969) to train unskilled personnel for duties in, for example, the health care field which would permit them to move up and out. It appears that, at least in the medical system, it is impossible to implement these ideas without the cooperation of the system. This is one critical interface between the neighborhood health center and the medical system--unless the latter collaborates,

one important function of the former is subverted.

It is possible that the Pearl and Reissman concept is an unrealistic one. The screening process involved in successive career sequences which they described would invariably involve failure for many individuals attempting advancement; this might do so much psychological damage that the price could be considered too high. It is even possible that not too many unskilled workers or third-generation welfare clients would want to become RNs or MDs. But these are not the issues here; the issue is really a much narrower one: here was a group of people who had the courage to admit ignorance and face possible contempt by professionals; who were willing to learn and work; who expected to be able to utilize their skills all over their city, or the country for that matter. But these individuals found that there were no more funds available for training; that what training they had received was probably inadequate for employment outside the center; that their skills were really denegrated by the medical establishment, including some of its representatives within their own neighborhood health center system.

The question of ethnicity

Table 8.3 shows that, although Hispanics accounted for 45% of all NWHC employees, the heaviest concentration--90% of this group--was among paraprofessional and clerical workers. Blacks accounted for 27% of staff and Whites for 28%. Of the former group 62% were non-professionals, and of the latter group 11%.[51] These figures have possible significance for at least three reasons:

1. Most physicians were White--this fact might have been resented by employees and patients of the other two groups. There was, however, no openly expressed indication of such resentment. Staff knew tht the center had difficulty finding physicians and that minority applicants got first consideration. As for patients, in both interviews I and II only one Hispanic respondent each referred to the need for more Spanish-speaking staff. The only Int. I Hispanic respondent who reported a request for change of physicians did so because the one she wanted knew her and her family. She did not indicate if either of the two physicians were Hispanic or not. The largest reported number of requests for change of physicians came from White respondents (N = six); three Blacks did so also. The reasons given by these nine individuals had to do with rejection of certain physicians' personalities

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[51] Line supervisors (two Hispanics and two Blacks) are not included in this tabulation because they did not, at that time, have official recognition as supervisors.

(e.g., "I did not like the way I was treated," "the doctor lacked personal interest in me," "the doctor was rude") and perceived incompetence.

On the other hand, as was noted earlier in this chapter, Hispanics were least likely either to single center physicians out for praise, or to connect satisfaction of center services with physicians specifically. The Int. I question regarding the importance of employing Spanish-speaking staff at the center elicited some indication that prime factors for desiring such personnel were the ability to communicate linguistically and to relate emotionally. It is obviously more desirable to do the latter without the need of a translator.

2. Hispanic employees could feel discriminated against because they held the lowliest positions at the center, despite the facts that the majority of the center's patient population belonged to their ethnic group, and that they represented the largest single group of center employees. Some confirmation for this supposition was found.

> There is friction between groups, there has been from the beginning. At first they hired mainly Spanish, then people complained they should hire Blacks, so they tried to even it out . . . people stay in their cubby to avoid friction. . . . people here think that whenever there is a free position here, the Black get it. J. is the only Spanish supervisor and the Spanish staff resent that, they feel that the Spanish have ability and should be trained to be qualified for supervisor. . . . The Blacks are more together than

> the Spanish; here the majority of us are Puerto Rican, and even we are not together--if we could unite we could get a lot accomplished.
>
> I.O. (clerical)

The idea that Blacks throughout the country and at the center were more ready to fight for their rights than Hispanics was mentioned by several of the Hispanic employees.

3. White patients, especially the elderly, might have felt in an alien environment when coming to the center because most patients and, with the exception of physicians, most employees they dealt with were non-White. But, except for the three White Int. I respondents who, as was reported previously, made discriminatory remarks and reported prejudicial treatment on the part of non-medical personnel, there was no direct indication that this was so. It is difficult at this point to determine whether, for example, the greater degree of trust given physicians as compared to other personnel was due to the fact that the former were also White, or because these White patients were more traditional in their concepts regarding health care providers.

As for my own experience at NWHC, I was never conscious of mistrust or dislike due to ethnicity; where these existed it was because of the insecure position of the center in the scheme of politics and government financing and/or personality factors. One Black dentist kept injecting the issue of racism in our society whenever

I talked to him. He felt that this affected the position of NWHC, its employees and patients. The general tenor of his comments was to equate "poor" with minority people--especially Blacks. He never once voiced concern for poor Whites and I cannot help but wonder what his behavior toward his White patients, and their feelings for him, were. One White non-professional alluded to the "hard feelings and competition" in the city and the center between Blacks and Hispanics, and among the various nationalities in the latter group. Mention of some tension between Blacks and Hispanics on staff crept up in many interviews with members of these two groups. Finally, I came away with the impression that no White, regardless of qualification or capability, could hope to become project director of the center.

However, while the question of ethnicity would seem to have involved some friction, this did not appear to be one of the major problems of NWHC. Several things might be responsible for this: (a) the fact that the center provided jobs was of primary importance, their distribution among the various ethnic groups only of secondary concern; (b) Hispanics at the center, as a group, perhaps lacked self-confidence; (c) most of the staff were committed enough to the concept of community health care facilities to accept setbacks in their own positions; (d) most had reason to take some pride in their work--even if they felt

that some group or groups are favored over others--thus, for example, from S.W., a technician:

> This isn't a production line like other clinics. There I don't really feel like I'm helping a person; here I can get to know them, to make them understand what I'm doing. I feel appreciated; it makes me feel proud of what I'm doing.

To sum up the findings concerning staff presented in this chapter: They appeared to have made an honest attempt to provide their patients with dignified and individualized care. While the goal of comprehensive team care has not been reached, the approach of NWHC staff was more holistic than is usually the case in our medical system. Part of the failure to achieve this goal completely was due to generally poor communication between the various segments of center staff, partly to administrative style and some of the problems in supervision that have been previously cited and, lastly, inadequate space. Patients' attitudes, which might or might not be changed through education, were also to blame. Finally, if city and federal agencies and institutions do not cooperate, completely comprehensive care will never be achieved, no matter how well center staff performs its functions.

The new approach in medical care represented by neighborhood health centers requires new role concepts on the part of all individuals involved. Not all were equally willing or well prepared to adopt these concepts. The ethnic question might have aggravated this situation

somewhat, but to a much smaller extent than could have been expected; the question of career ladders, on the other hand, did so much more.

Summary

Observation of the North-West Health Center and information gathered from its staff and patients indicate that this facility represented a viable addition to the health care system of the city. While the goals of continued and comprehensive care for the family unit by multidisciplinary teams of providers had not been fully met, patients reported satisfaction with, and use of, the center--though the latter not in as sustained a manner as could be desired. There was, at least, an attempt at an holistic approach, to treat the patient more as an individual and less as an object than in many other facilities, and to build some personal relationships with patients. Employment of community people was viewed as conducive to rendering better and more comprehensive care because patients were generally thought to be less shy about mentioning non-medical problems to paraprofessional community people; fear of breach of confidentiality did not appear to represent a problem. However, until all city and federal government agencies cooperate, really comprehensive care is impossible, regardless of how well the center might succeed within its system.

Although some patients voiced dissatisfaction with NWHC, most commented favorably on its convenient location, the quality of care they received, and the fact that care was much more personalized than at clinics generally. They liked being seen by the same providers and the fact that this permitted getting to know personnel, and being known in turn. Judgments about the quality of care in various health care facilities were often coupled with comments regarding attitudes and behavior of health care personnel, rather than simple mention of being helped with given medical complaints. Care by private physicians was assumed to be better by a number of patients who, reportedly, were unfamiliar with such care--an indication, perhaps, that Americans are socialized to believe that this is the most desirable way to organize health care.

Hispanic patients, as compared to Blacks and Whites, appear to be somewhat more passive. Indicators for this are the reports by some that they were less likely to utilize several health care facilities or to prefer making their own choice of facility. They also appeared to have less knowledge regarding agents affecting health, they offered fewer definite criticisms, and much more unqualified positive appraisal of the clinic. This latter factor could have been a function of the presence of a large number of Hispanic staff members at NWHC; the apparent passivity might have been due to mistrust in an alien society and/or

language difficulties. If these suppositions are correct, they would point to the importance of taking social and cultural variables into account when planning health care.

There was a very slight indication that the absence of Spanish-speaking physicians and White paraprofessionals put some strain on Hispanic and White patients respectively. The shortage of White personnel and the fact that they represented a minority in the patient population as well might have made the social environment somewhat alien for White patients, especially if they were old. Ill effects of this could have been mitigated by the fact that the majority of physicians belonged to this group. Black patients were in a minority too, and only a few Black doctors worked at the center. However, Blacks were well represented among other professional and non-professional staff. It is conceivable that the shortage of Black and Hispanic physicians, White non-professional personnel and patients could have been dysfunctional for patients' health care in that it might have kept some from seeking preventive care, or from getting the proper amount of follow-up care and, therefore, made the achievement of comprehensive care more difficult.

Ethnic distribution among the various staff categories created some slight resentment on the part of personnel, especially among Hispanics, because they were under-represented in professional and supervisory statuses.

Just plain prejudice between, and even within, ethnic groups was occasionally apparent. But non-professionals, regardless of which ethnic group they belonged to, were likely to be disappointed because the promise of career ladders had not been fully realized. While they have received training which enabled them to perform their duties at the center, and while there was some mobility between the various departments and, for a few, upward mobility within the center system, hardly anybody has managed to find equal or better positions in the city's health care system. Responsibility for this rested with (a) the federal government because it did not then fund training, despite the "Great Society" promises; (b) the medical system because it usually still required traditional, academic credentials; (c) NWHC which did not do enough to help personnel acquire these credentials, and (d) with those non-professionals who were either afraid, not ambitious enough, and/or too comfortable with their jobs to sacrifice now in order to achieve more in the future.

While interpersonal relationships among center staff were generally fair, they often suffered from frequent threats to center funding and from poor communication within the center. Finally, not all staff was as yet comfortable with the new role concepts necessitated by a comprehensive team care system which, moreover, was managed by lay people--this, in turn, caused tension. There was generally

poor understanding of the true function of various groups of employees and their importance in this fairly novel scheme of patient care.

Supervision in many of the departments was quite inadequate; the administrative style was generally laissez faire. Closely related, both these factors might have been due in part to the shortage of administrators and supervisors, partly to an overly democratic administrative philosophy, and lastly to a reluctance to be too demanding of community employees. Whatever the reasons, they affected personnel's productivity adversely, hindered education of both staff and patients, caused insufficient attention to details which, in turn, led to failure to follow up on implementation of new procedures--all of which detracted from rendering maximal care. Some changes have taken place since this study was completed.

Despite these shortcomings, however, NWHC appeared to offer its patients an alternative which was more convenient, emotionally satisfying, and perhaps even medically more efficient since health care here was less fragmented and depersonalized than in conventional health care delivery systems.

CHAPTER XII

NWHC'S PHYSICAL ENVIRONMENT: HOW IT WAS PERCEIVED BY AND INFLUENCED THE INDIVIDUALS IN IT

In planning for urban neighborhood health centers it was hoped that their decentralization would

1. provide greater autonomy from the medical system and, therefore, permit innovations;

2. make them more easily accessible, which in turn should lead to greater utilization by individuals who had hitherto received inadequate medical care because they belong to ethnic minorities and/or are poor. To these groups one should add those who suffer from a lack of mobility due to old age, physical disabilities, language difficulties, etc. And finally,

3. would make them less overpowering and impersonal because of their relatively small size, and that this feature, too, would encourage their use.

Previous sections of this report presented a description of NWHC's physical setting, data concerning innovations at NWHC and their effects on patient care; and utilization of the center by its patients. The present chapter will address itself to the effects of the physical setting on the people who must spend time in it. On first acquaintance

with NWHC in a study which involved the comparison of waiting rooms (O'Mara & Kirsners, 1972) we were struck by the following points of comparison between hospital OPD waiting rooms and the waiting room at NWHC: we noted, first of all, the limited scale of the latter institution. Next, we were surprised by the rather low noise level, despite the number of people present at all times--this we attributed, in part, to the lack of a public address system. (This impression was modified with increasing familiarity.) Finally, we commented on the (a) periodic crowding due to a general lack of space; (b) dismal appearance in terms of wall paint, lighting, and sparse furnishings and (c) apparent underutilization of the playroom. As I found out later, this last point was often due as much to the presence of a larger number of children than the playroom could hold as to the unwillingness of some parents and/or children to utilize it.

When the present research was planned, the physical environment was considered a variable which might affect both perception and delivery of care. It was hypothesized that the environmental setting of any health care facility could symbolize the quality of care to be expected from this facility, as well as serve as a symbol for the community in which it is placed. A second hypothesis proposed that staff would be more affected by the environment than patients because the former spent more time in

it, were engaged in more complex activities, and that the environment helped structure their functions and role perception. Data which were gathered in the course of this investigation lent little support to the first hypothesis, but it supported the second hypothesis quite strongly.

Effects of the physical environment on patients' perception of care

Perceptions of size, crowding, noise, the degree of privacy available in contacts with various staff members, comfort, the existence of a playroom and, finally, the location of NWHC were utilized to assess the way patients reacted to the physical environment of NWHC, and whether these factors influenced their satisfaction with center services--which was here utilized as an indicator for perceived quality of care. All of these points were covered in Int. I, only some in Int. II, none of them figured in Int. III.

Density, noise, and comfort of NWHC. Taken as a group, a majority of Int. I respondents perceived the center as being too small, often (or at least sometimes) as crowded and noisy--yet most thought it quite comfortable (see tables 12.1, 12.2, 12.3 and 12.4). While more individuals thought of space, crowding, and comfort as important variables, fewer considered noise as such. As these tables show, however, significant differences among the three ethnic groups were apparent regarding all the

TABLE 12.1

PERCEIVED ADEQUACY OF SPACE AT N.W.H.C. (INT. I)

	Hisp.		Black		White		Total	
Space	f	%	f	%	f	%	f	%
Perceived amount of space at NWHC[a]								
Too little	10	33	15	50	24	80	49	54
Enough	19	64	13	43	4	13	36	40
Too much[b]	1	3	–	–	–	–	1	1
DK, NR	–	–	2	7	2	7	4	5
Total	30	100	30	100	30	100	90	100
χ^2=16.43; df=2 (without DK, NR category), p<.001								
Importance of adequacy of space[c]								
Very	13	44	17	57	7	23	37	41
Somewhat	14	47	6	20	7	23	27	30
Little	1	3	3	10	5	17	9	10
None	1	3	1	3	7	23	9	10
DK, NR, NA[d]	1	3	3	10	4	14	8	9
Total	30	100	30	100	30	100	90	100
χ^2=17.88; df=6 (without DK, NR, NA category), .001<p<.01								
Specific space/time[e]								
Yes	3	10	17	57	22	73	42	47
No	25	83	9	30	3	10	37	41
DK, NR, NA[d]	2	7	4	13	5	17	11	12
Total	30	100	30	100	30	100	90	100
χ^2=33.97; df=2 (without DK, NR, NA category), p<.001								

[a]Q. 42: "Would you say that NWHC has too much, enough or too little space?" (F.A.)

[b]As only one respondent thought the center had too much space, this category was combined with "enough" for the computation of χ^2 and for table 16, appendix N.

[c]Q. 42a: "Would you say that this is very important, somewhat important, of little importance or of no importance to you?" (F.A.).

[d]NA (not applicable) refers to respondents who did not give definite answers to Q. 42 and Q. 42a (omitted in χ^2 computation).

[e]Q. 42b: "Is there a specific area or time you are thinking about?" (F.A. and probe)

TABLE 12.2

PERCEIVED CROWDEDNESS AT N.W.H.C. (INT. I)

	Hisp.		Black		White		Total	
Crowding	f	%	f	%	f	%	f	%
Occurrence of crowding at NWHC[a]								
Often	2	7	14	47	22	74	38	42
Sometimes	21	70	10	33	7	23	38	42
Never	5	16	4	13	-	-	9	10
DK, NR	2	7	2	7	1	3	5	6
Total	30	100	30	100	30	100	90	100

χ^2=29.16; df=4 (without DK, NR category); p<.001

Importance of crowding[b]								
Very	8	27	14	47	8	27	30	33
Somewhat	16	53	7	23	7	23	30	33
Little	4	13	6	20	6	20	16	18
None	-	-	1	3	7	23	8	9
DK, NR, NA[c]	2	7	2	7	2	7	6	7
Total	30	100	30	100	30	100	90	100

χ^2=18.98; df=6 (without DK, NR, NA category), .001<p<.01

Specific space/time[d]								
Yes	11	37	22	73	26	86	59	66
No	15	50	5	17	2	7	22	24
DK, NR, NA[c]	4	13	3	10	2	7	9	10
Total	30	100	30	100	30	100	90	100

χ^2=18.95; df=2 (without DK, NR, NA category), p<.001

[a]Q. 43: "Would you say that NWHC is often, sometimes or never crowded?" (F.A.)

[b]Q. 43a: "Is this very important, somewhat important, of little importance or of no importance to you?" (F.A.)

[c]Respondents who did not answer Q. 43 or Q. 43a (omitted in χ^2 computation).

[d]Q. 43b: "Are there any specific areas or times you have in mind?" (F.A. and probe)

TABLE 12.3

PERCEIVED NOISE LEVEL AT N.W.H.C. (INT. I)

	Hisp.		Black		White		Total	
Noise	f	%	f	%	f	%	f	%
Presence of noise[a]								
Often	1	3	10	33	12	40	23	26
Sometimes	19	64	12	40	14	47	45	50
Never	6	20	6	20	3	10	15	17
DK, NR	4	13	2	7	1	3	7	7
Total	30	100	30	100	30	100	90	100
χ^2=12.04; df=4 (without DK, NR category); .01<p<.02								
Importance of noise[b]								
Very	1	3	6	20	3	10	10	11
Somewhat	14	47	3	10	6	20	23	25
Little	10	33	15	50	9	30	34	38
None	1	3	4	13	11	37	16	18
DK, NR, NA[c]	4	14	2	7	1	3	7	8
Total	30	100	30	100	30	100	90	100
χ^2=24.07; df=6 (without DK, NR, NA category), p<.001								
Specific space/time[d]								
Yes	5	17	22	74	25	83	52	58
No	20	66	4	13	2	7	26	29
DK, NR, NA[c]	5	17	4	13	3	10	12	13
Total	30	100	30	100	30	100	90	100

[a]Q. 44: "Do you feel that the center is often, sometimes or never noisy?" (F.A.)

[b]Q. 44a: "Is this very important, of little importance, or of no importance to you?" (F.A.)

[c]Respondents did not answer Q. 44 and Q. 44a; (left out in χ^2 computation.)

[d]Q. 44b: "Do you have any specific area or time in mind?" (F.A. and probe)

TABLE 12.4

PERCEIVED COMFORT AT N.W.H.C. (INT. I)

	Hisp.		Black		White		Total	
Comfort	f	%	f	%	f	%	f	%
Extent of comfort[a]								
Often	12	40	17	57	23	77	52	58
Sometimes	16	54	7	23	2	7	25	28
Never	1	3	4	13	4	13	9	10
DK, NR	1	3	2	7	1	3	4	4
Total	30	100	30	100	30	100	90	100
χ^2=16.67; df=4 (without DK, NR categy) .001<p < .01								
Importance of comfort[b]								
Very	9	30	19	64	7	23	35	39
Somewhat	19	64	4	13	8	27	31	35
Little	1	3	4	13	5	17	10	11
None	-	-	1	3	9	30	10	11
DK, NR, NA[c]	1	3	2	7	1	3	4	4
Total	30	100	30	100	30	100	90	100
χ^2=35.86; df=6 (without DK, NR, NA category), p<.001								
Specific space/time[d]								
Yes	2	7	20	67	18	60	40	44
No	26	86	7	23	9	30	42	47
DK, NR, NA[c]	2	7	3	10	3	10	8	9
Total	30	100	30	100	30	100	90	100
χ^2=27.88; df=2 (without DK, NR, NA category), p<.001								

[a]Q. 45: "Do you believe that the center is often, sometimes or never comfortable?" (F.A.)

[b]Q. 45a: "Is this very important, somewhat important, of little importance, or of no importance to you?" (F.A.)

[c]Respondents did not answer Q. 45 and Q. 45a; (left out in χ^2 computation).

[d]Q. 45b: "Do you have a specific area or time in mind?" (F.A. and probe)

variables: Looking at the first rows of the four tables, it appears that Hispanics--despite the fact that they found the center less small, crowded, and noisy than the other two groups (especially Whites, where the differences are quite marked)--also found the place least comfortable. Lacking a frame of reference, it is impossible to interpret this finding: just what did "comfortable" mean to these 90 individuals?

Next, Blacks consistently attached more importance to all four variables; with the exception of "noise," they were followed by Hispanics in frequency, with Whites being last. Does this mean that this latter group felt the greatest lack of power and, therefore, accepted conditions more readily? Was the provision of care important enough to make the setting relatively unimportant? Again, this was a question which could not be answered with the data on hand. It will, however, be related in the last chapter to findings reported in earlier sections in order to discuss possible ways in which strain created by the social and/or physical environment could play a role in the satisfaction with, as well as perception and utilization of, health services.

It is interesting to note that in all the above sets of variables, Hispanics had the largest number of intermediate responses--i.e. "enough," "sometimes," "some"--they did not commit themselves to a definite point of view.

They were also, as the tables indicate, least likely to have specific areas or times in mind when talking about space, crowding, noise, and comfort of NWHC. The probes which were meant to pin down these areas and/or times were unfortunately, rather unproductive with all three groups (see table 16, appendix N).

The one fact which emerged most clearly from these probes was that the waiting room was more consistently perceived as being too small, crowded, noisy--but also as the most comfortable! This says very little indeed for the comfort of the rest of the clinic.

But did the physical environment influence perception of the quality of care? Taking all 90 Int. I respondents as one group, of all those who voiced overall satisfaction with the service they received at NWHC, 51% perceived as having too little space; 42%, 25%, and 61% respectively thought it was often overcrowded, too noisy, yet comfortable (see table 17, appendix N). But once more the three ethnic groups showed differences. Thus, for example, a large majority of satisfied Whites perceived the center as too small and frequently overcrowded; an equal percentage of Blacks saw it as having too little and enough space, and the proportion who perceived it as often crowded was smaller than among Whites. A majority of satisfied Hispanics, on the other hand, thought NWHC had enough space and that it was only occasionally too full.

The above findings appeared to indicate that the physical environment of NWHC did not affect or specifically relate to the perception of Int. I respondents regarding the medical care they received at the center to any great extent. Since respondents varied in their assessment of the space, crowdedness, noise and comfort at the center--and the importance they attributed to each of these variables, it was cumbersome to find a relationship between each of these variables and various indices of satisfaction with center services. An overall score for the perception of the physical environment was therefore computed on the basis of respondents' answers to the questions dealing with space, crowding, noise, and comfort at NWHC (see appendix 0).

This score is referred to as the "dissatisfaction index with the physical environment"--rather than "satisfaction index"--for two reasons: (a) It made it easier to distinguish it from "satisfaction with services," and (b) because it had been postulated that perception of the environment as poor would tend to lead to perception of care as inferior.

The assignment of values for the computation of this overall score was totally arbitrary and equal weights and equal intervals were assigned to each item although it was recognized that these items may, in fact, not have the same weights and intervals. This procedure was deemed allowable because the final dissatisfaction score is

considered a purely descriptive one and no parametric statistics will be used in the examination of possible relationships between this index and various indicators of satisfaction with center services. Table 12.5 shows the totals, ranges, means, and medians for the dissatisfaction scores. Blacks showed the highest total scores and Whites the lowest; Blacks the broadest range, and Hispanics the narrowest.

TABLE 12.5

SCORES OF OVERALL DISSATISFACTION WITH THE PHYSICAL ENVIRONMENT OF NWHC (INT. I)[a]

Measures	Hispanic (N = 30)	Black (N = 29)[b]	White (N = 30)
Total scores	681	748	651
Range	9 - 37	5 - 44	8 - 44
Mean	22.7	25.8	21.7
Median[c]	24.5	25.7	21.5

NOTE: See appendix 0.

[a]Q's 42, 42a, 43, 43a, 44, 44a, 45, 45a. See tables 12.1 - 12.4 for wording.

[b]One respondent did not answer any of the questions dealing with the physical environment.

[c]Testing for the significance of the differences between the 3 medians (Extension of the Median Test, Siegel, 1956) yielded $\chi^2 = 2.94$, df = 2, $.20 < p < .30$.

Cross-tabulation of the dissatisfaction score of every Int. I respondent in each of the three ethnic groups with his or her use of center services during a one-year period, satisfaction with and recommendation of the center, and age yielded no discernible trends.[52] When all 90 respondents were used as one group it appeared that

1. respondents who reported more yearly use of center services tended to complain more about the physical environment while people who used the center less voiced fewer such complaints;

2. among people who voiced satisfaction with center services there was a slight tendency to express less dissatisfaction with the physical environment, while individuals who were not satisfied with the services rendered by NWHC were more likely to express complaints about the center's physical setting;

3. somewhat more individuals who voiced greater dissatisfaction with the physical environment also reported recommending others to the center;

4. older respondents showed a slight tendency to complain less about the physical environment (see table 18, appendix N).

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[52]Although not an indicator of satisfaction with center services, age was included to see if a relationship existed between it and perception of the physical environment.

As table 18 (appendix N) shows, all of the above relationships are slight, and not always easy to interpret --e.g. do the people who use the center less voice fewer complaints about its physical setting because they are not often exposed to it, or do they come to the center less because of the setting? Does dissatisfaction with center services feed into a negative perception of the environment or vice versa? Or are these relationships spurious? Possible implications about conceivable relationships between the perception of a service people receive and the extent to which the environment is a variable in this perception will be discussed in the last chapter.

Of the 25 Int. II respondents, 10 (40%) thought the physical set-up of NWHC was fine, though some complained about long waiting times. A desire for more space was voiced by 7 (28%); 5 of these did not feel that, though small, crowded, and sometimes noisy, this reflected inferior care. For, as E.P.[53] commented,

> doctors all study from the same books; therefore there is little difference in the care and know-how one doctor has over another. The center is doing its best . . . if the budget were larger, the care and services would likewise reflect that enlarged budget. Given [existing] limitations, the center is performing to the best of its capacity.

[53]Male, age 31, living with his wife and 5 children.

Or, to quote D.C.[54]

> Sure there should be more space . . . but I accept the crowded situation. I don't think it represents lower quality care because I'm familiar with the treatment and it is good. . . . The center is noisy, but that is because of the love of talking of the Spanish patients and staff.

M.P.[55] offered the opinion that it would be advisable to "separate people with diseases from the children in the waiting room," but otherwise did not connect physical environment and quality of care. Two of the seven respondents who voiced a need for more space, however, did so. According to J.C.[56]

> The center is overcrowded. This tends to indicate inferior care because in the waiting room one can contract a cold or some other illness from people around you.

C.B.[57] stated that

> the physical set-up is simply bad. . . . It's bad all the way around. For instance, there is only one bathroom and the workers don't even have one of their own. The sitting area . . . has no kneeroom. There is continual buzzing from so much talk--but people need to talk. But the space situation is the worst. . . . a nurse carrying special medicine past the waiting room could trip over a child. The crowded conditions make for inferior care. When it comes to us poor people, they give us only so much and no more, unless we demand it.

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[54]Female, age 33, living with 3 children.

[55]Female, age 31, living with husband and 2 children.

[56]Female, age 37, living with husband and 3 children.

[57]Female, age 42, living with 4 children.

Two respondents liked the fact that patients could get free coffee while they waited and mentioned the playroom favorably because children were offered both activities and refreshments--this was the only volunteered comment about the playroom. The subject was not broached specifically during Int. II. It did, however, form part of Int. I. Of these 90 individuals, 31 (34%) did not know whether the center had a playroom and 11 (12%) said there was none--we find both people with and without children among these respondents (see table 12.6).

Not surprisingly, a larger proportion of respondents without children were unaware of the playroom's existence. However, not all those with children and who knew about it utilized it's services. The children of 9 of the 11 (82%) Hispanics, 7 or the 14 Blacks, and 2 of the 4 Whites used the playroom, while the rest did not. Reasons offered for non-utilization were that children were either too old or too young, had special problems such as a physical handicap, or that they could amuse themselves.

A majority of all respondents (79 or 88%, consisting of 24 Hispanics, 27 Blacks, and 28 Whites) thought that there should be a playroom. The rest felt that it was the parents' duty--rather than the clinic's--to watch their children; some had children who refused to leave them, and others thought the waiting time was not long enough to make a visit to the playroom worth while. Reasons for

TABLE 12.6

KNOWLEDGE ABOUT EXISTENCE OF PLAYROOM AT N.W.H.C. AMONG INT. I. RESPONDENTS[a]

	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Respondents with children								
Yes	11	61	14	82	4	80	29	73
No	-	-	1	6	1	20	2	5
DK, NR	7	39	2	12	-	-	9	22
Total	18	100	17	100	5	100	40	100
Respondents without children								
Yes	2	17	4	31	12	48	18	36
No	1	8	4	31	4	16	9	18
DK, NR	9	75	5	38	9	36	23	46
Total	12	100	13	100	25	100	50	100

[a]Q 46: "Does the center have a playroom for children?" FA followed by another FA ("if yes, do you use it?") and by a probe regarding non-use.

thinking that the center should have a playroom are shown on table 12.7. (These reasons were offered by respondents with and without children, those who did or did not utilize it.) While all three groups mentioned concern for children most often, Hispanics indicated least and Whites the greatest concern for adults (be they patients, parents, or staff) in the center. The fact that White respondents

were more likely to be elderly and without children might have something to do with this phenomenon. In general, though, the finding that only 3 (3%) of these respondents mentioned concern with staff might indicate that most did not feel that the presence of children in the clinic area interfered with staff's function, and therefore with the quality of care they offered.

TABLE 12.7

REASONS OFFERED BY INT. I. RESPONDENTS FOR THINKING A PLAYROOM AT N.W.H.C. DESIRABLE[a]

	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Concern for patients	1	4	7	22	10	27	18	18
Concern for children	22	78	14	44	15	40	51	53
Concern for parents	4	14	10	31	11	30	25	26
Concern for staff	1	4	1	3	1	3	3	3
Total[a]	28	100	32	100	37	100	97	100

[a]Probe following Q 47, which reads: "Do you think there should be a playroom for children?" Since this was an open-ended question, multiple answers were possible. Respondents who did not offer an opinion on this probe are not included. The totals, therefore, need not be the same as the ones given for each group who answered Q 47 in the affirmative. (See beginning of preceding paragraph.)

The fact that so few respondents voiced concern for staff could also mean that physicians were of primary concern when talking about perception of the quality of care--and they were out of the children's way in their offices. The questions regarding privacy appeared to lend credence to this supposition.

Privacy. When Int. I respondents were asked where they usually talked to their doctors, 28 (93%) each Hispanics and Whites and 29 (97%) Blacks named the doctor's office. Most thought the amount of privacy good or at least adequate, and a majority of those who voiced affect in their answer expressed positive feelings; the picture was not quite as clear-cut with regard to other staff members (see table 19, appendix N). Since few staff members other than physicians had private offices, it is not surprising that assessment of privacy in contact with them was lower than for physicians.

Many respondents (12 or 40% Hispanics, 10 or 33% Blacks, and 13 or 43% Whites) did not give any reasons for the affect they voiced regarding the amount of privacy they had in contacts with both physicians and other staff members. Some just said that there was "enough" privacy, especially with the door to the doctor's office closed and/or when alone with the doctor. Among the rest, one encountered such comments as "I never thought to criticize,"

I mind [the lack of privacy] only when it's personal," or "I don't like not being alone with the doctor." Only one (Black) respondent feared that the presence of community people offered a threat to one's privacy. Others complained about interruptions and noise. Some just said they were bothered, nervous, annoyed, afraid people could hear them unless they whispered (e.g. in intake).

Perception of privacy as being adequate/inadequate was not necessarily accompanied by positive/negative feelings in respondents. Table 20 (appendix N) shows, for example, that although a high degree of perceived privacy was never coupled with negative affect, it could be with indifference or failure to mention any affect. By the same token, perception of the degree of privacy did not necessarily influence overall satisfaction with center services. Thus individuals who perceived privacy to be adequate or good might be dissatisfied with the quality of care they received, while some who were satisfied regarded the degree of privacy to be inadequate (see table 21, appendix N).

To summarize--while many patients were aware of, and might have been bothered by the lack of space, periodic crowding and noise, most did not find the center uncomfortable. Although a large majority of Int. I respondents believed that the center should have a playroom, not all of those with children utilized it or were aware of its

existence. Finally, more Int. I respondents reported good or adequate privacy in their dealings with physicians than with other personnel. In general, no direct relationship was apparent between perception of the degree of privacy and affect voiced regarding it; neither was there between perceived privacy and quality of care.

Some indication of a relationship between perception of the physical environment on the one hand, and a few indices of satisfaction with the care rendered by NWHC on the other hand emerged with use of the overall environmental score compiled for Int. I respondents. These findings were, however, not definite enough to reach specific conclusions. It is possible that

1. the physical environment only influenced perception of the quality of health care to a very small extent--as was indicated by Int. II respondents. Or,

2. NWHC patients did not have very high environmental expectations and, therefore, did not verbalize too many negative feelings.

The difficulty presented by the question of expectations and their influence on perceptions and feelings will be discussed in the concluding chapter.

How did the center's physical environment appear to staff--and how were they affected by it?

Patients only spent little time at NWHC; when they came they needed help with a particular problem--and as long

as they could get this help in an environment which was not grossly inadequate they apparently did not mind too much. They might have wished for a larger, better lit and ventilated waiting room, more comfortable chairs, fewer children underfoot, etc., but spending a comparatively short while in somewhat unattractive and/or uncomfortable surroundings could be considered a small price to pay for personalized and competent care. If one might take some concepts of social psychological exchange theories (e.g. Thibaut & Kelly, 1959; Homans, 1961) and apply them to the interaction between a given environment and the individual and/or group in it (instead of social interaction between two or more people), the cost to NWHC patients was possible short-term discomfort in exchange for (hopefully) long-term relief.

Staff was in a different position. What were the rewards involved? First, many who could not do so before were now able to work and earn a reasonable salary. Second, they could do this in a setting where they were able to help other human beings and where gratitude by the recipients of this help might be an immediate reward. Third, even if a planned and concerted effort at building up their self-image-and-esteem was not always made, there was also no conscious attempt to tear it down.

What price did they pay? Most spent at least 35 hours each week in an overcrowded, poorly lit and ventilated,

uncomfortable and rather cheerless environment. Those without private offices had no place to which they could withdraw if the press of humanity which surrounded them became overpowering. They had to function while being hemmed in by distracting people, activities, and noise. They were--or imagined that they were--under constant scrutiny. If they remained in NWHC employment, it could be hypothesized that the rewards outweighed the costs;this might be particularly true for individuals who were not too certain of their employability outside the NWHC system.

Of the 70 people interviewed, only 9 did not bring up the subject of NWHC's physical environment and its effects on staff and patients (see table 12.8).

Staff usually believed that they suffered more than patients from environmental shortcomings, although there was some recognition that the effects of these shortcomings on staff's moods and tempers could affect their performance and, therefore, the treatment--both medical and personal--patients received. I am not competent to judge whether the quality of medical treatment did, in fact, suffer because of environmental factors; a few of the physicians I talked to thought it might. I could, however, observe occasional rudeness to patients and colleagues by otherwise polite and pleasant individuals when the clinic area was particularly hot, crowded, and/or noisy. Finally, quite a few staff members volunteered comments regarding the lack

TABLE 12.8

STAFF COMMENTS ABOUT NWHC'S PHYSICAL ENVIRONMENT WHICH EMERGED DURING FOCUSED INTERVIEWS (N=79)

		f	%
Need for more space		45	57
Crowded; congested; no peace and quiet at work		34	43
Noisy		5	6
Too much like other clinics; shabby; poor; depressing		6	8
Lack of ventilation and light; dirty; dingy		24	30
Not hygienic[a]		9	11
Psychological ill-effects on staff[b]		42	53
Existing environment makes staff less efficient[c]		29	37
More space: could serve more patients; offer more services		7	9
Interferes with patients' rights[d]		30	38
Interferes with quality care, treatment of patients:	Yes	16	20
	No	8	10
Existing environment symbolizes inferior care, lack of concern by establishment; keeps patients away:	Yes	15	19
	No	2	3
	Perhaps	2	3
Need separate areas for children, adults; each team		7	9
Separation of dental department from rest is bad[e]		3	4
Small size is good, intimate, less intimidating		6	8
I am not bothered by environment		2	3
Good treatment is more important than appearance		5	6
No comment about physical environment		9	11

Examples of answers:

[a]Many examining rooms and the ER do not have running water. The ER is partly used for storage of supplies. There are only two toilets.

[b]The environment is depressing; it creates friction, irritation, poor interpersonal relationships, lack of good communication; there is no room set apart for staff to take a break and relax.

[c]More space would permit; better traffic flow; less duplication of movement by personnel; better utilization of MAs; two offices/MD. MHSS now wastes time looking for an empty office for a therapy session. Lack of space interferes with physicians/everybody's work.

[d]Children, drunks, and addicts are all thrown together; possibility of infection from other patients; lack of privacy (e.g., intake, the FHC room); patients often have no place to sit; wires on the floor create a fire hazard; old people are bothered by kids.

[e]Hampers communication between dental department and rest of clinic; does not further goal of comprehensive care.

of privacy patients encountered when talking to non-medical personnel.

A few of the categories appearing on table 12.8 can be assessed from a purely factual and objective point of view.

1. It was easy to see that given more space, NWHC could accommodate more services and patients. Even if only the poor or near-poor of the catchment area were to be taken into account, there were many more potential clients than the clinic could possibly serve in the quarters it then occupied. And if patients would not have to go to another institution for special tests and treatments (especially one where they did not like staff's attitudes and behavior) the chances that they would avoid going could be diminished, and health care might, therefore, be improved.

2. Several physicians commented that if each of them had two examining rooms at their disposal, they could not only see a larger number of patients daily, but MAs could be more profitably utilized. Thus the MA could get one patient ready for examination, take temperature, weight, blood pressure, or whatever else was necessary and they were trained for in one office, while the physician was with another patient in the second office. Too much time was being wasted by physicians waiting for patients to get ready for examination and in performing tasks the MA could

do just as well. This also meant, as was mentioned in other sections of this report, that most MAs had no chance to utilize all their skills and therefore felt that their role potential was diminished.

3. It is more difficult to keep a small, overcrowded area clean than a larger, less crowded space.

4. One is hard-put to find any excuse for a health care facility without running water in all examining rooms and the ER; with only two toilets (one for men, and one for women) for all staff and patients; and an ER which also served as (a) the repository for X-ray films, (b) the EGK room, and (c) the storage room for oxygen, refrigerated medications, and some other supplies.

Most of these shortcomings had nothing to do with the size of staff or patient populations--they would indicate poor planning and indifference for basic hygienic principles if the center only served 2000 people instead of almost ten times that number.

5. Telephone and electrical extension wires were on the floors in several locations because of a very real need for more telephones, lights, and electrical appliances attendant to the increase in the number of patients and staff. This represented a fire hazard, could cause accidents, and looked untidy.

6. There simply were not enough spaces in which a patient's privacy could be honored. Intake, for example,

had to ask for financial information, and social service listened to personal problems. Yet staff in these two departments had to share offices while I was at the center. How does one feel talking about being on Welfare or having been beaten by one's husband in a setting where the chances of being overheard are great? How does this practice agree with the value system of our society which stresses privacy for the discussion of certain issues? Staff had no choice; even if they felt that patients should not be exposed to such situations--and many told me that they did--the system did not give them the opportunity to ensure patients' privacy.

The other categories on table 12.8 deal with subjective feelings, personal judgments and observation on the part of staff members; they are, therefore, harder to evaluate. The fact that, although I spent much less time at NWHC than did most staff members, I, too, frequently felt oppressed by the physical environment merely adds one more subjective feeling. Observation did, however, confirm periodic tension, friction, spite, etc. While it was true that (a) recurrent financial crises due to threatened budget cuts, (b) administrative and supervisory style, and (c) poor communication between various departments probably were partly responsible for the indications of psychological stress on the part of many staff members, these factors remained relatively constant throughout the two-year period

of the study, while manifestations of strain did not--they fluctuated during different periods of the day, and different days of the week; they even varied with the seasons somewhat.

I have no means of assessing the relative weight of the effects on staff's emotional well-being of financial, administrative, and communication factors on one hand, and of the physical environment on the other hand. All I can do here is to offer a few of my own observations and the comments of some staff members. Before I do so, however, the following should be noted. First, most of what follows does not really concern physicians or two members of the administration. Each had his or her own air-conditioned (though not necessarily sound-proof) office which--regardless of the workload--could serve as a sanctuary. Second, employees of certain departments, e.g. those working in the clinic area, the record room, and the social service department suffered more from environmental factors than did members of the business office, laboratories, or FHCs--the latter because much of their work took them outside the center.[58] Finally, some individuals simply appeared to remain unaffected by environmental factors, no matter how much these seemed to tax colleagues working right next to them. It must, of

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[58]Although it should be mentioned in this context that some outreach personnel were afraid of being assaulted while working in the field.

course, be kept in mind that superficial observations may not pick up environmental effects which can be quite subtle and may also cause a delayed reaction. All I could note regarding these people was that they did not mention being affected by environmental variables and did not exhibit any overt effects when I observed them.

Some things struck me very shortly after I started participant observation at NWHC. The first was that tempers usually seemed much better earlier in the work-day or on the rare days when the clinic was not too busy. There were fewer complaints about headaches, lack of air, and/or dirt. Second, I noticed that appointment clerks (a very close-knit group) who sat, as it were, in a cage surrounded by people, almost never socialized with other personnel. They were visible, yet separate. Third, the medical records room was a 385 square foot area which held all the patients' medical records, 4 desks, 3-5 workers at any one time, plus various other staff members who came for a specific record. In contrast to appointments, friction could frequently be observed, rumors were discussed, and almost all people I talked to complained about the center, their colleagues, and adverse effects of the room on their work. I attributed the differences between the appointment and medical records departments to personality differences in the respective line supervisors, but also to the fact that the former department was sealed off from the rest of

staff, while the latter was not.

Finally, there was continuous jockeying for space throughout the center. The supervisor in charge of intake, records, appointments, and housekeeping, for example, was forever on the prowl to secure office space for his line supervisors and more space generally for his departments; the MHSS unit pounced on any square foot of space which was vacated in that section of NWHC; everybody had their eyes on the FHC room or, since they could not displace the outreach department from this room, they tried to squeeze non-outreach personnel into it. Enlarging one's work area by a few square feet or enclosing it by some sort of partition became a status symbol and, consequently, a cause for jealousy by one's colleagues.

The comments of most people I interviewed far surpassed my observations in pointing out the dysfunctional aspects of NWHC's physical environment. The few examples which follow will give an indication of the general tenor of staff's remarks.

