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The Politics of Community Medicine Projects: A Conflict Analysis

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The community health center is a new institution which has been promoted by the Office of Economic Opportunity to provide health services to the poor, to establish an alternate model for medical practice, and to help reintegrate the poor into the mainstream of society. Among the barriers to the success of this innovation has been a lack of political realism on the part of many of the participants. A sociological analysis of the process of project evolution, demonstrating the many opportunities for controversy and conflict to develop, is presented. Inferences from conflict theory are presented to show how a sophisticated approach to controversy can expedite social change. If health professionals are to be involved in the wide range of social and physical ills of their patients they must be familiar with these strategies.

The physicians are the natural attorneys of the poor and social problems fall to a large extent within their jurisdiction.—Virchow, 1848

ONE OF the dramatic activities of the Office of Economic Opportunity (OEO) has been their Healthright program. Created to provide "equal access to health services for the poor . . . so that they do not have to barter their dignity for their health,"[1] these activities met with enthusiastic support from liberal physicians, health workers, and the patient community. As of the end of 1968, OEO had spent $114.5 million to finance 52 neighborhood health centers, of which 42 were already providing services to about 300,000 persons and ten were in the process of being organized.[2] Their scale varied from referral and outreach programs, integrating patients into pre-existing medical activities, to substantial facilities staffed to provide comprehensive health care. Moreover, fundamental to this program was OEO's attempt to insure "maximum feasible participation of residents of the areas and members of the groups served . . .,"[3] i.e., the consumers of health care—in this case, mostly impoverished.

The neighborhood health center was a new institution, created to provide help to people in the context of their environment, primarily insofar as these people are ill, and especially if their environment is disadvantageous. Since the community health

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center was a strategy for restructuring the medical care system within the broader purpose of reintegrating an alienated population into the political and social fabric of society, the task of establishing and legitimizing this institution has been especially difficult. As innovation evoked resistance (which it always does), the process became politicized. ("Politics" here has the broad connotation of the distribution of power and responsibility among the members of a society, as well as the process of how that distribution is made.) However, those members of the medical professions, among others, involved in this process have tended to deny the political dimensions of health care. It is the thesis of this paper that this has limited their ability to deal with the situation and has hindered the development of the program. Time and again, when opposition arose, conflict was denied, avoided, or squelched as professionals tried to innovate within their usual style of intellectual analysis and imposed technological solution. This has been especially handicapping in dealing with consumer involvement. As will be seen, an understanding of political behavior would be of great benefit. In fact, the constructive use of conflict and social dissonance can facilitate the process of social change, if only it is understood, anticipated, and used rather than denied. Furthermore, no comparative analysis of the administrative and political problems involved in establishing a large-scale community health services program *de novo* or integrated within pre-existing services in a deprived neighborhood has been attempted previously. I present here an analysis based upon the meager literature,[4] personal conversations with community medicine organizers,[5] and an informal personal acquaintance with ten health centers[6] established or in creation under federal funding.

The Participants

It is important to review the actors in this drama. As Davis and Tranquada[7] point out, the foci of power "are all separately characterized by conflict." OEO was the funding catalyst. This organization, a compromise coalition of the interests of the Department of Labor, the Department of Health, Education and Welfare, the Council of Economic Advisors, the Bureau of the Budget, and Congress, was created to deal innovatively with problems established governmental agencies had not yet faced, naturally creating jurisdictional jealousy among those Departments. The OEO effort was focused on the "War on Poverty." Although some of its strategies were adopted by other federal agencies: HUD in the Model Cities Program, and PHS in the Partnership for Health Legislation, the new ideas were not really fully accepted in all quarters. Thus, the new Federal agency's capacity for concerted action was diminished.

Consumer participation, the primary technique of the OEO strategy, may or may not be a valid and effective means of political reform.[8, 9] On the one hand, this was an ideological commitment recognizing that poverty is the lack of power, influence, and self-respect as well as of funds, and rejecting the once-commonly-held moralistic judgment that poverty is due to personal incompetence and sin.[10] On the other hand, this was a political tactic to insure that these innovative programs would not be wholly controlled by entrenched and unaccountable politicians.[11]

The OEO had many important goals in supporting the Healthright program, including providing health services to the poor, whose medical morbidity is disproportionately high, establishing the comprehensive health center as a model for the medical practice of the future (public

or private), and using health concerns as a tactical approach toward interrupting the cycle of poverty. The OEO, as a federal agency, had a responsibility to preserve harmony, but many of the program goals and activities continued to be viewed with suspicion both within and outside the government. Congress had been skeptical about the need for OEO as an administrative strategy for change. The health centers, both as a model for medical practice and in their very provision of services, were liable to antagonize organized medicine as represented by the attitudes of the American Medical Association and many local medical societies.[12] Nonetheless, the OEO worked hard to produce demonstrable results and to avoid controversy, while faced with problems that demanded ingenious innovation and experimentation. The OEO imparted many of its anxieties to its projects. Demonstrations were supervised from Washington with careful guidelines; they were pressured to show rapid improvements in a relatively short time; and they were made very aware of the dangers of controversy locally and of the uncertainty of future funding. Pressures from other quarters sometimes produced guidelines which directly frustrated the program's purpose. Thus, the OEO has not always appeared as a wholly benevolent participant, being at times an advocate, at other times an inquisitor. Now that there is a new presidential administration, OEO faces new uncertainties. Both to resolve jurisdictional disputes and to institutionalize successful projects, some programs will be allocated to the appropriate federal departments. The impact of the possible transfer of the Healthright program to the Public Health Service remains to be seen.