S.W., for example, believed that lack of space curtailed NWHC's services, symbolized inferior care to patients, and affected staff interaction among themselves and with patients:

> The space available to us does not allow us to make the program available to more people; there are too many physical limitations--we just don't have enough space. Lack of space has many ramifications in the kind of health care you are giving, even in terms of how staff

> interact with one another and with patients. I think that people tend to get very short-tempered because they are constantly piled one on top of another; you kind of forget about common courtesy, about just being pleasant to one another and to patients because you are constantly being crowded. That's one problem. I think space limitations also don't let us advertise ourselves the way we ought to to bring in people qualified with the sliding fee scale--we're almost wishing, I think, that they would stay away because there is just no place to put them once they come. On the other hand we need them very badly and I'm sure they need us. It just gets to be a tremendous problem. I also think that you get the feeling that whatever powers that be just don't care enough about us to provide us with anything better. I'm sure the patients feel that very much so. If they don't think about it actively, I'm sure they sense that maybe this is something that is considered second-class by those in power and I would think that this would tend to make them prejudge the care they can expect to get here. I think if I were to walk into a clinic that was crowded and cramped and dirty and where people were not as pleasant as I might expect them to be I might walk out, thinking that the medical care was pretty crummy too without giving it a chance to show me otherwise. I think we give adequate medical care, certainly better than you would find in other clinics, but I do think that the physical setting does influence the quality of care we can give because there is just no room to do the things we ought to be doing; I think this all is apparent to patients when they come in. Even if they don't zero right in on it and say "this is what's wrong, one, two, three, four" at least the feeling is there, and this might turn patients off.
>
> S.W. (RN)

E.R. blamed NWHC's physical set-up for poor communication between, and tension of, the clinic staff. She also believed that it made it difficult to achieve privacy for patients, and that it contributed to the malfunction of the teams:

> The physical set-up has a lot to do with the lack of communication here. For one thing, people here are working in very cramped conditions, so you get on each other's nerves, and that can cause a lack of

> communication because if you get people working very, very close together . . . then little things that a person doesn't like, they start annoying each other, so what you find people doing instead of relating, they just start resenting and not talking to each other. . . . You find people just functioning from nine to five, or whatever time and not really saying what's bothering them. In our department, we really tried to bring everything out into the open. Finally we rearranged our space, got a little more room and privacy for each of us, and now the atmosphere is much better. . . . but there is not much we can do about the lack of privacy while patients are being interviewed. It is really very unfair to the patients because there is no privacy in intake at all--there is just an illusion of privacy with the partitions we have, but it's not private at all because people can hear unless you talk very low, and staff and patients are constantly walking into the department--even by having intake looking at the files [located next to most desks] while patients are being interviewed, you make the patient very upset. I've had many complaints by patients. Also, what they [patients] do is they hold back information or get very indignant, very annoyed. . . . There is nothing we can do about the lack of privacy because there just is no space. I also think that the whole clinic set-up looks confused to patients--when they walk in, it's so crowded, so confusing, you don't know which way to turn. That little entrance up to the clinic area receptionist [see floor plan] is entrance, exit, traffic of nurses going up and down, staff--it's awful. The waiting area is very small, patients have to stand up . . . we just need more room. But there is really nothing we can do about space. . . . I also think one of the reasons why teams don't function is because of physical separation. Each team, with its internists, pediatricians, a secretary for appointments and secretarial work, two MAs and one N-P should work together in one corner, physically work together. But I don't know how we could do it in our present space.
>
> E.R. (Intake supervisor)

K.S. pointed to the fact that crowded conditions interfered with the work and personal relationships of many staff members:

> It's hectic back there [clinic area] for MAs--under the conditions they function as well as they can. It's too

> congested back there, there is no room to move, there are people sitting practically on top of them. I've seen them sitting at their desk, the patient is inside, the next patient--instead of staying in the waiting area, comes right up and sits at the MA's desk as if to pressure her to hurry up and get them in. So she really can't do her job with the person who was inside [the examining room] because when that person comes out, there is no place for her to explain things to that patient. The physical set-up really interferes with the performance of their work. It interferes with my work too. We [business office] are much too crowded too--we're constantly interfered with all day long, people come in all the time--patients and staff who really have no business in our office; there isn't enough peace and quiet to work in. I think everyone at the clinic is hindered in their work by the physical set-up because people are on top of them at all times. You can perform better if you are alone, if you are not too crowded. Take Medical Records, I don't know how they can move about in there--I would go out screaming. And the same in our department--too many people keep coming in. It [the set-up] also creates tension between people sometimes. It might even interfere with personal relationships for a while, but usually--if you work together--things get ironed out.
>
> K.S. (clerical)

Here we find an association between lack of space on the one hand, and the utilization of MAs, poor ventilation, and the possibility that NWHC's physical environment might symbolize inferior health care to its patients on the other hand:

> Space makes things difficult; more space would give MAs an opportunity to take blood pressure, etc. before the patient comes into the office. Now all the tables [MAs' desks] have charts on them, and it's not so nice for the patients to be in front of everyone [when they talk to MA]. The waiting room has no windows, it's rather depressing, it gives me claustrophobia. I don't know if it [setting] interferes with the delivery of health care, except that there is poor air circulation, more elegant surroundings would not necessarily improve the care--but the place could be a little cleaner . . . that could symbolize inferior care to patients--I don't know if they notice it, but I do. . . . It's a pity,

> I think we give better care than OPDs, but it's a little tight here.
>
> A.E. (MD)

Another comment about the difficulty to keep a crowded space clean:

> We need some space; we need more bathrooms, especially for children. We have all sorts of people coming here, clean ones and dirty ones. . . . if we could get some more space, at least the kids wouldn't have to mess around in the toilet. I've seen mothers put their children on the washbowl to urinate if they don't want to put them to use the toilet bowl. They also put them on the floor to peepee. . . . If we had more room we could keep the place cleaner. . . . A place like this, it takes a lot to keep it clean because there is a lot of people in and out and nobody cares and nobody takes care, they step in water by the fountain and they carry it all around. . . . they throw paper on the floor . . . but if they don't make mess, NWHC would not need me. So I go over and over the place and clean it up.
>
> E.D. (housekeeping)

Following are the comments of one individual who thought small size was both an asset and a handicap: Having all the outreach workers of one team in the same office helped communication and, therefore, patient care; being small kept bureaucratization to a minimum. K.A. commented, however, that she and her team's FHCs found it difficult to talk to clients in their office because of continuous disruptions--aggravated by the presence of the center's drivers in the same office. Tight space interfered with the work of some departments, with patient care, and with staff relationships:

> It's impossible for me to talk to patients in my office. The office is used by too many different people. When we're fully staffed, we have the three FHCs from my team, and there is one other FHC who belongs to another

team. . . . and now the transportation people were put into our office too--this means that there are three guys in and out constantly working with transportation, plus everybody demanding transportation, from staff to patients, who are also in and out all the time. In addition, our door is the nearest one as you come into the clinic, so people who want information also come in there. Some patients come looking for us [i.e. outreach personnel of the one team], telephone calls are constantly coming in--so we don't talk privately with anybody in that room. Fortunately most of my contacts with patients is in their homes--although in the home there may be disruptions of children and things like that, its less disrupting than talking to patients here. But if I want to talk to patients here, I go and look for an empty office or examining room, and I usually tell my people not to look for me. In general, the effect of tight space depends tremendously on how people work together--I'm very happy to be in the room with the three FHCs from my team--I work with three excellent FHCs. . . . I like being in the same room with the three people that I supervise because it's the easiest possible way to work with them--we know all of each other's patients because of that and most of the patients know more than one of us--even our Spanish-speaking patients, and my Spanish is limited, but I can manage, even they will come in and talk to me because they know that I am Mrs. D's supervisor or Mrs. S's supervisor. Also, sometimes we have spontaneous discussions about patients during the day. So the actual situation of the team being in that one room I like very much. Transportation has added an additional pressure to that room. . . . Since no personal discussions go on in this office, there is no break in confidentiality. Telephone discussion [with patients] do go on, but because transportation staff is part of the center staff I don't consider this a breach in confidentiality--in fact in some cases it's important that transportation know something about the patients they are transporting, especially in the case of patients with psychiatric problems. . . . But in general I just don't talk about extremely private things in that office at all. . . . One of the things that's special about NWHC is that we are more personal because we're smaller--I feel size is an important thing. Although we have bureaucracy, it's a lot less bureaucratic than other health care institutions--you lose your clinic card here, it's not a major crisis, you lose your clinic card at . . . [the back-up hospital] and it's all over. Here, you can usually find someone if you have a problem who will sit down

> and work it out for you, who will get things past the bureaucratic nonsense; that way you can generally solve a problem. . . . Lack of space affects personal relationships between people working here--and no wonder when you keep stepping on each other's toes. Even the mental health unit has a space problem, and there you have to have individual rooms to interview people, that often involves displacing people or being thrown out. Besides, when you have to move three times while you see a patient, this interferes. Patients also like to identify "their" doctor's office--if their doctor doesn't have an office they don't know where to find him next time they come; they like to identify not only the individual, but his physical location in connection with themselves. The physical location of the provider's office is important because, remember, the door is closed and you can't see the person behind the door, and if you sit in front of the door and you think your doctor is going to come out, and somebody else comes out, it's a little bit disappointing.
>
> K.A. (PHN)

A.A. thought the physical separation of the dental department from the rest of the clinic a handicap for communication and comprehensive care; and the lack of space in general dysfunctional for staff. Hers was one of the few calls for radical action:

> The fact that I worked upstairs before I started to work in dental makes me know much more about the whole program than the dental department people without experience upstairs. The physical separation makes for a lack of coordination of services, a lack of knowledge--that doesn't help make care comprehensive. . . . the place is crowded and somewhat uncomfortable, plus the fact that there is only one waiting room upstairs for walk-ins and appointments and whoever comes as a walk-in often doesn't know that appointments are seen first, so they get mad because a person who came after them is taken first. And sometimes when a patient goes to the bathroom he doesn't hear his name called, so he misses his turn and must wait another couple of hours, because he doesn't know who he got to talk to to tell that he's going to the bathroom. . . . I think part of all this is the physical problem, the lack of space. I am a radical. The way I feel is that we should have a sit-in: Look, we need this space, the City Health Department has got a lot of wasted space.

> We got the people, we got the power--we could take the building over and who is going to make us give it back? The city doesn't want a scandal, I'm sure; our congressman doesn't want to lose our votes. I won't say that a sit-in would automatically get us the space but it would be a great help in cutting a lot of red tape. By the time you get it through their heads that we cannot give these people proper care because of the lack of space, we have fire hazards; a lot of time is wasted. The lack of space is tremendous, we have much too many people per square feet. I definitely feel that the lack of space interferes with giving quality health care because, for one thing, if we had more space the human resources we have could be used better . . . plus the fact that the sense of being so crowded creates discomfort among the people that are serving the patients, the providers--it's just a terrible thing.
>
> A.A. (DA)

Following is a clear distinction between the effects of the physical environment on patients and staff--the latter being assumed to suffer more than patients who were used to worse conditions in hospital ERs. Staff morale and functions, on the other hand, were thought to suffer because of environmental limitations.

> At times the physical set-up has a depressing effect, especially for the people working here. Sometimes the clinic area is so crowded, it's unbearable. Our patients are used to the worst conditions--they are used to ERs--so this to them is not as bad, it's even more pleasant. But more space would be a blessing for staff; you'd have room to move around without bumping into each other and into things; you'd have air to breathe. Confined quarters impede the quality of work; for example, MAs are constantly interrupted when they want to give information to patients; in the mental health unit they don't have room to interview people. We waste time--it's like a make-shift atmosphere; it's not conducive to feeling professional, it's not conducive to really presenting an image of being together, that you know what you're doing, that everything is organized, that there is structure. More space would raise morale, of doctors too--it's horrible for physicians to have to trade offices with specialists. Space is a problem.
>
> O.B. (clerical)

Once again, the belief that staff suffered more than patients:

> My office is in the cashier's office, so if I have to talk to some of my workers I must find some other office, so that interferes with my work. We have a lot of people here and the place is too small--you can find four or five people working in one small office; the place is overcrowded--it's bad for workers, I don't know about patients, I don't think they mind too much, people working here mind more. It makes for bad blood between people because it's too tight, you're on top of each other--if you want to write a letter and the people speak next to you you get mad at them because you can become confused. The clinic area is bad for people working there; there are no windows, no air; people come in sick and you don't know which one has the germ and the employees have to take this air. Doctor's offices have airconditioners, but not the clinic--that's not fair.
>
> M.D. (housekeeping supervisor)

Although C.B. recognized the difficulties created for both patients and staff by limited space, quite a lot of blame is also placed on poor utilization of what little space was available:

> The place is too small. The waiting room is overcrowded. But if you try hard enough, you can stretch things a little. I know we lack space, but we could utilize the space we have better. Or look at the ER--if I were . . . [the back-up hospital] I would close this whole clinic up. You can have a patient in the ER bleeding to death, undressed, and I walk right in to look for an X-ray film--the doctor gets disturbed, that's a bad situation. It does interfere with the work of the doctor or nurse there with a patient, or the EKG work, that I have to come in for films, that there is so much traffic--how can people relax if the door opens constantly? Maybe these things are minor, but you'd be surprised how much damage they do to the patient, to the doctor. Maybe the word "minor" is the wrong one--anyway, it's bad. It's also bad to have all these people working on top of each other--really on top of each other, both workers and patients. You can have one MA explaining to a patient about the medication, and me right next to her translating for

> a doctor--so you have two patients trying to understand what's said to them--that's very irritating. I'm getting irritated because I'm overhearing what she's saying and I'm not concentrating while I'm trying to give words to the patient. And then you have some of the kids floating all over the clinic area because sometimes the playroom is not open or too full. And you have carriages all over the clinic area . . . you have a patient coming in with a kid going into convulsions and everything is in the middle of the way. You got people in the hallways talking all at the same time. All this is friction. . . . I know of patients that can't hear what's said to them. You sit back there [the clinic area] a couple of months, you get to know about the friction and the problems and all this. So everybody gets tense, it gets to your nerves --one FHC comes in and says "look, this patient has been here all day, what's going on?" You say "look, I don't want to hear it from you today, I got a headache from this morning with all the doctors and all the patients, and that's it"--and you get this friction from each one of them talking to each other, and you get this from overcrowdedness, from the lack of space. We need more space, more privacy--like the wall between the ER and the office of one doctor is just the metal shelf where I keep my X-ray films. I know he can hear me at the shelf, and if I would listen, I could probably hear him with his patient. . . . Sometimes I hear a doctor asking a patient right out in the hall what's wrong--you don't do that, the patient wants privacy to tell the doctor his trouble.
>
> C.B. (paraprofessional)

Space limitations, according to D.O., affected patient care, staff efficiency and interpersonal relationships:

> We are all frustrated by space limitations. There are demands from patients which can't be met because of space limitations--the irritations are myriad. I spend most of my time in the office, away from the flow of traffic, but when I go out on the floor, let's say to the record room, three people will accost me with different questions. All patients are thrown together, infants and drunks and addicts--but there is nothing you can do because of physical limitations. It interferes with your work considerably--in private practice you would have three examining rooms, a patient is prepared in one, you are examining in

> another, consulting in a third--here you have to move all your equipment from office to office, instead of just walking to the next one where everything is ready; we waste time taking temperatures, waiting while patients dress and undress. The frustrations sometimes affect interpersonal relationships. No man or woman is an island--so if you're taking it from one source, you have to give it to another. For the most part people are able to control themselves--the last thing you would want is to take it out on a patient, they'd be the least understanding, and they are the people you are here to serve. Some of the irritations do interfere with patient care; if, for example, I get five phone calls while I'm examining one patient, that affects continuity.
>
> D.O. (MD)

Lack of space prevented NWHC from offering a complete range of services, created interpersonal difficulties among staff, and inconvenienced patients:

> We don't have enough space, can't have some of the specialties that we promised the people so that they wouldn't have to go to different hospital clinics, so that they could get treated here, in their own community place, the way they haven't been treated before. It also affects the temper of the people working here. It's so small, and with the patient load we have, the number of people we have to take care of each day, the animosity and hatred build up because of the closeness; when there is room, you can withdraw from time to time. Now you feel claustrophobia, tension is more likely to build. Lack of space also causes delay in service, and we have to pack too many people in now.
>
> J.F. (FHC)

There was no room for staff members to relax, socialize--or cry!

> I have no place I can rest or relax, no place where we can sit together and eat. The coffee room is used by patients--we have no place. I have no place to cry even when a patient insulted me. With such a small place there are more rumors; everybody is on top of each other. There is no privacy to talk to anybody. We get on each other's nerves at times--though I don't think there is lasting ill-will. I don't think it makes for better communication than bigger quarters

> would. Besides, if we get on each other's nerves it might affect the treatment of patients. Also, we are watched by the patients all the time, they know when you're upset, crying, and so forth--that's not always good for our relationships with them, it makes us feel edgy.
>
> B.P. (MA)

N.H. thought that an organization functions better if provisions for periodic withdrawal by staff to a designated area are institutionalized. She also commented on the impressions created by crowding and disorder:

> I think the crowded waiting area might give a bad impression to patients--I would find it rather objectionable myself. Some areas look messy--that should not be tolerated. Staff doesn't have any place to relax in, therefore they will sneak off and hide someplace and then when you need them you can't find them--so I think that is really one of the priorities: staff must be able to take a few minutes off during the day, they must be given a room to do it in--then, if you need somebody you would know where to look.
>
> H.N. (RN)

Finally, lack of space prevented some patients from discussing problems, created friction among staff and could, therefore, have affected patient care:

> Space has for years been our most critical problem; in all places of the clinic--our department [social service], the clinic area. Even that we only have one bathroom, that's very bad. I think the tightness of space makes people so close to each other that there is too much noise, or sometimes people don't want to tell us their problems--some patients will talk about their problems openly with everybody, they do not care --but others do, they are nervous, they do not like it. And I know that not having room creates friction between staff. I have the feeling that most of us are good, but once we're so close together, friction is inevitable--they have to be; and that is what happens: Sometimes we are practically one on top of the other. That's alright for one day, but if you have it day after day, week after week, month after month, you know--unfortunately, some days you don't feel well, or you have a problem, and just the smallest thing can make

> you explode. It's not the right thing, but unfortunately it happens. And being crowded makes it worse. And, in a way, it must affect patient care--maybe we get a little short-tempered. Usually I get along fine with patients; I rarely have problems--usually I can persuade them to accept things they would not otherwise accept--but sometimes, because we are so close, it creates problems. Our department's staff is really more or less nice, but even so we get more upset with each other because of that closeness--but it doesn't last long. . . . One of our greatest problems is that all three of us [two social service workers and the MHSS secretary] sit in the same room--it's bad for us sometimes, and it's bad for the patient. If there is an empty office anywhere in this section, we try to go there when we want privacy for the patient.
>
> A.D. (paraprofessional)

The grammar might not always be correct or the language too elegant, but what emerged from these interviews--and was confirmed by most of the others and my observations --was that (a) the physical environment does affect attitudes, behaviors, moods, and interpersonal relationships if one spends enough time in it; it does so even more if one is engaged in somewhat taxing work. (b) Lack of space, poorly designed and/or utilized space can create effects which might interfere with the purpose and goals of the system in question, both because of purely physical limitations and because the attendant stress is dysfunctional for many individuals. If the given system happens to be a health care facility the ill-effects might influence quality of care adversely.

Significance of NWHC's location

There can be little doubt that the location of NWHC contributed to its utilization. It was located in the

heart of the catchment area, and therefore easily accessible to most residents. Being next door to the public library and a playground, opposite the police and fire stations, with several schools and churches within a radius of a few blocks, its block should be familiar territory to many people in the area for one reason or another. Whether the center itself served as a symbol for the neighborhood or community was much more difficult to determine.

Council members believed it did--but they might be considered a biased group since they were supposed to represent the community and help administer the center. Staff was more ambivalent regarding this question. Most believed that the center was a "community-or-neighborhood facility" because (a) it existed to serve the people in the area; (b) neighborhood people were employed in it, and (c) it operated with community participation. Most believed that patients regarded the center as "their" clinic. On the other hand, hardly anybody among either staff or patients talked about NWHC as a symbol and/or rallying point for the community.

Transcripts of the interviews with the all-Hispanic group of patients (Int. II) revealed that every one of these 25 individuals used the terms community or neighborhood in connection with NWHC at one point or another. Only a few examples of such comments can be offered here: "The clinic is there for the people in the community"; "it is a

place where people are from your area and speak your language which makes it easier to communicate and that instills confidence"; "it is where people who live in the area meet--it's a communal center"; "it's location is good because it is near everyone"; "the common needs of the people in the community bring people together"; "it gives more life to the community."

Following are a few indicators that at least some of Int. I respondents, too, thought of NWHC as a community or neighborhood facility: In response to open-ended questions, 49 (54%) of the 90 Int. I respondents (20 Hispanics, 15 Blacks, 14 Whites) mentioned residence in the area as a specific eligibility requirement for center service, all but 8 of these agreed with this requirement; 19 (21%: 14 Hispanics, 4 Blacks, 1 White) said that neighborhood health centers were created to offer decentralized facilities to communities; 9 (10%: 1 Hispanic and 4 each Blacks and Whites) knew that the center was operated with community participation; 2 (Black) respondents said that what they liked most about NWHC was that it was a community facility.

Interview I respondents who were dissatisfied with center and/or back-up hospital services were more likely to blame staff at the hospital, and less likely to do so where the center was concerned (see table 22, appendix N). They were also somewhat less apt to believe that it was in their power to change conditions at the back-up hospital (see table 12.9).

TABLE 12.9

PERCEIVED ABILITY TO CHANGE CONDITIONS AT N.W.H.C./ BACK-UP HOSPITAL (INT. I)[a]

Perception of Power	Facility		
	N.W.H.C.	Back-up Hospital	Total
Yes[b]	5	3	8
No[c]	4	11	15
DK, NR	6	3	9
Total	15	17	32

$\chi^2 = 4.67$; df=2; $.05<p<.10$

Computation without the "DK, NR" category resulted in:

$\chi^2 = 2.83$; df=1; $.05<p<.10$

[a]Qs. 77b and 78b--see table 22, appendix N for wording of questions.

[b]Includes categories 4, 5, and 6 in part 2 of table 22.

[c]Includes categories 1, 2 and 3 in part 2 of table 22.

Because NWHC was a decentralized health care facility and was operated with community participation, I had thought it possible that some of its users would perceive this place as a symbol of (a) an innovation in medical care and (b) involvement of the community in an issue of interest to it. The Int. II comments cited before indicate that NWHC was considered a community facility by these people--though probably not by others living in the area. However, among all Int. I and Int. II respondents, only four of the latter group referred directly to the symbolic value of the building. Thus, two individuals each commented that

"the building itself represents social help," and "the building represents a refuge for the poor."

Since the center occupied space in a City Health Department building this should, perhaps, have been anticipated. Its location within this building might also have been one reason why so many people in the catchment area did not know of the center's existence, a fact brought up in almost all staff interviews, and confirmed by my knowledge of the area. Despite a large sign at the gate to the compound which contains the library and HD building, many people who pass might not differentiate between NWHC and HD, and reject the former because they think of it as part of the latter.

In view of the overall satisfaction with NWHC services, and the fact that the clinic offered much more comprehensive care than HD or other health care facilities, it is quite possible that if it occupied a building of its own--with room for more medical and social services, and meeting rooms for community groups--this building could indeed come to serve as a symbol for the community which it serves. This might be particularly true for the Hispanic segment of the population, since NWHC was one of the few institutions in the city where they need encounter no language difficulties. In this context it was interesting to note that (a) more Int. I Hispanic respondents could identify a photograph of the building in which NWHC was

housed than any other of eleven photographs of neighborhood sites, and (b) more Hispanics identified this photograph than did either Blacks or Whites. The use of photographs in this study will be referred to again in the next chapter.

But if the site of NWHC failed to symbolize much to the people who knew about it, there can be little doubt about the effect of its location on utilization of center services. Int. III offered a strong indication that respondents who lived closer to the center tended to visit it more often (see figure 5). Regardless of the number of visits reported for the year preceding Int. III, more individuals who lived within five blocks of NWHC tended to use center services than did those who lived farther away. The pattern held when data were cross-tabulated by age and being accompanied by a child (or children), in addition to distance from one's home to the center and the number of yearly visits to this facility (see table 23, appendix N). The relationship did not change when respondents were divided into "intense users" (25 or more yearly visits), "modal users" (2-24 yearly visits), and "non-intense users" (0-1 yearly visits)--see table 12.10.

Summary

Neighborhood health centers are more autonomous, easily accessible, and less impersonal than hospital OPDs, thus some of the objectives in conceiving this particular

TABLE 12.10

RELATIONSHIP BETWEEN DISTANCE OF RESPONDENTS' HOMES TO N.W.H.C. AND INTENSITY OF USE OF CENTER SERVICES (INT.III)

Distance between home and NWHC in city blocks	Intensity of use							
	Extreme= over 25 yearly visits		Modal= 2 - 24 yearly visits		None= 0 - 1 yearly visits		Total	
	f	%	f	%	f	%	f	%
1 - 5	46	69	216	64	29	55	291	64
6 - 10	20	30	105	31	18	34	143	31
11 - 18	1	1	17	5	6	11	24	5
Total	67	100	338	100	53	100	458	100

$\chi^2 = 6.87$; df = 4; $.10<p<.20$

form of health care facility have been realized. Relative autonomy has permitted some innovations at NWHC, accessibility was recognized by many patients as a great boon. But, as far as this particular center was concerned, lack of impersonality for patients was bought at quite a high price for staff because of scarcity of space.

What was the physical environment of NWHC actually like, and how did one experience it? The clinic was, by any standards, too small for the number of people it had to accommodate daily. The lay-out was, in many respects, dysfunctional for the work which had to be carried out there. It was often crowded, not too clean, and gave an impression of continued movement and disquiet. Its

ventilation and lighting were poor, and it was in need of redecorating. Most staff members had to work in cramped quarters; there was no place for them to relax in comparative privacy.

Many patients recognized that NWHC was too small, crowded, and somewhat noisy, yet this did not keep them from thinking it comfortable enough, and did not affect their perception of the quality of care they received adversely. Only very tenuous evidence emerged that inferior environment might symbolize inferior care. There is, however, one additional, though possibly indirect interaction between environment on the one hand, and patient perception of this environment and resulting patient behavior which affects care, on the other hand: As one of the nurses pointed out, patients might be more likely to come to the center for other than episodic care if the waiting room were less crowded, if NWHC generally presented a more pleasant atmosphere than was the case during the term of this study. This would make it easier to administer preventive care, give more attention to the chronically ill, and thereby come closer to the attainment of comprehensive care.

A majority of the patients believed that the center should have a playroom; not all who had children knew of its existence, nor did all who knew about it utilize it--children were often underfoot throughout the clinic.

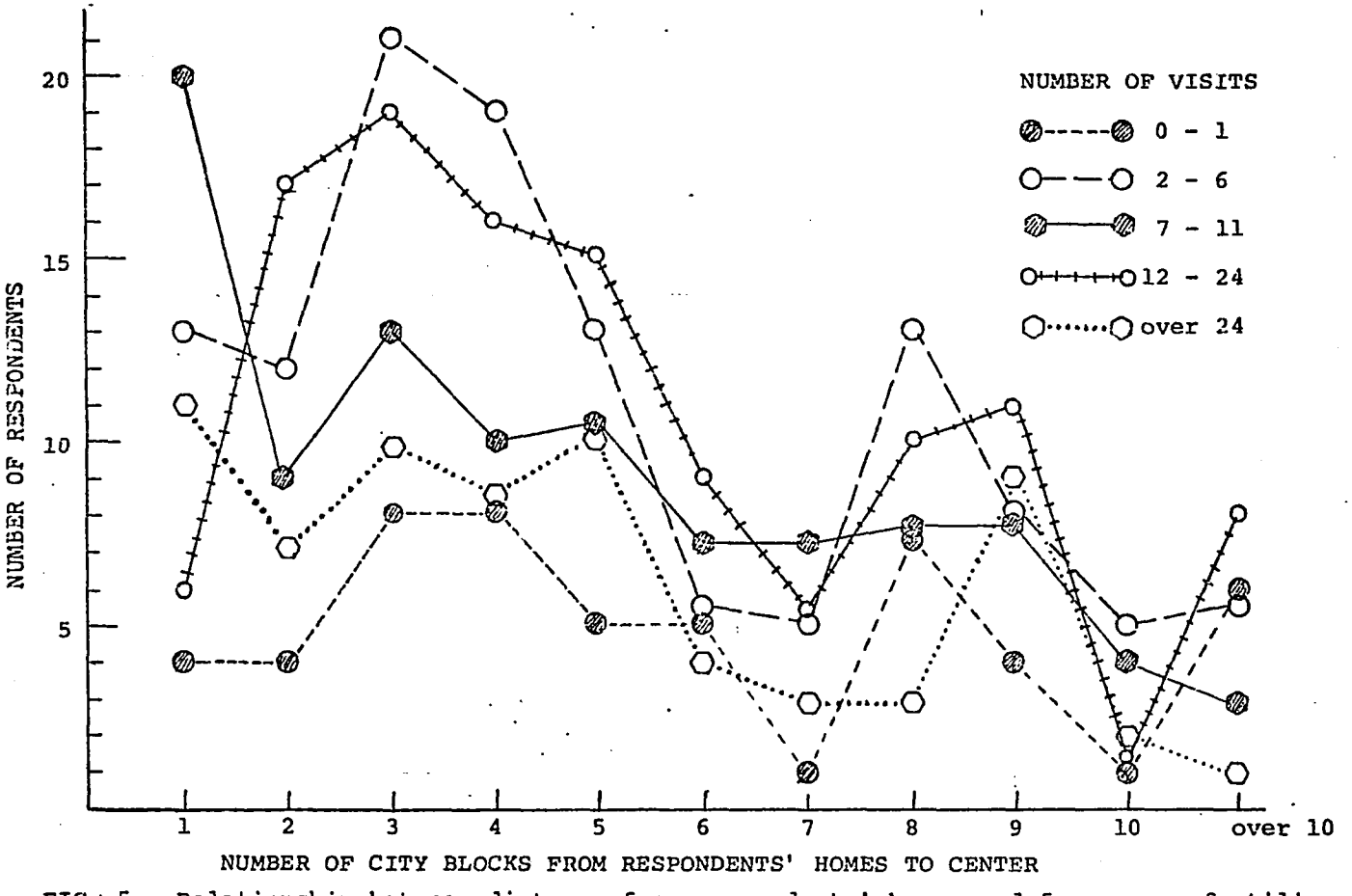

FIG. 5. Relationship between distance from respondents' homes and frequency of utilization of NWHC during year preceding Int. III. (N ≠ 485 because not all the respondents gave their addresses.)

Concern for children, parents, and patients were usually given as the reasons for the need of a playroom; concern for staff ran a very poor fourth. The question arises whether this was because respondents were concerned mainly that physicians should not be disturbed?

The degree of privacy in encounters with physicians was usually rated much higher than that of encounters with other center staff--as physicians were among the few lucky staff members with private offices (i.e. their examining rooms), this was not surprising. Among those respondents who voiced any feeling about perceived privacy, a consistently larger amount of positive affect was voiced regarding privacy with physicians compared to other staff. It should be noted, however, that (a) not all respondents seemed to feel a need for privacy to an equal extent, and (b) perception of privacy or the lack thereof did not necessarily influence satisfaction with center services.

In general, it appeared that the physical environment influenced perception of the quality of care in any direct fashion only to a small extent among patients.

In contrast to patients, staff was almost unanimous in complaining about the physical environment, and quite a few believed that it interfered with rendering the best possible care. Many also believed that it affected interpersonal relationships adversely, though most of these individuals did not think that this, in turn, affected

patient care. Finally, while most voiced the need for more space, several were, at the same time, anxious not to enlarge the center to an extent where size would prohibit the development of a sense of intimacy and belonging in patients, the evolvement of more personal relationships between patients and staff, or keep patients from feeling that they know their way about the whole clinic.

Since staff spent much more time at the center than did patients, and were engaged in sometimes quite taxing activities, it is not surprising that they should have felt the effects of the environment more. Interviews with staff did not, however, support the supposition that the physical environment helped structure staff's role perception. It appeared that trust in and the behavior of administration, quality of supervision, relationships between various staff categories, and influence of the peer group were much more important variables in this respect. But it was true that (a) lower level staff suffered more from the adverse physical setting--and they were aware of this, and (b) manipulative behavior to secure more and better space took place quite frequently.

While budgetary insecurity, administrative style, and lack of communication had to be taken into account when trying to assess the ambience of NWHC, it quickly became apparent that the plant of the center added immeasurably to its problems.

From a purely objective point of view, larger and better designed quarters would permit (a) serving more patients, (b) offering more services to patients and, thereby, coming closer to the goal of comprehensive care, (c) better utilization of staff, (d) maintenance of a cleaner, more hygienic, attractive, functional, and cheerful facility, and (e) more privacy for patients and staff.

Interestingly enough, more staff members believed that patients suffered from the lack of privacy than was apparent in patient interviews. Was this because patients had given up expecting privacy? Did NWHC compare favorably with other institutions? The concept of privacy is, after all, a relative one and it is likely that staff members projected how they would feel in similar situations onto the patients. Perhaps it was simply that some lack of privacy, some discomfort were considered small prices to pay for personalized and satisfactory care. The price staff paid, as far as environmental variables were concerned, was higher--but apparently their rewards outweighed the costs too.

Finally, it should be noted that while most staff members, but fewer patients, considered NWHC as a community facility, the physical plant itself did not appear to have any positive symbolic value as a monument to the community or innovative medical care for the individuals involved.

A likely reason was that NWHC occupied part of a Department of Health building. The situation might change were the center to move into a building of its own. The lack of space alone (apart from budgetary constraints) made it impossible to offer the community meeting rooms, programs for the elderly, teen-agers, or children under center aegis, and leadership in community action--all of which could have gone far toward making NWHC truly a community facility, and the place it occupied a symbol for both the community and health care systems.

CHAPTER XIII

HOW PEOPLE INVOLVED WITH NWHC FELT ABOUT NEIGHBORHOOD, COMMUNITY, AND COMMUNITY PARTICIPATION

The issues of neighborhood, community, and community participation are important in the context of this study because NWHC, a decentralized neighborhood health care facility, was mandated to operate with community participation. In the introductory section of this report the question was posed regarding the meaning of these concepts; who participates in the operation of what; how significant were these particular issues to people involved with NWHC; how much commitment was there to them? Data gathered over the two-year period of the study will be used to provide tentative answers to these questions.

Because these concepts are so closely interrelated they are discussed in one chapter; it will not usually be possible to present data in completely sequential order. Thus in the course of my talks with center staff and members of the North-West Neighborhood Health Council (N-W council) comments regarding community participation might, at times, lead to an evaluation of the community council then in office, and proceed from there with

opinions regarding the "real" functions of such a group. To give one other example, the subject of community participation could start individuals talking about priorities in peoples' lives--especially if they are poor; they might then speak about ethnic characteristics which, in turn, could trigger thoughts regarding community action. I shall, therefore, let my respondents lead me--as I did in the focused interviews with them, rather than subordinate their comments to fit a given frame of presentation. Where data from patient interviews are available, they will be interjected as needed.

Community participation

Not surprisingly, all council members and the two council employees who were interviewed voiced strong support for the idea of community participation. The reason given was (with some slight variations) that community people know what the community needs and ought to be capable of seeing to it that it gets what it needs. There were some allusions to the fact that it was up to the community representatives to see that as many jobs as possible were filled by community people, and that only those people would be hired who demonstrated acceptable attitudes toward minorities and the poor, toward community control of service agencies (or at least participation in the operation of such agencies), and the new role concepts involved in comprehensive team care. The functions of the

council were enumerated as follows: (a) to hire, as noted above; (b) to serve as advocate for patients and community people in center employment; (c) to function as a board of directors--and as such set policy and supervise the daily operation of the center; and (d) to be the grantee agency which receives and administers government funds. However, about one third of this group of twelve expressed some doubt that the council, as it was then constituted, was equipped to handle that last function at that time.

Opinions regarding community participation were less unanimous among those staff members who commented on this subject (65 out of 79 respondents; i.e. 82%; see table 13.1). For brevity's sake, staff is referred to as either "professional" (prof.) or "non-professional" (non-prof.). The former category includes administration, physicians, dentists, social workers, nurses, laboratory and X-ray technicians. This might appear to be a somewhat arbitrary categorization since a bookkeeper for example can, of course, have as much professional standing as a technician and might have had more extensive formal education. In dividing staff in this manner I was guided by the fact that individuals in the so-called non-professional category had to live within the center's catchment area when hired for these positions, while this was not true for those I call professionals. (However, some non-professionals had, by the time they were interviewed, moved out of the area, while

TABLE 13.1

N.W.H.C. STAFF OPINIONS REGARDING COMMUNITY PARTICIPATION IN HEALTH CARE[a]

	Description of Staff Categories					
	Non-Professional		Professional		Total	
Opinions	f	%	f	%	f	%
In favor of community participation						
Yes	22	56	18	69	40	62
No	3	8	1	4	4	6
DK, Ambivalent	14	36	7	27	21	32
Total	39	100	26	100	65	100

$\chi^2 = 1.11$; df=1 ("No" and"DK, Ambivalent" categories were combined to achieve an acceptable minimum expected frequency); $.20<p<.30$

[a]Coded from transcripts of focused interviews with staff.

Some professionals lived in it.)

Although the differences shown in table 13.1 are not significant a somewhat higher percentage of professionals were wholly in favor of community participation (and in one case even absolute control); more non-professionals were either against it, undecided, or ambivalent. How far should this participation extend--and why?

> I don't have a very good attitude about the council. I just can't see how they could think of becoming grantee over NWHC--I just don't see how they can sit back there

> on . . . street and pass all the rules and bylaws, and be grantee over moneys and budgets and all that. I don't like their attitudes; I don't like their behavior --like when we were in . . . [the project director's] office during the sit-in the woman who is chairlady just walked in, uninvited. . . . They used to have meetings down there, they were always confused, people shouting at each other. It might help if staff were represented on the council. Right now the general attitude among staff is that they don't really care for the council and they don't want the council to have anything to say--not the administration, but staff feels this way. I don't really see where it's actually necessary to have a council! I think this center could function very well between HEW and . . . [the back-up hospital]. I don't know what the council does that we can't do, because we live in the area and our families are patients here--so we are consumers too. The council is superfluous.
>
> L.A. (non-prof.)

The feeling that (a) staff knew what the community needed, (b) administration was capable of running the center, and (c) the back-up hospital had the expertise to administer government funds--so that a community council was really not needed--generally formed the bases for the comments of all those who expressed opposition to community participation. But not everybody was as sanguine as L.A. regarding staff's ability to supply the necessary amount of information about the health care needs of the community.

> Input is very important. The community can sometimes pick up problems we've been ignoring. I don't, however, believe in community control.
>
> D.H. (prof.)

The key word in most comments was "input." The main thought--that the consumers of a service facility often know better what their needs are than do the providers. This was true for individuals who were totally in favor of

community participation as well as for those who felt a certain ambivalence about it.

> I think the community should have a say in the way clinics are run up to a certain extent, and not up to a certain extent. Because if you let the community run a program, forget it. The Haitians want to do one thing, the Puerto Ricans another, the Blacks want to do something different, the Whites want to do something different. So it's a waste. You can ask their opinion, but you should not let them run the place--and some of the council members try to run it. . . . And if the place is open to everybody in the catchment area [the interview took place after the sliding fee scale was instituted], then everybody should be represented on the council, not only the poor people. If everybody gets involved, high income, middle income, low income --if everybody would really get involved, this in some ways would be a better place because you have people with better education, better contacts, you have people who know what the problems are--that is the poor people, and maybe this way they could be helped better than they are now. This business that the council is either all Black, all Puerto Rican, all Haitian, all poor--that's nonsense.
>
> V.N. (non-prof.)

The council was, of course, at no time composed of members of only one specific ethnic group. But V.N. raised three important issues which were also introduced by many other individuals: one had to do with ethnicity, the second with expertise, and the third with the question of just how characteristic community councils really were of the community they supposedly represented.

Ethnicity

Strangely enough, there were many more allusions to the questions of ethnicity and possible ethnic conflict in connection with community participation and the N-W council than I encountered in association with the question of

staff's ethnicity. This difference was particularly striking in interviews with non-professionals. My impression is that, when thinking about employment opportunities at the center, non-professionals identified themselves first with the economically underprivileged segment of the population, and only secondly with given ethnic groups. Giving work to the poor was, therefore, of primary importance; which ethnic groups these poor belonged to was of some concern, but only secondarily so. Being an unpaid member of the community council, however, meant that one occupied a position of possible prestige, influence in the community, and power. This power would be greatly enhanced if the council were to become the grantee for the center. It is possible that individuals wanted prestige, influence, and power to reside in their own ethnic group--not only because of the glory reflected on the whole group and the advantages one expects to accrue to this group, but also because of mistrust of all other groups. There appears to be a tacit belief that each ethnic group looks out for its own members at the expense of all others. This is perhaps inevitable in a heterogeneous society.

Expertise

The question of expertise transcended the problem of ethnicity. Many individuals, both professionals and non-professionals expressed doubt about the council's ability to be in charge of as intricate a system as NWHC.

It should be remembered that at the time of this study the N-W council consisted primarily of center patients which, by definition, then meant low-income people many of whom were also undereducated.

A.K., doubting council members' ability to plan for the health care of the community, saw health education as a worthwhile function for them.

> I'm not so sure about community participation. I am of two minds: it sounds like a very good idea that people should have some say about the type of health care they are getting, yet on the other hand I wonder if people know enough to participate in the planning of health care. I've attended some of the council meetings and wasn't impressed. Their function should be to try and get services that they see the community needs . . . put on a health fair--that's good publicity, good health education, it gets people interested in the center. . . . I suspect right now the council doesn't do too much about health education. They can put on demonstrations protesting bad housing conditions, budget cuts, etc. I don't object to their being somewhat militant; it might be a good idea to have some people carry placards in front of city hall. But I don't think they have the technical knowledge to plan everything here [at NWHC].
>
> A.K. (prof.)

G.H. appeared to agree, and stressed the difference between participation and control.

> I'm not entirely for community participation because most people do not have the right education and background to lead a council. Participation is good, but not to a great extent. We <u>should</u> communicate. Participation is good when it spreads the word of what the center is doing--but a community person might not have the resources to lead people in the most meaningful way and that can be destructive. So I believe in community participation but not in community control.
>
> G.H. (prof.)

While J.F. apparently wanted to believe that the community was more ready now to manage its own affairs than it had been before, he raised the issues of disharmony among the poor--especially if they are of different ethnic backgrounds, and the risk to employees if fiscal matters were to be mismanaged.

> I did not particularly like community participation at first because the people did not know enough to run a program like this. But by now they know more, they've gathered more strength, so I hope it will work better now. With more knowledge, attitudes change--you learn what is and is not possible. . . . The council has had a lot of infighting. People who live in poverty, who really have nothing to call their own, if they can't get their way, they will fight. Also, they have members of little community cliques sitting on the council . . . they haven't learned to sit down and work things out; they're just starting to learn how to live with each other. But there is still very little harmony. And it's always a racial issue when power is involved. Every group wants to be in power. . . . I am a little skeptical about the council getting the grant. They must be given the opportunity to show what they can do, but I like my salary like everyone else and I wouldn't want to see them misuse the money to an extent that they can't meet the payroll.
>
> J.F. (non-prof.)

J.F. then went on to talk about the leader of the community group which had for many years opposed all center councils as an example of the erosive force of power struggles within the community

> then you get a guy like T.V. who makes nothing but trouble, who only wants power. I can't stand that guy . . . he's more of an instigator than a helper, he is always keying people up to be against one another. He is always threatening the peace and harmony of the place. . . . He doesn't even live in the area, but he's always making trouble for all sorts of programs in the area. I've heard a lot of rumors that he is a professional instigator. He comes in and destroys, he

> never builds. He would rather destroy than see people get good health care which this center does provide. We give as good care as we possibly can.

T.V. was frequently mentioned by respondents. Many felt that he must be paid by the federal government to destroy poverty programs because (a) why else would he get involved in the question of community participation, control, true representation, etc. (to the extent of going to court to challenge election results) in a community in which he did not live; (b) where did the money for court cases come from; and (c) how did he manage to wreck all programs over which he gained control? "He just destroys what he touches and walks away" was an often repeated comment.

I had, of course, no means to verify either of these allegations. The only reason why this issue is mentioned is because it illuminates some of the problems attendant upon the question of community participation. It also serves as an illustration of a basic mistrust in the federal government, an unwillingness to believe that it really is interested in the poor and/or health care, or that government feels a commitment to honor the obligations assumed by previous administrations. This, in turn, contributed to the feeling of insecurity alluded to in previous chapters. I got the impression that this insecurity was magnified for some people, at least, by the prospect of the assumption of granteeship on part of the

council.

> Many employees feel that the council shouldn't be made a grantee, because it takes a lot of know-how to handle billions of bucks and deal with a program as complex as this is--even though it might not look so complex--and the feeling is that the council does not have this know-how. If we have problems now, when we have the help of . . . [the back-up hospital] and all the big brains they're supposed to have there, and with all the big brains that we're supposed to have working here helping the council, what's supposed to happen with these people [council members] who do not really have that much experience, and some of them who really have trouble handling their budget at home? How are they going to handle a budget of 2.5 million? Are we going to come to a pay-less payday? I don't say that I feel this will happen if the council becomes grantee, but I'm asking the question. Right now they should be more interested in how to handle the employees and about patient care directly. You don't hear about that so much. You hear about administration going here and going there about space, but we never hear what the council's been doing to get more space.
>
> A.A. (non-prof.)

Much as they disliked the back-up hospital, many employees felt that the financial affairs of the center were in better hands there than they would be with the council.

Not so E.M. (prof.):

> I don't think that the role of the consumer or of neighborhood representatives has at all been worked out. Secondly, the question of funding remains unresolved, and that, I think, is the Achilles heel with most community control movements. As long as funding is dispensed as it is now, they are always at the mercy of the funding agency, which is usually the government. . . . We need complete consumer control . . . practically speaking I don't think there is any in-between. Or let me put it differently: that I think all in-betweens are necessarily vague or ill-defined. That has been the history of the struggle for community control in education. And when you have an ill-defined situation, you have an untenable situation in which both parties are really encouraged to be at each other's necks. "Maximal feasible participation" is fuzzy, and its fuzziness--I don't know whether this was intentional or not--has resulted in a lot of unnecessary skirmishes.

But even this individual admitted that the council would need some guidance by professionals in certain areas, for example in hiring physicians--though only guidance in strictly technical matters. Many staff members, especially non-professionals, disagreed with E.M. (see table 13.2).

TABLE 13.2

STAFF OPINIONS CONCERNING THE COUNCIL'S FUNCTION IN HIRING AND FIRING CENTER PERSONNEL[a]

	Non-Professionals		Professionals		Total	
Opinions	f	%	f	%	f	%
Should the council have the power to hire and fire?						
Yes	3	10	1	5	4	8
No	13	43	2	10	15	30
Only on cooperation with center supervisors	11	37	14	70	25	50
Only the director	1	3	3	15	4	8
DK	2	7	-	-	2	4
Total	30	100	20	100	50	100

χ^2= 7.2, df=1 (the following categories were combined to achieve an acceptable minimum expected frequency; "yes," "only in cooperation with center supervisors," and "only the director;" the "DK" category was left out), .001<p<.01.

[a]This information emerged in the course of focused interviews with staff.

The reasons offered by those who would not want to grant the council hiring and firing power had almost always to do with council members' alleged lack of expertise. The usual comments were "they just don't know enough about anything," "they don't know what goes on here," "they don't know what is involved in working in a place like this," "they have no idea what the various jobs entail," etc.

A few (though very few) council members thought they could use some middle class expertise. At the same time they expressed fear that any board composed of both lower and middle class people would automatically be dominated by the former, would kill all initiative in the latter. But as one individual pointed out: the middle class might have expertise--however it does not know how to relate to the poor; the poor know how to do that, but lack expertise. So it really is a situation where each group must both teach and learn--a great, though not impossible, challenge. It was usually these same individuals who also admitted that, despite the training they had received, there were many areas in which they would need to learn much more before they could function as a really effective board of directors. Much of staff agreed with them (see table 13.3).

TABLE 13.3

STAFF OPINIONS CONCERNING THE QUALITY OF COUNCIL PERFORMANCE[a]

Opinions	Non-Professionals		Professionals		Total	
	f	%	f	%	f	%
Satisfied with council						
Yes	-	-	2	9	2	4
No	23	62	9	4	32	55
Ambivalent, DK[b]	14	3	10	4	24	41
Total	37	100	21	100	58	100

χ^2= 2.03, df=1 (in order to achieve an acceptable minimum expected frequency, the "Yes" and "Ambivalent, DK" categories were combined), .10<p<.20.

[a]Emerged from focused interviews with staff.

[b]"DK" includes those who said they had no idea just what the council did.

As the following few examples of comments will show, reasons for non-satisfaction were usually closely tied to respondent's idea of what the "proper" function of a community council should be. They also indicated poor techniques in handling employees and almost complete lack of effective communication between staff and council.

> They should send out flyers to let the community know about the center and what we can do for them, that's one of their functions. They only come when we're having problems like with the union or budget cuts, otherwise we never see them. They should be here more

> often to observe--not to complain so much about employees not wearing their smocks; they should get into patients' complaints more, and they should talk to us too without making it appear that we're complaining about administration. They should get more of a feel of what's going on, how people feel, think--both patients and us, because we are the community too, besides our families use the center. Council should be advocates for the patients--that was their role in the beginning; I don't know about their role vis-à-vis staff. The council is very puzzling as to how they go about doing their job. . . . Staff has no vote at the council, and if I were to go down there and raise the question I would feel the static; it would be better if an outsider were to raise it. I get the feeling that if employees go to meetings and raise questions, that they [council members] think that you're starting trouble . . . that's why most of us don't go to meetings any more. They should look after the patients' interests, and they should be the ones to fight for us about going to school--the career ladder thing, all of a sudden it was dropped . . . we should be able to call on them for all sorts of things.
>
> M.L. (non-prof.)

> The council could do better to publicize the program. I never go to their meetings because I know you're not allowed to speak--even if you like to say something, you have to shut your mouth. . . . Sometimes when we have a difficulty, whenever we have problems, we don't see them. I don't really think they take interest in patients. But anything concerning the workers here, they are always present. When we started with the union . . . [one of the council members] came here and said if we join the union we're going to get fired. . . . We don't join the union because we need more money; we joined because we are trying to protect our jobs.
>
> M.M. (non-prof.)

While it was true that staff members were not represented on the council--a policy to which the majority of staff objected--it was, of course, not true that staff was not allowed to speak at open meetings. I did notice, however, that the few times employees did attend meetings and spoke up, their comments were handled in a manner which, they later told me, they had found unsatisfactory. I could

indeed feel the "static" M.L. referred to. This was, however, only true for the period beginning with the Fall of 1972. Before that time the council had a community organizer on its staff who not only filled this role admirably, but also guided council functions in general and who managed council-staff interactions (especially in open meetings) tactfully. Could dealing with employees be more difficult for people with low SES who, perhaps, have had little work experience?

> When the petition for the union came up, the council came up with a leaflet that insulted staff and staff voted for the union--a lot of staff that I knew were against the union. The leaflet was so insulting I threw it away. . . . This council should be more involved in the center than they are, they should start applying themselves more to the needs of the community. The whole five years I've been here, what I've seen is the council fighting staff and vice versa--it's really rare to see them stand up and fight for somethings together. We're here to serve the community, so let's get together and find out what the community needs and go fight for it as one group.
>
> E.R. (non-prof.)

The largest percentage of individuals I talked to felt that the council should function mainly as trouble shooter for the community and as liaison between community and center. This was closely followed by the opinion that council really ought to be better informed about the clinic (see table 13.4). A surprisingly large number of people assumed a fairly broad view of council functions: comparatively few believed that it should be concerned with petty issues, or be involved in the day-by-day operation of NWHC. They believed that a council should be out in the community, act

TABLE 13.4

IDEAL FUNCTIONS OF THE COUNCIL, AS PERCEIVED BY CENTER STAFF[a]

Opinion	Non-Professionals f	Non-Professionals %	Professionals f	Professionals %	Total f	Total %
Serve as trouble-shooter for and in community[b]	20	30	12	34	32	31
Be informed about center[c]	16	24	3	9	19	19
Lobby for program[d]	6	9	3	9	9	9
Serve as advocate for:						
employees	7	10	-	-	7	7
patients	5	7	1	3	6	6
Determine policies and priorities:						
Yes	4	6	8	23	12	12
No	2	3	1	3	3	3
In cooperation with administration	-	-	3	9	3	3
Be involved in day-by-day operation of center:						
Yes	-	-	-	-	-	-
No	3	5	2	5	5	4
In cooperation with administration	4	6	2	5	6	6
Total	67	100	35	100	102	100

[a]Emerged from focused interviews; multiple answers were possible.

[b]E.g.: Be involved in community education about health care; keep community together; organize it for action; provide leadership; coordinate center affairs with other agencies; learn about needs of community; provide communications between community and center; public relations.

[c]E.g.: See that center is properly managed; teach work ethics.

[d]E.g.: Get money, help for program, contacts.

for the community, and represent the community.

Representativeness

> You see, the council has all the power because they have the people. . . . If it comes to it and the council calls and really acts they have the people because this clinic is filling a very important part in the health of the people. . . . If the council really talks and educates the community, so that the community really knows that they have power. . . . They should concentrate on communication with patients, on educating the patients, on getting money for the program. . . . Few people attend the meetings; many people don't even know that there is such a council. . . . . there should be a way where the council gets through and tells them "look, we're going to have meetings to discuss what's going on in that clinic about your care"--90% of our patients don't know what happens with the clinic, they don't know that these people who are supposedly being elected by them are there, they don't know that there is a health council. There should be real community participation in health care.
>
> A.A. (non-prof.)

How could A.A. feel that the council had the power and consent of the people if, at the same time, she indicated that this council did not represent the community? This contradiction was evident in many interviews, and the only explanation I can find is that respondents kept moving back and forth in their minds and their comments between ideal concepts and reality (or perceived reality). Ideally, a community council should represent the whole community, have the allegience of this community, and the ability to lead it. Quite a few individuals expressed doubt, however, that the N-W council then in office was, indeed, representative of the whole community. At the time interviews were carried out the

situation was aggravated by the fact that a sliding-fee scale had recently been instituted which made all residents of the catchment area eligible for center services and, therefore, for representation on the council; but sliding fees preceded council elections by a year.

The comments offered in the interviews can be broadly characterized as falling into three categories: (a) "The council is non-representative even by old eligibility standards." (b) "Now that everybody is eligible, everybody should be represented." (c) "Regardless of eligibility requirements, any community facility should include a broader spectrum of its population on its community councils." This was often coupled with comments regarding the need for expertise which middle class people could supply.

T.A. commented on the lack of representativeness of the council, questioned their competence and attitudes toward professionals, as well as their influence over the center's project director.

> The council is elected by a very small percentage of the people who are patients here. I don't know what their level of competence is in running a program; I think that to some extent they are anti-professional. I am not very sure of whether the council should be the sole arbiter of how the program runs--certainly not of professional standards, though they've been taking a bigger and bigger role here. Of course, the position of program director has been controlled by the council to a large extent. It is run by a small group, and they are elected by a very, very small electorate. The main reason is that the average patient has not been a participator in any political activity. In Europe and elsewhere this type of activity has been the province

> of the intellectual, and the people who have been able to be involved have been at least in the skilled worker status and were educated. People who don't have anything and are concerned with just keeping alive don't have the energy or the skill, the knowledge to participate, or even the drive.
>
> T.A. (prof.)

K.S. also voiced doubt that the N-W council represented the community--she advocated a broader based council --especially one with expertise in child care.

> A neighborhood group of people started the clinic--it was only poor people and I believe one of the priests. . . . But now that the clinic is open to the entire area, we should have other people on the board too. The council should include people from all walks of life. . . . I think it would be great if, for example, we had some teachers who live and teach in the community on that council . . . we have so many schools and children in the community, they would know what services are needed for the kids--and I think the center should be more atuned to the needs of children; to achieve comprehensive care you must start young and raise them right. . . . I get very depressed every time I go to council meetings and see the same few faces sitting there--this is a large community, yet it seems that a little clique runs the place. If you know so and so, you get in, if you don't know them, you're not in. . . . I think the council needs a wider range. . . . It seems like the people who are on the council now are the same little group that pops up in all the things that go on in the community--I don't think that's too great. Some staff should be on the council too.
>
> K.S. (non-prof.)

Finally, the often-present ambivalence between a theoretical belief in community control on the one hand, and questioning the motives, personalities, and/or expertise of those who sit on community boards on the other hand.

> Community control is very necessary, but on the other hand I find that in many communities, and this one is no exception, the people who often seek control are the ones who aren't necessarily representative of the community, but who have made themselves known more than

> others; they may be a little more aggressive than others. They are those who tend to see this kind of involvement as a way of life for themselves, it satisfies a need for them--not necessarily because they have something better to offer than the next person. I think it sort of mushrooms in that maybe people who have something to offer, who have creative ideas, who are more responsible, see one or two people get up at meetings and shout all the time, so others don't want to get involved in this and take a backseat--and consequently just a couple of people in the community take over and run something and they are not always the most qualified people to handle it. . . . I don't entirely buy the theory that if you come from the community you understand how to run a community-based program; I think that's assuming a whole lot--I mean that only poor people can understand the problems of the poor. . . . It is not fair to anyone involved, especially the patients, to make that kind of assumption --we're kind of stuck with the results of that.
>
> S.W. (prof.)

S.W. was one of many who were, in principle, in favor of community participation or control but were somewhat disenchanted with the developments which have taken place in various institutions operating with community input. The comment that usually the very same people--and not necessarily the most capable ones--sat on most community boards, was repeated quite often. Another thought frequently expressed in conjunction with philosophical agreement with community participation touched upon the need to provide some guidance to the community in order to make it fully capable of participating. A few individuals also recognized the possibility of ensuing complications.

> Philosophically I do believe that the community has to be involved in the services that they are getting . . . to get an advisory committee together to get patient input, to speak up if the services are not

> good, to be involved in changing the services. . . . In practice it may become a problem for agencies when you have a group of people having input. For example, the schools may have been run tighter when the teachers ran things, before community boards--but that is what we believe in . . . you have to get people involved, have to help them understand the workings of a place like this, so you have to have ongoing communication, have to have meetings together to explain--our own staff gets confused about what's happening here. The people of the community are knowledgeable enough to help run a place like this--of course they are. Most people probably have less interest in their health care than they do in their schools, which they are also running, but they rally around issues.
>
> G.G. (prof.)

G.G., and to some extent T.A., raised the important issue of priorities in the lives of individuals. Poverty produces stress in any society, but especially so in ours where the discrepancy between socially induced aspirations and realistically attainable goals is probably perceived by a relatively large segment of society. Stress can drain one's strength, reduce hope and drive. Given this situation, the poor must apportion their energies carefully to achieve the things they deem most important. If health care is not among these, our social and medical systems are to blame. This does not mean, however, that priorities cannot change.

Only 48 (53% of the 91 focused interview respondents) addressed themselves to the question of possible community action if the center were faced by a serious threat to its

existence because of cessation of government support in funding. Of these, 26 (54%) believed such action would take place, especially if some individual or group (e.g. the council) would inform and organize the people. The rest thought any kind of action rather unlikely. Comments here usually alluded to the fact that Hispanics, supposedly, were not apt to fight for their rights, that the center's patient population was preoccupied with other worries and/or felt completely powerless vis-à-vis the government.

M.P. believed that Hispanics were less likely to speak out than Blacks, and attributed this largely to language difficulties.

> A lot of our patients look at this as <u>their</u> clinic, but sometimes I wonder if they would do something about it if this place were to close. Some of them really act as if they're really close to this clinic--sometimes they feel so much, spend so much time here that I wonder what they would do. But I don't know the answer to that because sometimes they are so afraid to speak up that I wonder if they would act. I think Spanish people are more afraid to speak up than Blacks. I think this has to do a lot with lanugage--a lot of them really don't speak any English, even the young ones.
>
> M.P. (non-prof.)

G.A., on the other hand, believed that Hispanics had not yet learned to fight for their rights.

> Our patients think the clinic is here and it's always going to be here. Would they react if the clinic were to close? That's a problem--I don't know; Spanish people would rather have someone else fight for them. . . . . maybe if they didn't have a roof over their heads they would do something--it's bad, because the Puerto Ricans have been here for so long, and they'll never get any more than they have, but the Blacks fight. . . . Maybe the younger generation will know

> better; the teenagers know where it's at, they aren't willing to just take what they're given, and that's why they are always in trouble. People say they are fresh, but they are fighting for their rights.
>
> C.A. (non-prof.)

A number of Hispanic respondents, especially middle-aged women, referred to the fact that they (and Hispanics in general) were raised to respect the authority of their parents and, by extension, that of all people in charge. A few commented that this was the way they brought up their children too, but that they now regretted it because one "must learn to fight for one's rights."

Others believed that non-action is a function of poverty.

> People who get serviced here are not people who are functioning on the outside, so they don't know about keeping a place like this open. Their minds are not on that, they're channelled on paying their rent, getting their food stamps--that's not to put them down; their minds are on how to stay alive.
>
> R.A. (non-prof.)

Data available from patient interviews tended to confirm assessments by staff and council members. All of Int. II respondents thought that closing the clinic would hurt the community, that the people would be badly upset. Of these 25 individuals, 11 (44% believed that the people would probably unite and protest; 8 (32%) felt somewhat pessimistic, but were not ready to give up all hope that the community could influence events; 6 (24%) were unwilling to act, and did not believe that others would act.

Indications of a perceived lack of power were often apparent in responses--but by no means all.

> People who are responsible for the center's budget cuts are rats--you put that in your report and I gladly sign it! I get so angry when I hear about cuts in the budgets for programs for the poor. Poor people need to demand their rights . . . health and education are the fields where the greatest help for the poor is needed. If the center were to close, people would flock to . . . [the back-up hospital] which would mean carfare for many, besides it's costly and they don't treat you right. Having the center nearby, you can hobble over with a hurt leg knowing that good care and attention are not far off. I would picket if the center were closed. I have done it before and would not hesitate to do it again. I would also send letters to motivate people. It could be done. All one needs is hand power, feet power, and mouth power. It could be done. First the people in my building would get together, and someone would know others in the next building and someone in that building would know someone else--numbers are what matters. If people are sitting in the courtyard doing nothing, you could ask them for their time--they wouldn't need to say anything or do anything as long as they lend their presence because that makes a greater impression than one loud voice with no supporters. But something needs to happen before anyone becomes interested; something to anger the people into action (italics mine).
>
> C.B.[59]

It is clear that C.B.'s description coincides with what I have called an "active community." But compare the militancy of C.B. with H.C.'s[60] comments. While lamenting the effects if the center were to close, she felt that there was little one could do:

> The people would be very sad if the center were to be closed. It would be necessary to go to . . . [the back-hospital]. But if the closing came about, I

---

[59] Female, age 42, living with 4 children.

[60] Female, age 35, living with 2 children.

> would not protest. There is nothing I can do. It is not in my character to protest or get involved in such activities. I would sign a petition only if I could be sure of no consequences. I can't see the people getting together for the purpose of keeping the center open. I am not the type to initiate action for community involvement and would prefer not to be involved at all, and I feel sure that other people are of the same opinion.

While the subject of community action was not broached with Int. I respondents, some data regarding their knowledge about the N-W council, attitudes toward community participation, membership in voluntary organizations, and voting records are available. Among this group of 90 individuals, 44 (49%: 16 Hispanics, 15 Blacks, and 13 Whites) reported familiarity with the N-W council and 16 (18%: 4 Hispanics, 5 Blacks, 7 Whites) said they knew about the dissident health council. Hispanics were less likely to voice an opinion regarding community health councils than either Blacks or Whites (see table 13.5).

It is intriguing to note that the only negative assessments of health councils came from White respondents --perhaps another slight indication of alienation from the social environment? It is also interesting that the largest percentage of those who voiced affect gave "need for community input/organization" as their reason (see table 13.6).

TABLE 13.5

INCIDENCE OF EXPRESSING ANY OPINION ABOUT COMMUNITY HEALTH COUNCILS (INT. I)[a]

Did respondent voice opinion?	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Yes	13	43	21	70	23	77	57	63
No	17	57	9	30	7	23	33	37
Total	30	100	30	100	30	100	90	100

$\chi^2 = 8.01$; df=2; $.01 < p < .02$

[a]Computed with the use of Q. 106: "How do you feel about . . . [health council] organizations?" (O.E. and probe)

TABLE 13.6

FEELINGS ABOUT THE EXISTENCE OF HEALTH COUNCILS AND REASONS FOR THESE FEELINGS (INT. I)[a]

	Hisp.		Black		White		Total	
Affect	f	%	f	%	f	%	f	%
Positive	13	43	21	70	18	60	52	58
Negative[b]	-	-	-	-	5	17	5	5
DK, NR	17	57	9	30	7	23	33	37
Total	30	100	30	100	30	100	90	100

$\chi^2 = 4.5$; df=2; (to arrive at an acceptable minimum expected frequency "Negative" and "DK, NR" categories were combined); $.10 \leq p < .20$

Reasons for positive affect:								
Improved services	3	23	-	-	2	11	5	10
Help people	3	23	9	43	2	11	14	27
Provide consumer input organize community	4	31	9	43	8	45	21	40
No reason given	3	23	3	14	6	33	12	23
Total	13	100	21	100	18	100	52	100

$\chi^2 = 3.54$; df=4 (to arrive at an acceptable minimum expected frequency "Improve services and "Help people" categories were combined); N.S.

[a]Q. 106: "How do you feel about such organizations?" (e.g., the N.W. Council) F.A. and probe.

[b]Reason for negative affect were:
Council has wrong attitudes (N=3)
Council is ineffective (N=1)
Council is prejudiced (N=1)

The relationship between attitudes regarding community participation in health care and Int. I respondents' ages, length of residence in the city, family status, as well as the extent of their mobility around the city and activities outside the home--the individuals social spaces (see chapter VII)--were examined. An index for social space was computed for each Int. I respondent (see appendix M). As was the case with the "dissatisfaction index with the physical environment of NWHC" (see chapter XII), values, intervals, and weights were again arbitrarily assigned, and this index is regarded as a descriptive tool only.

Following are the totals, means, medians, modes and ranges of this score for the three ethnic groups (see table 13.7). Although Hispanics reported the narrowest range and Whites the widest, the former attained the largest social space scores and the latter the lowest.

Table 24 (appendix N) shows the relationship between knowledge about the N-W council on the one hand, and each of the five variables mentioned above. Taking all Int. I respondents as one group, no significant relationship between acquaintance with the council and length of residence in the city or social space emerged; education, family status, and age did, however, appear to have some influence: Generally, individuals with at least some high school education, and those who lived with some member(s)

TABLE 13.7

SOCIAL SPACE SCORES OF INT. I. RESPONDENTS[a]

Measures	Hispanic (N=29)	Black (N=29)	White (N=29)
Sum of scores	1126	984	808
Mean	38.83	33.93	27.86
Median[b]	40.13	30.75	22.00
Mode	24.5	24.5	24.5
Range	20-65	6-63	0-80

[a]Q. 108, see appendix M for wording of question and computation of the social space scores.

[b]Testing for the significance of difference between the medians through the extended median test (Siegel, 1956) yielded $\chi^2=4$, df=2, $.20<p<.10$.

of their family were more likely to know about the council's existence; the very old were least likely to do so.

When the three ethnic groups are examined separately, the picture changes somewhat (see tables 25-27, appendix N): (a) Social space remains insignificant for Black and White respondents, although not for Hispanics--members of this group who reported a more restricted social space were less likely to know about the council. (b) Length of residence assumes some significance for all three groups--thus, for

example, fewer Hispanics who came to the city since 1940 and fewer Whites who were born here reported knowledge about the council. (c) Age ceases to be significant for Blacks, and (d) educational status for Whites.

All respondents reported fairly good participation in national elections; Whites somewhat more so than the other two groups--they also appeared to have a greater tendency to join voluntary organizations (see table 13.8). It seems that at least these 90 indigents were more likely to vote than to join voluntary organizations.

It would also seem that this relatively good showing in general elections did not extend to council elections: 38 respondents (10 Hispanics, 13 Blacks, and 15 Whites) reported having received notification of the 1972 council elections. Of these, 10% each Hispanics and Blacks and 40% Whites indicated that they planned to vote (or had already voted) in this election. The main reasons given for not wishing to vote were lack of information, lack of interest, and inability to get to the polling places. It is impossible to know how many of the Int. I respondents actually did vote in the July 1972 elections for council members.

Although Int. I respondents showed a greater tendency to see some community influence in the operation of NWHC as compared to the back-up hospital, a large number

TABLE 13.8

REPORTED MEMBERSHIP IN VOLUNTARY ORGANIZATIONS AND GENERAL VOTING ACTIVITIES (INT. I.)

Membership in voluntary organizations[a]	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
Yes	2	6	4	13	10	33	16	18
No	23	77	25	84	15	50	63	70
DK, NR	5	17	1	3	5	17	11	12
Total	30	100	30	100	30	100	90	100
χ^2= 12.15; df=4; .01<p<.02								
Participation in November elections preceding interview[b]								
Yes	15	50	15	50	18	60	48	54
No	14	47	14	47	11	37	39	43
DK, NR	1	3	1	3	1	3	3	3
Total	30	100	30	100	30	100	90	100
χ^2 = .86; df=2; (to arrive at an acceptable minimum expected frequency the "DK, NR" category was left out); N.S.								
Participation in presidential election preceding interview								
Yes	15	50	17	57	19	64	51	57
No	15	50	12	40	10	33	37	41
DK, NR	-	-	1	3	1	3	2	2
Total	30	100	30	100	30	100	90	100
χ^2= 1.5; df=2 (to arrive at an acceptable minimum expected frequency the "DK, NR" category was left out); N.S.								

[a]Q. 103: "Which neighborhood organization do you belong to?" (O.E.)

[b]Q. 88: "Did you vote in the general election last November?" (F.A. and probe)

[c]Q. 89: "Did you vote in the last presidential election?" (F.A. and probe)

perceived none or were unable to address themselves to this question (see table 13.9).

TABLE 13.9

PERCEPTION OF COMMUNITY INFLUENCE (INT. I)[a]

Respondents perceive some degree of community influence in these facilities	Facility				Total	
	N.W.H.C.		Back-up Hospital			
	f	%	f	%	f	%
Yes	37	41	11	12	48	27
No	8	9	14	16	22	12
DK, NR	45	50	65	72	110	61
Total	90	100	90	100	180	100

$\chi^2 = 19.44$; df=2; $p<.001$

[a]Q. 67 and Q. 68: "How much do you think people in the neighborhood have to say about the kind of medical care they receive at the center/ the back-up hospital?" (F.A. and probe)

The three ethnic groups did not differ significantly with respect to their perception of the extent of community influence in the operation of the center, but they did so regarding the back-up hospital (see table 28, appendix N). Generally, Blacks saw more community influence in the operation of both facilities than did either Hispanics or Whites. The largest percentage of White respondents

declined to offer an opinion with respect to the center, while only one Hispanic expressed a view on this question regarding the back-up hospital.

Table 29 (appendix N) indicates that, taking all groups together, the largest number of those who expressed an opinion about community influence in health care cited a need for autonomy as a reason for favoring such influence. Whites were, however, much less likely to do so than members of the other two groups; and one also finds in this group the only individuals (although only a very small number) who expressed acceptance of things as they were because they "lacked the power to change them." Looking simply at the number of respondents who did or did not voice an opinion about community influence in health care, Blacks were most likely to do so and Hispanics least likely ($\chi^2 = 5.58$; df = 2; $.05 < p < .10$). Blacks were also the only group that did not report any feeling against community influence in health care; Whites were more likely to do so than Hispanics.

Asked the meaning of community participation and control in general, 41 of the 90 Int. I respondents (46%: 16 Hispanics, 11 Blacks, 14 Whites) were unable to define the terms. Definitions offered by the remaining forty-nine individuals are shown in table 13.10. The largest percentage perceived it as joint action toward a common goal.

TABLE 13.10

DEFINITIONS OF THE TERM COMMUNITY PARTICIPATION AND CONTROL (INT. I)[a]

Definitions	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
Joining together to work toward a common goal, a better community or neighborhood	12	80	6	30	7	33	25	45
Belonging to voluntary organizations	1	7	2	10	5	24	8	14
Having a voice in controlling the community facilities	1	7	11	55	8	38	20	36
Control over environment, destiny	1	7	1	5	1	5	3	5
Total	15	100	20	100	21	100	56	100

Note: The total number of respondents who could define the term was 49. Because of multiple answers the total shown on this table is 56.

[a]Q. 101: "What does the idea of community participation and control mean to you?" (O.E. + probes)

In view of the opinion voiced by some NWHC staff members that Hispanics are rather passive, it is interesting to note that more individuals in this group thought in terms of joint action than did people in the other two groups (see table 30, appendix N). Most of the respondents who expressed an opinion on the subject voiced either qualified or unqualified approval of community participation. However, not all of those who approved perceived it as a complete

success in their community. Even among individuals who had no doubt that community participation was necessary, one found quite a few who either did not think it worked too well (if at all), or who knew how it worked in their part of the city.

Throughout the preceding pages the terms community and neighborhood have cropped up. Before offering data regarding these concepts, the findings presented so far will be summarized briefly.

Most respondents, be they council members, staff, or patients, were in favor of some form of community participation both at NWHC and in other service organizations. By no means all patients, however, were aware of the fact that NWHC was operated with community input. The reasons for this were probably two-fold:

1. As the low numbers of individuals who reported membership in voluntary organizations within the community indicated, few of these people apparently took an active interest in community organizations. This might, at least partly, have been due to stress caused by poverty.

2. The N-W council had not succeeded in informing and educating the public, in making itself known to much of the patient population, or in arousing great interest in its elections and in center affairs.

While a few Int. II respondents indicated that they would protest if the center were to close due to budget

cuts, the impression of most staff members, shared by me, was that unless strong leadership emerged, the majority of NWHC patients would, however regretfully, simply switch to other health care facilities especially the back-up hospital's OPD.

Staff opinions regarding the most desirable extent of community participation in center affairs varied. By far the largest number of those who addressed themselves to this question saw council's function as a communication link between center and community, and as a general trouble-shooter in and for the community--including lobbying for the program and liaison with other agencies. Only very few thought that council should involve itself in the daily operation of the center.

Complete satisfaction with the N-W council was minimal. This question was, however, closely tied to respondents' ideas regarding the ideal functions of such a body. Partial or complete dissatisfaction might have been caused, at least to some extent by the fact that the N-W council did not realize these various, often contradictory, ideals. Other reasons for dissatisfaction were the perceptions by varying numbers of staff members of (a) ethnic conflict and/or bias within the council, (b) a lack of expertise in managing a health care system, and (c) lack of true representativeness of this group either because only patients were allowed to vote, or because only

a tiny fraction of the patient population did, in fact, vote. There were frequent allusions to the fact that the same individuals, representing a small number of community cliques, sat on most community boards.

Neighborhood and community

Conceptual differentiations between neighborhood, latent and active community were proposed in chapter five. Neighborhood is here conceived of as a given bounded geographic area, with its demographic factors, institutions, and the characteristics attributed to it. This definition excludes any reference to psycho-social aspects of the behavior of individuals living in this area. These aspects are included in the definition of latent community, which is a collectivity of interacting and interdependent individuals and organizations contained within a given region. There is, however no assumption of commitment and joint action to achieve given goals--this is the mark of an active community.

Community participation, by definition, presupposes an active community of some sorts. Table 13.10 indicates that a number of Int. I respondents agreed with this interpretation. What happened when people were asked to define the terms "neighborhood" and "community?"

When the 90 Int. I respondents were asked what they considered "their" neighborhood, 48% gave a purely descriptive answer (e.g. my block, my street, a few blocks around

here, etc.), 33% responded in numerical terms only--i.e. they listed the boundaries of the area, and 19% did not answer at all (see table 13.11).

TABLE 13.11

CONCEPTUALIZATION OF THE TERM "NEIGHBORHOOD" (INT. I.)[a]

Type of Response	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
Descriptive terms only	22	74	9	30	12	40	43	48
Numerical terms only	1	3	17	57	12	40	30	33
DK, NR	7	23	4	13	6	20	17	19
Total	30	100	30	100	30	100	90	100

$\chi^2 = 20.7$; df = 4; $p<.001$

Testing for the significance of differences without the DK, NR category:

$\chi^2 = 19.93$; df=2; $p<.001$

[a]Q. 90: "What do you consider to be <u>your</u> neighborhood?" (O.E.)

The differences between Hispanics and the other two groups are especially striking: The former were much more apt to answer in purely descriptive terms.

It was therefore surprising to find that, when asked to identify photographs of 11 sites within NWHC's catchment area, Hispanics offered fewer correct identifications than the other two groups; the number of incorrect identifications and refusals to answer was also very slightly higher

in this group (see table 13.12).

TABLE 13.12

ABILITY TO IDENTIFY PHOTOGRAPHS OF ELEVEN SITES WITHIN N.W.H.C.'S CATCHMENT AREA(INT. I)[a]

Identification of Photographs	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
Correct	90	27	117	35	101	31	308	31
Incorrect	94	29	81	25	89	27	264	27
DK, NR	146	44	132	40	140	42	418	42
Total	330	100	330	100	330	100	990	100

$\chi^2 = 5.95$; df=4; $.20 < p < .30$

Note: Omitting the "DK, NR" category, $\chi^2 = 4.0$; df=2; $.10 < p < .20$. However, this second, more significant χ^2 is not utilized because non-response, in this particular case, is considered a result worthy of note.

[a]Q. 94: "Would you please look at these photos and tell me what places they are." (Instruction to interviewer: Shuffle pictures before presenting them.)

If one treats the 90 respondents as one group, the largest percentage identified NWHC; this was followed by correct identification of the two subway stations and one church which was located on the corner of a major cross-town artery. NWHC was the only place correctly identified by more Hispanics than Blacks or Whites (see table 13.13).

TABLE 13.13

IDENTIFICATION OF PHOTOGRAPHS OF LOCATIONS WITHIN THE CENTER'S CATCHMENT AREA (INT. I)[a]

	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
			Correct Identification					
1. Church at crosstown artery	7	8	6	5	6	6	19	6
2. Vestpocket park	8	9	8	7	8	8	24	8
3. NWHC	27	30	11	9	9	9	47	15
4. Subway on major street	8	9	12	10	10	10	30	10
5. Church on side street	4	4	13	11	5	5	22	7
6. Residential street	6	7	7	6	6	6	19	6
7. Church on side street	8	9	9	8	9	9	27	9
8. Major subway & street	10	11	16	14	18	17	44	14
9. Playground on side st.	5	5	10	9	8	8	23	7
10. Church on crosstown artery	7	8	13	11	10	10	30	10
11. Urban renewal project	–	–	12	10	12	12	24	8
Total	90	100	117	100	101	100	308	100
			Incorrect Identification					
1. Church at crosstown artery	10	11	13	16	13	15	36	13
2. Vestpocket park	7	7	10	12	10	11	27	10
3. NWHC	1	1	7	9	9	10	17	7
4. Subway on major street	11	12	6	7	9	10	26	10
5. Church on side street	7	7	4	5	8	9	19	7
6. Residential street	11	12	9	11	9	10	29	11
7. Church on side street	12	13	8	10	5	6	25	9
8. Major subway & street	6	7	4	5	3	3	13	5
9. Playground on side st.	8	8	7	9	9	10	24	9
10. Church on crosstown artery	8	8	5	6	5	6	18	8
11. Urban renewal project	13	14	8	10	9	10	30	11
Total	94	100	81	100	89	100	264	100
			DK, NR					
1. Church at crosstown artery	13	9	11	8	11	8	35	8
2. Vestpocket park	15	10	12	9	12	9	39	9
3. NWHC	2	1	12	9	12	9	26	7
4. Subway on major street	11	8	12	9	11	8	34	8
5. Church on side street	19	13	13	10	17	12	49	12
6. Residential street	13	9	14	11	15	10	42	10
7. Church on side street	10	7	13	10	16	11	39	9
8. Major subway & street	14	10	10	8	9	7	33	8
9. Playground on side st.	17	12	13	10	13	9	43	10
10. Church on crosstown artery	15	10	12	9	15	10	42	10
11. Urban renewal project	17	11	10	7	9	7	36	9
Total	146	100	132	100	140	100	418	100

[a] Q. 95: See table 13.12.

It is possible that Hispanics recognized fewer places simply because they did not walk as much about the area, and/or utilized local shops, parks, and playgrounds less than did members of the other two groups and, as was reported previously (chapter XI and table 7, appendix N), they were less likely to walk to NWHC or other health care facilities than Blacks or Whites. Several possible reasons for this come to mind: These Hispanics could, quite simply, have disliked physical activity more; they might have felt uncomfortable on the street because of language difficulties; or they might just have wanted to spend more time at home. But it is also possible that fear kept them off the streets. It was found that Hispanics and Whites were more likely to complain about lack of safety on the streets than Blacks, while the latter group was more apt to voice general complaints about the area (see table 13.14).

It could be postulated that individuals who voice more concern for the conditions of their physical environment would be more likely to notice and remember features of this environment. It could also be hypothesized that those who are kept off the streets by fear are less likely to look around them and notice sites when they are outside. As table 13.14 indicates, the complaints of Hispanics tended to be connected with undesirable behavior of other people rather than with the physical condition of

TABLE 13.14

NEGATIVE ASPECTS ABOUT THEIR NEIGHBORHOOD MENTIONED BY INT. I RESPONDENTS[a]

Major categories of complaints	Ethnic Group							
	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Lack of safety[b]								
Yes	19	63	13	43	19	63	51	57
No	11	37	17	57	11	37	39	43
Total	30	100	30	100	30	100	90	100
χ^2= 3.24; df=2; .10<p<.20								
General complaints[c]								
Yes	9	30	20	67	18	60	47	52
No	21	70	10	33	12	40	43	48
Total	30	100	30	100	30	100	90	100

χ^2= 9.18; df=2; .01<p<.02

[a]Q. 98: "What do you particularly dislike about . . . [your neighborhood]?" (O.E.)

[b]This category contains comments such as: Streets are not safe; robberies; muggers; addicts; suspicious people; etc.

[c]This category contains comments such as: The area is deteriorating, noisy, dirty; I have no friends here; lack of facilities; etc.

the area. The situation is reversed for Blacks; and Whites assume a middle position. The same order holds in the case of correct identification of photographs.

Int. I respondents were also requested to mark the boundaries of what they considered their neighborhood and the location of their homes on a map, which was a simple lay-out of the catchment area with the major thoroughfares clearly marked (see appendix K).

More Hispanics were able to mark the location of their homes correctly than either Blacks or Whites. In all, 55 respondents (61%: 20 Hispanics, 18 Blacks, 17 Whites) did so. Incorrect markings were found on the maps of 14 individuals (16%: 4 Hispanics, 6 Blacks, 4 Whites); and 21 (23%: 6 Hispanics, 6 Blacks, 9 Whites) did not respond ($\chi^2 = 1.71$, df = 4, NS).

The greater aptitude of Hispanics in locating their homes on the maps while showing less ability to identify photographs of neighborhood sites is puzzling: One would presume that locating the home necessitates some understanding of and experience in the larger setting. A few explanations are possible: (a) More Hispanics reported having jobs which necessitated traveling (see table 13.15). (b) Hispanics, as a group, appeared to have a larger social space than Blacks or Whites (see table 13.7). (c) It is conceivable that more Hispanics simply felt they must know

how to locate their homes in relation to the major thoroughfares indicated on the map because of possible language difficulties. (d) Perhaps Hispanics' orientation in space was related to the home as a base more than was the case with members of the other two groups. Finally, (e) Although Int. I Hispanics did not report more ownership of automobiles than either Blacks or Whites, it is possible that because of their extended family structure these Hispanics had more opportunity to travel by car. This mode of transportation might make locating one's home on a map correctly more likely.

TABLE 13.15

WORK NECESSITATING TRAVEL IN THE CITY (INT. I)[a]

	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
Respondents work outside their homes								
Yes	13	43	11	37	4	13	28	31
No	16	54	18	60	25	84	59	66
NR	1	3	1	3	1	3	3	3
Total	30	100	30	100	30	100	90	100

$\chi^2 = 7.05$; df=2 (without "NR" category); $.02<p<.05$

[a]Q. 108: "I am interested in the amount of traveling you have to do around the city. I will mention a few activities to you and I would like you to tell me where you do them, how often and how you get there." One of the activities was "work".

Respondents who were able to deal with the task of marking the boundaries of what they considered "their" neighborhood (N = 58: 17 Hispanics, 22 Blacks, and 19 Whites) delimited an area which varied in size from 1-85 city blocks in longtitude (S-N), and from 1-5 blocks in latitude (W-E). It is interesting to note that the fact that the map did not extend that far in the S-N direction did not deter respondents from naming streets beyond, while nobody did so in the other direction. A probable explanation for this phenomenon is the existence of natural boundaries on both the western and eastern borders of the catchment area, but not at the northern or southern borders.

In order to arrive at a figure representing the area Int. I respondents considered "their" neighborhood, the S-N boundaries given by people who answered these questions were multiplied by his or her E-W boundaries. This yielded the measures of central tendency presented on table 13.16.

Table 13.17 shows the actual distribution of the number of blocks within the boundaries of respondents' neighborhoods. The differences between the three ethnic groups are not significant. Cross tabulating area by age, length of stay in the city, and education also yields insignificant results.

TABLE 13.16

MEASURES OF CENTRAL TENDENCY FOR INT. I RESPONDENTS' "NEIGHBORHOOD"[a]

Measures	Hispanic	Black	White
Mean[b]	65.53	77.50	67.16
Median	72.00	59.50	70.50
Mode(s)	100	6 and 42	70
Range	3 - 150	4 - 220	1 - 225

[a]Q. 90: "What do you consider to be your neighborhood?" (O.E. (if people gave numerical responses.)

Q. 92: "Could you please mark on this map where, you think, your neighborhood ends?"

[b]F=3.86; df=55, 2; N.S. See table 31 for summary of analysis of variance.

TABLE 13.17

NUMBER OF CITY BLOCKS OUTLINED BY RESPONDENTS AS "THEIR NEIGHBORHOOD" (INT. I.)[a]

Number of blocks comprising the neighborhood[b]	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
1-19	2	12	5	23	3	16	10	17
20-49	5	29	5	23	5	26	15	26
50-225	10	59	12	54	11	58	33	57
Sub-total	17	100	22	100	19	100	58	100

χ^2= .99; df=4; NS

Not included in χ^2 computation:

Descriptive, non-numerical	9	5	4	18
Refused, DK, NR	4	3	7	14
Sub-total	13	8	11	32
Grand total	30	30	30	90

[a]Q. 93: "Could you please mark on the map where you think your neighborhood ends?"

[b]Number of city blocks as marked by respondents on their maps.

Taking all 90 Int. I respondents as one group,[60] it appears that people who gave the largest area as their neighborhood tended to use the center least often; those with smaller neighborhoods were both more likely to know about the N-W council and to perceive some degree of community influence in the operation of NWHC--none of the above relationships are statistically significant (see table 32, appendix N). Individuals who claimed larger areas as their neighborhoods showed, however, a significantly greater tendency to report a larger social space.

Finally, respondents were asked why they considered the area they had marked as "their" neighborhood. Asking this question following presentation of the map might possibly have influenced some individuals to think in physical terms in connection with the word "neighborhood." It also kept some interviewers from putting this question to respondents who did not used the map, thus losing some data which could be helpful in defining the term (see table 13.18).

Taking the information presented in this table at face value (i.e. without consideration of the difficulties mentioned above), the first 4 categories (59% of all respondents who answered this question) fall well within

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[61]This was made necessary because too many respondents left one or more questions unanswered to make cross-tabulation by ethnic groups and the computation of Chi-squares feasible.

TABLE 13.18

CRITERIA FOR CONSIDERING AN AREA ONE'S NEIGHBORHOOD (INT.I)[a]

Criteria	Ethnic Group							
	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
A given area[b]	8	36	5	16	3	12	16	21
Shopping; services; recreation	3	14	5	16	7	28	15	19
It is safe; familiar; comfortable	-	-	9	29	1	4	10	13
Where I lived a long time/ grew up	-	-	3	10	2	8	5	6
The area one lives in[d]	4	18	5	16	6	24	15	19
People[e]	7	32	4	13	3	12	14	18
I don't consider it mine	-	-	-	-	3	12	3	4
Sub-total	22	100	31	100	25	100	78	100
DK, NR, ireelvant	5		3		6		14	
Question was not asked; answers not volunteered	10		3		5		18	
Sub-total	15		6		11		32	
Grand total	37		37		36		110	

Note: N≠30 for each group because of multiple answers.

[a]Q. 93: "What makes you consider the area which you marked as your neighborhood?" (O.E.)

[b]This category includes the following answers: "Certain geographic boundaries (e.g. streets); within walking distance from one's house; the buildings around me; the area around our house; an area of a few blocks; where I walk around; the blocks I use most often; places I visit; going to the same place all the time."

[c]This category includes: "It's separate from . . . [a ghetto area]; I am secure here but am afraid below . . . street and above . . . street; the people and houses are all about of the same kind; other places don't feel the same, have different types of people and buildings."

[d]This category includes: "The area one does things in; where I do most things; where I spend most of my time."

[e]This category includes: "People, relatives, friends; where I know the most people; where we have our friends; where I visit people."

the definition of neighborhood offered in this report (see p. 92); while categories 5 and 6 (37%) fit the concept of latent community better (see pp. 99-100). The 3 White respondents (4%) who did not consider the area "their" neighborhood--although they lived there--were all over 60 years old, had lived in the City either since birth or early childhood, and were relocated to their present dwellings by the City Department of Social Service or the Housing Authority.

When Int. I respondents were asked what they liked about their neighborhood, Hispanics were more likely than members of the other two groups to say that it was the people in the area (see table 13.19).

Stressing people was perhaps due to the fact that more Hispanics (21, in contrast to 15 Blacks and 12 Whites) lived in this area for a long time or moved there to be near friends and family and/or because they considered NWHC's catchment area an improvement over the place they came from. A contributing factor might be that only two Hispanics, as compared with five Blacks and nine Whites, came to the area due to relocation by some authority. In this context it is interesting to note that not one of the 25 Hispanics who said they were satisfied with center services mentioned the availability of services in general as a reason for liking their neighborhood. Among members of the other 2 groups who reported satisfaction with NWHC, 6 (55%) Blacks

and 4 (80%) Whites did mention "services" as a positive aspect of the area they lived in.

When defining "community" all Int. I respondents put greater stress on people (see table 13.20).

TABLE 13.19

POSITIVE ASPECTS OF RESPONDENTS' NEIGHBORHOOD (INT. I)[a]

Features named by respondents	Hisp.		Black		White		Total	
	f	%	f	%	f	%	f	%
I know people; neighbors are nice	16	35	5	9	3	6	24	16
Convenient transportation	7	15	10	19	13	26	30	20
Shopping; recreation; urban renewal	9	20	14	27	13	26	36	24
Good for children; services	-	-	11	21	5	10	16	11
Exciting/ heterogeneous	3	7	2	4	3	6	8	6
Safe; clean; quiet; spacious	7	15	4	8	3	6	14	9
My apartment, building, street	2	4	2	4	4	8	8	6
Nothing	1	2	2	4	3	6	6	4
DK, NR	1	2	2	4	3	6	6	4
Total	46	100	52	100	50	100	148	100

[a]Q. 97: "What do you particularly like about . . . [your neighborhood]?" (O.E.) Multiple answers were possible.

TABLE 13.20

DEFINITION OF "COMMUNITY" (INT. I)[a]

Definition	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Geographic area; facilities in it; neighborhood[d]	1	3	1	3	4	13	6	6
Area; aggregate of people	10	33	3	10	3	10	16	18
Interaction[c]	5	17	13	44	17	57	35	39
Working together for neighborhood and its people	3	10	9	30	4	13	16	18
DK, NR	11	37	4	13	2	7	17	19
Total	30	100	30	100	30	100	90	100

$\chi^2 = 27.27$; df=8; $p<.001$ Omitting the "DK, NR" category: $\chi^2 = 18.98$; df=6; $.001<p<.01$

[a]Q. 100: "What does the word "community" mean to you?" (O.E.)

[b]Two White and one Black respondent answered Q. 100 with the word "neighborhood". The Black did not give any criteria for neighborhood on Q. 93 (see table 13.180: the two Whites both defined neighborhood as "the place where I live and shop."

[c]This category includes: "A place/neighborhood where you live together, work together; where you live near people with common background, interests; neighborliness, sharing, helping, cooperation, fellowship, togetherness."

TABLE 13.21

DEFINITIONS OF NEIGHBORHOOD AND COMMUNITY OFFERED BY N.W.H.C. STAFF AND MEMBERS OF THE N-W COUNCIL[a]

	Neighborhood		Community	
	f	%	f	%
Definitions:				
Geographic area	22	30	2	2
Area and people, physical proximity	9	12	5	6
Buildings and facilities around you	9	12	4	5
Place where you live and work, know people	17	24	8	10
Localized area which connotes neighborliness, helping each other	5	7	3	4
People	-	-	5	6
Group with certain interests in common: ethnic background, togetherness, involvement, dedication	6	8	18	22
People living in given area and working toward common goal	5	7	26	32
Group of people interacting for common purpose	-	-	11	13
Total	73	100	82	100

[a]These definitions emerged during the focused interviews with these two groups.

However, 24% of the respondents (the first 2 categories on table 13.20) thought of community in terms which fits the definition of neighborhood utilized in this study. Latent community was described by 35 people (39%), and the answers of 16 individuals (18%) qualify for the concept of active community. As with the questions regarding community participation, Hispanics were least likely to offer a definition. A larger percentage of the all-Hispanic Int. II respondents (84%) did, however, respond to this question.

When asked about the meaning of the term "neighborhood," 11 of the 25 Int. II respondents (44%) referred to geographic location only: "my block," "where I live," "the area around here." The responses of 10 individuals (40%) included allusions to people, e.g. "neighbors in the building," "people in the area," "people get to know one another because of their nearness," and 4 (16%) included the concept of helping each other, sharing problems.

In defining "community" 8 of the Int. II respondents (32%) still referred only to physical properties such as location, agencies, and other facilities, 2 (8%) felt that the concept included the people in the area, 7 respondents (28%) brought in the idea of helping one another, and another 4 (16%) of uniting to achieve certain goals. As among Int. I respondents, these Hispanics were not too likely to think in terms of united action to achieve a common goal; the majority again utilized definitions which

are proposed for "neighborhood" or "latent community."

There is an apparent contradiction as far as Hispanics are concerned: (a) it will be remembered that several staff members commented that Hispanics are unlikely to unite for action, and (b) when asked to define community, Hispanics tended not to think in terms of joint action--yet (c) when asked about the meaning of community participation it appears that more Hispanics thought in terms of joint action to achieve a common goal than did Blacks or Whites.

One possible explanation lies in language. The English word "community" has two Spanish equivalents: comunidad and sociedad--this latter term, however, also means society, which does not necessarily imply joint action (that is a coalition!). Participar, on the other hand, clearly means to participate, to share. Is it not possible then, that when asked to define "community participation" those who were able to do so were led to think of it in terms of shared action? No such clear guide is available in the terms comunidad or sociedad.

But failure to think of community in terms of joint action might also simply be a cultural trait. The extended family has, historically, been an important factor in Hispanic cultures. These kinship structures are, in effect, community participation structures--except that the community consists of individuals who are related by blood,

marriage, god-parentship, or other social obligations. Members of this group or community participate and join in common goals, namely for the benefit of this group. Being attuned to the community of one's kinship group might prevent thinking in terms of joint action with those outside the group.

In addition, it is possible that the co-existence of so many different Spanish-speaking nationals (who do not always feel great sympathy for each other) in close proximity might hinder identifying oneself as Hispanic rather than as Cuban, Dominican, Puerto Rican, etc. Having a distinct culture and different language, on the other hand, could prevent identification with other ethnic groups in the area.

In contrast to patients, a larger percentage of NWHC staff and N-W council members tended to think of community in terms of interaction and cooperative efforts to achieve common goals (see table 13.21). Definitions of neighborhood, on the other hand, tended to involve more physical and demographic variables. There is, of course, some overlap. A few comments will serve to give the flavor.

H.N. thought of neighborhood in terms of a rather diffuse friendliness, while community was felt to involve shared interests.

> We moved here because it's a neighborhood--in contrast to . . . [area of former residence], there it's not at all a neighborhood, nobody knows anybody, you're just totally in your building but here everybody is much more friendly in the street and I think it's really a very nice area. . . . I think of "neighborhood"--it's sort of like in Sesame Street where they show "these are the people in your neighborhood, people you're familiar with, that you see." You get to see the same people in the stores that you do business with and you have a reasonably friendly relationship--for example, they accept your check in stores. I've noticed a tremendous difference here [as compared to other area]--any store I've gone into and asked to pay by check, they haven't even asked for any identification--so it means there must be something in the neighborhood which sort of promotes this kind of thing on the commercial level--a friendliness. . . . I think community is much larger than the neighborhood itself. . . .Sometims I think community is more a community of people who have like interests rather than just people who happen to be living within an area. You might have a community of scholars, a community of musicians that would come from several different neighborhoods.
>
> H.N. (prof.)

The next two quotes define neighborhood in purely physical terms and community as involving both friendly interaction and joint action for common goals.

> Given the right approach, like explanations, discussions, etc., any group can be organized into a community to do things together and for each other. The important concept is to want to work together as a group and, therefore, a need for each other would grow. . . . You could also say that a community is a group of people living together--but it's more than that, they should be working together instead of being lonely, refusing to open your door to the next person or giving you a good morning--it's trying to build together. . . . it's living together, working together to make a better people; where everybody works toward a goal. . . . Neighborhood is just the territory, an area, the place you live.
>
> J.F. (non-prof.)

> A community is the members of a given section of the city, with the same goals in their minds, working together to attain the best for their community. It's somewhat like a family rather than just a group of people, with the same interests for the betterment of every member of their community; with an understanding that some sacrifices on their parts may be necessary in order to attain their goals. . . . Neighborhood is the vicinity, a section of the city; a community is people working together.
>
> G.H. (prof.)

A.A. introduced the idea of shared fate and background explicitly--the former as a prelude to joint action which typifies community, the latter as the basis for neighborhood.

> Community means a group of people who live together, they have to share the problems, like crime, bad housing, etc. Problems are not personal, they are so general they affect everybody. So if these people who live together can get together to fight these problems it would be easier to solve them. It's like a big, huge family who have to work together to solve their problems because most of the problems affect all of them. . . . Neighborhood is the area where you live with people with the same ethnic background, the same customs.
>
> A.A. (non-prof.)

Another individual who distinguishes between neighborhood as a geographic area, and community as interaction/joint action.

> Community is a group of people interacting together for a common purpose. It could be a town, it could be a street, a community can happen in a building--NWHC can be referred to as a community--it's the interaction which makes it a community. Neighborhood, on the other hand, I see as something more geographic, though neighborhood infers the people who would be neighborly. We know the people next door, and some interaction can occur--but it does not imply interaction for a common purpose.
>
> K.A. (prof.)

Finally, for O.B. community has an emotional connotation which neighborhood lacks.

> Community means home; a place where you not only live with others, but it means caring about that section of the city where you live, which you call your community, and which you are very aware of--not only that it's physically here, but you're aware of its heart. The heart of the community is something you know because it's part of you. You are offering something to that community too, you get involved in ways that you can help people. It's a feeling of belonging. But neighborhood has no emotional connotation: it's just a physical area, and the reputation it has
>
> O.B. (non-prof.)

In summary then, staff and council members were more likely to think of community in terms of interaction and/or united action for common goals than patients. Table 13.22 indicates that, if one takes all respondents as one group, their descriptions offered support for the definitions of neighborhood and community proposed in chapter five at least to the extent that a larger percentage of respondents saw neighborhood in non-interactional terms and active community in terms of united action. Almost as many, however, defined neighborhood and community in terms which fit the hypothesized concept of latent community.

Whether an active community would, in fact, emerge in case of need cannot be determined at this point. No very serious emergency arose during the two-year period of the study--it was therefore impossible to observe just how the people living in the catchment area of NWHC would behave. Defining community in terms of joint action is no guarantee that such action would, in fact take place.

TABLE 13.22

EXTENT TO WHICH DEFINITIONS OF NEIGHBORHOOD AND COMMUNITY OFFERED BY RESPONDENTS COINCIDED WITH THOSE HYPOTHESIZED IN THIS STUDY[a]

Definitions Offered by Respondents for:	Proposed Definitions for:					
	Neighborhood		Community Latent		Community Active	
	f	%	f	%	f	%
Neighborhood (N=181)						
Geographic area and facilities	64	18				
Attributes	7	2				
Area and people	28	8				
People	-	-				
Interaction/ neighborliness			71	20		
Common background/ interests			6	2		
United action for common goal					5	1
Community (N=180)						
Geographic area and facilities	15	4				
Attributes	-	-				
Area and people	23	6				
People[b]	4	1				
Interaction/ neighborliness			54	15		
Common background/ interests			27	7		
United action for common goal					57	16

[a]This table includes the answers of all respondents (patients, staff and council members) who offered definitions. The total number of answers =361. Percentages are based on this figure.

[b]This use of the term "people" is distinguished from the way it was used in table 13.18: There it implies friends, relatives, social network systems--here it was just offered as a general statement that a community is made up of human beings; it is neutral aggregate.

Summary

All respondents connected with the N-W community council were in favor of community participation in the operation of service organizations. Approval by NWHC staff, on the other hand, was less unanimous, with professionals somewhat more in favor of such participation than non-professionals. Whether ambivalent or negative opinions were directed against the council then in office or against community participation per se was often difficult to determine. There was some indication, however, that many non-professionals felt safer in the hands of an established institution like NWHC's back-up hospital than with members of their own SES when it came to such concrete fiscal matters as responsibility for paychecks and pension funds. But regardless of their position at the center, most respondents who were in favor of community participation or expressed ambivalent feelings about it thought in terms of community input rather than control.

Several facts emerged from this study:

1. Communications between the N-W council and both center staff and patients was very poor.

2. Views regarding the ideal functions of the council varied greatly and, in the case of staff, individually held opinions influenced assessment of the quality of the council.

3. Most staff members did not award the council high

marks for expertise or performance in office.

4. The question of the council's representativeness was raised by many of the center's staff.

5. The issue of ethnicity appeared to concern staff members more in connection with the council than with employment at NWHC. It was as though power raised the specter of conflict and bias.

It was impossible to determine if the management training council members received improved their ability to govern a complex system like NWHC appreciably since there was no way of knowing how they would have functioned without such training. The apparent lack of confidence in council's ability on the part of staff could have been partly due to the large turn-over in council membership. It is also possible that training should have been geared more carefully to individual council members' past experience and their ability to deal with abstract concepts. Participation by some people with middle class and professional expertise, if kept in proper check, might have been an asset. (The new council does have some members with such expertise.)

Only slightly more than half of Int. I respondents were able to define the term "community participation"--many of these individuals perceived it in terms of joint action toward a common goal. A similar percentage was in favor of groups such as the council; the most frequently

cited reason here was the need to provide for community input in health care. Most of the respondents who were familiar with the concept favored some form of participation, though not all felt that it was effectively operating in their area. It should not, therefore, come as a surprise that fewer than half of the Int. I respondents reported knowing of the N-W council's existence. Specifically, only 41% of this group of 90 perceived the presence of varying degrees of community influence on the operation of NWHC; the relevant figures for the back-up hospital were much smaller.

Although fairly large numbers of Int. I respondents reported voting in city, state and national elections, few voted in council elections (and many reported never having received notification of the 1972 election) or belonged to other voluntary organizations.

Most interviews and my personal observations created doubt that loss of the center would constitute sufficient cause to unite residents of the center's catchment area in common action, i.e. the creation of an active community, unless strong leadership emerged.

On the other hand, findings of this study lent some support for the definitions of neighborhood and community offered previously: a majority of individuals appeared to perceive of "community" in terms which included psychosocial aspects, e.g. interaction, help in case of need, joint

action toward common goals, rather than in purely physical and institutional terms. The case for "neighborhood" was less clear-cut: although a large percentage perceived it in non-interactional terms, almost as many included interaction in their definition; only a tiny fraction, however, mentioned united action for the common good.

The extent of the areas Int. I respondents designated as "their" neighborhoods did not differ significantly. There appeared to be a slight trend for people with larger neighborhoods to use center services less often, and for those with smaller neighborhood to know about the N-W council and to perceive varying extents of community influence in the operation of NWHC. Size of neighborhood showed a significant relationship to respondents' social space.

PART III

DISCUSSION AND CONCLUSIONS

CHAPTER XIV

RECAPITULATION, IMPLICATIONS, AND RECOMMENDATIONS

The aims of this study were to investigate:

1. the dynamics of a decentralized, comprehensive health care facility which was operated with community input, in the hope of adding to knowledge regarding viable urban health care delivery systems.

2. the degree to which a neighborhood health care center could alleviate some negative aspects of the American health care system.

3. the degree to which the North-West Health Center fulfilled the mandates of enabling legislation regulating health care, including that of community participation in the planning and management of this care.

4. the effects of the physical environment on this health care facility and on the individuals within it.

5. the value of the working definitions for the concepts of neighborhood and community proposed in this study.

An holistic approach was utilized because of a belief that a variety of factors influence the dynamics of any system under investigation--including the perceptions of the investigator. The questions raised in the body of the paper were formulated with this in mind. Principal methods of

investigation were participant observation and various types of interviews; these led to the following conclusions:

1. Most patients, staff, and council members were satisfied with the care by NWHC. The most frequently cited reasons were: Easy accessibility of the clinic; low-cost, personalized, and dignified care of good quality which was attuned to patients' psychological needs; staff's positive attitudes toward patients; less fragmented care; some attempt at comprehensive care; continuity of care with the same providers.

2. Ethnicity, age, social space, and distance of patients' homes from NWHC all influenced utilization of center services to varying degrees--it should be remembered that some of these variables were nested.

3. Being a decentralized facility, NWHC presented a less imposing facade and achieved some organizational autonomy, thus making it less intimidating for patients.

4. The concept of career ladders for non-professionals was perceived as a failure by staff. It must be noted, however, that many individuals received their first jobs and training at the center.

5. While a large percentage of patients expressed philosophical approval of community participation in health care, few knew that NWHC operated with such participation. This implies that the community council did not function adequately as a liaison between NWHC and the community.

Many staff members approved of community participation, but felt that the actual board input was not satisfactory. As no firm guidelines for council functions had been established by the enabling legislation, staff was assessing council performance according to personal standards.

6. Staff was more likely than patients to regard NWHC as a community facility. The center did not, however, serve at all as a focal point for community activities.

7. Fifty-five percent of all respondents conceptualized "neighborhood" in physical and demographic terms, and 32% thought of "community" in interactional terms. The characteristics proposed in this study for "latent community" were ascribed by respondents as often to neighborhood as to community.

8. Hardly any patients and few staff members thought it likely that a closing of NWHC would lead to a spontaneous formation of an active community within the catchment area. However, ever-present threats of financial disaster did affect staff morale adversely.

9. The hypothesis that NWHC's physical lay-out, comfort, and appearance would affect staff--especially lower level staff--more overtly than patients was confirmed. No confirmation was found for the proposition that the building itself might serve as a symbol for better health care to the community. Little support was found for the suggestion that the physical plant would influence perception of the quality of care. Environmental factors did, however, shape

staff's functions and role perceptions to some extent; this in turn seemed to increase the continual jockeying for better and/or more space among staff.

10. Lack of space might also have played a part in the imperfect implementation of the team concept, and the failure to utilize medical assistants as new professionals more fully.

Implications of the findings

The concept of a systems model, discussed in Chapter I, serves as a useful framework for a discussion of the implications of the data generated in this study. This discussion is organized around the following principal areas: The North-West Health Center, the health care system, and community.

The North-West Health Center System

Selected characteristics of patients and staff. One of the notable characteristics of NWHC was the skewed distribution of ethnic groups among its patients and among various staff categories. Thus, the majority of patients was Hispanic, but hardly any Hispanic professionals worked at the clinic. Whites formed a minority among patients, yet most physicians--but hardly any non-professionals--were White. There were few Black doctors at the center, though Blacks were well represented among other staff categories and patients.

The findings regarding ethnicity of NWHC physicians

differed from those reported by Tilson (1973) in his study of characteristics of neighborhood health center (NHC) physicians. Tilson compared a number of features of nationwide NHC physicians with non-NHC physicians of similar age and who practiced in the same cities. Although NHCs surveyed in his study showed great diversity in most variables, Tilson found that generally NHC physicians, as compared to both his control group and the national average, were much more likely ($p<.001$) to be Black, and to be women--yet, according to Tilson, these 2 groups represented only 2% and 7% respectively of the national physician population in 1968. NHC physicians were also more likely to be internists or pediatricians (i.e. in the primary care specialties). They were less likely to be board certified ($p<.05$). In addition, NHC physicians showed a somewhat higher tendency to be foreign medical graduates. There were no differences between NHC physicians and the control group with reference to AMA membership or to mean age of graduation; but NHC physicians tended to be younger than the control group--which might help explain the lower incidence of board certification among the former.

NWHC did employ a relatively large number (37%) of women MDs. As far as I could ascertain, 26% of its full-time physicians were trained abroad; 98% of those working full time were either internists or pediatricians. Although I believe that a majority was board certified, I have no data on prevalence of such certification. Neither

do I have any data on age, AMA membership, or age at graduation. Income of NWHC physicians was higher than the medians reported by Tilson--inflation, as well as regional differences, may explain this to some extent.

Tilson found that NHC physicians were in a financially favorable position when compared to their national peer group in the same specialties; and that among NHC physicians the starting salaries of Blacks were usually higher, and those of women lower than the salaries of non-Black, male NHC physicians. Physician turn-over tended to be great. Tilson did not compile any data on Hispanic physicians in NHCs; they probably formed part of those mentioned as holding foreign degrees.

In view of his findings regarding the high percentage of Black physicians in NHCs, their scarcity at NWHC is puzzling. It is, of course, possible that the existence of a Black and Hispanic middle class in that specific metropolitan area in which NWHC was located induced the majority of the small number of physicians belonging to these ethnic groups to enter private practice rather than to accept a salaried position. The difficulties with obtaining attending privileges at NWHC's back-up hospital might have been an additional reason against entering center service.

One of the assumptions underlying OEO planning of NHCs was the desirability of some ethnic congruence between patients and physicians (Tilson, 1973). It is possible, however, that attempting to achieve such congruence could

create new problems, while solving some existing ones.

The belief of OEO planners (shared by me) was that patients would feel more comfortable in a health care facility which is staffed by members of their own ethnic groups on all organizational levels. The data tend to support this assumption to some extent. Yet it leaves several questions unanswered. One of these has to do with the problem of the ideal concept of what constitutes quality care; another with the relationship among various subcultural groups; a third with the general question of expectations.

Given our social system in which most prestigious occupations and wealth are held by Whites, is there a conscious or sub-conscious equation of "White" with "quality"? If Black patients come to a health care facility and see many Black physicians, do they feel more confident and comfortable or would they question the quality of care? With Hispanics an additional facet is added to the problem: Apart from the paucity of Hispanic physicians in this country, there is the additional fact that the various Hispanic nationalities on occasion do not feel very comfortable with each other. Would a Puerto Rican or Dominican feel more at home with a Cuban physician than a White North American? And would a Cuban patient trust the expertise of a Puerto Rican doctor?

These are hidden issues which could only be dealt with in a research project which concentrates on intra-

and-inter-ethnic relationships and evaluations of various occupational groups. It was not one of the primary subjects of the present study. Despite this fact, it did appear in several instances that ethnicity affected perception of the center. The study indicated, for example, that:

1. Over 90% of Hispanic Interview I respondents commented favorably about the linguistic and emotional communication made possible by the presence of Spanish-speaking personnel. Hispanic patients singled out Hispanic non-medical staff when commenting about personality factors they liked in NWHC employees because they felt more comfortable with people who spoke their language and who shared a Latin cultural background. It is possible that they did not mention physicians' personalities because of cultural and/or linguistic communication difficulties. This omission might, however, well rest in the difference of the relationship with high status professionals on the one hand, and with individuals who are closer to one's own SES on the other hand. As the data show, Hispanic patients obviously had no doubt about the professional competence of non-Hispanic physicians.

2. The fact that some White patients (a) commented about prejudice on the part of Hispanic or Black center staff and (b) expressed feelings of displacement and powerlessness in both NWHC and the neighborhood was taken as an indication that these Whites perceived the social environ-

ment as stressful.

3. Black patients might have been socialized to perceive the status of doctor as over-riding the ethnic question.

4. Finally, relatively new immigrants are likely to have a unique outlook, face different problems. Just being a newcomer usually prevents one from knowing the prevailing culture, customs, services, etc. This was true for every wave of immigrants to this and other cities; it might be true for Hispanic newcomers. The similarities in attitudes held by Blacks and Whites in this sample--and the differences exhibited by the Hispanic respondents--may be due to the fact that American-born or raised Blacks and Whites, despite long-standing mistrust of each other, share more common attitudes and expectations with one another than either does with first-generation Hispanics. This situation is intensified by the fact that, as Wagenheim (1972) pointed out, White immigrants were usually more rapidly acculturated than Hispanics--especially Puerto Ricans, who are now only three hours and some dollars removed from their homeland and, therefore, habitually shuttle back and forth. Wagenheim asserted that many second-generation Puerto Ricans still suffer from identity crises and vacillate between the North American and Latin cultures.

In general, it should be noted that patients did not refer directly to the shortage of Hispanic professional personnel or White non-professionals. Such references did

occur in staff interviews. These talks also yielded indications of tension due to ethnicity among staff and council members. Differences between patients and staff can be attributed to a dissimilarity in priorities: Patients looked first and foremost for the best health care available to them--who rendered this care was probably of secondary importance. Staff's chief concern was with their own job security and working conditions. Tension between ethnic groups which is apparent in American society at large was bound to affect center staff.

Hispanic, Black, and White patients could also have had different medical expectations which were, at least partly, shaped by their past history in medical care. While the health care system of Puerto Rico was quite deficient prior to World War II, an excellent government-directed health care program (one quarter of it federally financed) has been instituted since then (Wagenheim, 1972). By 1972 the island had a modern medical center in San Juan, a large number of regional hospitals, free public health care clinics even in small towns. Almost three-quarters of Puerto Rico's doctors were government employed. Thus, although 60% of the island's residents could not afford private medical or dental care, anyone who lived within reach of a small town could have clinic care. The resulting advances in lower infant mortality, greater life expectancy, and generally improved health status might also explain those positive attitudes toward health care

personnel found among many Hispanic respondents, and the fact that Hispanics reported much more consistent use of NWHC than did Black or White respondents.[62]

Availability of health care facilities did not, however, according to Wagenheim (1972), preclude a high incidence of spiritism both on the island and in the barrios of mainland towns. One form this spiritism takes is the use of various herbs, either in the form of teas or--mixed with alcohol--as rubs, incense, candles, magical powders, as well as Christian and Pagan symbols which are sold in botánicas.

Black NWHC patients came largely from the rural South or the ghettos of this and other cities--in either case they were accustomed to deficient medical care and/or to ER care (e.g. Ginzberg, 1971; D. Schorr, 1970; Strauss, 1970). The medical facilities they had encountered in the past were often inhospitable and culturally alien. The mental set they had developed was on crisis intervention rather than prevention or rehabilitation.

NWHC's White patient population--especially the old--had immigrated from Europe. Many of them had a history of hospital ER use. However, due to sub-cultural self-help or charitable organizations, settlement houses, physicians of the same background who rendered low-cost service, and a

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[62]No data on other Hispanic countries are offered because Puerto Ricans constituted the majority of Hispanic center patients.

larger membership in the unionized working class or the lower middle class (e.g. Glazer & Moynihan, 1970; Herberg, 1960; Sochen, 1974), many of them had been accustomed to different, perhaps more effective and culturally less alien health care delivery facilities.

The physical environment. The data presented in this study show that NWHC's physical environment affected the goals and operations of the center and the work of many staff members to some extent. The physical lay-out, apart from the scarcity of space, appeared to interfere with communications between the various departments and the administration. For example, placing all physicians and the waiting room in one wing of the floor, and outreach personnel in another lessened the chances of spontaneous consultation. The fact that the dental department was the only NWHC section which was placed on a different floor set it apart from the rest of the organization; it was less well integrated than other departments. The mental health and social services (MHSS) department which, although on the main floor, was somewhat removed from the rest of the clinic area (see Fig. 2, Appendix A) also seemed to remain a little outside the mainstream of the organization. It was, however, difficult to assess how much of this apparent separation was due to personnel characteristics of MHSS, and how much was due to the location of their offices.

One of the initial goals of NWHC was comprehensiveness and continuity of care. Use of multidisciplinary

teams was seen as one of the principal mechanisms to achieve this goal. As discussed in Chapters XI and XII, the physical lay-out was one of the factors which inhibited the realization of this goal. Failure to use existing space optimally, as well as shortage of space, also obviated the most efficacious utilization of paramedical and paraprofessional personnel. In addition to functional effects, this created some negative subjective feelings for several staff members. Thus, lack of room to perform one's function efficiently (as in the case of nurse-practitioners) sometimes resulted in the apparent downgrading of the function itself. Lack of space in which to practice newly acquired skills (e.g. medical assistants) resulted in some doubt about one's ability to perform these skills. The fact that lower-level staff were not allowed any privacy and comfort was taken by some to reflect on their worth as human beings.

Lack of space was also responsible for the curtailment of services and thereby made center care less community oriented. It made it difficult to always assure the comfort and privacy of patients. In the course of my two years at the clinic I also had the purely subjective impression (i.e. I never actually timed encounters) that paramedical and paraprofessional staff spent less time with patients on those occasions when the clinic was crowded. I do not believe that this was as true of physicians. Their own environment was more protected by both the

appointment system and the fact that they did not need to leave their examining rooms--they had barriers and buffers. MAs, on the other hand, were hemmed in by the crowd. Besides, since it was usually the patients who upset the schedule by being late, by missing appointments, or by walking in for service without appointments, most doctors did not mind keeping them waiting. Screening nurses and MAs were the ones who had to explain to these patients why they had to wait.

In this context it should be noted that while walk-ins and missed appointments could seem to support Strauss' (1970) contention that an appointment system is not geared to the life style of the poor, many NWHC patients picked precisely the fact that appointments were given as one of the positive aspects of this clinic. Moreover, sending reminder cards reduced missed appointments drastically. This indicates that it might have been less the appointment per se than the time which elapsed until the appointed day which caused the large rate of missed appointments.

The fact that patients did not generally complain too much about the physical environment was probably again an issue of personal priorities: Patients came for care; they received this care--which they usually perceived as satisfactory--in a relatively short time, as compared to hospital ERs. The setting in which this care was rendered was apparently not of primary importance. This agrees with the findings of Kasmar, et. al. (1968).

In addition, one must look at the whole life situation of these patients. Many lived in crowded quarters, and their past experience with service organizations probably did not lead them to expect anything different.

It is also difficult to detect possible subtle detrimental effects of the environment through a study like the present one. Anxiety, created by the situation in NWHC's waiting room can serve as one example. At times patients expressed anxiety about hearing their names called or about being heard when talking to staff members. Patients were not always sure that they could see or be seen by the screening nurse, MA, etc. as they sat in the waiting room. Sometimes they wondered whether large numbers of waiting patients would prevent them from receiving the care they sought. Crowding per se created stress and tension for a few. If the medical problems of some of these waiting patients included hypertension or other conditions adversely affected by anxiety, then both the physical and social structures could contribute to the physiological ill-being of these patients and could, therefore, go totally against the raison d'être of a health care facility. This is one clear example of how a specific aspect of a physical plant --such as a waiting room which is often crowded, somewhat noisy and disorganized--can be counter-productive to the goals of both patients and institution.

It is important to keep in mind, however, that the effects and perceptions of there being too many people in

a given space vary. It may be just as easy to sit in long rows than in more informal U-shaped groupings. A situation where only a few seats are available might be easier for some people because they need not decide which seat to choose. One could argue that it provides something of an anonymous privacy state. Thus, what is salient in terms of the presence of others is possibly not so much the number of people in a given space, but the way they are distributed and interact, and what this distribution and interaction represents to the people involved.

If one occupies one of many seats which are arranged in rows, and which make interaction awkward, one becomes like "everybody else." In addition to being anonymous and private, there is a certain depersonalization involved because each occupant of these seats can easily feel that he or she is not noticed as a separate individual human being--an unsettling feeling if one waits for a needed service, although a waiting room setting does contain expectations of a mass until the point of seeing the person(s) waited for. The presence of many others does not necessarily interfere with what the person is doing--in this case waiting; it is the "being placed," a lack of freedom of choice, which could possibly create a symbolic sense of worthlessness. It may or many not impede one's getting proper health care, it may or may not interfere with the transmission of information. It might determine the amount of time staff will devote to each individual. Here

it is possible to speculate that being kept waiting could convey the message that one's time--and, by extension, oneself--is not worth very much, can be wasted.

In this context it is important to remember that many people, NWHC patients included, may evaluate a given situation in terms of stereotyped ideals, e.g. the way people who use the services of private physicians are presumed to be treated. If they have never waited in the offices of busy practitioners, they really have no means to compare the situation in clinics vs private office, or one office against another. Again, one must deal not only with the question of what NWHC patients expected, based either on hearsay or on their own past experience with clinics, social service agencies, the offices of private physicians, etc., but also with the more intangible effects on feelings and behavior of what these people believed they deserved to receive.

Observation of NWHC and interviews with various categories of people connected with the center indicated that a larger and better designed facility might have made it possible to serve a larger patient population, to offer more varied services, and to utilize personnel more efficiently. On the other hand, it is doubtful that one could increase the number of services, patients and, inevitably, staff appreciably without making the center too large to retain its ambience of personalized care. A clinic such as NWHC should be kept small enough to permit intimacy

between staff and patients--a feeling of comfort, belonging, and orientation on the part of patients--since this had much to do with overall NWHC patient satisfaction.

Talking about NWHC as it was until the fall of 1973, it should have been made more attractive, hygienic and functional, offering more comfort and privacy to patients. It should have provided staff with more space to work in, a place to relax, and to withdraw from one another periodically. This might have helped to lessen anxiety, tensions and hostilities. Taken in conjunction, all these environmental factors might have improved both the quality of care and the atmosphere in which it was rendered. This, in turn, might help bring people to the clinic for other than episodic care--the goal of comprehensive care would, thereby, be advanced.

A desire for additional space can, of course, be voiced in many situations, even where the amount of space one actually needs is really small. This may be due to at least two factors. One of these is that supposed lack of space is a simple, obvious environmental variable to which one can assign blame in the case of one's inability to deal with complex reasons for the way one behaves. The other reason has to do with the fact that some people never seem to have enough space, while others are good at utilizing whatever space is available ot them to their best advantage. This probably involves an ability to evaluate one's use of space critically, to recognize which spots are underutilized

or unused; how one places things; or if one carries out activities in a manner which makes the room appear cluttered --regardless of how much space there is.

It is probably true that even in a place like NWHC, which was small for the number of people and activities it had to accommodate, there were under-utilized corners, "cluttering" activities, etc. But the actual amount of space is only one factor of the possible effects of space on behavior and feelings. Others, probably equally important ones, are (a) the design qualities of any given space, (b) how these suit the functions performed it it, (c) the organization of these functions, (d) the influence of past experience, including cultural background, on expectations regarding space and behavior in it, (e) the effect of expectations one brings to a situation, and (f) how these expectations influence perception of the situation.

The central location of NWHC was an important factor in utilization of this facility. The data did not indicate that the building which housed the center had any symbolic value for the majority of respondents. Since it was located in the middle of the catchment area and in the immediate vicinity of several institutions important to one segment of the population or another, this finding was surprising. It might mean that (a) none of these institutions (e.g. police department, church, library, school) were viewed as a center of a community; (b) the two city blocks--i.e. the

one containing the Health Department compound--and the opposite one housing other service organizations, did not have the necessary qualities to make this a focal point--they did not invite, encourage, or enhance interaction. It is, however, also possible that the research instruments utilized in this study were partly responsible. Perhaps they were not sensitive enough to uncover these functions and meanings if they existed.

Thus the building appeared to be merely part of the medical system and part of the neighborhood or latent community system, both by definition and function. It did not form part of any active community at the time of this research. Its most important attribute seemed to be easy accessibility from patients' homes--one of the reasons given for use of NWHC.

Administration and supervision. Although NWHC had a definite table of organization, I was quite often struck by an impression that its chain of command, rules and regulations were not very clear or effective. Part of this was probably a very subjective reaction, due to a personal need for structure. Becoming aware of this quite early in the study, I attempted throughout my stay at the center to weigh my impressions very carefully. Yet I am still convinced that more stringent supervision by administration would have benefitted center operation. This impression was confirmed by many of my respondents. Several factors

were responsible for existing conditions.

The four people who formed the administration for most of the time of this study attempted to fill too many roles at once to be able to do justice to all of them. Some departments--especially those for which line supervisors had been trained--were better supervised than others. Some of the four members of the administration were less inclined to believe in laissez-faire than others. But many employees were left fairly well to their own devices; discipline and performance were, however, rather good in most instances.

Perhaps three of the most dysfunctional effects of NWHC's administrative style were the poorly defined functions of the N-W council, inadequate follow-up on new plans and programs, and insufficient attention to communication within the center. In this context it should be noted that each of these problems apparently existed from early on in the center's existence.

Neither council nor staff seemed to have a very clear idea of just what the former's role in the daily operation of the center was or should have been. Supervisors complained that their disciplinary measures were countermanded by council members; staff voiced resentment that various members of the council "stuck their noses into things they knew nothing about;" council, and to some extent administration, were loath to discipline community employees. Administration attempted to do justice to staff and council, but often only managed to aggravate both.

Poor attention to new plans, procedures, and programs often resulted in their being dropped, mismanaged, or subverted. Teams offer one example. On the basis of the data I gathered--and my interpretation of it--I believe that many of the problems with teams at NWHC might have been avoided if the concept had been consistently implemented from the beginning. Once a certain structure is set up within a system, it is difficult to change it, especially if it involves a concept which is new and/or alien to some of the members of the system. The situation at the center presented several aspects: One team seemed to function well as a unit. As for the rest, some providers knew which people in other departments handled a given patient and the patient's family and contacted these individuals when a problem arose, but they did not <u>think</u> of them as members of their own team. Conversely, some providers knew who the members of their teams were, but did not necessarily <u>contact</u> these individuals when they needed the service of another department. Finally, some providers simply <u>ignored</u> the whole idea of comprehensive care, did not look at a patient's problems beyond their own sphere of interest, and made unilateral decisions without informing other people on their teams.

Education, guidance, pressure, and consistent involvement by administration could have helped alleviate these existing shortcomings in the operation of teams. I do, however, believe that the physical lay-out of the

center contributed heavily to team malfunctioning. The floorplan of NWHC and its shortage of space offered a ready-made excuse not to attempt the implementation of certain center goals to providers who were not really dedicated to comprehensive care, to the team concept, and to new roles for health care providers, including the use of paramedical and paraprofessional personnel.

The physical environment was also partly responsible for poor communication, although here too plant and administrative style must share the blame. Shortage of interoffice telephones, lounges, and meeting rooms, the dispersion of departments which should have been within easy communicating distance of each other, and the placement of administrators' offices at a distance from the clinic area all contributed to poor communication; administration did not, however, make much of an effort to improve them. This caused much misunderstanding, ill-will, insecurity, and misinformation--all of which aggravated the difficulties which were created by financial uncertainty and lack of space.

Uncertainty of funding. This was one of the major problems facing NWHC. While under OEO sponsorship, this and all other OEO centers had, in effect, operated on a basis whereby overspending was eventually covered by OEO. This, as many programs have shown, is inefficient because it does not induce a habit of weighing costs against re-

sults. But the remedy is not to close programs because they are suddenly deemed to be too expensive, or to slash funds without serious scrutiny of all possible consequences. It is, rather, to design efficient programs and institute viable controls.

It is possible that the precarious financial situation, which developed when NWHC sponsorship passed from OEO to HEW, brought about some efforts on the part of the administration to scrutinize costs and third-party payments more closely. Since changes of sponsorship took place at about the same time as the change in center administration, it is impossible to speculate which of these two factors was the primary cause for greater fiscal responsibility. But, in addition to this positive development, recurrent financial crises also had several disruptive effects. It quite obviously was not conducive to long-term planning because it would hardly seem worth while to institute any new program without assurance that it would be allowed to prove itself. In addition, shortages of funds curtailed center services, thus making truly comprehensive care impossible. Only a few reasons for this last effect can be mentioned here.

Although NWHC, in conjunction with its back-up hospital could theoretically have achieved comprehensive care for center patients, in practice several circumstances worked against such a result. First, communication between the two institutions was not good, despite the use of the same chart for each patient by both institutions. In

addition, lacking admitting privileges, most center internists had no institutionalized means to influence treatments given by the hospital. I was told time and again that hospital physicians rarely communicated with a patient's center internist. They often did not bother to return calls, and almost never asked for or accepted advice of the NWHC practitioner. There were fewer complaints about this situation in the pediatric and mental health departments.

Second, many patients, especially non-Hispanic ones, were quite knowledgeable regarding the quality of service in the ERs and OPDs of the various voluntary and city hospitals. If they could not obtain the specialized services they might require at NWHC, they would seek these services in the clinics of other hospitals which they liked best. Thus one patient might utilize the arthritis clinic at hospital A and the cardiac clinic at hospital B, because she preferred these to the cardiac and arthritis clinics of the back-up hospital--while using the center for episodic care. The chances that her NWHC physician would be kept abreast with the developments of these various treatments were slight indeed.

Third, most hospital OPDs have the habit of referring patients from one of their clinics to others (Goodwin, 1975); a NWHC patient might easily get absorbed into the system of a given hospital and thus be lost to the center.

Finally, since patients were sent to the back-up hospital for given services by NWHC, they could slip into

the habit of going there even for services available at NWHC and at hours when the center was open. Many center patients were found to use the ER of the back-up hospital inappropriately (Gorman & Nelson, 1974).

On the other hand, as was pointed out before, offering a complete array of services at the center would make it too large and, probably, institutional. One solution might lie in (a) offering a few more of the most often used specialty services at NWHC, (b) establishing better communication with the back-up hospital, (c) instituting effective patient education regarding the importance of continuity of care, and (d) establishing a communication system with those ER and OPD services used by center patients.

Another consequence of the uncertainty of funding was that it made the establishment of other than direct health services problematic. Even if, in one given year, there had been sufficient funds to start some special programs for teen-agers, the elderly, or SRO residents, there was no guarantee that it would be possible to continue any or all of these programs the following year. Few, if any, such programs were therefore attempted. This not only made care less than comprehensive, it also prevented NWHC from developing into a valid community facility.

Less obvious consequences were no less harmful. Chief among these was the feeling of insecurity, most notable among non-professional personnel, engendered by fear of

impending budget cuts. Despite reality testing, this insecurity often prevented people from assimilating information in a meaningful way. It produced continued stress which interfered with interpersonal relationships, functions, and ambitions regarding continued training and schooling.

Financial uncertainty also absorbed too much of the time of administration and council. They were therefore unable to devote more of their energies to the actual operation of the center and to community relations. A project director or council chairperson whose time is primarily occupied in meetings with HEW, local, and national politicians, in order to prevent cut-backs in funding and/or assure funds for the coming year cannot be expected to have the energy and time needed to supervise center functions or to devise better means of communication with the community.

It also appeared to me that financial uncertainty caused each neighborhoood health center to become so absorbed in its own needs that undue competition in the scramble for funds developed both within and between the various regions of the country.

Finally, being threatened with cutbacks or even cessation of funding might have been counterproductive to the rendering of comprehensive care. Although efficiency and cost controls are necessary, it could be questioned whether improvements in productivity statistics are always compatible

with effective and comprehensive care. Some patients might need a great deal of time with physicians or other providers. Are they to be denied this time because it would lower the productivity figures of providers? It is difficult to visualize an improved health care system which operates with assembly line and time-and-motion study mentality. NWHC physicians lost ime because patients were late for or missed appointments. Efforts, such as reminding patients of approaching appointment dates, can be directed at improving efficiency without sacrificing time with patients. Many physicians and other primary care providers spent more time with their patients than would perhaps have been strictly necessary for a purely physical examination of the complaint which was being presented. But is this not part of the concept of comprehensive care? I cannot count the times when I witnessed some professional or paraprofessional staff member receiving phone calls from patients because they needed advice, help--or simply someone to talk to. This time could not be entered on encounter forms, but is this not part of an holistic approach to medical care? Should the elderly patients who came to the center simply to find some human companionship be shunted aside because the few minutes spent with them could not be statistically accounted for? It is difficult to see how truly holistic, comprehensive care can be achieved with a cost-effectiveness orientation. Even if one looks at the question from a purely economic point of view, giving some extra time to patients

occasionally saved money in the long run. Perhaps it kept a few people out of nursing homes a bit longer; it probably helped decrease admissions to mental hospitals. It has been shown that institutionalization is more expensive than ambulatory care, and that ambulatory care which attracts patients does reduce institutionalization (e.g. Endicott, 1975).

The Health Care System

There are obvious shortcomings in the American health care system: replete with stop-gap measures and demonstration projects, it either lacks agreed-upon, long-term goals or it is not given the tools to implement whatever goals there are. Trying to assign blame for this condition is a fruitless exercise. The fight against long-range plans has at times produced such strange bedfellows as the American Medical Association and Samuel Gompers of the American Federation of Labor (Bullough & Bullough, 1972). No goals beneficial to the majority of citizens can be agreed upon as long as individuals and organized groups are permitted to give priority to their own interests over those of the public. Besides, the problems of the American health care system are only part of a larger picture of inequities in our society, as for example in housing, nutrition, education, employment--all of which reflect our social and political values and systems. Neighborhood health center patients might get more considerate care than that which is

offered by hospital clinics, but many continue to live in injurious physical and social environments (Muller, 1971). Our "political culture" (i.e. those aspects of the general culture which are concerned with the role of government) shows ambivalence: It would seem to vacillate between the old ethos of a Protestant ethic, self-sufficiency, and free enterprise on the one hand, and a firm commitment to government responsibility for assuring equity for all, together with the necessary long-range planning to achieve these goals, on the other hand (Bernstein, 1970).

One example of lack of coherent goals is offered by the proposed national health insurance bills; another by the uncertainty surrounding funding of neighborhood health centers. The health insurance bills which have been introduced so far neither agree on the degree of responsibility government should assume, nor on the amount of protection to which the public is entitled. They do not agree on the need for comprehensive quality care, rational organization of delivery, and greater input by consumers, and they have no clear-cut plans for accomplishing whatever goals each set for itself.

Observation of NWHC for two years made it abundantly clear that fiscal uncertainty was dysfunctional. It caused stress, dissention, poor morale and mistrust; none of these are phenomena conducive to the smooth functioning of an organization. Perpetual uncertainty regarding function, and doubt about continued existence made long-range planning

impossible--and without such planning it is difficult to fashion any complex system which would do justice to all the individuals involved in it, as well as to overall social goals. Yet, as these data also show, a center like NWHC could--if properly funded and administered--offer comprehensive health care, as well as training and work for community people. It could attract patients because of easy accessibility and because it is part of their neighborhood. Finally, it might institutionalize consumer input, team care, and a generally holistic approach to health care.

The need to regard the patient as a whole human being rather than a case is often mentioned as one of the desirable goals for our health care system (e.g. Balint, 1957; Bloom, 1963; Brown, 1961, 1962, 1964; Chez, et. al., 1974; Merton, 1957)--it underlies the whole concept of comprehensive care. Ideally, medical care for any individual should take account of the entire person--not just the presenting complaint. Health care providers should consider patients' entire life situation--where they live and with whom; where their children (if any) go to school and how they are doing; what kinds of problems they face when they get up in the morning; how they were socialized as children and what continued socialization they face as adults; what their social networks are and how these meet psychosocial needs. All these have to be taken in conjunction with the physical ailments they bring to health care providers because so very often these complaints are just a manifestation of various

other problems confronting patients in their daily lives--they are Balint's (1957) "presenting symptoms." Recognizing this, and dealing with the syndrome instead of just the presenting symptom might enable health care personnel to help people fashion better lives for themselves, rather than just being in frequent need of crisis intervention.

Ideal conditions are rarely realized in any sphere of life. The medical system faces, in addition, the very real problem that no one person (e.g. physician) could be expected to keep the total life situation of all his or her patients in mind. If, however, patients are in the hands of multi-disciplinary teams such holistic care is not impossible. It would involve the socialization of all the people in the medical system--providers and patients alike--to accept the goal of team care, and the new role concepts which are implicit in an institutionalization of the activities of various paramedical and paraprofessional providers. It would, in effect, involve changes in the values of both the cultural and medical systems. At this stage, most Americans believe that treatment by a private practitioner is superior to any other--and given the fact that for many people "other" means hospital ERs and OPDs, this is perhaps not surprising. Most American physicians want a fee-for-service system, with provision for clinic care for the indigent (e.g. Freidson, 1970). Values direct socialization, and socialization affects what we might have wanted by usually changing it to what we think we should want.

It has been shown that there is a close relationship between poor health and disabilities on the one hand, and poverty on the other (e.g. Endicott, 1975). Many of our nation's poor need not be in such dire economic straits if they had received adequate medical care in time, or if rehabilitative measures would now be taken (Cohen, 1970). These people are deprived of primary, secondary, and tertiary preventive care. The reason for this is partly that health care facilities are not readily available to many of them, and in part that they do not always utilize services which are there. The need is, therefore, twofold: (a) to insure the existence of readily accessible health care facilities which provide quality care in a dignified manner to the whole family, and (b) to educate people to use these facilities in an appropriate manner.

Leaving humane arguments aside, there is a good economic argument for such a course of action: healthy citizens are productive, they are less of a drain on the nation's economy. Viable health services therefore represent a sound investment (Baily, 1970). Rice (1966) suggested in this connection that one should think about the problem in terms of both direct cost--i.e. the purchase of health services, and indirect cost--the loss of productivity.

But in order to be viable, health services must fit the needs of those they want to reach. Knowledge about, demand for, and utilization of a given health care facility might depend on such diverse variables as cultural background,

age, work history, family status, one's place of residence, etc. The present study has shown that the poor are not an homogeneous mass--it makes no more sense to talk about "the poor" than it does to think in terms of "the old," "the women," or any other aggregate of people who share certain characteristics. This has been confirmed by a study of low-income public housing projects (Walter, 1972) which clearly indicated that, although residents shared the characteristic of having low incomes, they differed in family structure, life styles, etc. Suttles (1968) and Rainwater (1970) made similar points. Perhaps one of the problems with the formulation of various programs which were meant to help the poor is that they define these people as homogeneous because they are poor.

Although many segments of the American population have rising expectations due to greater knowledge in various spheres of life--including health care--there are still large pockets who do not utilize available services. Some reasons for this are lack of knowledge, low expectancies regarding the efficacy of the service, cultural blocks, fatalism, mistrust of the system, etc. These people must be reached if we want to break the vicious cycle of poverty which causes poor health, which in turn prevents people from working, thus causing greater financial want, bad nutrition, living conditions, and more ill health, and so on ad infinitum (Sigerist, 1943).

Neighborhood health centers--decentralized facilities

which aim to provide comprehensive care by multi-disciplinary teams--have the potential of breaking this cycle because they are equipped to acquire the requisite knowledge about their patients' medical, social, economic, and psychological characteristics. The utilization of teams can prevent fragmentation of care without sacrificing the advanced knowledge of various specialties. Such centers also reduce the patient loads of hospital ERs.

Community System

The idea for creating NWHC had come primarily from community people, and had been executed by these same individuals and the back-up hospital. Prospective patients had been involved in center affairs from the very beginning. This was one of the reasons why I had thought it possible that NWHC could have enventually formed the nucleus of an active community. Secondly, it served residents of the area with two important functions: The delivery of comprehensive health care, as well as training and employment for some of the area's indigents. Finally, it operated with government-mandated community participation. This could, at least theoretically, have encouraged further joint action to alleviate other needs of the residents. Why, then, did the center apparently fail to help create an active community?

Several explanations seem reasonable.

1. NWHC's patients, staff, and council members (center

people) did not reflect the actual distribution of various demographic characteristics of the catchment area's population. At the time when the center had financial eligibility requirements, and thus could not be representative of the area's economic characteristics, center people did not reflect either the ethnic or age distributions of the population of its catchment area: 13% of the families living in this area were listed as Puerto Rican in the 1970 Census, yet 37% of NWHC's 1973 patient population were Puerto Ricans (see Tables 8.2 and 9.3)--this group was thus overrepresented at the center, while Blacks with 17% of the area's families, and Whites[63] were underrepresented.

On the other hand, individuals over age 65 were not well enough represented among center people: 1970 Census figures for the City Planning District which included the center's catchment area, but extended 26 additional blocks southward, showed that 31% of the district's population were 65 years or older--94% of this group designated themselves as White. Yet only 7% of NWHC's individual patients were in that age group, and White families of all ages formed only 2% of the total patient population. Considering that Medicaid and Medicare are permitting a portion of the poor and most old people greater freedom of choice among various health care providers, it is impossible to

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[63]The census figures I had available did not give separate figures for Whites and such other groups as Cubans, Dominicans, Haitians, Indians, etc. Knowledge of the area indicated, however, that Whites constituted at least 50% of the catchment area's population.

speculate whether the groups which were underrepresented at the center did not use it because they were unaware of its existence, or because they preferred other facilities.

Table 8.4 indicates that the ethnic distribution among staff was 45%, 27%, and 20% for Hispanics, Blacks and Whites respectively, with the remaining 8% belonging to other ethnic groups, especially Haitians. No age distribution for staff was available, but I do not remember encountering anybody even approaching age 65.

The 20 N-W council members in office in the spring of 1973 were 35% Hispanic, 40% Black, and 25% White. Two of these 20 individuals were obviously over age 65, a third one might have been.

It is impossible to predict whether NWHC's patient population could ever reflect the income distribution of area residents. Considering the crowded quarters occupied by the center during the time of this study, and the comparatively high fees stipulated by the sliding-fee scale which was instituted in the summer of 1973, I doubt that NWHC would attract even a minute fraction of the area's non-poor residents; perhaps an especially high quality of service might do so.

2. The fact that different catchment areas were designated for various services and political activities made it difficult for the people involved with NWHC to enter into sustained interaction with each other. Sexton (1965) noted in this connection that the poor of East

Harlem--many of whom were Puerto Rican--might have been more likely to become involved in community action if all city departments had the same boundaries, and if the city had provided ombudsmen for this area. To this one might add the need for the existence of a nucleus of residents who have been provided with expertise in management and self-rule.

Since center people differed in so many respects--e.g. their ethnic distribution at the center, their histories in the US and the city, SES, age, social space, life style, the extent of their social networks, their cultural background, the development of consciousness as members of a given ethnic group with attendant perception of rights and power, or lack thereof--association at NWHC appeared to be insufficient ground for the formation of an active community. Whether a strong and determined leadership and/or a crisis situation would have changed the situation cannot be determined with the data on hand.

3. The commitment of center people to the center and community could have been expected to vary in proportion with the degree of importance these two bodies had for psychosocial, political, and material reasons. Status emerged as a determining factor for depth of commitment to the center, while ethnicity played a greater role in commitment to the community. Patients were fairly strongly committed to NWHC because they liked the care they received there, because the clinic was easily accessible, and--for Hispanics

and Haitians (about two-thirds of the patient population)--because they found employees of their own ethnic groups there. Members of the council's executive board and their staff were strongly committed because they were in a position of leadership and some power. It was impossible to separate this factor from a political belief in community participation. The rest of council gave an impression of a much lower degree of commitment. Center administration's strong commitment was based mainly on ideology and was heavily overlaid by emotional attachment. Non-administrative staff varied: The pay for all categories was good, but professionals would have encountered less difficulty in finding comparable salaries than non-professionals; commitment for economic reasons was, therefore, probably stronger on the part of the latter. Some individuals were truly dedicated to the ideals of decentralized, comprehensive care and/or community participation; others looked at NWHC as a convenient workplace which did not engage any emotional or normative attachment.

As for commitment to the community at large, the data do not permit more than an indication that Hispanics of all statuses and White patients were least committed; Blacks of all statuses and White professionals were most committed.

4. The N-W council had failed to develop adequate means to acquaint the electorate with council functions and council candidates, to inspire people to vote in council elections, or to serve as a channel of communication between center and

community.

The 1972 N-W council by-laws were dysfunctional to the extent that a two-year tenure in office proved insufficient to acquire the necessary skills to manage the center, develop a constituency in the community, involve community people in sustained interaction, and assume community leadership roles. Those who drafted the by-laws believed that enough council members would be re-elected in bi-annual elections to provide some continuity;[64] this was, however, by no means a certainty. They also did not allow for the high attrition rates in membership which made continuity unlikely. Some provision, such as staggered tenure, should have been incorporated in the by-laws.

An added problem was created by the fact that several lower-echelon staff members made it clear that the poor do not necessarily trust members of their own SES to manage programs where large sums of money are involved. This situation is aggravated in ethnically heterogeneous communities.

But unlike many other community boards, the N-W council did not face serious opposition from the medical system as represented by center physicians and the back-up hospital, or from HEW.

5. It is impossible to ascertain whether better implementation of the career ladder and team concepts would

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[64]This was stated in an open council meeting on April 20, 1972.

have fostered a closer relationship between providers and patients, center and community and, thereby, would have enhanced the likelihood of the center forming the nucleus for an active community or not. On the one hand it is possible that well-functioning teams would better educate patients than single practitioners. The best way to teach people to believe that they are entitled to explanations is by consistently explaining. The easiest means of fostering a demand for accountability is by regularly and voluntarily offering such accountability.

Satisfied center-trained health care personnel who believe in community participation and assume positions in other health care facilities might instill beliefs in community participation in people using these facilities. It is, however, equally likely that these staff members would eventually adopt the values of the new system they join.

6. It is difficult to determine whether active participation by center patients in center and community affairs was minimal because no great crisis arose during my stay there to create an active community. A sizeable number of people involved with NWHC considered the place a community facility and were committed to it. Their commitment did not, however, seem to be due to their thinking of it as a community facility, but rather because most felt that the care was better. In addition, patients felt more comfortable and less depersonalized than in hospital ERs; and non-professional staff had been offered an opportunity

for upward mobility. Perhaps this is one meaning of "community care."

On the other hand, one may question why--given the many problems faced by the area's residents (e.g. inadequate housing and police protection, crime and drug addiction, extreme poverty, etc.)--an active community had not crystallized and whether NWHC could or should have assumed a more aggressive and diverse leadership role.

7. Finally, frequent mention by mass media and social scientists of the "non-involved" city dweller could be a self-fulfilling prophesy: If one is led to believe that others will not get involved, the chances are that one will decide against becoming involved.

It is, however, important to keep in mind that an active community might have negative consequences as well as positive ones--it might become exclusive, discriminatory, parochial, i.e. analogous to Suttles' (1972) "defended neighborhood." Sexton (1965) thought that this is what happened in Chicago's Back-of-the-Yards.

Once again, as with the question of evaluation and perception of health care and the physical environment, expectations of the people involved probably helped influence attitudes toward community and the degree of participation.

The Role of Expectations

Expectations are not only determined by societal

values, but also by one's past history, the current conditions in one's life, and such factors as ethnic background, SES, and age, It could thus be postulated that individuals who are upwardly mobile or who have been used to better services in the past than they can currently afford might expect more from public services than those who have always been poor and have no hope of improving their condition. Members of an ethnic group which has achieved a certain degree of consciousness and militancy might expect more than people who belong to a group which has not yet attained these attitudes. Government promises and programs will raise expectations in all who know about them. Lastly, expectations often conform to prevailing cultural values. It is extremely difficult to separate these factors, to determine which attitude and belief is conditioned by what aspect of life.

Expectations will influence perception and use of services, as well as behavior within service organizations. People who expect little because our society has implied in more or less subtle ways that they are not worth much, are more likely not to use the services or to accept what is given without complaint. It is difficult to judge what one never experienced.

If these services are rendered in physically unattractive and/or inadequate environments it might reinforce lower self-evaluation and, therefore, lower expectations. This would mean, in effect, that for the poor--and apart

from the people who work in these environments--effects of the physical environment are largely symbolic and cannot really be separated from those of the social environment.

Finally, the researcher has his or her own ideas of what subjects "really" expect, or should expect. These ideas might structure the research design and, therefore, the results to some extent.

Recommendations

The North-West Health Center

All of the following recommendations arise out of the findings of this study. They are based on the assumptions that (a) the center now occupies the same space that it did at the time of the study, (b) administrative and supervisory structure and style have not changed appreciably, and (c) the SES and ethnic composition of patients and staff have remained basically unaltered.

Physical lay-out. Because poor communication and poor functioning of teams were partly influenced by the existing floorplan of NWHC, and because of the dysfunctional effects of spatial organization on staff, the following suggestions for changes are offered.

The proposed changes aim at placing all members of a given team in close proximity to each other within a defined area. In addition to improving communication between team members, this would also provide paramedical and parapro-

fessional personnel with adequate workspace. Finally, one could make provision for some rooms to which staff could withdraw periodically. Offices of the medical and project directors, and of supervisors involved in primary care would be placed in strategic locations throughout the team areas to allow for more effective supervision and communication.

If one were to remove most of the partitions throughout the main floor, it should be possible to create separate areas for four teams. Each of these areas would contain the team's physicians, dentist(s), RNs and NPs, MAs and DAs, outreach and MHSS personnel, secretaries and appointment clerks. Each would have its own, informally furnished waiting area with coffee dispenser and pay telephone; each would have its own toilet. This would permit easier visibility of and by staff, as well as more comfort for all individuals in the area.

The space now occupied by the dental department on the ground floor, including the waiting room used jointly by NWHC and HD dental patients [65] would thus be available for some of the employees who have no direct contact with patients. Specifically, I would suggest placing the medical records department, the offices of the business department, fiscal administrator, training department, and transportation

---

[65]This waiting room comprises approximately 800 square feet which were not included in the total NWHC area mentioned in the body of this report.

there. A supervised playroom for children who accompany their parents to the clinic but who are not themselves waiting for any service should also be located in this groundfloor area.

The eastern wing of the main floor (see Fig. 2, Appendix A) should house the laboratory, X-ray, and intake departments--all sharing a small waiting area; and a supervised playroom for children who are waiting for treatment. Separating sick children from well ones reduces risk of contagion. Separating the two playrooms from the team areas would reduce some of the noise and movement in these areas. Although some children might wish to remain with their siblings and/or parents, some improvement in comfort for both children and adults would result.

The northern and southern wings could then become available for team areas. The offices presently occupied by transportation, training, and part of intake would be excluded--they would, instead, house the ER, EKG room, and the nutritionist's office. These rooms are suited for this purpose because, being placed along a corridor, they do not really form an integral part of any other area. On the other hand, they are centrally located for use by all teams.

Installation of a solid-state telephone panel next to the receptionist would free the existing telephone room for inclusion in one of the team areas. The storage room in this wing could be freed by consolidating all supplies in

one central location.

The whole of NWHC should be repainted, with each team area, the east wing, and the groundfloor area in a distinct but complementary color scheme which should be clearly identified on a large sign at the entrance to both the HD building and the second floor. This will make orientation at the center easier for patients.

Installation of central air conditioning (a.c) to improve temperature and ventilation is feasible because the original ceilings are 11 1/2 feet high, and because there is no additional floor over the southern wing of NWHC. One could thus place a large a.c. unit on the roof, drop all ceilings, and install a complete system of ducts. Elimination of window a.c. units and improved electrical wiring would also remove hazards of overloaded circuits. Audio-visual installations in the waiting areas could be used for patient health education.

Organization. Although the prevailing low level of bureaucratization was perceived by some patients and many staff members as one of the positive aspects of NWHC, a better defined organizational structure might make center operation more efficient. By removing uncertainties regarding functions and responsibilities, it could also improve morale and the quality of work.

A strict definition of council functions should be one of the first steps in this direction. Next, each de-

partment should be provided with its own supervisor--a position referred to as line supervisor in this report. They would be accountable to the director of their department. These directors--with the exception of the medical and dental director (both of whom should spend part of their time as health care providers) would each head a number of departments. All would report to the project director. Project director and department directors would form the center's administration.

Project director, department directors, and supervisors would be responsible for communication within and between departments. In addition, they should be responsible for making certain that new programs and procedures are carried out and that the effects of innovations are evaluated. It might be profitable to consider the feasibility of appointing a team coordinator.

Ongoing in-house evaluation of center function should be institutionalized. Ideally, this should be an instrument which--with modifications to fit regional characteristics--could be utilized by all centers in the country. Comparison between centers would thus be possible.

Although there may not be any funds available to send center personnel for training outside the institution, it should be possible to devise a creative and continuous training program for both professionals and paraprofessionals within the center. This might alleviate the feeling of stagnation and doubt in one's ability which was apparent

among some of the non-professionals. Such training sessions could also offer individuals some factual knowledge outside their own specialties.

Many of my talks with staff indicated that communication and morale of personnel could be improved if some procedure were established whereby small groups could meet periodically in order to clarify doubts, air grievances, reinforce the objectives of the center, and keep staff alert to the needs of patients, other staff categories, and the institution as a whole. These meetings might be conducted by someone with training in group dynamics to avoid the dangers inherent in any group setting where given individuals can easily be singled out for abuse.

Finally, NWHC should attempt to hire more Hispanic and Black professionals, especially doctors; and a few more White paraprofessionals.

The effects of group sessions, of the ongoing training program, the organizational changes, and of a more representative ethnic distribution of job categories should all be included in the proposed periodic self-evaluation of the center.

Community participation. Because so many patients were found to be unaware of the existence of the N-W Health Council, a campaign should be mounted to acquaint patients with the fact that such a body exists, and that NWHC is supposed to be "their" center--a facility where they can

have some influence in determining how it is operated. Since the mailing of notices has in the past not achieved this result (either because the addresses were inaccurate, or because patients did not read the material), it might be necessary to conduct a house-to-house campaign. It should also be possible to have a council representative at the center in order to educate patients to the possibility of assuming some active role in the community. Some space would have to be set aside for this program.

The lack of awareness on the part of patients indicates that the various councils in office since NWHC was opened have not met fully the specific requirement to serve as liaison between center and community. Data presented in this report also indicate that they did not always exhibit the necessary managerial skills. This, in turn, might mean that the training they received had not been very effective. Training of council members, regardless of their SES, should be continuous, and be geared to their level of education and their past life experience.

Government policy regarding health care. It is hoped that government will arrive at a definite long-range policy which will encompass the total health care field. What is needed is a firm and lasting commitment to health care. Stepping into the breach in one problem area or another, as Medicaid and Medicare have shown, has not worked. Although these programs were necessary, they inflated medical costs

for the whole population because they were not part of a total, well-integrated plan which could be supplied with adequate safeguards against spiraling costs.

Government responsibility should go beyond formulating programs for the health care of the underprivileged segment of the population Bayley (1970), for example, suggested that it needs to mediate such questions as the relative value to society of a short prolongation of life for a few vs better care for many. This is not a popular issue with either the medical profession or the public in general. Or, to take another issue, the law of supply and demand so dear to a market economy simply will not work in medicine--the demand for adequate medical services by urban ghetto dwellers or by residents of rural communities does not insure supply. Finally, the medical system as such simply does not stress preventive care. The role of leading the way to a more rational distribution of facilities and personnel, and a more rational determiniation of the types of services to be stressed really falls to the federal government. It must be this body because past experience with Medicaid, foodstamps, direct financial support, and other poverty programs has shown that not all state governments can be trusted to enact viable programs.

The fact that ours is the only industrialized country in the world without some form of national health insurance would seem to indicate that in the rest of the industrialized world there is recognition that government has a responsibility

for the medical care of its citizens. One cannot expect the medical profession or commercial insurance companies to formulate a national health insurance scheme which would provide the same basic services to all residents, regardless of income.

Conclusion

On the basis of this study, I would suggest the need for an holistic framework for evaluations of ambulatory health care--and probably a variety of other--facilities. As became apparent here, one must take into consideration the transactional nature of the relationships between goals, functions, hierarchical structure, administrative style and funding of the organization, the space it occupies, the type of people it serves and employs, its relationship with other organizations both within and outside the health care system, and the degree of comprehensiveness of care it renders. Special attention should be given to the following aspects.

The population which is to be served--its numbers, SES, age, ethnicity, family status, social space and networks, past and present health care habits because all these appear to influence utilization, perception and expectation of, demand for, and satisfaction with given services.

The epidemiological characteristics of the catchment area--in order to identify the scope of existing problems. Facilities in an area which has a comparatively large number

of inhabitants whith chronic diseases will have to stress tertiary preventive services; one with a large incidence of narcotics or alcohol addiction or suicide rates will need extensive psychiatric, detoxification, and suicide prevention services. Factors such as these must be taken into consideration for planning, and in evaluating how given facilities meet the specific needs of the area they serve.

The number and types of all medical and non-medical services--in order to evaluate the extent of duplication or gaps among these various services; coordination and cooperation between them; and the extent to which each is being used by the catchment area's population. This will give an indication of the comprehensiveness and efficiency of available care.

The ramifications of policy decisions by sponsoring agencies--on the goals and operation of the facility, its clients and staff.

The existing grassroot organizations representing clients--who belong to them, and how effective are they? Federal rhetoric incorporated in Great Society legislation appeared to aim at the creation of political power bases within the community. It is necessary to evaluate if this is actually desired and expected in a given community, if it has been realized, or if a possible gap between expectations and reality exists. If such a gap does exist, does it have any effects on the health care facility and the individuals involved with it?

The hierarchical structure and role relationships within the organization--this affects staff, patients, and interpersonal relationships within and between these groups. Ethnicity, SES, and age are additional factors which might be important in given settings.

The role of the physical environment--what is its importance to specific groups and at specific times? It should be established what degree of saliency it has for particular statuses in the hierarchy, and for the physical and psychological well-being of the individuals who fill various roles in the organization. What are the environment's effects on organizational structure, efficiency, communication, and goals? In settings with goals similar to those of NWHC particular attention must be paid to the role played by the environment on achieving comprehensive care by multidisciplinary teams, the training and utilization of paraprofessionals, and the possible circumvention of given goals by some people. At what times and under what conditions does the physical setting play a greater role, and when is it of less importance?

The use of research methods, instruments, and data analysis appropriate to the research site--is especially crucial with certain segments of our population. The urban poor, for example, are suspicious of research and might therefore refuse when asked to fill out yet another questionnaire. They might not, however, object to focused interviews which permit them to voice opinions on matters

important to them--especially once they have learned to trust the researcher. Description of phenomena which the researcher observed might yield better understanding of the facility and the people in it than statistics of frequencies of these phenomena. Finally, computation of arithmetic means might be misleading in establishing the actual degree of utilization of health care facilities. Looking at above and below median use appears to offer a more reliable picture of the distribution of use. Successful comprehensive care should eventually achieve a fairly consistent level of use rather than both minimal and maximal use by the same people. The latter could indicate an orientation which is predominantly geared at crisis intervention, rather than prevention and continuity of care.

The expectations people bring to a service and its setting, and the meanings these assume in the individuals' minds--are of utmost importance to most of the foregoing points. There is a strong need to develop reliable methods for investigating expectations, evaluating meanings--and how to partial out the researcher's own expectations and meanings ascribed to others from those of the people he or she studies.

APPENDICES

LIST OF APPENDICES

Appendix		Page
A	Floorplan of the North-West Health Center (Main Floor Only)	529
B	Guideline for Pilot Study with Patients	530
C	First Letter to Prospective Interview I Respondents	532
D	Follow-up Letter to Prospective Interview I Respondents	533
E	Interview Schedule for Interview I	534
F	Guideline for Open-Ended Interviews with Hispanic Respondents	577
G	Guideline for Pilot Study with Center Supervisors	582
H	Guideline for Focused Interviews with Center Staff	583
I	Guideline for Focused Interviews with Council Members and Their Staff	585
J	Specific Incident Schedule	587
K	Map of the Catchment Area of the North-West Health Center	588
L	Photographs of 11 Locations within the Catchment Area of the North-West Health Center	589
M	Computation of the Social Space Score	595
N	Additional Tables (See Separate Listing)	598
O	Computation of the Score for Dissatisfaction with the Physical Environment of the North-West Health Center	634

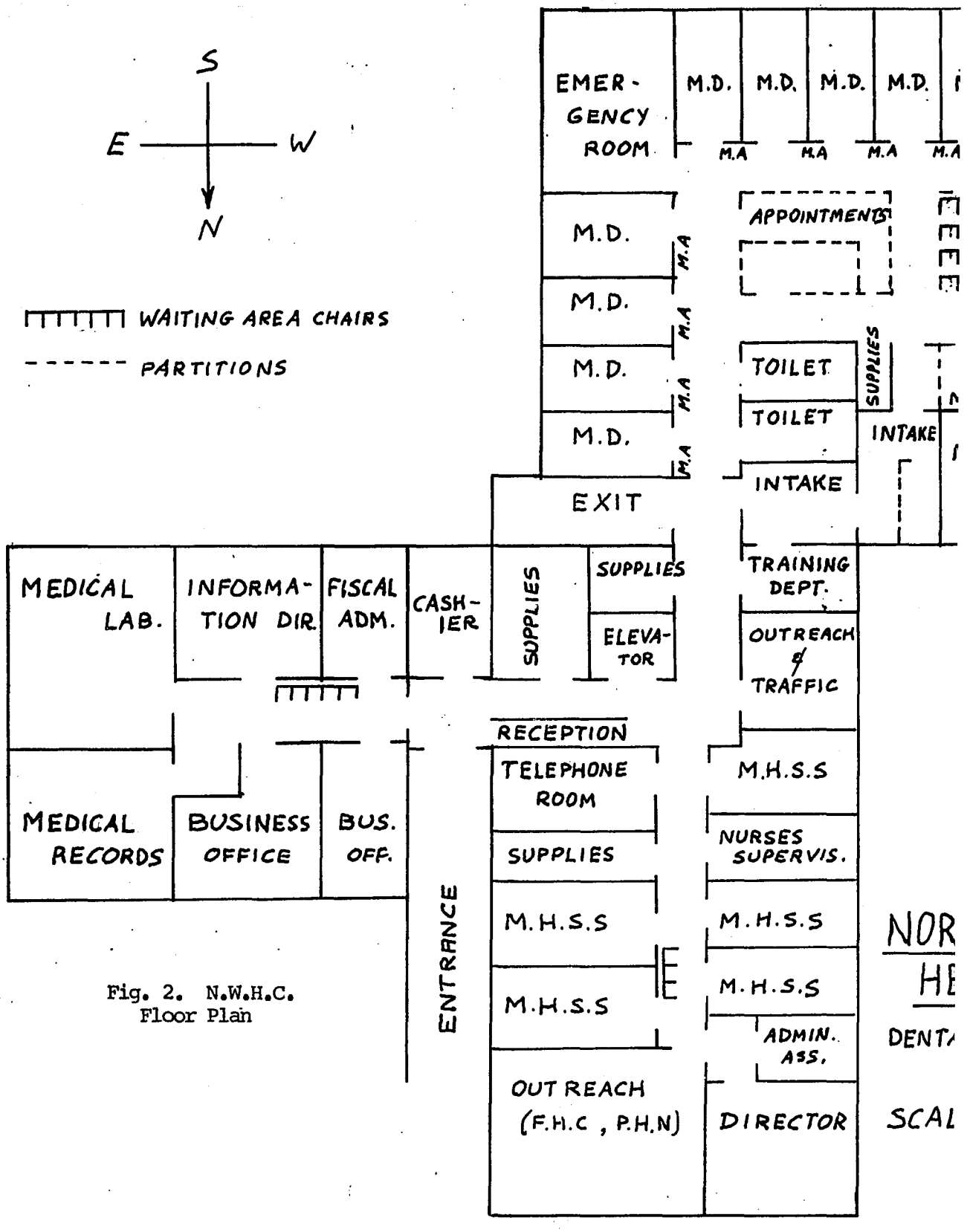
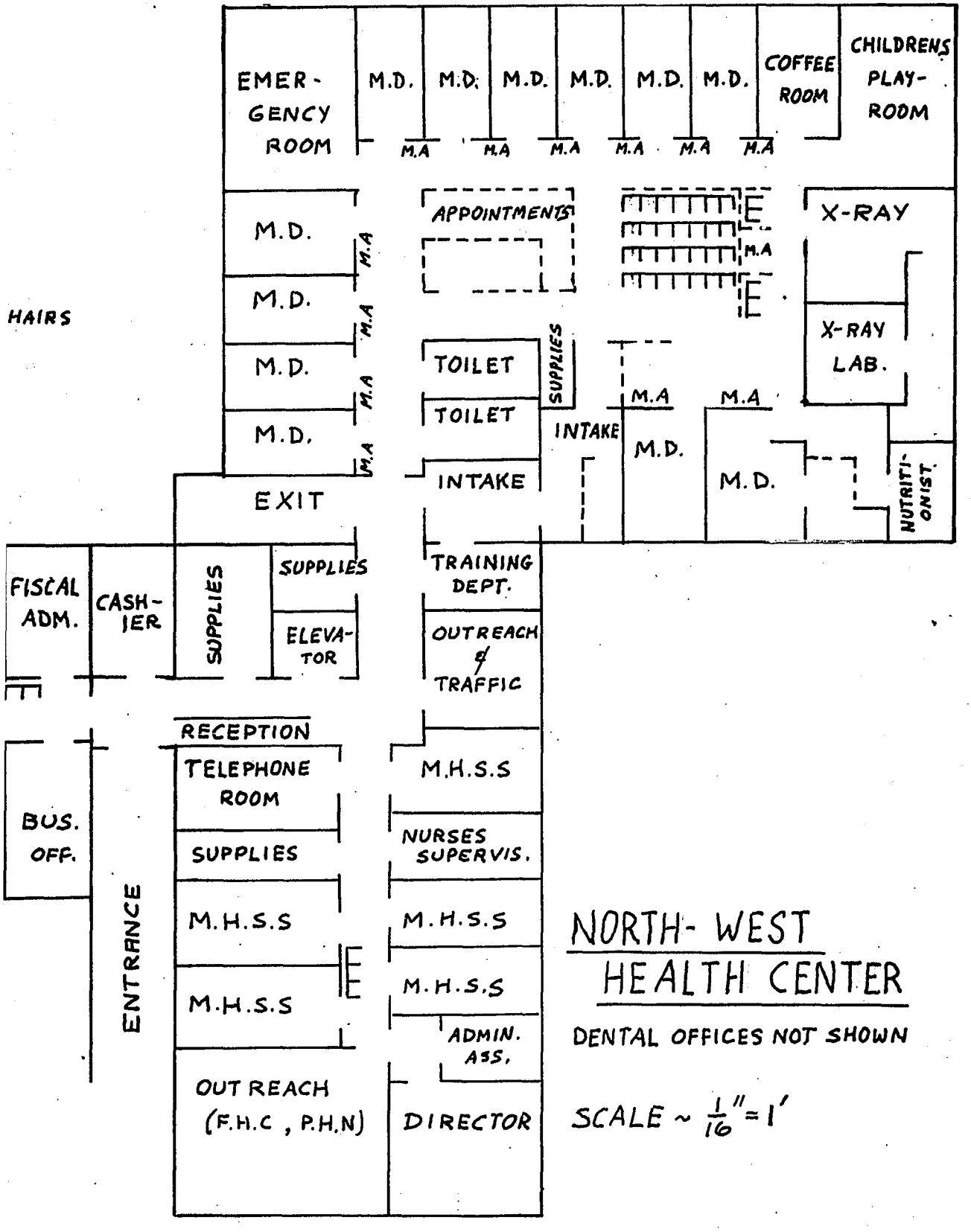


Fig. 2. N.W.H.C.
Floor Plan



NORTH- WEST HEALTH CENTER

DENTAL OFFICES NOT SHOWN

SCALE ~ $\frac{1}{16}'' = 1'$

APPENDIX B

GUIDELINE FOR PILOT STUDY WITH PATIENTS

Introduction

I am a student at . . . [name of university] and am trying to find out what health care people in . . . [name of city] get. Would you be willing to talk to me about your experiences? (If yes): Have you used this clinic before? (If yes): Can you tell me how you feel about it? (Respondents who are at the clinic for the first time will not be used.)

1. Demographic--gotten without direct questions (guesstimate)
2. Use of other clinics--which ones
3. Comparison of NWHC with others (here note especially adjectives such as "ours," "mine," etc.)
4. Awareness of options
   a) if yes--reasons for using this clinic
   b) if not--why not
   c) is there division of use
5. Source of information regarding center
6. Knowledge of criteria for eligibility
7. Thoughts about physical set-up--find out especially about
   a) waiting facilities

b) treatment rooms

c) facilities for children

d) ease of orientation

8. Location of center--e.g. accessibility

9. Satisfaction with care received at NWHC

a) medical competence

b) personal attention

c) teaching self-care

10. Awareness that some center personnel live in neighborhood

a) is this important--if yes, why

b) does it make a difference in care provided

c) does it affect perceived freedom to complain, effect changes, demand rights, etc.

APPENDIX C

[The center's letter head]

May 15, 1972

Your Neighborhood Health Center is interested in giving you the best possible services. To help us do this, we need all the information we can get about how you see your needs and how we can work to help you with your health problems. A study is, therefore, being conducted by an independent group of researchers to gather this kind of information. Anything you tell them will be kept strictly confidential as your name will not appear any place on the questionnaire.

One of the researchers will contact you for an appointment at your convenience. This interview can be carried out either in your home or any other place you prefer. Thank you very much for your cooperation.

Sincerely yours,

Medical Director

APPENDIX D

May 19, 1972

A few days ago, you received a letter about a study being done concerning your Neighborhood Health Center located at . . . I have been asked to interview an adult member of your family in order to find out how the health center might best serve your needs. I would like to say again that any information you give will not contain your name.

I will be phoning you soon to arrange a convenient time for the interview. If you do not have a telephone, I will contact you personally. I hope you will find it possible to speak with me for a short while, since the services provided by the clinic can meet your needs only if you make them known. If you have any questions about the nature of this study, I will answer them when I contact you to make the appointment.

Sincerely yours,

Interviewer

Hello. Mr. (Mrs.) _____? I am _____ who asked to talk to you about the health center on 100th Street. I am interested in how you and other people feel about the service at the health center, and would like to ask you some questions about it. There are no right or wrong answers -- I am really interested in what you have to say, in your experience.

Anything you say will be confidential, your name will not appear anywhere. When I am finished with all the interviews, I will just give the people at the health center some idea about what their patients like or dislike about it.

If I ask a question you would rather not answer, please feel free to tell me and we will skip it and go on to the next one. If there is something you don't understand, please ask and I'll be happy to explain.

Are there any questions you have now?

[NOTE: At all times, if you see a puzzled look, please inquire if respondent has any questions.]

CARD I

Interviewer _____

Date _____

1 _____
2 _____
3 _____
4 _____
5 _____

Time Started _____ Time Finished _____

Code # for respondent [indicate whether male and/or female adult(s)] _____

E.G. _____
S _____

6 _____
7 _____
8 _____
R.C. 9 _____
10 _____

APPENDIX E

CARD I

1. The first thing I would like to ask is if you, yourself, use the Neighborhood Health Center on 100th Street .....

11
yes _____ (1)
no _____ (2)
N.R. _____ (3) GO TO 2

a. IF YES ASK:

About how often did you use the center during the past year

_____

12 _____ times

2. Do you use any other places for health care?
[NOTE: This information will be used in Question 18, 32, 40, 71, 72].

13
yes _____(1)
no _____(2) GO TO 3
N.R. _____(3)

a. IF YES: Can you give me their names, please?

_____

_____

14 _____

b. About how often during the past year did you go to them?.....

15 _____ times

c. For what reasons?_____

_____

_____

16 _____(1)

d. IF St. Luke's is not mentioned as specific "other"place, ask:

Do you use St. Luke's? .....

17
yes _____(1)
no _____(2) GO TO 3
N.R. _____(3)

e. IF YES: About how often did you use St. Luke's during the past year?

18 _____ times

f. For what reasons? _____

_____

_____

19 _____

CARD 1

For respondents who live alone, skip to Q 5: For those sharing quarters with other family members, ask:

3. Do other members of your family use the health center?..... 20

yes _____(1)
no _____(2)
NR _____(3) GO TO 4

a. IF YES: Which? 21

husband _____(1) _____
wife _____(2) _____
children _____(3) _____
mother _____(4) _____
father _____(5) _____
sister _____(6) _____
brother _____(7) _____
other (specify) _____(8) _____
N. R. _____(9) _____

4. I'll mention other members of your family. Will you tell me where do they go for their health care?

_____

_____

_____

_____

husband _____(1) 22
wife _____(2) 23
children _____(3) 24
mother _____(4) 25
father _____(5) 26
sister _____(6) 27
brother _____(7) 28
other (specify) _____(8) 29
N. R. _____(9) 30

5. When you talk about the neighborhood health center at home, what do you call the place?

_____ 31 _____

_____

[NOTE: If possible, use this term for the rest of the interview.]

CARD 1

For respondents who live alone, skip to Q 7: For respondents who live with other family members, say: From now on when I say "you", I mean you and your family.

6. Please think of this past year and tell me about how many times your family used the center ..... 32 _____ times

7. For what complaints? _____

_____ 33 _____

_____ 34 _____

_____

_____

CARD I

8. Would you say that this year was typical for your family?

35

yes _____(1) GO TO 9
no _____(2)
D.K. _____(3) CONTINUE ON 8a
N.R. _____(4)

a. In what way wasn't it typical? _____

_____

_____

_____ 36 _____

_____ 37 _____

_____

9. Where did you get your medical treatment before you used this center?

_____

_____ 38 _____

_____

10. As you look back over the past year, when members of your family were sick, where -- besides this center -- did you go for advice? Here I would like you to think of all the different people or places you went to for such advice _____

_____ 39 _____

_____ 40 _____

_____

Are there any questions you would like to ask?

11. Think about the health center and the care the doctors and nurses give you, compare it with other places you know and tell me how they compare. On the whole, would you say it is better, worse, or about the same than other places you know .....

41

better _____(1)
worse _____(2)
about the same _____(3)
D. K. _____(4)
N. R. _____(5)

11. a. Why? _____

CARD I

42 _____

43 _____

12. Think about the care you get at the center, compare it with what you know about the care people get from private doctors and tell me if you think it is better, worse, or about the same.

44

better _____(1)
worse _____(2)
about the same _____(3)
D. K. _____(4)
N. R. _____(5)

a. Why? _____

45 _____

46 _____

13. Think about the care you get at the center, compare it with what you know about the care people get at St. Luke's clinics and tell me if you think it is better, worse, or about the same.

47

better _____(1)
worse _____(2)
about the same _____(3)
D. K. _____(4)
N. R. _____(5)

a. Why? _____

48 _____

49 _____

CARD 1

14. Now think about the care you get at this center, compare it with what you know about the care people get at other New York hospital clinics you know about and tell me if you think it is better, worse, or about the same.

50
better _____(1)
worse _____(2)
about the same _____(3)
D. K. _____(4)
N. R. _____(5)

a. Why? _____

_____

_____

_____

_____

_____

51 _____

52 _____

15. Finally, think about the care you get at this center, compare it with the care you think most New Yorkers get and tell me if you think it is better, worse, or about the same.

53
better _____(1)
worse _____(2)
about the same _____(3)
D. K. _____(4)
N. R. _____(5)

a. Why? _____

_____

_____

_____

_____

54 _____

55 _____

16. What transportation do you use to get to the health center?

56
walk _____(1)
car _____(2)
bus _____(3)
subway _____(4)
center provided _____(5)
other (specify) _____(6)

17. How long does it usually take you to get there? _____ minutes

CARD I

57
less than 5 minutes _____(1)
5 - 10 minutes _____(2)
11 - 15 minutes _____(3)
16 - 20 minutes _____(4)
21 - 25 minutes _____(5)
26 - 30 minutes _____(6)
more than 1/2 hour _____(7)
D. K. _____(8)

18. [If the respondent uses other places for health care too -- see Question 2 -- fill in names below and ask for each of them what means of transportation is used and how long it takes to reach it.]

Facility	Means of Transportation: walk	car	bus	sub-way	center prov'd	other (specify)	Time (in minutes)
1.							
2.							
3.							
4.							
5.							
6.							

58 _____
59 _____
60 _____
61 _____
62 _____
63 _____
64 _____
65 _____
66 _____
67 _____
68 _____
69 _____

19. When you decide where to go for health care, is the amount of time you spend in getting there very important, somewhat important, of little importance, or of no importance?.....

70
very important _____(1)
somewhat important _____(2)
of little importance _____(3)
of no importance _____(4)
D. K. _____(5)
N. R. _____(6)

a. Are there any other things connected with transportation which influence where you go for health care? .....

71
yes _____(1)
no _____(2)
D.K. _____(3) } GO TO 20
N.R. _____(4)

CARD I

19. b. IF YES: Can you tell me what these things are? _____

_____

_____ 72 _____

_____

20. Which times of the day do you prefer to go for medical services? 73

morning	_____	(1)
afternoon	_____	(2)
evening	_____	(3)
any time	_____	(4)
doesn't matter	_____	(5)
other (specify)	_____	(6)
D.K	_____	(7)
N.R	_____	(8)

a. Why? _____

_____ 74 _____

_____

21. Which of the places you use makes it possible for you to go at the times most convenient for you and how do they do it? [If answer is NONE, go to 22.]

List places from 21	Reason	
_____	_____	75 _____
_____	_____	76 _____
_____	_____	77 _____
_____	_____	78 _____
_____	_____	79 _____
_____	_____	80 _____

CARD 2

22. Would you say that these office hours influence your choice of where you go for care a great deal, somewhat, little, or not at all? ....

. . .

11

a great deal	_____	(1)
somewhat	_____	(2)
little	_____	(3)
not at all	_____	(4)
D.K.	_____	(5)
N.R.	_____	(6)

CARD 2

23. How soon after you start feeling ill do you go for medical help?

_____ 12 _____

_____ 13 _____

_____

_____

Are there any questions you would like to ask?

24. Do you have a family health coordinator assigned to you at the neighborhood health center? .....

14

yes _____(1)
no _____(2)
DK _____(3) } GO TO 25 & 26
NR _____(4)

a. IF YES: Does she (or he) come to see you at home? .....

15

yes _____(1)
no _____(2) } GO TO 27
NR _____(3)

25. Do you think you should have one? .....

16

yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

26. Why do you think you don't have one? _____

_____ 17 _____

_____

_____

27. Do you know what family health coordinators are supposed to do?

18

yes _____(1)
no _____(2)
NR _____(3)

IF YES:

a. How do you feel about the family health coordinator services?

_____ 19 _____

_____ 20 _____

CARD 2

28. Think about each of the health workers at the center in terms of their ability to give you good advice -- not necessarily only in medical matters -- would you please tell me.

a. Do you think the doctors you see can give you good advice .....

21
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

b. Why or why not? _____

_____

_____

_____

22 _____

c. How about the nurses? .....

23
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

d. Why or why not? _____

_____

_____

_____

24 _____

e. what about technicians? Are they able to give you good advice?

25
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

f. Why or why not? _____

_____

_____

_____

26 _____

CARD 2

g. how about medical assistants? .....

27
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

h. Why of why not? _____

_____

28 _____

_____

_____

i. do you think family health coordinators can give you good advice?

29
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

j. Why or why not? _____

_____

_____

30 _____

_____

k. is there anyone else you can think of whose advice you would value?

_____

31 _____

_____

NOTE:

Move on to Q 31 on page 13.

CARD 2

31. As you think about members of the staff at the neighborhood health center:

a. How many would you say you know by name? _____ 32 _____

_____

b. What type of jobs do they have? 33

doctor	_____(1)
nurse	_____(2)
medical assistant	_____(3)
family health coordinator	_____(4)
social worker	_____(5)
technician	_____(6)
other (specify)	_____(7)
DK	_____(8)
NR	_____(9)

c. How many know your name? _____

_____ 34 _____

d. What type of jobs do they have?..... 35

doctor	_____(1)
nurse	_____(2)
medical assistant	_____(3)
family health coordinator	_____(4)
social worker	_____(5)
technician	_____(6)
other (specify)	_____(7)
DK	_____(8)
NR	_____(9)

e. Are there some you prefer to deal with more than others?..... 36

yes	_____(1)
no	_____(2)
DK	_____(3)
NR	_____(4)

} GO TO f

f. Why or why not? _____

_____

_____ 37 _____

_____

_____

CARD 2

g. Are there some you see regularly? .....

38
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

h. Why or why not? _____

_____

_____

39 _____

_____

For respondents familiar with St. Luke's (see Q 2a & c) ask: 32a through h; For others, skip to Q 33.

32. As you think about the members of the staff at St. Luke's:

a. how many do you know by name? _____

40 _____

_____

b. what type of jobs do they have? .....

41
doctor _____(1)
nurse _____(2)
medical assistant _____(3)
family health coordinator _____(4)
social worker _____(5)
technician _____(6)
other (specify) _____(7)
DK _____(8)
NR _____(9)

c. How many know your name? _____

_____

42 _____

CARD 2

d. what type of jobs do they have? .....

43
doctor _____(1)
nurse _____(2)
medical assistant _____(3)
family health coordinator _____(4)
social worker _____(5)
technician _____(6)
other (specify) _____(7)
DK _____(8)
NR _____(9)

e. are there some you prefer to deal with more than others?.....

44
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

f. Why or why not? _____

_____

_____

_____

_____

_____

45 _____

g. are there some you see regularly? .....

46
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

h. Why or why not? _____

_____

_____

_____

_____

_____

47 _____

CARD 2

33. Would you say that the fact that health workers know your personally, and you know them, influences your choice of where to go for your health care a great deal, somewhat, very little, or not at all?

48
- a great deal _____(1)
- somewhat _____(2)
- very little _____(3)
- not at all _____(4)
- DK _____(5)
- NR _____(6)

FOR NON-FRENCH & NON-SPANISH SPEAKING respondents skip to Q 36;
FOR SPANISH-SPEAKING respondents, ask Q 34; FOR FRENCH SPEAKING respondents, skip to Q 35.

---

34. a. Would you say that having Spanish speaking people working at the health center is very important, somewhat important, of little importance or of no importance?

49
- very important _____(1)
- somewhat important _____(2)
- of little importance _____(3)
- of no importance _____(4)

b. would you say that this affects the care you get? .....

50
- yes _____(1)
- no _____(2)
- DK _____(3) } GO TO 36
- NR _____(4) }

c. Why or why not? _____

_____

_____ 51 _____

_____

_____

For FRENCH-SPEAKING respondents ask Q 35:

35. a. Are there French-speaking people working at the center? .....

52
- yes _____(1)
- no _____(2)
- DK _____(3)
- NR _____(4)

CARD 2

b. Would you say that having French speaking people working at the health center is very important, somewhat important, of little importance, or of no importance?

53
very important _____(1)
somewhat important _____(2)
of little importance _____(3)
of no importance _____(4)
DK _____(5)
NR _____(6)

c. Would you say that this affects the care you get? .....

54
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)
GO TO 36

d. Why or why not? _____

55 _____

---

36. As you think about your experience at the center, have you ever refused to be treated by one specific doctor and asked to see another?

56
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)
GO TO 37

a. IF YES: Can you tell me why? _____

57 _____

CARD 2

b. Were you assigned a new doctor? .....

58
yes _____(1)
no _____(2)
NR _____(3)

37. Who decides which doctor you see at the center? .....

59. _____

38. How do you feel about this? _____

60 _____

61 _____

39. Should people have a right to choose their doctor? .....

62
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)
GO TO 40

a. Why or why not? _____

63 _____

40. Who decides which doctor you see at St. Luke's? _____

64 _____

41. Do you have anything to say about this? .....

65
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

Do you have any questions you would like to ask?

CARD 2

I'm going to ask for your opinion about a few specific things at the center. I am also going to ask how important you think these are in determining whether you come to the center for care.

42. First, would you say that the neighborhood health center has too much, enough, or too little space? .....

66
too much _____(1)
enough _____(2)
too little _____(3)
DK _____(4)
NR _____(5) GO TO 43

---

a. Would you say that this is very important, somewhat important, of little importance, or of no importance to you? .....

67
very important _____(1)
somewhat important _____(2)
of little importance _____(3)
of no importance _____(4)
DK _____(5)
NR _____(6) GO TO 43

---

b. Is there a specific area or time you are thinking about? .....

68
yes _____(1)
no _____(2)
NR _____(3)

---

c. IF YES: Which one? _____

---

43. Would you say that the center is often, sometimes or never crowded?

69
often _____(1)
sometimes _____(2)
never _____(3)
DK _____(4)
NR _____(5) GO TO 44

---

a. Is this very important, somewhat important, of little importance, or of no importance to you? .....

70
very important _____(1)
somewhat important _____(2)
of little importance _____(3)
of no importance _____(4)
DK _____(5) GO TO 44
NR _____(6)

---

b. Are there any specific times or areas you have in mind? .....

71
yes _____(1)
no _____(2)
NR _____(3)

43. c. IF YES: Which ones? _____

CARD 2

72 _____

CARD 3

44. Do you feel that the center is often, sometimes, or never nosiy? ..

11

often _____(1)
sometimes _____(2)
never _____(3)
DK _____(4) } GO TO 45
NR _____(5) }

a. Is this very important, somewhat important, of little importance, or of no importance to you? .....

12

very important _____(1)
somewhat important _____(2)
of little importance _____(3)
of no importance _____(4)
DK _____(5) } GO TO 46
NR _____(6) }

b. Do you have a specific area or time in mind? .....

13

yes _____(1)
no _____(2)
NR _____(3)

c. IF YES: Which ones? _____

14 _____

45. Do you believe that the center is often, sometimes, or never comfortable?

15

often _____(1)
sometimes _____(2)
never _____(3)
DK _____(4) } GO TO 46
NR _____(5) }

a. Is this very important, somewhat important, of little importance, or of no importance to you? .....

16

very important _____(1)
somewhat important _____(2)
of little importance _____(3)
of no importance _____(4)
DK _____(5) } GO TO 47
NR _____(6) }

b. Do you have a specific area or time in mind? .....

17

yes _____(1)
no _____(2)
NR _____(3)

c. IF YES: Which ones? _____

18 _____

CARD 3

46. Does the center have a playroom for children? .....

19

yes _____(1)
no _____(2)
DK _____(3) } GO TO 47
NR _____(4)

---

a. IF YES: Do you use it? .....

20

yes _____(1) GO TO 47
no _____(2) for respondents with children GO TO b
NR _____(3) GO TO 47

If respondent has children and answers NO to above ask:

b. Why not? _____

_____

_____

21 _____

47. Do you think there should be a playroom for children? .....

22

yes _____(1)
no _____(2)
DK _____(3) } GO TO 48
NR _____(4)

a. Why or why not? _____

_____

_____

23 _____

48. If you think about the times you have talked to a doctor at the center:

a. where did you talk with him? _____

_____

24 _____

b. what do you think about the amount of privacy you had? _____

_____

_____

25 _____

CARD 3

48. c. Can you describe how you felt about it? _____

_____

_____ 26 _____

_____ 27 _____

_____

_____

49. If you think about the times you talked with other center personnel:

a. where did you talk with them? _____

_____ 28 _____

b. what do you think about the amount of privacy you had? _____

_____ 29 _____

_____

c. can you describe how you felt about it? _____

_____

_____ 30 _____

_____ 31 _____

_____

_____

50. When you go to the center, do the people working there try to teach you how to take care of your health and that of your family? .....

32

yes _____(1)

no _____(2) GO TO b

DK _____(3)

NR _____(4) GO TO 51

IF YES, ASK a and b.

CARD 3

50. a. How do they do this? _____

_____ 33 _____

_____ 34 _____

_____

_____

_____

b. Do you think they should do so? 35

yes _____(1)
no _____(2)
DK _____(3) } GO TO 51
NR _____(4) }

c. Why or why not? _____

_____

_____ 36 _____

_____ 37 _____

_____

_____

51. Can you think of a time when the center personnel helped you with some problems which were not directly health problems? 38

yes _____(1) GO TO a and b
no _____(2) GO TO c
DK _____(3) }
NR _____(4) } GO TO 52

IF YES: ASK a and b

a. Can you give me some examples? _____

_____

_____

_____ 39 _____

_____ 40 _____

CARD 3

51. b. Can you tell me what type of job these people had? .....

41

doctor _____(1)
nurse _____(2)
medical assistant _____(3)
family health coordinator _____(4)
social worker _____(5)
technician _____(6)
other (specify) _____(7)
DK _____(8)
NR _____(9)

c. Would you have liked them to do so? .....

42

yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

52. Have you gotten such help from other clinics you used? .....

43

yes _____(1) GO TO 53
no _____(2)
DK _____(3)
NR _____(4)

IF NO, DK OR NR, ASK:

a. Would you liked them to do so? .....

44

yes _____(1)
no _____(2)
DK _____(3)
NR _____(4)

53. Does the center train people from this community for many of the jobs at the center? .....

45

yes _____(1)
no _____(2)
DK _____(3) } GO TO 54
NR _____(4) }

a. IF YES: How do you feel about this training program? Why? ___

_____

_____

_____

_____

_____

_____

46 _____

47 _____

CARD 3

54. Do you think there should be such a program? .....

48
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4) } GO TO 55

a. Why or why not? _____

_____

_____ 49 _____

_____ 50 _____

_____

_____

55. If you find that you cannot come to the center when you have an appointment, what do you do? _____

_____ 51 _____

_____

56. What are some of the reasons which might make it likely for you to miss an appointment? _____

_____ 52 _____

_____

57. If you do not keep an appointment, do you think this affects the work of the center? .....

53
yes _____(1)
no _____(2)
DK _____(3)
NR _____(4) } GO TO 58

a. Why or why not? _____

_____ 54 _____

_____ 55 _____

_____

CARD 3

58. Do you think the fact that you missed an appointment affects the way you are treated the next time you come to the center?

56
yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) } GO TO 59

a. Why or why not? _____

_____

_____

_____

_____

_____

57 _____

58 _____

59. Think of the times when you have just walked in to the center without an appointment, and think of other times when you have kept your appointment-- can you tell me if there were any differences?.....

59
yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) GO TO 60

a. IF YES: What were they? _____

_____

_____

_____

_____

60 _____

60. Is there a lot of paper work, answering questions, waiting around, and so forth connected with getting care at the center? .....

61
yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4)

61. How does this compare with other places you have used? _____

_____

_____

CARD 3

61. _____

62 _____

63

62. Have you ever recommended the center to people you know?..... yes _____ (1)
no _____ (2)
NR _____ (3) GO TO 63

a. Why or why not? _____

64 _____

63. Who decides how the center is to be operated? _____

65 _____

64. Where does the money for the center come from, and who decides how much the center should get every year? _____

66 _____

67 _____

65. Who is allowed to use the center? _____

68 _____

CARD 3

66. Are you satisfied with this practice?.....

69

yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) } GO TO 67

a. Why or why not? _____

_____

_____

_____

_____

70 _____

67. How much do you think the people in the neighborhood have to say about the kind of medical care they receive at the center?.....

71

a great deal ____ (1)
some ____ (2)
a little ____ (3)
nothing ____ (4)
DK ____ (5)
NR ____ (6) } GO TO 68

a. How do you feel about that? _____

_____

_____

_____

_____

72 _____

68. How much do you think the people in the neighborhood have to say about the kind of medical care they receive at St. Luke's?.....

73

a great deal ____ (1)
some ____ (2)
a little ____ (3)
nothing ____ (4)
DK ____ (5)
NR ____ (6) } GO TO 69

CARD 3

a. How do you feel about that? _____

74 _____

69. Why do you think clinics like the neighborhood health center were started? _____

75 _____

76 _____

70. Does the center provide anything that is not available anywhere else?..... 77

yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) } GO TO 71

a. IF YES: What? _____

78 _____

CARD 4

71. What do other health facilities provide that you cannot get at the center? [NOTE: Get name of SPECIFIC FACILITIES]

Name of Facility	Service	
		11
		12
		13
		14
		15
		16

72. Think of a time when someone in your family did not feel well when the center was closed-- what did you do? _____

	17
	18

73. Is there anything you especially like about the center?..... 19

yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) } GO TO 74

a. IF YES: What? _____

	20
	21

CARD 4

74. Is there anything you really dislike about the center?..... 22

yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) } GO TO 75

a. IF YES: What? _____

_____

_____ 23 _____

_____ 24 _____

_____

_____

Are there any questions you would like to ask?

75. Have you ever used medical services outside New York City?..... 25

yes _____ (1)
no _____ (2)
NR _____ (3) } GO TO 77

76. When you think about the medical care you got there, how does this compare to:

a. the care you are getting in New York? _____

_____

_____ 26 _____

_____

_____

b. the care you are getting at the center? _____

_____

_____ 27 _____

_____

_____

CARD 4

77. Are you satisfied with the service at the center?.....

28

yes _____ (1) GO TO 78
no _____ (2)
DK _____ (3)
NR _____ (4) GO TO 78

IF NOT SATISFIED ASK:

a. Who do you think is responsible for this?_____

_____

_____

29 _____

_____

b. Is there anything you can do about it? _____

_____

30 _____

For respondents familiar with St. Luke's (see Q 2a & c) ask: 78.
For others skip to 79.

78. Are you satisfied with the service at St. Luke's?.....

31

yes _____ (1) GO TO 79
no _____ (2)
DK _____ (3)
NR _____ (4) GO TO 79

IF NOT SATISFIED ASK:

a. Who do you think is responsible for this?_____

_____

32 _____

_____

_____

b. Is there anything you can do about it?_____

_____

33 _____

_____

79. Can you think of any ways that the center could give better service?..

34

yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) GO TO 80

CARD 4

a. IF YES: How? _____ 35 _____

_____ 36 _____

_____ 37 _____

_____

_____

_____

80. What things can affect your health? _____

_____ 38 _____

_____ 39 _____

_____

81. When you were a child, where did your parents go for help when someone in the family did not feel well? _____

_____ 40 _____

_____

82. Were there any special ways your family used to treat various illnesses?..... 41

yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) GO TO 82

a. IF YES: Can you give me some examples (i.e. DISEASE & TREATMENT)? _____

_____

_____ 42 _____

_____

83. How did your parents feel about doctors and hospitals? _____

_____ 43 _____

_____

CARD 4

84. How do you feel about doctors? _____

_____ 44 _____

_____

_____

85. How do you feel about nurses? _____

_____ 45 _____

_____

_____

86. Do you prefer to make your own decisions about where to go for health services, or would you rather someone else told you where to go?..... 46

own decision ____ (1)
told ____ (2)
DK ____ (3)
NR ____ (4) } GO TO 87

a. IF "OWN DECISION" & "TOLD" ASK: Why? _____

_____

_____ 42 _____

_____

87. What do you think are some reasons that people get ahead in life?

_____

_____

_____ 48 _____

_____ 49 _____

_____

_____

CARD 4

88. Did you vote in the general election last November?.....

50

yes _____ (1) GO TO 89
no _____ (2)
NR _____ (3) GO TO 89

a. IF NO: Why not? _____

_____

_____

51 _____

89. Did you vote in the last Presidential election?.....

52

yes _____ (1) GO TO 90
no _____ (2)
NR _____ (3) GO TO 90

a. IF NO: Why not? _____

_____

_____

53 _____

I'm going to change the topic now because I want to find out more about your neighborhood.

90. What do you consider to be "your" neighborhood? _____

_____

_____

54 _____

USE MAP & PICTURES

91. I would like you to look at this map and tell me about where your home is located.....

55

correct _____ (1)
incorrect _____ (2)
DK _____ (3)
NR _____ (4)

CARD 4

92. Could you please mark on the map where you think your neighborhood ends?..... 56 _____
57 _____
58 _____
59 _____
60 _____
61 _____
62 _____
63 _____

93. What makes you consider the area which you marked as "your" neighborhood? _____

_____

_____ 64 _____

_____

_____

_____

94. Would you please look at these photos and tell me what places they are? (NOTE: Shuffle pictures before presenting them)

#1.....65C___( )	NC___( )	DK___( )	NR___( )	R___( )
#2.....66C___( )	NC___( )	DK___( )	NR___( )	R___( )
#3.....67C___( )	NC___( )	DK___( )	NR___( )	R___( )
#4.....68C___( )	NC___( )	DK___( )	NR___( )	R___( )
#5.....69C___( )	NC___( )	DK___( )	NR___( )	R___( )
#6.....70C___( )	NC___( )	DK___( )	NR___( )	R___( )
#7.....71C___( )	NC___( )	DK___( )	NR___( )	R___( )
#8.....72C___( )	NC___( )	DK___( )	NR___( )	R___( )
#9.....73C___( )	NC___( )	DK___( )	NR___( )	R___( )
#10.....74C___( )	NC___( )	DK___( )	NR___( )	R___( )
#11.....75C___( )	NC___( )	DK___( )	NR___( )	R___( )

CARD 5

NOTE:

Continue with Q 96.

96. How do you feel about your neighborhood?_____

_____

_____ 22 _____

_____ 23 _____

_____

_____

97. What do you particularly like about it? _____

_____

_____ 24 _____

_____ 25 _____

_____

_____

98. What do you particularly dislike about it? _____

_____

_____

_____

CARD 5

98. _____ 26 _____

_____ 27 _____

99. How did you come to live in this neighborhood? _____

_____

_____ 28 _____

_____

100. What does the work "community" mean to you? _____

_____

_____ 29 _____

_____ 30 _____

_____

_____

101. What does the idea of community participation and control mean to you? (NOTE: If respondent doesn't know about or can't define the term, SKIP TO Q 102) _____

_____

_____ 31 _____

_____ 32 _____

_____

_____

_____

_____

a. How do you like the idea? _____

_____

_____

CARD 5

101. a. _____

_____ 33 _____

_____

b. How is it working on the West Side? _____

_____

_____ 34 _____

_____

102. What West Side neighborhood organizations do you know? What do they do?

NAME	FUNCTION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

35 _____

36 _____

37 _____

38 _____

103. Do you belong to any of them?..... 39

yes _____ (1)
no _____ (2)
NR _____ (3) GO TO 104

IF YES, ASK "a" & "b"

CARD 5

103. a. Which ones do you belong to?_____

_____ 40 _____

_____ 41 _____

_____

b. About how often do you go to meetings?..... 42 _____ times

104. (IF NOT MENTIONED SPONTANEOUSLY) Are you familiar with:

a. the neighborhood health council?..... 43

yes _____ (1)
no _____ (2)
NR _____ (3) TO TO 106

b. the people's health council..... 44

yes _____ (1)
no _____ (2)
NR _____ (3) TO TO 106

c. the group for better health..... 45

yes _____ (1)
no _____ (2)
NR _____ (3) GO TO 106

105. Which of these three do you think is best? Why? _____

_____

_____ 46 _____

_____ 47 _____

_____

_____

_____

106. How do you feel about such organizations? Why? _____

_____

_____

CARD 5

106. _____ 48 _____

_____ 49 _____

_____

107. Did you get any information in the mail about the reorganization of the neighborhood health council?..... 50

yes _____ (1)
no _____ (2)
NR _____ (3) } GO TO 108

a. Do you plan to vote?..... 51

yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) } GO TO 108

b. Why or why not? _____

_____ 52 _____

_____

108. I am interested in the amount of traveling you have to do around the city. I will mention a few things to you and I would like you to tell me where you do them, how often, and how you get there:

ACTIVITY	WHERE	HOW OFTEN	TRANSPORTATION		
				53 _____	54 _____
a. work				55 _____	56 _____
b. shopping				57 _____	58 _____
c. gov't agencies				59 _____	60 _____
d. visit relatives				61 _____	62 _____
e. visit friends				63 _____	64 _____
f. amusement				65 _____	66 _____
g. parks				67 _____	68 _____
h. other (specify)				69 _____	70 _____

CARD 5

109. CAN YOU PLEASE TELL ME:

a. your age.....

71

under 20	____	(1)
20-30	____	(2)
30-40	____	(3)
40-50	____	(4)
50-60	____	(5)
over 60	____	(6)
NR	____	(7)

b. where were you born?.....

72

NYC	___	(1)
U.S.	___	(2)
other (specify)	___	(3)
NR	___	(4)

c. (If outside NYC) When did you come to New York?_____

73 _____

d. Which grade did you finish in school? _____

74

less than elementary	_____	(1)
elementary	_____	(2)
less than high	_____	(3)
high	_____	(4)
some college	_____	(5)
B.A. or B.S.	_____	(6)
graduate degree	_____	(7)
other	_____	(8)

e. Are you assigned to a medical team at the center?.....

75

yes	_____	(1)
no	_____	(2)
DK	_____	(3)
NR	_____	(4)

GO TO "g"

f. IF YES: Which team are you assigned to?

76

Team 1	_____	(1)
Team 2	_____	(2)
Team 3	_____	(3)
Team 4	_____	(4)
SRO Team	_____	(5)

CARD 5

g. Do you usually see the same doctor(s)?.....

77
yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) GO TO "c"

h. IF YES: Can you tell me his (their) name(s)_____

78 _____

i. Are you eligible for Medicaid?.....

79
yes _____ (1)
no _____ (2)
DK _____ (3)
NR _____ (4) END HERE

j. IF YES: Do you get Medicaid?.....

80
yes _____ (1) END HERE
no _____ (2)
NR _____ (3) END HERE

CARD 6

k. Why not? (IF ELIGIBLE, BUT NOT RECEIVING MEDICAID) _____

11 _____

Thank you very much. I really appreciate the time you gave me. Are there any questions you would like to ask now?

Can you think of anyone in this house or in the neighborhood who is eligible to use the neighborhood health center but does not do so, and who would be willing to talk to me?

TO BE ANSWERED BY INTERVIEWER

For persons of Spanish or Haitian background: How well do they speak English?.....

12
excellent _____ (1)
good _____ (2)
fair _____ (3)
poor _____ (4)
not at all _____ (5)
can't judge _____ (6)

Appendix F

Open-ended interviews with Hispanic respondents

1. The clinic is often called a neighborhood or community facility--what does that mean to you?
   a) what do you expect of such a place?
2. What does "neighborhood" mean to you?
3. What does "community" mean to you?
   a) can you tell me in a few words what you see as the main difference between the two?

(I'll use the term "community" facility when talking about NWHC.)

4. Do you feel the fact that the center is located on . . . street helps make it a community facility?
   a) is there anything about NWHC which makes you think of it as a community facility?
5. How important is it to have such a clinic within the community--why?
   (Probe for symbolic value of building.)
6. Who is allowed to use the center?
   (Probe especially for economic variable--i.e., is it seen as a place for the poor only; and if so, is this perceived as a positive or negative factor.)
   a) do you think there should be places which give medical care mainly to poor people?
7. Do you know about any recent changes in the center's

budget?

a) what effects would such changes have?

b) how do you feel about the fact that the government cut funds from programs like the center?

8. How would the people in this area feel if the center were forced to close--what would they do--what would you do--can people do anything?

(Probe especially for possible sense of lack of power, possible projection of power.)

9. Can you think of anything (or "anything else"--whichever applies after answer to Q. 8) which would bring the people in the community together to act as one group?

10. What does the center offer which other health care facilities do not provide?

11. Do you consider the center as your main health care provider?

a) what other place(s) do you use--for what reasons?

b) in what way is the care and treatment you receive at the center different from OPD clinics you are familiar with?

(Probe for competence of staff and extent of staff's interest in patients; also whether treatment is considered dignified, personal, holistic.)

12. What do you think is meant by the term "comprehensive health care?"

(Provide explanation where necessary.)

a) do you think you get such care at the center?

b) do you get it anyplace else?

c) would you like to get such care?

13. Do you have dealings with center personnel other than doctors?

a) who are these people?

b) how do you feel about it?

c) how would you feel about having specially trained nurses give some treatments?

(We want to find out how respondent feels about para-professional and paramedical personnel.)

14. If you have a medical problem, do you prefer to talk to doctors or other staff members who might have more time for you?

a) what about other problems?

b) how do you feel about having non-medical personnel help you with various problems?

(Probe for respondent's perception of just what roles of various staff members should entail.)

15. How do you feel about the set-up of the center?

(We are interested here in the <u>physical</u> environment--see if it is perceived as crowded, cramped and noisy--how important is this? What are the impressions of the reception area and waiting room--do these shape expectations regarding care?)

16. How does the center differ from other clinics?

a) what do you like or dislike about it?

b) if you could change the center (the way it is run, the place it is in, the people who work there, the way it looks, and anything else you can think of) what would you do?

17. Have you ever had any contact with anyone of the community group which helps run the center?
    a) what was the reason for this contact?
    b) would you approach this group to help you solve any of your problems--which?
    c) have you ever run for office in this group--would you?
    d) what do you think the function of such groups should be?
    e) did you vote in the last community board election?

    (Probe for anything pertaining to community participation.)

18. What do you think are the most important things a neighborhood health center should do?

19. If somebody new in the neighborhood asked you where to go for health care, would you want to send them to the center?
    a) what would you tell them?
    b) how would you describe the center to them?
    c) what things would you want them to know about it so that they would get the most out of their use of the center?

20. In a few words, how would you summarize the general aim of the center.

Appendix G

Guide for pilot interviews with supervisors

How do you feel about the American health care delivery system--how would you change it--what is your concept of care?

What are your aims, hopes for the center

What do you think about career ladders

What do the terms neighborhood and community mean to you

How do you feel about community participation

Tell me about the work-load of staff in general, physicians in particular

What are the chances of achieving comprehensive health care here

How do you go about educating the population (health, political awareness)

How do you feel about my plan to probe further into patient perception of this program

Are there any questions you are particularly interested in

Appendix H

Focused interviews--staff

(Get: length of employment at center; any other experience with group health care facilities; street respondent lives on.)

Neighborhood
difference
Community

Neighborhood or community facility--meaning

Does location of center help make it a community facility

Is there anything about center which makes people think of it as a community facility

Importance of clinic

Career ladders

Own career at center

[After first few interviews] Quality of supervision; administration

How do you judge the services offered by the center to its patients--what works best, what least

What does center offer which other clinics do not provide

How well do you get to know patients

Comprehensive care--what is it--how do you feel about it--your part in providing such care here--does center give it

Team concept--does it work--patients reaction to treatment by people other than doctors--your feeling about it

Rights and responsibilities of patients--staff

Patient education

Function of paraprofessionals--ideal, real

Line supervisors

Physical set-up:

- what is your office like
- does set-up facilitate or hinder work
- what does it look like to patients
- does it affect emotional well-being of staff--staff relations

Budget cuts--effects on center--on staff

Community participation

Council--what is authority, what should it be--what should their function be--how well do they work

Who should have authority to hire and fire center personnel

What are the most important functions of a neighborhood health center

What should health care be like--what is role of centers like this

How would you change center

If someone you knew were coming to work here, what are the things you would tell that person about the center so that the working relationship would be as good as possible

What would happen if center were forced to close--what would you do--patients--council

What event(s) would cause people living in the community to band together for action

Summarize general aim of center in few words

Appendix I

Focused interviews--council members

Neighborhood
difference
Community

Neighborhood or community facility--meaning

Does location of center help make it a community facility--does anything else

Importance of clinic

Role of council--in center--in making it a community facility

Communication with patients--how maintained

What would happen if center were forced to close--what would council do

What event(s) would cause people living in the community to band together for action

Career ladders

How do you judge quality of service at center--what works best, what least

What should health care be like--role of neighborhood health centers in this

What does center offer which other health care facilities do not--what would you change

Comprehensive care

Paraprofessionals

Physical set-up

Budget cuts

Community participation

Function of council--ideal, real--authority--hiring and firing

Cooperation among council members--leadership--administrative structure

Most important functions of a neighborhood health center

If somebody you know wanted to run for office at the council, what would you tell that person about the council so that his or her function would be as smooth and productive as possible

Summarize general aims of center and council

Appendix J

Specific indicent

TIME	1	APPROX AGE	2	ETHNIC BACKGROUND	3
Morning	___(1)	Under 20	___(1)	Black	___(1)
Afternoon	___(2)	20-40	___(2)	Spanish Speaking	___(2)
Evening	___(3)	40-60	___(3)	Other	___(3)
		Over 60	___(4)		

SEX	4		5
Female	___(1)	With Children	___(1)
Male	___(2)	Without Children	___(2)

1. Why did you come to the Center today? 6_____

   7_____

2. How long did you have to wait? 8_____

3. How does this compare to your usual waiting time? 9
   Longer ___(1)
   Shorter ___(2)
   Same ___(3)

4. Who took care of you? 10_____

   11_ _____

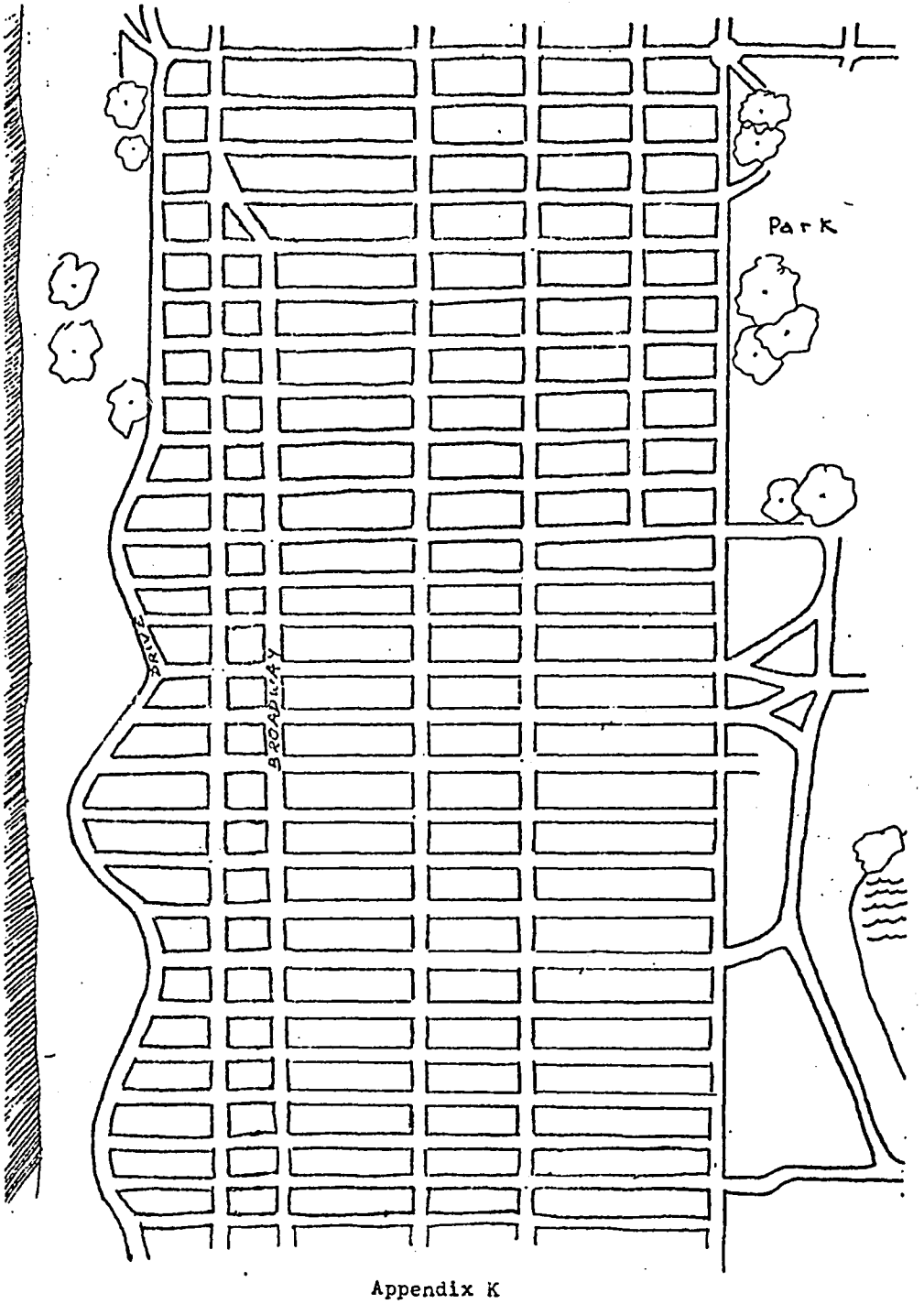
5. Did you see the person you came to see? 12
   Yes ___ (1)
   No ___ (2)

6. Are you satisfied with the result of your visit? 13_____

7. About how often have you visited the Center in the past year? 14
   Never (1)
   Once (2)
   2-6 times (3)
   7-11 times (4)
   12-24 times (5)
   More than twice a month (6)

8. About how many blocks from here do you live? 15_____

   16_____

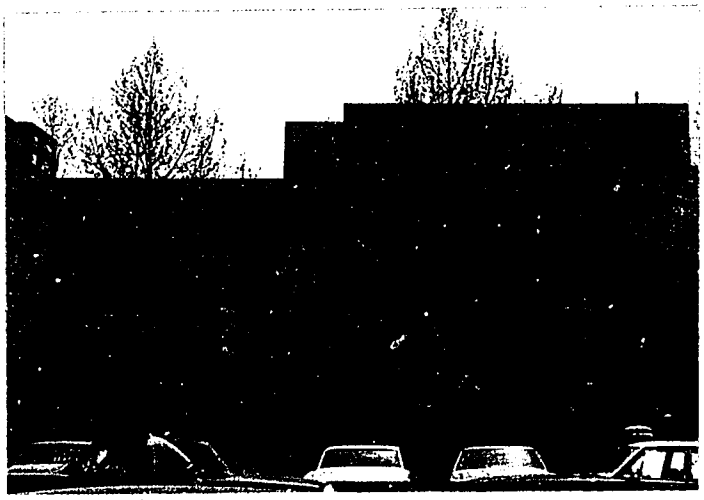


Appendix K

Appendix L

#1. CHURCH, CROSSTOWN ARTERY

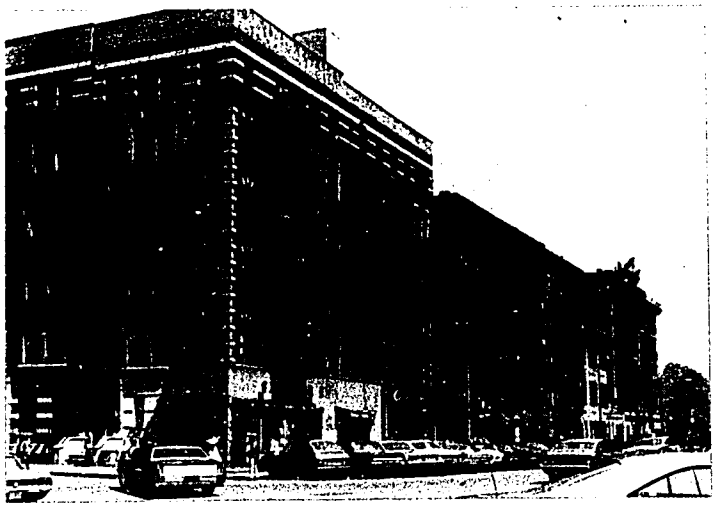
#2. VESTPOCKET PARK



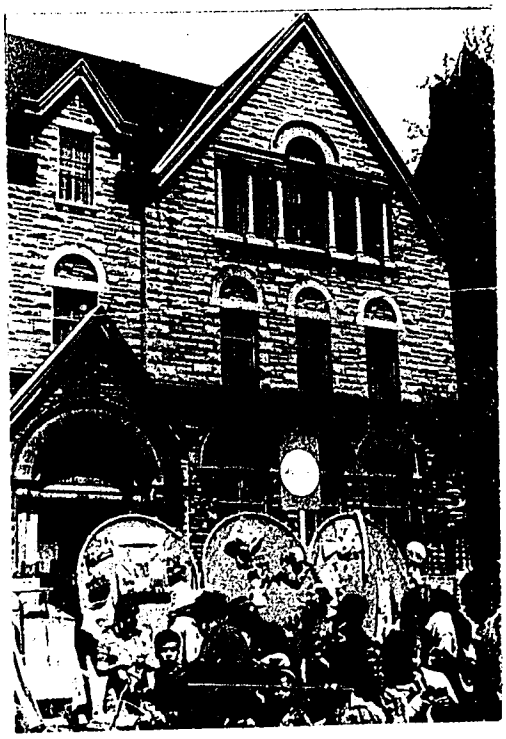
#3. N.W.H.C.

#4. SUBWAY, MAJOR SHOPPING STREET

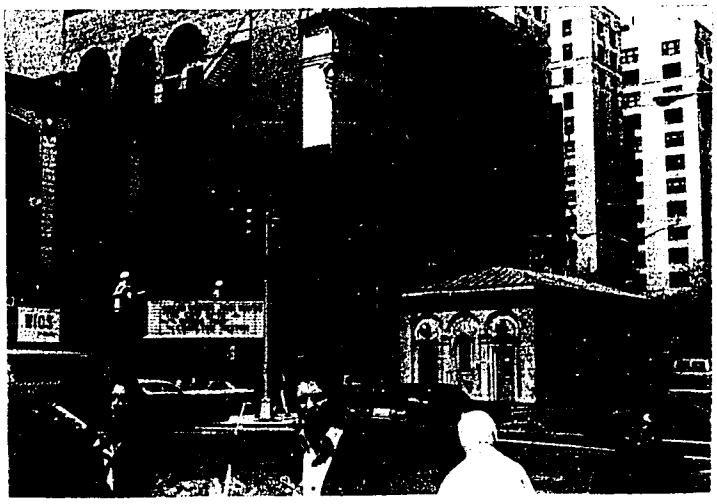
#5. CHURCH, SIDE STREET



#6. RESIDENTIAL STREET



#7. CHURCH, SIDE STREET



#8. MAJOR SUBWAY AND STREET

#9. PLAYGROUND, SIDE STREET

#10. CHURCH, CROSSTOWN ARTERY

#11. URBAN RENEWAL PROJECT

Appendix M

Social Space Score

The following arbitrary numerical values were assigned to each of the categories which emerged from respondents' answers to question 108. This question read as follows:

I am interested in the amount of traveling you have to do around the city. I will mention a few things to you and I would like you to tell me where you do them, how often, and how you get there:

ACTIVITY	WHERE	HOW OFTEN	TRANSPORTATION
a. work			
b. shopping			
c. gov't. agencies			
d. visit relatives			
e. visit friends			
f. amusement			
g. parks			
h. other (specify			

Following are the categories of answers, and the values assigned by me to these categories:

Work . . . . . None=0
At home=1
In the neighborhood=2
Within the borough in which respondent resided=3
Within the metropolitan area=4

Shopping . . . . . None=0
In the neighborhood=1
Downtown=2
All over the city=3

Government agency . . . . . None=0
Within own neighborhood=1
Downtown=2

Visit relatives/friends . . . Never=0
In own home/building=1
In the neighborhood=2
Within own borough=3
Within metropolitan area=4
Outside metropolitan area/
state=5

Amusement . . . . . None=0
In own home/building=1
In the neighborhood=2
Within own borough=3
Within metropolitan area=4

Parks/Beaches . . . . . None=0
Playgrounds=1
Parks bordering catchment
area (East and West)=2
All over metropolitan area=3

Other . . . . . None=0
Religious activities=1
College=2
Senior Citizen clubs=3

Frequency: Never=0
Rarely/occasionally=1
Seasonal=2
4-6 times per year=3
1-2 times per month=4
1-2 times per week=5
Almost daily=6
Daily=7

Transportation: None=0
Walk=1
Public transportation=2
Private cars=3

The appropriate value was assigned to each part of a respondent's answer; these were added and the sum thus derived constituted respondent's social space score.

If a respondent reported more than one location and/or mode of transportation for a given activity, each of these was assigned the appropriate value and all were included in the total score.

TABLE 1

ANALYSIS OF VARIANCE FOR REPORTED NUMBER OF VISITS TO N.W.H.C. DURING THE YEAR PRECEDING INT.I.

Source	SS	df	MS	F	df
Between ethnic groups (Hispanics, Blacks, Whites)	2278.51	2	1139.26	3.21	2,73
Within ethnic groups	25907.85	73	354.9		
Total	28186.36	75			

TABLE 2

AGE AND UTILIZATION PATTERNS OF N.W.H.C. SERVICES BY INT. I. USERS[a] (SUMMER 1971-SUMMER 1972[b])

	Number of Visits									
	0-1		2-6		7-11		Over 11		Total	
	f	%	f	%	f	%	f	%	f	%
	Hispanic (N = 27)[c]									
20-29	-	-	3	14	-	-	-	-	3	11
30-39	-	-	5	23	1	20	-	-	6	22
40-49	-	-	9	41	1	20	-	-	10	37
50-59	-	-	4	18	1	20	-	-	5	19
Over 59	-	-	1	4	2	40	-	-	3	11
Total[d]	-	-	22	100	5	100	-	-	27	100
	Black (N = 24)[c]									
20-29	-	-	2	40	-	-	-	-	2	8
30-39	2	22	1	20	3	100	2	29	8	33
40-49	4	44	-	-	-	-	2	29	6	25
50-59	1	11	-	-	-	-	1	14	2	8
Over 59	2	22	2	40	-	-	2	29	6	25
Total[d]	9	99	5	100	3	100	7	101	24	99
	White (N = 25)[c]									
20-29	-	-	-	-	-	-	1	10	1	4
30-39	-	-	-	-	2	50	-	-	2	8
40-49	1	25	-	-	-	-	1	10	2	8
50-59	-	-	-	-	-	-	1	10	1	4
Over 59	3	75	7	100	2	50	7	70	19	76
Total[d]	4	100	7	100	4	100	10	100	25	100

[a]Individuals who used the center at least once during the two year period preceding Int. I.; others were considered "non-users".

[b]Q 1a: "About how often did you use the center during the past year?" (Open-ended [O.E.]).

Q 109a: "Can you please tell me your age?" (F.A.).

[c]N ≠ 30 because non-users, N.R. and D.K. were not included.

TABLE 3

ANALYSIS OF VARIANCE FOR THE AVERAGE DISTANCE
OF INT. I. RESPONDENTS' HOMES
FROM N.W.H.C

Source	SS	df	MS	F	df
Between ethnic groups (Hispanics, Blacks, Whites)	65.68	2	32.84	32.35	87,2
Within ethnic groups	92417.21	87	1062.26		
Total	92482.89	89			

TABLE 4

AGE AND UTILIZATION PATTERNS OF N.W.H.C. SERVICES BY INT. III. USERS (SUMMER 1972-SUMMER 1973)

Age Groups	Number of Visits									
	0-1		2-6		7-11		Over 11		Total	
	f	%	f	%	f	%	f	%	f	%
	Hispanic									
Under 20	6	14	6	7	8	12	4	3	24	7
20-40	27	65	63	73	44	64	80	57	214	64
40-60	8	19	10	12	12	18	43	31	73	22
Over 60	1	2	7	8	4	6	12	9	24	7
Total	42	100	86	100	68	100	139	100	335	100
	Black									
Under 20	2	22	3	14	2	9	1	3	8	9
20-40	5	56	15	68	16	77	16	50	52	62
40-60	2	22	3	14	2	9	12	38	19	23
Over 60	-	-	1	4	1	5	3	9	5	6
Total	9	100	22	100	21	100	32	100	84	100
	Other									
Under 20	-	-	-	-	1	10	-	-	1	2
20-40	4	80	7	54	3	30	4	22	18	39
40-60	-	-	3	23	2	20	8	44	13	28
Over 60	1	20	3	23	4	40	6	34	14	31
Total	5	100	13	100	10	100	18	100	46	100

Note: Information was missing on 22 respondents for one or more of the three variables. These individuals are not included in this tabulation.

TABLE 5

ATTITUDES TOWARD THE CENTER, ITS BACK-UP HOSPITAL, DOCTORS AND NURSES[a]

Attitudes	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Satisfied with NWHC	26	86	21	70	25	83	72	80
Not satisfied with NWHC	2	7	6	20	2	7	10	11
DK, NR	2	7	3	10	3	10	8	9
Total	30	100	30	100	30	100	90	100
$\chi^2 = 4.14$; df = 4; NS. Computed without the "DK, NR" category: $\chi^2 = 3.77$; df = 2; .10 < p < .20								
Satisfied with back-up hospital[b]	6	86	9	50	19	86	34	72
Not satisfied with back-up hospital	1	14	9	50	3	14	13	28
Total	7	100	18	100	22	100	47	100
$\chi^2 = 7.29$; df = 2; .02 < p < .05								
Positive attitude toward doctors[c]	24	80	16	55	9	30	49	55
Negative attitude toward doctors[d]	2	7	2	7	3	10	7	8
Ambivalent attitude toward doctors[e]	4	13	11	38	18	60	33	37
Total	30	100	29	100	30	100	89	100
$\chi^2 = 15.93$; df = 4; .001 < p < .01								
Positive attitude toward nurses	23	82	15	52	10	34	48	56
Negative attitude toward nurses	1	4	3	10	5	17	9	10
Ambivalent attitude toward nurses	4	14	11	38	14	49	29	34
Total	29	100	29	100	29	100	86	100
$\chi^2 = 13.59$; df = 4; .001 < p < .01								

Note: Where N ≠ 30, DK, NR were not included in the tabulation.

[a]Q 77: "Are you satisfied with services at the center?" (F.A. and probe)

Q 78: "Are you satisfied with services at . . . [name of back-up hospital]?" (F.A. and probe)

Q 84: "How do you feel about doctors?" (O.E.)

Q 85: "How do you feel about nurses?" (O.E.)

[b]17 Hispanics, 6 Blacks and 7 Whites did not use back-up hospital.

[c]This category included answers such as: "I trust and admire them"; "they are nice and friendly"; "they serve an important function".

[d]Examples of answers: "They are arrogant/grouchy/not dedicated";

[e]"They aren't good, but do their job"; I'm not afraid of them."

TABLE 6

FURTHER INDICATORS OF SATISFACTION OR DISSATISFACTION WITH N.W.H.C.

	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
"Is there anything you especially like about the center?" (Q 73)								
Yes	20	67	27	90	22	73	69	77
No	2	7	1	3	5	17	8	9
DK, NR	8	26	2	7	3	10	13	14
Total	30	100	30	100	30	100	90	100
$\chi^2 = 9.09$; df = 4; $.05 < p < .10$. Without the "DK, NR" category: $\chi^2 = 3.39$; df = 2; $.30 < p < .50$.								
"Is there anything you really dislike about the center?" (Q 74)								
Yes	2	7	10	33	7	24	19	21
No	22	73	19	64	22	73	63	70
DK, NR	6	20	1	3	1	3	8	9
Total	30	100	30	100	30	100	90	100
$\chi^2 = 11.61$; df = 4; $.02 < p < .05$ Without the "DK, NR" category: $\chi^2 = 5.08$; df = 2; $.05 < p < .10$.								
"Have you ever recommended the center to friends?" (Q 62)								
Yes	18	60	21	70	17	57	56	62
No	8	27	9	30	13	43	30	33
DK, NR	4	13	-	-	-	-	4	5
Total	30	100	30	100	30	100	90	100
$\chi^2 = 1.46$; df = 2 ("DK, NR" category had to be left out to achieve an acceptable minimum expected frequency); N.S.								

Note: Each of the three questions was followed by a probe.

TABLE 7

MODE OF TRANSPORTATION AND TIME REQUIRED TO REACH THE CENTER AND OTHER HEALTH CARE FACILITIES[a]

Mode of Transportation And Minutes Required	N.W.H.C.								All Other Facilities							
	Hispanic		Black		White		Total		Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
Walk																
1-10	8	26	19	56	12	36	39	40	1	5	1	3	2	6	4	4
11-20	8	26	5	15	9	27	22	22	-	-	6	15	-	-	6	6
21 +	-	-	3	8	3	9	6	6	-	-	4	10	4	12	8	9
DK, NR	-	-	1	3	-	-	1	1	-	-	-	-	-	-	-	-
Sub-total	16	52	28	82	24	72	68	69	1	5	11	28	6	18	18	19
Public Transportation																
1-10	3	10	-	-	5	15	8	8	1	5	2	5	4	12	7	7
11-20	8	26	5	15	-	-	13	14	3	14	9	23	14	43	26	28
21 +	3	10	1	3	-	-	4	4	7	33	12	30	7	21	26	28
DK, NR	-	-	-	-	-	-	-	-	4	19	3	7	-	-	7	7
Sub-total	14	46	6	18	5	15	25	26	16	76	26	65	27	82	69	74
Other	1	3	-	-	4	13	5	5	4	19	3	7	-	-	7	7
Grand Total	31	101	34	100	33	100	98	100	21	100	40	100	33	100	94	100

[a] Q. 16: "What transportation do you use to get to the center?" (F.A.).
Q. 17: "How long does it usually take you to get there?" (F.A.).
Q. 18: If respondent uses other places for health care--ask names, time required to reach them and means of transport (O.E.).

[b] This included: Private car (3 Hispanics); center-provided transport (1 Hispanic, 1 Black, 4 Whites); taxi; ambulance; police (1 Hispanic, 2 Blacks, 1 White).

Note: Percentages were not computed because of the small totals in many of the columns.

TABLE 8

COMPARISON BETWEEN N.W.H.C. AND PRIVATE PHYSICIANS BASED ON FAMILIARITY WITH THE LATTER[a]

N.W.H.C. Is	Hispanic						Black						White						Total	
	Better	Worse	Same	DK	Total #	Total %	Better	Worse	Same	DK	Total #	Total %	Better	Worse	Same	DK	Total #	Total %		
Familiarity with care by private physician	2	3	8	2	15	50	2	9	-	-	11	37	2	3	3	2	10	34	36	40
No such familiarity	1	1	7	-	9	30	4	4	4	-	12	40	4	-	7	-	11	38	32	36
No familiarity and no attempt to compare	-	-	-	6	6	20	-	-	-	7	7	23	-	-	-	8	8	28	21	24
Total					30	100					30	100					29[b]	100	89	100

Note: Percentages for each column are not included because the figures in many cells are small.

[a]Assessment of familiarity was based on the following questions:

Q 2a, 2b: "Do you use any places other than N.W.H.C. for health care? Can you give me their names? How often during the past year did you go to them?"

Q 4: "I'll mention members of your family? Will you tell me where they go for health care?"

Q 9: "Where did you get medical treatment before you used this center?"

Q 10: "As you look back over the past year, when members of your family were sick, where did you go for advice? I would like to think of all the different people or places you went to for such advice?"

Q 18: Instruction to interviewer: If respondent uses other places for health care too (see Q 2) ask for the names of each of them.

[b]One respondent did not answer questions.

TABLE 9

ASSESSMENT OF CENTER QUALITIES AS COMPARED TO OTHER FACILITIES[a]

N.W.H.C. Compared To:	Other Places	Private Doctors	Back-Up Hospital	Other Clinics	Most City Residents	Total f	Total %
Staff / service / care more personal, considerate	20	10	7	14	9	60	12
Staff listens, gives information	4	3	3	4	2	16	3
Care available, competent, service is good	8	2	7	3	10	30	6
Generally satisfactory, convenient	2	-	2	-	-	4	1
Get same doctor every time	1	1	2	1	1	6	1
Doctors not mercenary	-	9	-	-	-	9	2
Waiting shorter / service faster	4	-	12	4	3	23	5
Less crowded less noisy	-	-	5	7	3	15	3
Cleaner / smaller	1	-	-	4	1	6	1
Adequate specialty clinics / facilities / staff	2	2	1	-	-	5	1
Staff / service / care less personal, less considerate	4	5	1	-	-	10	2
Staff does not listen, gives no information	1	2	1	-	-	4	1
Care less competent	3	7	5	1	1	17	3
Get different doctor every time	1	2	-	-	-	3	1
Waiting longer / service slower	2	5	-	1	-	8	2
Less clean	-	1	-	-	-	1	1
Inadequate specialty clinics/facilities / staff	3	-	3	1	-	7	1
Better than most clinics / worse than private doctors	2	1	-	1	2	6	1
Generally acceptable treatment everywhere	15	14	8	7	5	49	10
None too satisfactory	3	1	2	3	1	10	2
Overall negative appraisal	-	-	-	1	2	3	1
Unable to judge / not enough experience	8	8	16	13	15	60	12
DK, NR, inappropriate answer	17	21	27	37	43	145	29
Total						497	101

Note: In this table the three ethnic groups are combined because the number of responses falling into many cells was very small (often zero). Presenting the data as they are shown is thought to afford a better overview.

[a]Based on probes for questions listed in footnote #38 on page

TABLE 10

SOURCE OF ADVICE SOUGHT ON VARIOUS PROBLEMS--INCLUDING NON-MEDICAL ONES, AND TESTS FOR THE SIGNIFICANCE OF DIFFERENCES BETWEEN THE THREE ETHNIC GROUPS

Sources Where Advice Was Sought	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
N.W.H.C. personnel[a]								
Doctors	23	30	16	32	19	49	58	35
Nurses	23	30	14	28	8	20	45	27
Technicians	10	13	10	20	6	15	26	16
Medical assistants	10	13	4	8	3	8	17	10
Family health coordinators	10	13	5	10	-	-	15	9
Mental health staff	-	-	1	2	3	8	4	3
Total	76	99	50	100	39	100	165	100
Outside N.W.H.C.[b]								
Other doctors	4	13	3	10	2	6	9	10
Family	10	31	3	10	1	3	14	15
Friends	3	9	-	-	-	-	3	3
God	1	3	-	-	-	-	1	1
Nobody	6	19	22	73	20	65	48	52
DK, NR	8	25	2	7	8	26	18	19
Total	32	100	30	100	31	100	93	100
Tests of significance[c]								
Seek advice outside N.W.H.C. excluding doctors								
Yes	13		3		1		17	
No	6		22		20		48	
Total	19		25		21		65	
$\chi^2 = 25.16$; df = 2; $p < .001$								
Seek advice outside including doctors								
Yes	16		6		3		25	
No	6		22		20		48	
Total	22		28		23		73	
$\chi^2 = 21.17$; df = 2; $p < .001$								

[a] Q 28a-j: "Think about each of the workers at the center in terms of their ability to give you good advice--not necessarily only in medical matters--. Would you please tell me if you think. . .could give you good advice?" This question was asked separately for each job classification listed in this part of the table. (F.A. and probe). Multiple answers were possible.

[b] Q 28k: "Is there anyone else you can think of whose advice you would value?" (O.E.). Multiple answers were possible.

[c] Each respondent was counted only once, regardless of how many outside sources he or she might utilize for advice. "DK, NR" category was not included in this tabulation.

TABLE 11

REASONS FOR SEEKING OR SHUNNING ADVICE OF VARIOUS N.W.H.C. PERSONNEL[a]

	Hispanic						Black						White						Grand Total	
	Doctor	Nurse	Tech-nician	MA	FHC	Total	Doctor	Nurse	Tech-nician	MA	FHC	Total	Doctor	Nurse	Tech-nician	MA	FHC	Total		
Personal quality	-	2	-	-	-	2	-	2	3	-	1	6	2	1	1	-	-	4	12	2.54
Attitude toward patient	2	1	-	-	1	4	8	6	4	2	2	22	5	2	-	-	-	7	33	6.99
Works for my well-being	4	4	3	3	1	15	-	-	-	-	-	-	2	-	-	-	-	2	17	3.60
Knows me is sensitive to needs	-	-	-	-	5	5	-	-	-	2	2	2	-	-	-	-	-	-	7	1.48
Competent in his/her work	19	16	8	7	2	52	7	4	3	1	-	15	7	4	4	3	-	18	85	18.01
Their advice worked in past	-	1	-	-	1	2	1	1	1	1	-	4	-	-	-	-	-	-	6	1.27
Depends on individual	-	-	-	-	-	-	2	-	-	-	-	2	1	-	1	-	-	2	4	.85
Yes--but	1	-	-	-	-	1	-	-	-	-	-	-	1	-	-	-	-	1	2	.42
They are too busy	-	-	-	-	-	-	-	3	2	1	-	6	2	-	-	-	-	2	8	1.69
Are incompetent, prejudiced[b]	-	-	-	-	-	-	-	-	-	-	-	-	-	2	1	1	1	5	5	1.06
I never asked	-	-	1	-	-	1	3	3	2	2	3	13	4	4	4	3	3	18	32	6.78
Don't have enough contact	-	-	1	1	1	3	-	1	-	-	-	1	-	6	2	1	-	9	13	2.75
No personal relationship	-	1	1	1	1	4	2	1	1	1	-	5	1	1	-	-	-	2	11	2.33
Wrong attitude to patients	-	-	-	-	-	-	2	2	-	-	-	4	1	-	1	-	-	2	6	1.27
Not qualified to give advice.	2	1	-	-	-	3	4	1	-	-	-	5	3	-	-	1	-	4	12	2.54
Don't trust them	-	-	-	-	-	-	-	-	-	-	1	1	-	-	-	1	-	1	2	.42
DK, NR	4	7	17	18	18	64	4	7	15	22	22	70	7	12	17	21	26	83	217	45.97
Total	32	33	31	30	30	156	33	31	31	30	31	156	36	32	31	31	30	160	472	99.97

Note: Percentages were not computed because of the many empty cells.

[a]Probes for each part of A 28--see Table 10, Appendix N.

[b]Only three respondents offered this explanation--i.e. the figures in the "White" columns represent multiple answers.

TABLE 12

ATTITUDES OF INT. I. PATIENTS REGARDING THE TRAINING PROGRAM

	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Feelings About A Training Program								
Patients more comfortable	-	-	1	12	-	-	1	3
Good for community	7	50	2	25	3	23	12	34
Train for jobs/provide jobs	5	36	3	38	3	23	11	32
A good thing	-	-	1	12	3	23	4	11
People not qualified/cannot be trusted	1	7	-	-	3	23	4	11
DK, NR	1	7	1	12	1	8	3	9
Total[b]	14	100	8	99	13	100	35	100
Reasons Why There Should/ Should Not Be Such A Program								
Patients more comfortable	5	16	2	5	3	11	10	10
Good for community	12	38	8	21	4	14	24	24
Train for jobs/provide jobs	14	43	20	51	10	36	44	45
A good thing	-	-	6	15	4	14	10	10
People not qualified/cannot be trusted	-	-	-	-	2	7	2	2
If they are competent	-	-	-	-	2	7	2	2
Not necessary/no space no concern of mine	-	-	2	5	3	11	5	5
DK, NR	1	3	1	3	-	-	2	2
Total[b]	32	100	39	100	28	100	99	100

[a]Probe to Q 53; see Table 11.12.

[b]People who did not respond to Q 54 do not appear on this table. The data represent answers given by the 34 and 74 respondents to Q 53 and Q 54; see Table 11.12.

[c]Probe to Q 54; see Table 11.12.

TABLE 13

COMPARISON OF INT. I. RESPONDENTS' PREFERENCES FOR DEALING WITH STAFF OF EITHER N.W.H.C. OR BACK-UP HOSPITAL, AND RECURRENCE OF RESPONDENTS' CONTACT WITH THEM

Prefer to Deal With Given Staff Members[a]	Staff of N.W.H.C.								Staff of Back-Up Hospital[b]							
	Hispanic		Black		White		Total		Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
Yes	4	13	4	13	7	23	15	17	1	8	7	29	2	9	10	17
No	19	64	23	77	18	60	60	66	6	50	14	58	12	52	32	54
DK, NR	7	23	3	10	5	17	15	17	5	42	3	13	9	39	17	29
Total	30	100	30	100	30	100	90	100	12	100	24	100	23	100	59	100
	$\chi^2 = 3.42$, df = 4, $p > .30$[c]								$\chi^2 = 7.49$, df = 4, $.10 < p < .20$[d]							
See Certain Staff Members Regularly[e]																
Yes	9	30	18	60	19	63	46	51	-	-	7	29	11	48	18	31
No	16	53	12	40	8	27	36	40	8	67	16	67	8	35	32	54
DK, NR	5	17	-	-	3	10	8	9	4	33	1	4	4	17	9	15
Total	30	100	30	100	30	100	90	100	12	100	24	100	23	100	59	100
	$\chi^2 = 11.43$, df = 4, $.02 < p < .05$[f]								$\chi^2 = 8.75$, df = 2, $.01 < p < .02$[g]							

[a] Q 31e and 32e: "As you think about members of the staff at N.W.H.C./at the back-up hospital, are there some you would prefer to deal with more than others?" (F.A. + probe).

[b] N < 90 because some respondents did not report any use of the back-up hospital.

[c] Computation without the "DK, NR" category yielded a $\chi^2 = 1.43$, df = 2, $p > .30$

[d] Computation without the "DK, NR" category would result in an unacceptable minimum expected frequency.

[e] Q 31g and A 32g: "As you think about members of the staff at N.W.H.C./at the back-up hospital, are there some you see regularly? (F.A. + probe).

[f] Computation without the "DK, NR" category yielded a $\chi^2 = 6.89$, df = 2, $.02 < p < .05$.

[g] To achieve an acceptable minimum expected frequency, the "No" and "DK, NR" categories had to be combined.

TABLE 14

PERSONAL ACQUAINTANCE WITH STAFF MEMBERS OF N.W.H.C. AND THE BACK-UP HOSPITAL

Number of Staff Known by Name[a]	Staff of N.W.H.C.								Staff of Back-Up Hospital[a]							
	Hispanic		Black		White		Total		Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
None	12	40	13	43	8	27	33	37	11	92	20	83	10	43	41	70
1-2	7	23	6	20	7	23	20	22	1	8	3	13	8	35	12	21
3-4	7	23	2	7	10	33	19	21	-	-	-	-	2	9	2	3
5 +	-	-	4	13	2	7	6	7	-	-	1	4	1	4	2	3
By sight	1	4	5	17	3	10	9	10	-	-	-	-	-	-	-	-
DK, NR	3	10	-	-	-	-	3	3	-	-	-	-	2	9	2	3
Total	30	100	30	100	30	100	90	100	12	100	24	100	23	100	59	100
	$\chi^2 = 6.26$, df = 6, $p > .30$[c]								$\chi^2 = 10.03$, df = 2, $.001 < p < .01$[d]							
Number of staff who know respondents' names[e]																
None	7	23	14	46	12	40	33	37	9	75	18	75	13	57	40	68
1-2	7	23	2	7	5	17	14	16	-	-	3	13	6	26	9	15
3-4	7	23	3	10	6	20	16	18	-	-	1	4	2	9	3	5
5 +	-	-	7	23	6	20	13	14	-	-	1	4	1	4	2	3
By sight	-	-	2	7	1	3	3	3	-	-	-	-	-	-	-	-
DK, NR	9	30	2	7	-	-	11	12	3	25	1	4	1	4	5	9
Total	30	99	30	100	30	100	90	100	12	100	24	100	23	100	59	100
	$\chi^2 = 20.34$, df = 8, $.01 < p < .02$[f]								$\chi^2 = 5.94$, df = 2, $.05 < p < .10$[d]							

[a] Q 31a and Q 32a: "As you think about members of the staff at N.W.H.C./the back-up hospital, how many would you say you know by name?" (O-E).

[b] N < 90 because some respondents did not report use of the back-up hospital.

[c] Computed without the "DK, NR" category to arrive at an acceptable minimum expected frequency.

[d] To achieve an acceptable minimum expected frequency the "1-2," "3-4," and "5 +" categories had to be combined, and the "DK, NR" category excluded.

[e] Q 31 c and Q 32c: "As you think about members of the staff at N.W.H.C./ the back-up hospital, how many know your name?" (O-E).

[f] To arrive at an acceptable minimum expected frequency, "by sight" and "DK, NR" were combined; computation without these two categories yielded $\chi^2 = 10.9$, df = 6, $.05 < p < .10$.

TABLE 15

TYPE OF PERSONNEL AT THE N.W.H.C. AND THE BACK-UP HOSPITAL WITH WHOM ACQUAINTANCE IS REPORTED

Facility	North-West Health Center							
	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Staff Members known by name by respondents[a]								
Doctor	7	18	13	32	13	55	33	32
Nurse	9	24	4	10	3	13	16	15
MA[b]	2	5	4	10	-	-	6	6
FHC[c]	10	26	1	3	1	4	12	12
Social Worker	4	11	1	3	2	8	7	7
Technician	-	-	1	3	2	8	3	3
Clerical	1	3	6	15	1	4	8	8
Other[d]	1	3	4	10	1	4	6	6
DK, NR	4	10	6	15	1	4	11	11
Total	38	100	40	100	24	100	102	100
Staff members who know respondent's name[e]								
Doctor	5	12	5	19	7	59	17	21
Nurse	9	22	2	7	-	-	11	14
MA[b]	4	9	2	7	-	-	6	7
FHC[c]	8	19	-	-	-	-	8	10
Social Worker	5	12	-	-	1	8	6	7
Technician	-	-	3	11	-	-	3	4
Clerical	1	2	4	15	1	8	6	7
Other[d]	1	2	2	7	2	17	5	6
DK, NR	9	22	9	34	1	8	19	24
Total	42	100	27	100	12	100	31	400

[a] Q 31b and Q 32b: "As you think about members of the staff at NWHC/ the back-up hospital, what kind of jobs do the people you know by name have?" (F.A.). Multiple ansers were possible.

[b] The position of Aide at the back-up hospital approximated that of MA at NWHC.

TABLE 15 Continued

Facility	Back-Up Hospital[f]							
	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
Staff members known by name by respondents[a]								
Doctor	1	100	4	57	10	62	15	63
Nurse	-	-	2	29	2	13	4	17
MA[b]	-	-	-	-	2	13	2	8
Social Worker	-	-	-	-	1	6	1	4
Technician	-	-	-	-	-	-	-	-
Clerical	-	-	1	14	-	-	1	4
Other[d]	-	-	-	-	-	-	-	-
DK, NR	-	-	-	-	1	6	1	4
Total	1	100	7	100	16	100	24	100
Staff members who know respondent's name[e]								
Doctor	-	-	3	34	7	50	10	38
Nurse	-	-	2	22	3	22	5	19
MA[b]	-	-	-	-	1	7	1	4
Social Worker	-	-	-	-	1	7	1	4
Technician	-	-	1	11	-	-	1	4
Clerical	-	-	2	22	1	7	3	12
Other[d]	-	-	-	-	-	-	-	-
DK, NR	3	100	1	11	1	7	5	19
Total	3	100	9	100	14	100	26	100

[d]This category included guards, drivers, housekeeping and administrative personnel.

[e]Q 31d and 32d: "As you think about members of the staff at N.W.H.C./ the back-up hospital, what kind of jobs do the people who know your name have?" (F.A.). Multiple answers were possible.

[f]Only respondents who reported use of the back-up hospital were included here.

TABLE 16

LOCATION AND OCCASIONS NAMED BY INT. I. RESPONDENTS IN RELATION TO THEIR PERCEPTION OF SPACE, CROWDING, NOISE AND COMFORT AT THE N.W.H.C.[a]

Ethnic Group	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White
	Crowding									Noise								
	Often			Sometimes			Never			Often			Sometimes			Never		
Location:																		
Waiting room	1	10	18	5	7	5	-	2	-	1	7	12	-	8	10	-	2	-
Examining room	-	-	1	-	-	-	-	-	-	-	-	1	-	1	-	-	-	-
Entire clinic	-	-	1	-	-	-	-	-	-	-	-	1	1	-	-	-	-	-
Child area	-	-	-	-	-	-	-	1	-	-	1	-	3	1	-	-	-	-
Other/unspecified[b]	-	1	1	6	-	-	-	-	-	-	-	-	-	1	3	-	-	-
Total	1	11	21	11	7	5	-	3	-	1	9	14	5	12	13	-	2	-
Occasion:																		
Children present	-	-	-	-	-	-	-	-	-	-	3	2	-	1	5	-	-	-
Specific hour/day/ month/season	-	3	-	7	-	-	-	-	-	-	-	1	-	1	-	-	-	-
Other[c]	-	-	1	2	-	-	-	-	-	-	-	-	-	2	1	-	1	-
Total	-	3	1	9	-	-	-	-	-	-	3	3	-	4	6	-	1	-
	Comfort									Space								
	Often			Sometimes			Never			Too Little			Enough					
Location:																		
Waiting room	1	8	13	-	5	1	-	3	2	1	9	20	-	4	1			
Examining room	-	3	3	-	-	-	-	-	1	-	-	5	-	-	-			
Entire clinic	1	-	-	-	1	-	-	-	-	3	1	1	1	1	1			
Child area	-	-	-	-	-	-	-	-	-	-	1	-	-	2	1			
Other/inspecified[b]	-	-	1	-	1	1	-	1	-	-	2	1	-	2	1			
Total	2	11	17	-	7	2	-	4	3	4	13	27	1	9	2			

TABLE 16 Continued

Ethnic Group	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White	
	Often			Sometimes			Never			Too Little			Enough			
Occasion:																
Children present	-	-	-	-	-	-	-	-	-	-	-	2	-	-	-	
Crowded	-	-	1	-	-	1	-	2	-	-	-	2	-	-	-	
Specific hour/day/ month/season	-	-	-	-	-	-	-	1	-	-	1	-	-	-	-	
Other[c]	-	2	-	-	1	-	-	1	-	-	1	2	-	-	-	
Total	-	2	1	-	1	1	-	4	-	-	2	6	-	-	-	

Note: Respondents who did not answer these probes or Qs. 42, 43, 45, 45 are not included in this table.

[a]Probes for Qs. 42b, 43b, 44b, 45b:: "If yes, which ones?" (Specifically, in which locations and on what occasions?)

[b]This category includes EKG room, hallway, dental area.

[c]This category includes: walk-in, when sick, with high temperature, when waiting is long.

TABLE 17

OVERALL SATISFACTION WITH N.W.H.C.[a] BY PERCEPTION OF ITS SPACE, CROWDEDNESS AND COMFORT[b]

Satisfied With N.W.H.C.	Hispanic								Black							
	Yes		No		DK, NR		Total		Yes		No		DK, NR		Total	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
Amount of space at N.W.H.C.																
Too little	8	31	1	50	1	50	10	33	10	48	4	66	1	33	15	50
Enough	18	69	1	50	1	50	20	67	10	48	1	17	2	67	13	43
DK, NR	-	-	-	-	-	-	-	-	1	4	1	17	-	-	2	7
Total	26	100	2	100	2	100	30	100	21	100	6	100	3	100	30	100
Is N.W.H.C. crowded?																
Often	2	8	-	-	-	-	2	7	9	43	5	83	3	100	17	57
Sometimes	18	69	2	100	1	50	21	70	7	33	-	-	-	-	7	33
Never	5	19	-	-	-	-	5	16	4	19	-	-	-	-	4	13
DK, NR	1	4	-	-	1	50	2	7	1	5	1	17	-	-	2	7
Total	26	100	2	100	2	100	30	100	21	100	6	100	3	100	30	100
Is N.W.H.C. noisy?																
Often	1	4	-	-	-	-	1	3	6	28	2	33	2	67	10	33
Sometimes	16	62	2	100	1	50	19	64	9	43	3	50	-	-	12	40
Never	6	23	-	-	-	-	6	20	5	24	-	-	1	33	6	20
DK, NR	3	11	-	-	1	50	4	13	1	5	1	17	-	-	2	7
Total	26	100	2	100	2	100	30	100	21	100	6	100	3	100	30	100
Is N.W.H.C. comfortable?																
Often	12	46	-	-	-	-	12	40	12	57	2	33	3	100	17	58
Sometimes	13	50	2	100	1	50	16	54	6	29	1	17	-	-	7	23
Never	1	4	-	-	-	-	1	3	2	9	2	33	-	-	4	13
DK, NR	-	-	-	-	1	50	1	3	1	5	1	17	-	-	2	6
Total	26	100	2	100	2	100	30	100	21	100	6	100	3	100	30	100

TABLE 17 Continued

Satisfied With N.W.H.C.	White								Total Sample							
	Yes		No		DK, NR		Total		Yes		No		DK, NR		Total	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
Amount of space at N.W.H.C.																
Too little	19	76	2	100	3	100	24	80	37	51	7	70	5	6	49	55
Enough	4	16	-	-	-	-	4	13	32	45	2	20	3	37	37	41
DK, NR	2	8	-	-	-	-	2	7	3	4	1	10	-	-	4	4
Total	25	100	2	100	3	100	30	100	72	100	10	100	8	100	90	100
Is N.W.H.C. crowded?																
Often	19	76	2	100	1	33	22	73	30	42	7	70	4	50	41	4
Sometimes	6	24	-	-	1	33	7	24	31	43	2	20	2	25	35	3
Never	-	-	-	-	-	-	-	-	9	12	-	-	-	-	9	10
DK, NR	-	-	-	-	1	33	1	33	2	3	1	10	2	25	5	5
Total	25	100	2	100	3	99	30	100	72	100	10	100	8	100	90	100
Is N.W.H.C. noisy?																
Often	11	44	1	50	-	-	12	40	18	25	3	30	2	25	23	26
Sometimes	11	44	1	50	2	67	14	46	36	50	6	60	3	38	45	50
Never	3	12	-	-	-	-	3	10	14	19	-	-	1	12	15	16
DK, NR	-	-	-	-	1	33	1	3	4	6	1	10	2	25	7	8
Total	25	100	2	100	3	100	30	100	72	100	10	100	8	100	90	100
Is N.W.H.C. comfortable?																
Often	20	80	1	50	2	67	23	76	44	61	3	30	5	63	52	58
Sometimes	2	8	-	-	-	-	2	6	21	29	3	30	1	12	25	28
Never	3	12	1	50	-	-	4	13	6	9	3	30	-	-	9	10
DK, NR	-	-	-	-	1	33	1	3	1	1	1	10	2	25	4	4
Total	25	100	2	100	3	100	30	100	72	100	10	100	8	100	90	100

[a] Q 77: "Are you satisfied with the service at the center?" (F.A. + probe).

[b] See Tables 12.1-12.4 for wording of questions 42,43,44,45.

TABLE 18

RELATIONSHIP BETWEEN DISSATISFACTION WITH N.W.H.C.'S PHYSICAL ENVIRONMENT, SOME INDICATORS OF SATISFACTION WITH CENTER SERVICES AND RESPONDENTS' AGE (INT. I.)

Non-environmental variables	Environmental Dissatisfaction Score[a]					
	At or Above Median[b]		Below Median[b]		Total	
	f	%	f	%	f	%
"About how often did you use the center during the past year?" (Q 1a)						
At or above median	26	62	17	39	43	50
Below median	16	38	27	61	43	50
Total	42	100	44	100	86[c]	100
"Are you satisfied with the service at the center?" (Q 77)						
Yes	33	77	36	90	69	83
No	10	23	4	10	14	17
Total	43	100	40	100	83[c]	100
"Have you ever recommended the center to people you know?" (Q 62)						
Yes	31	72	25	60	56	66
No	12	28	17	40	29	34
Total	43	100	42	100	85[c]	100
"Can you please tell me your age?" (Q 109a)						
Below 40	16	36	13	30	29	33
Above 40	29	64	31	70	60	67
Total	45	100	44	100	89	100

[a]See appendix O for computation of this score.

[b]One median was computed for all 90 Int. I. respondents.

[c]Totals ≠ 90 because of missing data.

[d]Dividing age was set at 40 because respondents' exact ages had not been recorded.

TABLE 19

PRIVACY IN DEALING WITH STAFF MEMBERS (INT. I.)[a]

Patients	Hispanic						Black						White					
	Doctor		Other		Total		Doctor		Other		Total		Doctor		Other		Total	
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%
Patients privacy in contact with staff																		
Good	2	7	1	3	3	5	8	27	1	3	9	15	8	26	3	10	11	19
Adequate	23	76	11	37	34	57	15	50	6	20	21	35	17	57	1	3	18	30
Inadequate	2	7	5	17	7	11	3	10	1	3	4	7	2	7	4	14	6	10
None	-	-	-	-	-	-	1	3	-	-	1	2	-	-	3	10	3	5
Not important	1	3	4	13	5	8	2	7	3	10	5	8	1	3	1	3	2	3
Varies	-	-	1	3	1	2	-	-	-	-	-	-	-	-	-	-	-	-
DK, NR, IRR	2	7	2	7	4	7	1	3	12	40	13	22	2	7	12	40	14	23
NA[b]	-	-	6	20	6	10	-	-	7	24	7	11	-	-	6	20	6	10
Total	30	100	30	100	60	100	30	100	30	100	60	100	30	100	30	100	60	100
Feelings about privacy during these contacts																		
Positive	8	26	7	24	15	25	18	61	7	24	25	42	12	39	4	13	16	27
Negative	2	7	3	10	5	8	-	-	1	3	1	2	2	7	2	7	4	7
Indifferent	2	7	3	10	5	8	3	10	3	10	6	10	2	7	3	10	5	8
Ambivalent	3	10	1	3	4	7	4	13	-	-	4	7	3	10	-	-	3	5
None mentioned	13	43	-	-	13	22	4	13	1	3	5	8	9	30	2	7	11	18
DK, NR, IRR	2	7	10	33	12	20	1	3	11	37	12	20	2	7	13	43	15	25
NA[b]	-	-	6	20	6	10	-	-	7	23	7	11	-	-	6	20	6	10
Total	30	100	30	100	60	100	30	100	30	100	60	100	30	100	30	100	60	100

[a]Q 48 & 49: If you think about the times you have talked to a doctor/other personnel at the center
a. Where did you talk with him/them? (reported in text, not included in this table)
b. What do you think about the amount of privacy you had?
c. Can you describe how you felt about it?

[b]NA (Not applicable) refers to respondents who claimed that they never talked to staff other than physicians, or did not answer Qs 48, 49 a and/or b.

TABLE 20

AFFECT EXPRESSED BY RESPONDENTS REGARDING THE PERCEIVED DEGREE OF PRIVACY DURING ENCOUNTERS WITH N.W.H.C. STAFF (INT. I.)

Degree of Perceived Privacy	None			Inadequate			Adequate			Good			Unimportant		
	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White	Hispanic	Black	White
Affect with physicians															
Positive	-	-	-	-	-	-	6	12	8	2	5	4	-	-	-
Negative	-	-	-	2	-	2	-	-	1	-	-	-	-	-	-
Indifferent	1	-	-	-	-	-	6	-	1	-	-	2	-	2	-
Ambivalent	-	-	-	-	3	-	-	1	2	-	-	-	-	-	-
DK, NR, not mentioned	-	-	-	-	1	-	11	2	5	3	-	3	1	-	1
Affect with other staff															
Positive	-	-	1	-	-	-	6	5	-	1	1	2	-	-	-
Negative	-	-	-	3	1	2	-	1	-	-	-	-	-	-	-
Indifferent	-	-	1	1	-	1	-	1	-	-	-	-	-	-	-
Ambivalent	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-
DK, NR, not mentioned	-	-	1	-	-	1	4	-	-	-	-	1	4	-	-

[a] $N \neq 90$ in either of the two sections because only respondents who answered Q 48 and Q 49b are included; (see Table 12.9).

TABLE 21

CORRESPONDENCE BETWEEN OVERALL SATISFACTION WITH CENTER SERVICES AND PERCEPTION OF PRIVACY AT CENTER

Staff To Whom Privacy Questions Refer	Physicians				Other Staff			
Satisfaction With Center Services	Yes	No	DK	Total	Yes	No	DK	Total
Privacy When In Contact With Above Staff								
	Hispanic							
Good	2	-	-	2	1	-	-	1
Adequate	19	2	2	23	10	1	-	11
Inadequate	2	-	-	2	4	1	-	5
None	-	-	-	-	-	-	-	-
Not important	1	-	-	1	4	-	-	4
Varies	-	-	-	-	1	-	-	1
DK, NR, IRR, NA	2	-	-	2	6	-	2	8
Total	26	2	2	30	26	2	2	30
	Black							
Good	7	1	-	8	1	-	-	1
Adequate	10	3	2	15	1	3	2	6
Inadequate	3	-	-	3	1	-	-	1
None	-	-	1	1	-	-	-	-
Not important	-	2	-	2	1	2	-	3
Varies	-	-	-	-	-	-	-	-
DK, NR, IRR, NA	1	-	-	1	17	1	1	19
Total	21	6	3	30	21	6	3	30
	White							
Good	8	-	-	8	-	-	-	-
Adequate	14	2	1	17	1	-	-	1
Inadequate	2	-	-	2	3	1	-	4
None	-	-	-	-	3	-	-	3
Not important	1	-	-	1	1	-	-	1
Varies	-	-	-	-	2	-	1	3
DK, NR, IRR, NA	-	-	-	-	5	-	-	6
Total	25	2	3	30	25	2	3	30

TABLE 22

ATTRIBUTION OF RESPONSIBILITY FOR UNSATISFACTORY CONDITIONS AND FEELINGS OF ABILITY/INABILITY TO CHANGE THESE CONDITIONS

	N.W.H.C.					Back-Up Hospital				
	Hispanic	Black	White	Total		Hispanic	Black	White	Total	
				f	%				f	%
Responsibility for unsatisfactory condition lies with:										
Administration	-	4	1	5	28	-	3	2	5	24
Staff	-	2	1	3	17	-	9	1	10	48
Overcrowded/understaffed	-	2	-	2	11	-	1	1	2	9
Government	-	1	-	1	5	-	-	-	-	-
No one	-	1	-	1	5	-	-	-	-	-
DK, NR	2	4	-	6	34	1	3	-	4	19
Total	2	14	2	18	100	1	16	4	21	100
What respondents can do to change these conditions:										
Nothing	-	2	-	2	13	1	5	2	8	47
Nothing as individual	-	-	-	-	-	-	1	-	2	11
Complaints get worse treatment	-	1	1	2	13	-	-	1	1	6
Complain to N.W.H.C.	-	-	-	-	-	-	1	-	1	6
Talk to supervisor	-	1	-	1	7	-	1	-	1	6
Organize political pressure	-	4	-	4	27	-	1	-	1	6
DK, NR	2	3	1	6	40	-	3	-	3	18
Total	2	11	2	15	100	1	13	3	17	100

Note: N ≠ 90 because only users who were dissatisfied with services at the center and the back-up hospital are included. The totals on the two parts of this table are not the same because a few multiple answers were offered for the first part.

[a]Q 77 and A 78: "Are you satisfied with services at the center and the back-up hospital?" (FA; see Table 5, Appendix N for figures). "If not satisfied:

a. Who do you think is responsible for this? (O-E).

b. Is there anything you can do about it?" (O-E).

TABLE 23

FREQUENCY OF UTILIZATION OF CENTER SERVICES (INT. III.) IN RELATIONSHIP TO PATIENTS' AGE, DISTANCE OF THEIR HOME FROM CENTER, AND THEIR BEING ACCOMPANIED BY CHILDREN

Age of Respondent	Under 20			20-40			40-60			Over 60			
City Blocks From Home to Center	1-5	6-10	11-	1-5	6-10	11-	1-5	6-10	11-	1-5	6-10	11-	Total
	Respondent is Accompanied by Child (Children)												
Number of visits during the year preceding Int. III.													
0 - 1	2	-	-	5	6	4	3	1	-	-	-	-	21
2 - 6	1	-	-	23	11	3	1	1	-	-	-	1	41
7 -11	4	-	-	16	15	1	-	3	-	-	-	-	39
12 -24	1	-	-	22	9	3	7	-	1	2	-	-	45
Over 24	-	-	-	12	7	2	4	1	-	-	1	-	27
Total	8	-	-	78	48	13	15	6	1	2	1	1	173
	Respondent is Not Accompanied by Child (Children)												
Visits during year preceding Int. III.													
0 - 1	4	3	-	10	3	6	3	2	1	-	-	-	34
2 - 6	6	2	-	29	11	5	9	3	4	7	3	-	79
7 -11	11	-	-	19	7	3	7	5	-	4	3	1	60
12 -24	5	2	-	13	8	-	12	10	7	-	2	2	70
Over 24	-	1	-	15	3	3	15	4	2	2	3	-	48
Total	26	8	-	86	32	17	46	24	14	22	12	4	291
Grand Total	34	8	-	164	80	30	61	30	15	24	13	5	464

Note: N 487 because respondents with missing data on one or more of the variables are not included. There were 23 respondents with missing data.

TABLE 24

RELATIONSHIP BETWEEN INT. I. RESPONDENTS' KNOWLEDGE ABOUT N.W. COUNCIL AND THEIR AGES, EDUCATION, LENGTH OF RESIDENCE IN CITY, FAMILY STATUS AND SOCIAL SPACE

Variables	Knowledge About N.W. Council[a]							
	Yes		No		NR		Total	
	f	%	f	%	f	%	f	%
Age b								
20-29	7	16	4	9	-	-	11	12
30-39	12	27	5	12	1	33	18	20
40-49	9	21	9	21	1	33	19	21
50-59	5	11	7	16	-	-	12	14
60 and over	11	25	18	42	1	33	30	33
Total	44	100	43	100	3	99	90	100
$\chi^2 = 5.94$; df = 4 (without "NR" category); .20 < p < .30								
Start of residence in city[c]								
Since birth	9	20	11	26	-	-	20	22
Prior to 1939	9	20	6	14	1	33	16	18
1940-1959	12	28	13	30	1	33	26	29
1960 or later	6	14	9	21	-	-	15	17
NR	8	18	4	9	1	33	13	14
Total	44	100	43	100	3	99	90	100
$\chi^2 = 2.78$; df = 4 (without "NR" regarding Council); N.S.								
Family status[d]								
Lives with family	30	68	22	51	1	33	53	59
Lives alone	14	32	21	49	2	67	37	41
Total	44	100	43	100	3	100	90	100
$\chi^2 = 2.62$; df = 1 (without "NR" category); .10 < p < .20								
Years of schooling[e]								
Eight or less	5	11	17	40	1	33	23	26
Twelve or less	29	66	15	35	1	33	45	50
Thirteen or more	10	23	9	21	-	-	19	21
NR	-	-	2	4	1	33	3	3
Total	44	100	43	100	3	99	90	100
$\chi^2 = 10.97$; df = 2 (without both "NR" categories); .001 < p < .01								

TABLE 24 Continued

Variables	Knowledge About N.W. Council[a]							
	Yes		No		NR		Total	
	f	%	f	%	f	%	f	%
Social space score[f]								
0 - 1	2	5	3	7	-	-	5	6
10 -19	4	9	6	14	-	-	10	11
20 -29	11	25	16	37	1	33	28	31
30 -39	7	16	6	14	-	-	13	14
40 -49	8	19	7	17	-	-	15	17
50 -59	5	11	4	9	-	-	9	10
60 -69	5	11	1	2	-	-	6	7
70 -79	-	-	-	-	-	-	-	-
80 -89	1	2	-	-	-	-	1	1
NR	1	2	-	-	2	67	3	3
Total	44	100	43	100	3	100	90	100

χ^2 = 5.33; df = 6 (without "NR" categories and with scores 60-89 combined to achieve minimum expected acceptable frequency); N.S.

[a] Q 104 (if not mentioned spontaneously in response to Q 102): "Are you familiar with the...[N.W.] Council?" (F.A.)

[b] Q 109a: "Can you please tell me your age?"

[c] Q 109b,c: "Where were you born?" (F.A.) If outside the city: "When did you come t...[the city]?"

[d] Q 3: "Do members of your family use the health center?" (F.A.)
Q3a: "If yes, which?" (F.A.)
Q 4: "I'll mention other members of your family. Will you tell me where they go for their health care?" (F.A.)

[e] Q 109a: "Which grade did you finish in school?" (F.A.)

[f] See Appendix M.

TABLE 25

RELATIONSHIP BETWEEN INT. I. HISPANIC RESPONDENTS' KNOWLEDGE ABOUT N.W. COUNCIL AND THEIR AGES, EDUCATION, LENGTH OF RESIDENCE IN CITY, FAMILY STATUS AND SOCIAL SPACE.[a]

Variables	Knowledge About N.W. Council					
	Yes		No		Total	
	f	%	f	%	f	%
Age						
20-29	4	25	1	8	5	17
30-39	5	31	1	8	6	21
40-49	5	31	4	30	9	31
50 and over	2	13	7	54	9	31
Total	16	100	13	100	29	100
$\chi^2 = 7.11$; df = 3; .05 < p < .10						
Residence in city						
Since birth	5	31	1	8	6	21
Since 1940	5	31	8	61	13	45
NR	6	38	4	31	10	34
Total	16	100	13	100	29	100
$\chi^2 = 3.48$; df = 2; .10 < p < .20						
Family status						
Lives with family	12	75	10	77	22	76
Lives alone	4	25	3	23	7	24
Total	16	100	13	100	29	100
$\chi^2 = 4.27$ (with Yates' correction); df = 1; .02 < p < .05						
Social space score						
20-39	5	33	8	61	13	46
40-49	4	27	4	31	8	29
50-69	6	40	1	8	7	25
Total	15	100	13	100	28	100
$\chi^2 = 4.14$; df = 2; .10 < p < .20						
Education						
Elementary or less	. .	. . .	7	58	7	25
Some H.S.	16	100	5	42	21	75
Total	16	100	12	100	28	100
$\chi^2 = 3.2$ (with Yates' correction); df = 1; .05 < p < .10						

Note: In order to achieve acceptable minimum expected frequency some categories were combined. The one NR was not included.

[a]See Table 24 for questions which form the basis for this table.

TABLE 26

RELATIONSHIP BETWEEN INT. I. BLACK RESPONDENTS' KNOWLEDGE ABOUT N.W. COUNCIL AND THEIR AGES, EDUCATION, LENGTH OF RESIDENCE IN CITY, FAMILY STATUS AND SOCIAL SPACE.[a]

Variables	Knowledge About N.W. Council					
	Yes		No		Total	
	f	%	f	%	f	%
Age						
20-39	6	40	6	43	12	41
40-49	4	22	3	21	7	24
50 and over	5	33	5	36	10	35
Total	15	100	14	100	29	100
$\chi^2 = .09$; df = 2; N.S.						
Residence in city						
Prior to 1939	5	36	2	14	7	25
1940-1959	6	43	5	36	11	39
Since 1960	3	21	7	50	10	36
Total	14	100	14	100	28	100
$\chi^2 = 2.97$; df = 2; $.20 < p < .30$						
Family status						
Lives with family	13	87	7	50	20	69
Lives alone	2	13	7	50	9	31
Total	15	100	14	100	29	100
$\chi^2 = 1.25$ (with Yates correction); df = 1; $.20 < p < .30$						
Social space score						
0-19	3	20	3	21	6	20
20-29	4	27	4	29	8	28
30-49	4	27	4	29	8	28
50-69	4	27	3	21	7	24
Total	15	101	14	100	29	100
$\chi^2 = .09$; df = 3; N.S.						
Education						
Elementary or less	3	20	5	38	8	28
High school or less	10	67	4	31	14	50
Some college	2	13	4	31	6	32
Total	15	100	13	100	28	100
$\chi^2 = 3.61$; df = 2; $.10 < p < .20$						

[a]Questions are same as in Table 24.

TABLE 27

RELATIONSHIP BETWEEN INT. I. WHITE RESPONDENTS' KNOWLEDGE ABOUT N.W. COUNCIL AND THEIR AGES, EDUCATION, LENGTH OF RESIDENCE IN CITY, FAMILY STATUS AND SOCIAL SPACE.[a]

Variables	Knowledge About N.W. Council					
	Yes		No		Total	
	f	%	f	%	f	%
Age						
Under 49	4	31	3	19	7	24
Over 49	9	69	13	81	22	76
Total	13	100	16	100	29	100
$\chi^2 = 3.76$ (with Yates' correction); df = 1; .05 < p < .10						
Residence in city						
Whole life	2	17	10	63	12	43
Prior to 1939	6	50	4	25	10	36
Since 1940	4	33	2	12	6	21
Total	12	100	16	100	28	100
$\chi^2 = 5.96$; df = 2; .05 < p < .10						
Family status						
Lives with family	5	38	5	31	10	34
Lives alone	8	62	11	69	19	66
Total	13	100	16	100	29	100
$\chi^2 = 1.56$ (with Yates' correction); df = 1; .20 < p < .30						
Social space score						
0-19	3	24	6	38	9	32
20-29	5	38	5	31	10	34
Over 30	5	38	5	31	10	34
Total	13	100	16	100	29	100
$\chi^2 = .73$; df = 2; N.S.						
Education						
Elementary or less	2	15	5	31	7	24
High school or less	6	47	6	38	12	42
Some college	5	38	5	31	10	34
Total	13	100	16	100	29	100
$\chi^2 = .99$; df = 2; N.S.						

[a]Questions are same as Table 24.

TABLE 28

PERCEIVED EXTENT OF COMMUNITY INFLUENCE ON OPERATION OF N.W.H.C. AND OF BACK-UP HOSPITAL (INT. I.)[a]

Influence	Hispanic		Black		White		Total	
	f	%	f	%	f	%	f	%
	On N.W.H.C.							
Great deal	1	3	5	17	3	10	9	10
Some	9	30	6	20	3	10	18	20
Little	2	7	4	13	4	13	10	11
None	2	7	4	13	2	7	8	9
DK, NR	16	53	11	37	18	60	45	50
Total	30	100	30	100	30	100	90	100
$\chi^2 = 3.78$; df = 4[b]; N.S.								
	On Back-Up Hospital							
Great deal	-	-	2	7	1	3	3	3
Some	-	-	5	17	2	7	7	8
Little	-	-	-	-	1	3	1	1
None	1	3	7	23	6	20	14	16
DK, NR	29	97	16	53	20	67	65	72
Total	30	100	30	100	30	100	90	100
$\chi^2 = 15.3$; df = 4[b]; .001 < p < .01								

[a] Q 67 and 68: "How much do you think the people in the neighborhood have to say about the kind of medical care they receive at the center/ the back-up hospital?" (F.A. + probe).

[b] Combined "great deal, some and little" to achieve acceptable expected minimum frequency.

TABLE 29

FEELINGS ABOUT COMMUNITY INFLUENCES IN HEALTH CARE FACILITIES BASED ON COMMENTS ABOUT SUCH INFLUENCES (INT. I.)[a]

Reasons Given For Feelings	Feelings About Community Influence in Health Care											
	For				Against				Ambivalent No Opinion			
	Hispanic	Black	White	Total	Hispanic	Black	White	Total	Hispanic	Black	White	Total
Provides channel for complaints/ feedback	-	7	4	11	-	-	-	-	-	-	-	-
Leads to autonomy	8	8	3	19	-	-	-	-	-	-	-	-
People don't know enough	1	-	-	1	1	-	1	2	-	1	-	1
One cannot change things	-	-	-	-	-	-	2	2	-	-	1	1
No comment	1	3	2	6	-	-	-	-	-	1	1	2
Total	10	18	9	37	1	-	3	4	-	2	2	4

Note: N ≠ 30 for each group because only those respondents who voiced an opinion are included; Hispanic N = 11; Black N = 20; White N = 14. Multiple answers were possible.

[a]Probe for Q 67 and Q 68 (see Table 13.9).

TABLE 30

FEELINGS ABOUT COMMUNITY PARTICIPATION AND CONTROL BY PERCEIVED EFFECTIVENESS IN RESPONDENTS' OWN PART OF THE CITY[a]

Feelings About Community Participation and Control	Hispanic					Black					White					Grand Total	
	Unqualified Approval	Qualified Approval[b]	Opposed	Total		Unqualified Approval	Qualified Approval[b]	Opposed	Total		Unqualified Approval	Qualified Approval[b]	Opposed	Total			
	f	f	f	f	%	f	f	f	f	%	f	f	f	f	%		
Perception of effectiveness in respondents area:																	
Works	1	-	-	1	8	7	-	-	7	31	7	-	-	7	35	15	27
Works to some extent[c]	2	2	-	4	31	1	1	-	2	9	4	-	-	4	20	10	17
Does not work	1	1	-	2	15	3	4	-	7	30	3	2	1	6	30	15	27
DK, NR	5	1	-	6	46	3	2	2	7	30	2	-	1	3	15	16	29
Total	9	4	-	13	100	14	7	2	23	100	16	2	2	20	100	56	100

Note: The total number of respondents in this table is greater than the number who could define term "community participation and control" because some individuals who could not define it volunteered information regarding their feelings and perceptions spontaneously.

[a]Probes for Q 101; (see Table 13.10).

[b]This category includes the following comments: "There should not be complete control; it depends upon the leaders involved; it is good if it works".

[c]This category includes: "It works in some streets, blocks, spheres of activity, e.g. schools".

TABLE 31

ANALYSIS OF VARIANCE FOR AREA REPORTED AS RESPONDENTS' NEIGHBORHOOD (INT.I.)

Source	SS	df	MS	F	df
Between ethnic groups	1709.61	2	854.81	3.86	55.2
Within ethnic groups	181660.27	55	3302.91		
Total	183369.88	57			

TABLE 32

RELATIONSHIP OF AREA CLAIMED AS ONE'S NEIGHBORHOOD TO YEARLY USE OF N.W.H.C., TO KNOWLEDGE REGARDING N.W. COUNCIL, TO PERCEIVED INFLUENCE OF COMMUNITY IN OPERATION O N.W.H.C. AND TO RESPONDENTS' SOCIAL SPACE (INT. I.)[a]

	Number of Blocks in Perceived Neighborhood									
	1-19		20-39		40-59		60 +		Total	
	f	%	f	%	f	%	f	%	f	%
Visits to center during preceding Int. I.[b]										
0 - 1	3	30	1	20	3	27	12	40	19	34
2 - 6	2	20	1	20	3	27	10	33	16	29
7 -11	2	20	1	20	2	19	2	7	7	12
12 +	3	30	2	40	3	27	6	20	14	25
Total	10	100	5	100	11	100	30	100	56	100
$\chi^2 = 3.81$; df = 6 (combined "20-39" and "40-59" categories to achieve acceptable minimum expected frequency); N.S.										
Know N.W. Council[c]										
Yes	7	70	5	71	6	55	16	53	34	59
No	3	30	2	29	5	45	14	47	24	41
Total	10	100	7	100	11	100	30	100	58	100
$\chi^2 = 1.39$; df = 3; N.S.										
Community influence in operation of N.W.H.C.[d]										
Yes	6	86	3	60	3	60	10	59	22	65
No	1	14	2	40	2	40	7	41	12	35
Total	7	100	5	100	5	100	17	100	34	100
$\chi^2 = 1.7$; df = 3 (combined "20-39" and "40-59" categories to achieve acceptable minimum expected frequency); N.S.										
Social space[e]										
0 - 19	2	22	-	-	3	25	1	4	6	10
20 - 39	3	34	5	71	8	67	12	41	28	49
40 - 59	2	22	2	29	1	8	13	45	18	32
60 - 89	2	22	-	-	-	-	3	10	5	9
Total	9	100	7	100	12	100	29	100	57	100
$\chi^2 = 8.27$; df = 3 (combined "0-19 with "20-39" and "40-59" with "60-89" categories to achieve acceptable minimum expected frequency); $.02 < p < .05$.										

[a] Q 90: "What do you consider to be your neighborhood?" (O.E.).
Q 92: "Could you please mark on the map where you think your neighborhood ends?"

[b] Q 1a: "About how often did you use the center during past year?" (O.E.)

[c] Q 104: "Are you familiar with the...Council?" (F.A.)

[d] Q 67: "How much do you think people in the neighborhood have to say about the kind of medical care they receive at the center?" (F.A. + probe)

[e] See Appendix M.

Appendix O

Score for Dissatisfaction with NWHC's Physical Environment

Following are the texts of the fixed alternative questions, and the arbitrary values assigned to the answers, which were used in the computation of the dissatisfaction score. The "DK" and "NR" categories, which appear in the interview schedule (see appendix E) were not included in this computation.

Text of questions	Possible answers	Assigned value
Q. 42. Would you say that . . . [NWHC] has too much, enough, or too little space?	too much	1
	enough	2
	too little	3
Q. 42a. Would you say that this is very important, somewhat important, of little importance, or of no importance to you?	very important	4
	somewhat important	3
	of little importance . . .	2
	of no importance	1
Q. 43. Would you say that the center is often, sometimes, or never crowded?	often	3
	sometimes	2
	never	1
Q. 43a. Is this very important, somewhat important, of little importance, or of no importance to you?	very important	4
	somewhat important	3
	of little importance . . .	2
	of no importance	1
Q. 44. Do you feel that the center is often, sometimes, or never noisy?	often	3
	sometimes	2
	never	1
Q. 44a. Is this very important, somewhat important, of little importance, or of no importance to you?	very important	4
	somewhat important	3
	of little importance . . .	2
	of no importance	1
Q. 45. Do you believe that the center is often, sometimes, or never comfortable?	often	1
	sometimes	2
	never	3

Text of questions	Possible answers	Assigned value
Q. 45a. Is this very important, somewhat important, of little importance, or of no importance to you?	very important	4
	somewhat important . .	3
	of little importance .	2
	of no importance . . .	1

The dissatisfaction score for each respondent was computed by multiplying the two scores (amount and importance) for each question, and then adding the products of the four questions.

BIBLIOGRAPHY

Abel-Smith, Brian. The major pattern of financing and organization of medical services that have emerged in other countries. In New York Academy of Medicine Subcommittee on Special Studies, Social policy for health care, 1969. Pp 33-40.

Ackerknecht, Erwin H. A short history of medicine. New York: The Ronald Press, 1955.

Anderson, C.L. Community health. St. Louis, Mo.: C.V. Mosby, 1969.

Anderson, Odin W. Health care: Can there be equity? The United States, Sweden, and England. New York: John Wiley & Sons, 1972.

Aronowitz, Stanley. The dialectics of community control. Social Policy, May-June 1970:47-51.

Association of New York Neighborhood Health Centers. The need for neighborhood health center legislation. New York, Feb. 1973. (Mimeographed.)

Badillo, Herman. Presentation at a panel discussion on the "Role of the community in developing improved health care." Reprinted in Community participation for equity and excellence in health care. New York: Bulletin of the New York Academy of Medicine, 1970, 46(12): 1028-1030.

Bailey, Richard M. Economics and social costs of death. In O.B. Brim, M.E. Freeman, S. Levine, & N.A. Scotch (Eds.), The dying patient. New York: Russel Sage Foundation, 1970. Pp. 275-302.

Balint, Michael. The doctor, his patient and the illness. New York: International Universities Press, 1957.

Barker, R.R. Explorations in ecological psychology. American Psychologist, 1965, 20(1): 1-14.

Baum, A. & C.I. Greenberg. Waiting for a crowd: The behavioral and perceptual effects of anticipated crowding. Ms, 1975.

Becker, Howard S. Outsiders: Studies in the sociology of deviance. New York: The Free Press of Glencoe, 1963.

Becker, Howard S. (Ed.). The other side: Perspectives on deviance. New York: The Free Press of Glencoe, 1964.

Becker, Howard S. Problems of interference and proof in participant observation. Am. Sociological Review, 1958, 23: 652-660.

Bell, Alan. Noise: An occupational hazard and public nuisance. Geneva: World Health Organization, 1966.

Bernstein, Betty J. Public health--inside or outside the mainstream of the political process? Lessons from the passage of Medicaid. Am. J. Public Health, 1970, 60(9): 1690-1700.

Bloom, Samuel W. The doctor and his patient: A sociological interpretation. New York: Russell Sage Foundation, 1963.

Boelen, W.A. Marianne. Street corner society revisited. Unpublished Master's dissertation, Department of Sociology, New York: Columbia University, 1972.

Borkow, George. Use of alternate facilities by consumers at the Providence health centers. Inquiry, 1973, 10(1): 54-58.

Brieland, Donald. Community advisory boards and maximum feasible participation. Am. J. Public Health, 1971, 61(2): 292-296.

Brown, Esther L. Newer dimensions of patient care, 3 vol. New York: Russell Sage Foundation, 1961, 1962, 1964.

Brown, N.S. Introduction to the New York Academy of Medicine Subcommittee on Social Policy for Health Care of the Committee on Special Studies. Social Policy for Health Care. 1969. Pp. 6-11.

Bruyn, Severyn T. The human perspective in sociology: The methodology of participant observation. Englewood Cliffs, N.J.: Prentice-Hall, 1966.

Bullough, B. & V.L. Bullough. Poverty, ethnic identity and health care. New York: Appleton-Century-Crofts, 1972.

Buttimer, Anne. Social space and the planning of residential areas. Environment and Behavior, 1972, 4(3): 279-318.

_____ Social space in interdisciplinary perspective. The Geographical Review, 1969, 59(3): 417-426.

Calhoun, John B. The role of space in animal sociology. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970. Pp. 195-202.

Cassel, John. Health consequences of population density and crowding. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 249-268.

Chez, R.A., V. Jorgensen, M.E. Lane, & B.B. Perkins. Symposium: Health care and the liberated woman. Contemporary Ob/Gn, 1974, 3(2): 127-152.

Chisholm, Shirley. Community health and community participation. In Community participation for equity and excellence in health care. New York: Bulletin of the New York Academy of Medicine, 1970, 46(12): 1144-1148.

Christian, J.J. & D.E. Davis. Endocrines, behavior and population. Science, 1964, 146(3651): 1550-1560.

Citizens Board of Inquiry into Health Services for Americans. Heal Yourself: A Report. University of North Carolina and University of California at Los Angeles, 1971.

Clark, Kenneth B. Dark ghetto: Dilemmas of social power. New York: Harper & Row, 1965.

Cohen, Wilbur J. Government policy and the poor: Past, present and future. J. Social Issues, 1970, 26(3): 1-9.

Coleman, James S. Community disorganization. In R.K. Merton & R.A. Nisbet (Eds.) Contemporary social problems, 2nd ed. New York: Harcourt, Brace & World, 1966. Pp. 670-722.

Conant, Ralph W. The politics of community health. National Commission on Community Health Service; Report of the Community Action Studies Project. Washington, D.C.: Public Affairs Press, 1968.

Condorcet, Antoine-Nicolas de. Sketch for a historical picture of the progress of the human mind. New York: The Noonday Press, 1955. Original French Edition: 1795.

Congressional Record. Proceedings and Debates of the 91st Congress, Second Session. August 27, 1970 (403-137-22571).

Contemporary Ob/Gyn., 1974, 4(4): 45-49.

Cook, Donald A. Cultural innovation and disaster in the American city. In L.J. Duhl (Ed.) The urban condition: People and policy in the metropolis. New York: Simon & Schuster Clarion Books, 1963. Pp. 87-93.

Cowen, David L. Case study: Denver--neighborhood health centers, operating within an integrated system, provide dignified, comprehensive care for all. Hospitals, 1970, 44(13): 61-64.

Cox Commission Report. Crisis at Columbia. New York: Random House Vintage Books, 1968.

Craik, Kenneth. Environmental Psychology. New Directions in Psychology, 4. New York: Holt, Rinehart & Winston, 1970. Pp. 3-121.

Demchak, Terry. People's guide to health care: Health care cost facts. Cleveland, Ohio: Legal Aid Society, 1972.

Denton, T., C.P. Ind, J. McCollum, & R. Stutsman. Types of user building evaluation. In W.F.E. Preiser (Ed.) Environmental design research. Proceedings of EDRA IV Conference, Stroudsberg, Pa.: Dowden, Hutchinson & Ross, 1973. Vol. 1, pp. 324-333.

Dore, R.P. City life in Japan: A study of a Tokyo ward. Berkeley, Calif.: University of California Press, 1958.

Dubos, René. The despairing optimist. American Scholar, 1973, 42(3): 378-382.

_____ Man adapting. New Haven: Yale University Press, 1965.

Duhl, Leonard J. Introduction to The urban condition: People and policy in the metropolis. New York: Simon & Schuster Clarion Books, 1963. Pp. vii-xiii.

Durkheim, Emile. Suicide: A study in sociology. New York: The Free Press, 1951. Original French Edition: 1897.

Eddison, G.G. & B.M. Farmer. Problems in the creation of functioning multidisciplinary treatment teams. New York: Albert Einstein College of Medicine, Department of Community Health. MS, undated.

Ehrenreich, J. & O. Fein. National health insurance: The great leap sideways. Social Policy, Jan.-Feb. 1971: 5-9.

Eilers, Robert D. National health insurance: What kind and how much, 2 parts. New England J. of Medicine, 1971, 284(16 & 17): 881-886, 945-954.

Endicott, Kenneth M. Primary health care in the urban community: The role of government. Presented at the Annual Meeting of the American Association of the Advancement of Science, New York City, Jan. 26-31, 1975.

Esser, Aristide H. A biosocial perspective on crowding. In J.F. Wohlwill & D.H. Carson (Eds.) Environment and the social sciences: Perspectives and applications. Washington, D.C.: American Psychological Association, 1972. Pp. 15-28.

Farr, Lee E. Medical consequences of environmental home noises. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 202-211.

Federal Register, 38(97), Part II, May 21, 1973, pp. 13418-13119. Washington, D.C.

Fein, Rashi. Medical care needs in the coming decade. In New York Academy of Medicine Subcommittee on Social Policy for Health Care of the Committee of Special Studies. Social Policy for health care. 1969. Pp. 76-91.

Festinger, L., A. Pepitone, & T. Newcomb. Some consequences of deindividuation in a group. J. Abnormal & Social Psych., 1952, 47(2), Supplement, pp. 382-389.

Festinger, L., H.W. Riecken, & S. Schachter. When prophecy fails. Minneapolis, Minn.: University of Minnesota Press, 1956.

Field, Herman H. Environmental design implications for a changing health care system. Paper presented to a Conference on Environment and Cognition, City University of New York, June 4, 1971.

Fitch, James M. Experiential bases for aesthetic decision. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970. Pp. 76-84.

Flanagan, John C. The critical incident technique. Psychological Bulletin, 1954, 51(4): 327-358.

Freedman, J.L., S. Klevansky, & P. Ehrlich. The effect of crowding on human task performance. J. Applied Social Psych., 1971, 1(1): 7-25.

Freidson, Eliot. Patients' views of medical practice: A study of subscribers to a prepaid medical plan in the Bronx. New York: Russell Sage Foundation, 1961.

_____ Profession of medicine: A study of the sociology of applied knowledge. New York: Dodd, Mead & Co., 1971.

_____ Professional dominance: The social structure of medical care. New York: Atherton, 1970.

Fried, M. & P. Gleicher. Some sources of residential satisfaction in an urban slum. In H.M. Proshansky, W.H. Ittelson, & L.R. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970. Pp. 333-346.

Gans, Herbert. The Levittowners: Ways of life and politics in a new suburban community. New York: Vintage Books, 1967.

_____ The urban villagers. New York: The Free Press of Glencoe, 1962.

Ginzberg, Eli. The political economy of health. In New York Academy of Medicine Subcommittee on Social Policy for Health Care of the Committee on Special Studies. Social Policy for Health Care. 1969. Pp. 104-125.

Ginzberg, E. and the Conservation of Human Resources Staff, Columbia University. Urban health services: The case of New York. New York: Columbia University Press, 1971.

Glaser, Daniel. Architectural factors in isolation promotion in prisons. In J.F. Wohlwill & D.H. Carson. Environment and the social sciences: Perspectives and applications. Washington, D.C.: American Psychological Association, 1972. Pp. 105-113.

Glasgow, John M. Prepaid group practice as a national health policy: Problems and perspectives. Inquiry, 1972, 9(1): 3-15.

Glazer, N. & D.P. Moynihan. Beyond the melting pot: The Negroes, Puerto Ricans, Jews, Italians, and Irish of New York City. 2d ed. Cambridge, Mass.: M.I.T. Press, 1970.

Goffman, Erving. Asylums. New York: Doubleday Anchor Books, 1961.

Goldblatt, Harold. Arguments for and against community participation in urban renewal. In H.B. Spiegel (Ed.) Citizen participation in urban development. Washington, D.C.: Center for Community Affairs. NTL Institute for Applied Behavioral Science, 1968 & 1969. Pp. 31-42.

Goodman, W.I. & E.C. Freund, Eds. Principles and practice of urban planning. Washington, D.C.: International City Managers' Association, 1968. Ch. 8.

Goodwin, Norma J. Emergency room care in the urban setting. Presented at the Annual Meeting of the American Association of the Advancement of Science, New York City, Jan. 26-31, 1975.

Gorman, S.A. & H. Nelson. Meeting the data needs of a neighborhood health center. Presented at the 102nd Annual Meeting, American Public Health Association, New Orleans, La., Oct. 23, 1974.

Graham, Saxon. Sociological aspects of health and illness. In R.E.L. Faris (Ed.) Handbook of modern sociology. Chicago: Rand McNally, 1964. Pp. 310-347.

Greenberg, Selig. The troubled calling: Crisis in the medical establishment. New York: Macmillan, 1965.

Griffitt, W. & R. Veitch. Hot and crowded: Influence of population density and temperatures on interpersonal affective behavior. J. Personality & Soc. Psych., 1971, 17: 92-98.

Gutman, Robert (Ed.) People and buildings. New York: Basic Books, 1972.

Haberstroh, Chadwick J. Organization design and systems analysis. In J. G. March (Ed.) Handbook of organizations. Chicago: Rand McNally, 1965. Pp. 1171-1211.

Hall, Edward T. The hidden dimension. New York: Doubleday Anchor Books, 1969.

Handlin, Oscar. The newcomers: Negroes and Puerto Ricans in a changing metropolis. New York: Anchor Books, 1962.

Harris, Richard. A sacred trust. Rev. ed. Baltimore, Md.: Penguin Books, 1969.

Hatch, John W. Community shares in policy decisions for rural health center. Hospitals, 1969, 43(13): 109-112.

Hatch, John W. Presentation at a panel discussion on "The 'how' of community participation in the development of health care." Reprinted in Community participation for equality and excellence in health care. New York: Bulletin of the New York Academy of Medicine, 1970, 46(12): 1084-1090.

Health Almanac, An informational bulletin on H.I.P.'s prepaid group health plan, 1971, 1(1).

Health/PAC. Your health care in crisis: A special report. New York: Health Policy Advisory Center, 1972b.

Health/PAC Bulletin. Feb. 1971a, No. 28.

Health/PAC Bulletin. June 1972a, No. 42.

Health/PAC Bulletin. Nov. 1972c, No. 46.

Henderson, L.J. Physician and patient as a social system. New England J. of Medicine, 1935, 212: 819-823.

Herberg, Will. Protestant--Catholic--Jew: An essay in American religious sociology, new revised ed. Garden City, NY: Doubleday Anchor Books, 1960.

Hillman, B. & E. Charney. A neighborhood health center: What the patients know and think of its operation. Medical Care, 1972, 10(4): 336-344.

Holahan, C.J. & S. Saegert. Behavioral and attitudinal effects of large scale variation in the physical environment of psychiatric wards. J. Abn. Psychol., 1973, 82(3): 454-462.

Hollender, Marc H. The psychology of medical practice. Philadelphia: W.B. Sauders, 1958.

Homans, George C. Social behavior: Its elementary forms. New York: Harcourt, Brace & World, 1961.

Hospitals, 1971, 45(11).

Hyman, Martin D. Medicine. In P.F. Lazarsfeld, S.H. Sewell, & H. Wilensky (Eds.) The uses of sociology. New York: Basic Books, 1967. Pp. 119-155.

Ingraham, N.R. & W.J. Lear. A big city strives for relevance in its community health services. Am. J. Public Health, 1970, 60(5): 804-810.

Ittelson, Willian H. Environmental perception and contemporary perceptual theory. In W.H. Ittelson (Ed.) Environment and cognition. New York: Seminar Press, 1973. Pp. 1-19.

Ittelson, W.H., H.M. Proshansky, L.G. Rivlin, & G.H. Winkel. An introduction to environmental psychology. New York: Holt, Rinehart & Winston, 1974.

Ittelson, W.H., H.M. Proshansky, & L.G. Rivlin. The environmental psychology of the psychiatric ward. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970a. Pp. 419-439.

Ittelson, W.H., L.G. Rivlin, & H.M. Proshansky. The use of behavioral maps in environmental psychology. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970b. Pp. 658-668.

Jacobs, Jane. The death and life of great American cities. New York: Random House Vintage Books, 1961.

Jehlik, P.J. & R.L. McNamara. The relation of distance to the differential use of certain health personnel and facilities and to the extent of bed illness. Rural Sociology, 1952, 17: 261-265.

Jones, E.E. & H.B. Gerard. Foundations of social psychology. New York: Wiley & Sons, 1967.

Junker, Buford H. Field work: An introduction to the social sciences. Chicago: University of Chicago Press, 1960, cited by S.T. Bruyn, The human perspective in sociology: The methodology of participant observation. Englewood Cliffs, N.J.: Prentice-Hall, 1966, pp. 15-16.

Kanter, Rosabeth M. Commitment and social organization: A study of commitment mechanisms in utopian communities. Am. Sociol. Review, 1968, 33(4): 499-517.

Kasmar, J.V., W.V. Griffin, & J.H. Mauritzen. Effects of environmental surroundings on outpatients' mood and perception of psychiatrists. J. Consulting & Clinical Psychol., 1968, 32(2): 223-226.

Keller, Suzanne. The urban neighborhood: A sociological perspective. New York: Random House, 1968.

Kendall, Patricia L. The relationship between medical educators and medical practitioners: Sources of strain and occasions for cooperation. Evanstown, Ill.: Association of American Medical Colleges, 1965.

King, Stanley H. Perceptions of illness and medical practice. New York: Russell Sage Foundation, 1962.

Kira, Alexander. Privacy and the bathroom. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970. Pp. 269-275.

Kirsners, S. & J. Waters. The experience of being a hospital patient. Environmental Psychology and Social Psychology Programs, City University of New York Graduate School. MS, 1972.

Klausner, Samuel Z. On man and his environment. San Francisco: Jossey-Bass, 1971.

Knowles, John H. The medical center and the community health center. In New York Academy of Medicine Subcommittee on Social Policy for Health Care of the Committee on Special Studies. Social policy for health care. 1969. Pp. 157-187.

Kryter, K.D. The effects of noise on man. J. Speach & Hearing Disabilities, Monograph, Sept. 1950, 1, cited by L.E. Farr, Medical consequences of environmental home noises. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 202-211.

Lander, Louise. PSROs: A little toe in the door. Health/PAC Bulletin, July/Aug. 1974, No. 59; pp. 1-7 & 14-19.

Lansing, J.B., R.W. Morans, & R.B. Zehner. Planned residential environments. Ann Arbor, Mich.: University of Michigan, Institute for Social Research, 1970.

Lashof, Joyce C. Chicago project provides health care and career opportunities. Hospitals, 1969, 43(13): 105-108.

Laufer, R.S., H.M. Proshansky, & M. Wolfe. Some analytic dimensions of privacy. Presented at the 3rd International Conference in Architectural Psychology. Lund, Sweden, June 1973. (Mimeograph.)

Lazarsfeld, Paul F. The controversy over detailed interviews --an offer for negotiation. The Public Opinion Quarterly, Spring 1944, 8: 38-60.

Lee, Terrence. Urban neighborhood as a socio-spatial schema. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970. Pp. 349-370.

Levine, Gene N. The good physician: A study of physician-patient interaction. Working paper No. 3; Evaluation studies of the Cornell Comprehensive Care and Teaching Program. Bureau of Applied Social Research, Columbia University, June 1957. (Mimeograph.)

Loring, William C. Jr. Housing characteristics and social disorganization. Social Problems, 1956, 3(3): 160-168.

Lyford, Joseph P. The airtight cage: A study of New York's West Side. New York: Harper Colophon Books, 1966.

Lynch, Kevin. The image of the city. Cambridge, Mass.: M.I.T. Press, 1960.

Lyons, Richard D. A health-care bill? Prognosis is maybe. New York Times, Jan. 12, 1975.

Madge, Charles. Private and public spaces. Human Relations, 1950, 3: 197-199.

Manning, Peter (Ed.) Office design: A study of environment. Liverpool: University of Liverpool, 1965.

Marsden, Halsey M. Crowding and animal behavior. In J.F. Wohwill & D.H. Carson (Eds.) Environment and the social sciences: Perspectives and applications. Washington, D.C.: American Psychological Association, 1972. Pp. 5-14.

Marti-Ibañez, Felix (Ed.) Henry E. Sigerist on the history of medicine. New York: MD Publications, 1960.

Maslow, A.H. & N.L. Mintz. Effects of esthetic surroundings: I. Initial short-term effects of three esthetic conditions upon perceiving "energy" and "well-being" in faces. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 212-219.

McLaughlin, Herbert P. Jr. Post-occupancy evaluation of hospitals. J. Am. Inst. Architects, 1975, 63(1): 30-34.

Merton, Robert K. Selected problems of field work in the planned community. Am. Sociol. Review, 1947, 12(3): 304-312.

Merton, Robert K. Social theory and social structure. New York: The Free Press, 1964, cited by B. Schwartz, The social psychology of privacy. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972.

_____ Some preliminaries to a sociology of medical education. In R.K. Merton, G.G. Reader, & P.L. Kendall (Eds.) The student physician: Introductory studies in the sociology of medical education. Cambridge, Mass.: Harvard University Press (for the Commonwealth Fund), 1957. Pp. 3-79.

Merton, R.K. & P.L. Kendall. The focused interview. Am. J. Sociol., 1946, 51(6): 542-557

Merton, R.K., G.G. Reader, & P.L. Kendall (Eds.) The student physician: Introductory study in the sociology of medical education. Cambridge, Mass.: Harvard University Press (for the Commonwealth Fund), 1957.

Michelson, William. Man and his urban environment: A sociological approach. Reading, Mass.: Addison-Wesley, 1970.

Mid-Westside Neighborhood Health Council, Inc. Draft of the application to assume granteeship of the health center. 1973. (Mimeograph.)

Milgram, Stanley. The experience of living in cities. Science, 1970, 167: 1461-1468.

Mintz, Norbett L. Effects of esthetic surroundings: II. Prolonged and repeated experience in a "beautiful" and an "ugly" room. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 220-228.

Morehead, Mildred A. Evaluating quality of medical care in the neighborhood health center program of the Office of Economic Opportunity. Medical Care, 1970, 8(2): 118-131.

Moynihan, Daniel P. Maximum feasible misunderstanding: Community action in the war on poverty. New York: The Free Press, 1970.

Muller, Charlotte. National health insurance. Bulletin of the New York Academy of Medicine, 1971, 47(4): 403-410.

Nahemov, L. & L. Kogan. Reduced fare for the elderly. New York: The City University of New York, Center for Social Research, 1971. (Mimeograph.)

National Advisory Commission on Civil Disorders. Report. New York: Bantam Books, 1968.

National Association of Neighborhood Health Centers, Inc. Minutes of Region II Meeting, Feb. 2, 1973.

National Commission on Community Health Services. Health is a community affair. Cambridge, Mass.: Harvard University Press, 1966.

Neal, Olly Jr. Presentation at a panel discussion on "The 'how' of community participation in delivering health care." Reprinted in Community participation for equity and excellence in health care. New York: Bulletin of the New York Academy of Medicine, 1970, 46(12): 1091-1098.

Neutra, R., D. Neutra & R. Neutra. The architect's role in encouraging wider use of outpatient facilities. Hospitals, 1969, 43(13): 53-57.

The New England Journal of Medicine, Feb. 11, 1971, 284(6).

Newman, Howard N. Community leaders can help direct services to the poor. Hospitals, 1969, 43(13): 63-66.

The New York Academy of Medicine. The 1970 Health Conference: Community participation for equity and excellence in health care. New York: Bulletin of the New York Academy of Medicine, 1970, 46(12).

New York City Planning Commission. Plan for New York City: A proposal: Manhattan. 1969.

New York Office for the Aging. Planning district profiles of older New Yorkers. The City of New York, 1974, 6(3).

Nisbet, Robert A. The quest for community. Rev. ed. New York: Oxford University Press; paperback re-issue 1971; orig. publ. 1953.

Office for the Aging, New York. Planning district profiles of older New Yorkers. The City of New York, 1974, 6(3).

Olsen, Richard . The dialysis unit. In L.G. Rivlin (Ed.) Building evaluation--a view from the environmental psychologist's perspective. Environmental Psychology Program, City University of New York Graduate School, MS, n.d. Pp. 4-10.

Olsen Richard. Hospital design literature survey. Working paper. Environmental Psychology Program, City University of New York Graduate School, November 1974.

Olson, Stanley W. Health insurance for the nation. New England Journal of Medicine, 1971, 284(10): 525-533.

O'Mara, E. & S. Kirsners. Urban workshop research report: Patient perception of a neighborhood health center. Environmental Psychology Program, City University of New York Graduate School. MS. 1972.

Osmond, Humphry. Function as the basis of psychiatric ward design. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970. Pp. 560-569.

The Oxford Universal Dictionary on Historical Principles, 3d ed., rev. with addenda. London: Oxford University Press, 1964.

Parker, Alberta W. The team approach to primary health care. Neighborhood Health Center Seminar Program, Monograph Series, No. 3. Berkely, Calif.: Neighborhood Health Center Seminar Program, 1972.

Paul, Benjamin D. (Ed.) Health, culture and community: Case studies of public reactions to health programs. New York: Russell Sage Foundation, 1955.

Pearl, A. & F. Riessman. Poverty and new careers for non-professionals. In L.A. Ferman, J.L. Kornbluh, & A. Haber (Eds.) Poverty in America. Rev. ed., Ann Arbor: University of Michigan Press, 1969. Pp. 604-617.

Planning Commission, New York City. Plan for New York City: A proposal; Manhattan. The City of New York: 1969.

Proceedings of the Mid-Westside Health Council Meeting, July 27, 1972.

Proshansky, H.M., W.H. Ittelson, & L.G. Rivlin. Freedom of choice and behavior in a physical setting. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970a. Pp. 173-183.

_____ The influence of the physical environment on behavior: Some basic assumptions. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970b. Pp. 27-37.

Rainwater, Lee. Fear and the house-as-haven in the lower class. J. Am. Inst. Planners, Jan. 1966: 23-31.

Rainwater, Lee. Behind ghetto walls: Black families in a federal slum. Chicago: Aldine-Atherton, 1970.

Rapoport, Anatol. Foreword to W. Buckley (Ed.) Modern systems research for the behavioral scientist: A source book. Chicago: Aldine, 1968. Pp. xii-xxii.

Rapoport, A. & N. Watson. Cultural variability in physical standards. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 33-53.

Renthal, A. Gerald. Comprehensive health centers in large U.S. cities. Am. J. Public Health, 1971, 61(2): 324-336.

Rice, Dorothy. Estimating the cost of illness. Washington, D.C.: U.S. Public Health Service, Publication No. 947-G, 1966.

Richardson, William C. Poverty, illness and use of health services in the United States. Hospitals, 1969, 43(13): 43-54.

Rivlin, Leanne G. (Ed.) Building Evaluation--a view from the environmental psychologist's perspective. Environmental Psychology Program, City University of New York Graduate School, MS, n.d.

Rivlin, L.G., M. Wolfe, & M. Beyda. Age related differences in the use of space. In W.F.E. Preiser (Ed.) Environmental design research: Proceedings of EDRA IV Conference. Stroudsberg, Pa.: Dowden, Hutchinson & Ross, 1973.

Rogatz, P. & M. Rogatz. Role for the consumer. Social Policy, Jan./Feb. 1971: 52-56.

Rosengren, W.R. & S. DeVault. The sociology of time and space in an obstetrical hospital. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970. Pp. 439-453.

Ross, Elizabeth K. The dying patient's point of view. In O.C. Brim, H.E. Freeman, S. Levine, & N.A. Scotch (Eds.) The dying patient. New York: Russell Sage Foundation, 1970. Pp. 156-170.

Roth, Julius A. Staff and client control strategies in urban hospital emergency services. Urban Life and Culture, April 1972: 39-60.

Saegert, Susan. Crowding: Cognitive overload and behavioral constraint. In W.F.E. Preiser (Ed.) Environmental design research. Proceedings of EDRA IV Conference. Stroudsberg, Pa.: Dowden, Hutchinson & Ross, 1973.

Saegert, S., B. Mackintosh, & S. West. Two studies of crowding in urban public spaces. Environment and Behavior, 1975, 7(2).

Salber, E.J., J.J. Feldman, H. Johnson, & E. McKenna. Health practices and attitudes of consumers at a neighborhood health center. Inquiry, 1972, 9(1): 55-61.

Saunders, Lyle. Cultural difference and medical care: The case of the Spanish-speaking people of the Southwest. New York: Russell Sage Foundation, 1954.

Schmitt, Robert C. Density, health and social disorganization. J. Am. Inst. Architects, 1966, 32: 38-40.

_____ Implications of density in Hong Kong. J. Am. Inst. Planners, 1963, 29: 210-217.

Schorr, Alvin. Explorations in social policy. New York: Basic Books, 1968.

_____ Housing and its effects. In H.M. Proshansky, W.H. Ittelson, & R.G. Rivlin (Eds.) Environmental Psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970. Pp. 319-333.

_____ Slums and social insecurity. Washington, D.C.: Government Printing Office, 1963.

Schorr, Daniel. Don't get sick in America. Nashville: Aurora, 1970.

Schumaker, C.J. Jr. Attitudes toward change of health center sponsorship. Inquiry, 1972, 9(1): 62-65.

Schwartz, Barry. The social psychology of privacy. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 152-169.

Schwartz, Morris S. The mental hospital: The research person in the disturbed ward. In A.J. Vidich, J. Bensman, & M.R. Stein (Eds.) Reflections on community studies. New York: Harper Torchbooks, 1971. Pp. 85-117.

Schwartz, M.S. & C.G. Schwartz. Problems in participant observation. Am. J. Sociol., 1955, 60(1): 343-353.

Seeley, J.R., R.A. Sim, & E.W. Loosley. Crestwood Heights: A study of the culture of suburban life. New York: Basic Books, 1956.

Selltiz, C., M. Jahoda, M. Deutsch, & S.W. Cook. Research methods in social relations. Rev. ed., New York: Holt, Rinehart & Winston, 1964.

Sexton, Patricia Cayo. Spanish Harlem: Anatomy of Poverty. New York: Harper Colophon Book, 1965.

Siegel, Sidney. Nonparametric statistics for the behavioral sciences. New York: McGraw-Hill, 1956.

Sigerist, Henry E. Civilization and disease. Ithaca, N.Y.: Cornell University Press, 1943.

Simmel, Georg. The sociology of Georg Simmel. K.H. Wolff (Ed.) New York: The Free Press of Glencoe, 1950.

Sivadon, P. Space as experienced: Therapeutic implications. In H.M. Proshansky, W.H. Ittelson, & L.G. Rivlin (Eds.) Environmental psychology: Man and his physical setting. New York: Holt, Rinehart & Winston, 1970. Pp. 409-419.

Sochen, June. Herstory: A woman's view of American history. Port Washington, N.Y.: Alfred Publ. Co., 1974.

Sommer, Robert. Our airports are sociofugal, not sociopetal, and it's an outrage! New York Times, March 3, 1974.

_____ Personal space: The behavioral basis of design. Englewood Cliffs, N.J.: Prentice-Hall, 1969.

Sparer, G., G.B. Dines, & D. Smith. Consumer participation in OEO-assisted neighborhood health centers. Am. J. Public Health, 1970, 60(6): 1091-1102

Sparer, G. & L.M. Okada. Welfare and Medicaid coverage of the poor and near-poor in low-income areas. Health Services and Mental Health Administration Reports, 1971, 86(12): 1099-1106.

Spencer, Esther. Medicaid: Lessons and warnings. Social Policy, Jan./Feb. 1971: 47-51.

Spiegel, Hans B. (Ed.) Citizen participation in urban development, 2 vol. Washington, D.C.: Center for Community Affairs; NTL Institute for Applied Behavioral Science, 1968 & 1969.

St. Luke Hospital Center. A proposal for the establishment of a neighborhood health services program within the Riverside Health Center of the New York City Health Department. March 10, 1967. (Mimeograph.)

Stein, Maurice R. The eclipse of community: Some glances at the education of a sociologist. In A.J. Vidich, J. Bensman, & M.R. Stein (Eds.) Reflections on community studies. New York: Harper Torchbooks, 1971. Pp. 207-232.

Strauss, Anselm L. Medical ghettos. In A.L. Strauss (Ed.) Where medicine fails. New York: Aldine Transaction Books, 1970. Pp. 9-26.

Strauss, A. & G. Sparer. Basic utilization experience of OEO comprehensive health services projects. Inquiry, 1971, 8(4): 36-49.

Strayer, Joseph R. What is medieval history? In H. Ausubel (Ed.) The making of modern Europe, 2 vol. New York: Henry Holt & Co., 1951. Pp. 30-37 in vol. 1.

Suchman, E.A. Social patterns of illness and medical care. J. Health & Human Behav., 1965, 6: 2-16, cited by M.D. Hyman, Medicine. In P.F. Lazarsfeld, W.H. Sewell, & H.L. Wilensky (Eds.) The uses of sociology. New York: Basic Books, 1967. Pp. 119-155.

_____ Socio-medical variations among ethnic groups. Am. J. Sociol., 1964, 70: 319-331, cited by M.D. Hyman, Medicine. In P.F. Lazarsfeld, W.H. Sewell, & H.L. Wilenski (Eds.) The uses of sociology. New York: Basic Books, 1967. Pp. 119-155.

Suttles, Gerald D. The social order of the slum: Ethnicity and territory in the inner city. Chicago: University of Chicago Press, 1968.

_____ The social construction of communities. Chicago: University of Chicago Press, 1972.

Thibaut, J.W. & H.H. Kelly. The social psychology of groups. New York: Wiley & Sons, 1959.

Tilson, Hugh H. Characteristics of physicians in OEO neighborhood health centers. Inquiry, 1973, 10(2): 27-38.

Toennies, Ferdinand. Community and Society--Gemeinschaft und Gesellschaft. Trans. and ed., Charles P. Loomis. East Lansing, Mich.: Michigan State University Press, 1957. (Original German edition 1887.)

U.S. Bureau of Census. Census of Population and Housing. Census Tracts. Final Report PHC (1)--145 New York, SMSA Part II. U.S. Government Printing Office, Washington, D.C., 1972.

Vidich, A.J., J. Bensman, & M.R. Stein (Eds.) Reflections on community studies. New York: Harper Torchbooks, 1971.

Vielhauer, J. The development of a semantic scale for the description of the physical environment. Dissertation Abstracts, 1965, No. 66-756, cited by J.V. Kasmar, W.V. Griffin, & J.H. Mauritzen, Effects of environmental surroundings on outpatients' mood and perception of psychiatrists. J. Consulting & Clinical Psychol., 1968, 32(2): 223-226.

Wagenheim, Kal. Puerto Rico: A profile. New York: Praeger Paperbacks, 1972.

Waldron, Walter. Presentation at a panel discussion on "The role of the health profession in achieving effective consumer participation." Reprinted in Community participation for equity and excellence in health care. New York: Bulletin of the New York Academy of Medicine, 1970, 46(12): 1071-1076.

Weber, Max. The methodology of the social sciences, Trans., eds. E. Shils & H.A. Finch, New York: Free Press of Glencoe, 1949, cited by S.T. Bruyn. The human perspective in sociology: The methodology of participant observation. Englewood Cliffs, N.J.: Prentice-Hall, 1966.

Weiss, J.E., M.R. Greenlick, & J.F. Jones. Determinants of medical care utilization: The impact of spatial factors. Inquiry, 1971, 8(4): 50-57.

Wells, B.W.P. The psycho-social influence of building environment: Sociometric findings in large and small office spaces. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 97-119.

Westcott, Lloyd. Presentation at a panel discussion on "The role of the community in developing improved health care." Reprinted in Community participation for equity and excellence in health care. New York: Bulletin of the New York Academy of Medicine, 1970, 46(12): 1042-1047.

Westin, Alan P. Privacy and freedom. New York: Atheneum, 1967.

Whyte, William F. Street corner society, 2d ed. Chicago: The University of Chicago Press, 1955.

_____ The slum: On the evolution of street corner society. In A.J. Vidich, J. Bensman, & M.R. Stein (Eds.) Reflections on community studies. New York: Harper Torchbooks, 1971. Pp. 3-69.

Wilner, D.M. & R.P. Walkley. Effects of housing on health and performance. In L.J. Duhl (Ed.) The urban condition: People and policy in the metropolis. New York: Simon & Schuster, 1963. Pp. 215-228.

Wilson, James Q. Planning and politics: Citizen participation in urban renewal. In H.B. Spiegel (Ed.) Citizen participation in urban development. Washington, D.C.: Center for Community Affairs. NTL Institute for Applied Behavioral Science, 1968 & 1969. Vol. I, pp. 43-60.

Wirth, Louis. Urbanism as a way of life. Am. J. Sociology, 1938, 44(1): 1-24.

Wise, Harold. Report of the project director. New York: The Dr. Martin Luther King Jr. Health Center Growth Annual Report, January-December 1971. (Mimeograph.)

Wohlwill, Joachim F. The physical environment: A problem for a psychology of stimulation. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 83-93.

Wolfe, Maxine. The behavioral effects of room size, group size and density in a children's psychiatric facility. Environment and Behavior, 1975, 7(2).

Wolfe, M. & R. Laufer. The concept of privacy in childhood and adolescence. In S. Gargulis (Ed.) Privacy. Proceedings of EDRA V Conference. Stroudsburg, Pa.: Dowden, Hutchinson & Ross, 1974.

Wolfe, M. & H.M. Proshansky. The physical setting as a factor in group function and process. In Jacobs & Spradlin (Eds.) The group as agent of change. New York: Behavioral Publications, 1974.

Wolpert, Julian. Migration as an adjustment to environmental stress. J. Social Issues, 1966, 22(4): 92-102, cited by J.F. Wohlwill. The physical environment: A problem for a psychology of stimulation. In R. Gutman (Ed.) People and buildings. New York: Basic Books, 1972. Pp. 83-93.

Young, M. & P. Willmott. Family and kinship in East London. Rev. ed. Baltimore, Md.: Penguin Books, 1962.

Zborowski, Marc. People in pain. San Francisco: Josey-Bass, 1969.

Zlutnik, S. & I. Altman. Crowding and human behavior. In J.F. Wohlwill & D.H. Carson (Eds.) Environment and the social sciences: Perspectives and applications. Washington, D.C.: American Psychological Association, 1972. Pp. 44-58.