The sponsoring body, insofar as it included medical professionals, was, as well, in turmoil over its involvement. Although some projects, such as those sponsored by OEO community action agencies (8 per cent), new health corporations (17 per cent) and other nonprofit agencies were administered by community organizations, most projects, sponsored by hospitals (23 per cent), medical schools (19 per cent), health departments (13 per cent), group practices (6 per cent), and medical societies (2 per cent), were administered by medical institutions.[13] In addition, as we shall see, many of the community agencies organized around health were fronts for medical institutions. The American medical establishment is a superb example of scientific technological virtuosity, but this may not be the appropriate mode of approach to a slum environment and its problems. The primary emphasis of community medicine is on service, prevention, and rehabilitation, and the total ecology of disease, and not upon research and education, acute disease, and the individual patient. The "ivory tower" attitude of academia combined with the professionalism of the physician produces a tactical style which conflicts with the needs of the ghetto and may adversely confront those members of the medical profession concerned with an emphasis on community service.

Considering the broader definition of health as "complete physical, mental, and social well-being, not merely the absence of disease or infirmity,"[14] health involves the whole context upon which a person's life, productivity, and satisfaction are based. It is simple to appreciate this, but this global recognition does not have immediate motivational effects. For the presence of diagnostic instruments and curative therapies does not insure their use; the desire for comprehensive, and especially preventive and family-centered, medicine, does not insure its development. Health is of relatively little concern to most people while they are well.[15] Even

more so, in deprived areas the peri-medical concerns, food, clothing, housing, and employment, have higher priorities than health maintenance (narrowly defined).[16] Meanwhile, science has overcome many of the problems of treatment of acute medical crises and some health professions are beginning to face up to the broader mandate. Both because of a renewal of concern with preventive medicine and environmental problems and because of an increasing responsibility to maintain chronically-ill people at minimal levels of disability, the physician has become more interested in obtaining the active cooperation of the patient. Many of the outstanding problems in medical practice today (*e.g.*, limiting alcohol, nicotine, and drug abuse; nutrition; family planning) revolve around effectively motivating the patient and the prospective patient to be concerned with his health. This is especially true in a deprived environment. The community health center with its technique of consumer participation may be a way to create this cooperation effectively. Consumer participation is the *sine qua non* of the successful approach to the broad problems of disease. Many health professionals, including some of those presently involved in neighborhood health centers, do not accept this approach. Further dissension is created by other characteristics of some neighborhood health centers, *e.g.*, prepayment, salaried physicians, and expanded roles for medical assistants. Many physicians reject these innovations, opposing the health center concept altogether. Thus, there is a great deal of conflict within the medical community.

Finally, the clientele itself, impoverished but proud, frustrated and angry, is no longer a quiet submerged subculture. Propaganda, actual economic improvements, and the phenomena of relative deprivation and rising expectations have created, for some at least, a new identity. The most vocal, the militants, are now very dissatisfied with the *status quo* and are as impatient with their peers as they are with the establishment. The poor, especially in urban areas, are likely to be Negro or Spanish-speaking as well, and the added dimension of racial and ethnic concerns is ubiquitous. Frustration, confrontation, and overt conflict are more and more becoming the modes of problem-centered action by those interested enough to get involved. In the past, service projects were not cooperative ventures; they were imposed—albeit in a charitable way—from the one side, and the clients were at least expected to be happy with what they got. Today that is impossible. The new identity and increased self-esteem of the "other America" has rejected the supplicant's role and demands more than charity.

The Process

What then happens when a health service facility is created? Dr. H. Jack Geiger, one of the original OEO consultants on health and general director of two community health centers,[17] divides the process up into four phases which transpire over several years. Only the satisfactory resolution of all of these stages will permit valid community participation and, therefore, allow success of the project. It is evident that the process is one of confrontation, conflict, compromise and accommodation, of disequilibriums striving to be resolved. It is an illusion to think that the medical and social goals of community health projects can or should be achieved without controversies.

Instant Community

The sponsoring agency, suppressing its internal conflicts between research and service, has decided to make its work relevant and to minister to the needy com-

munity. The motivation is not without its romantic aspects. In the professional intellectual tradition, needs are specified and a rational plan of attack is devised which is submitted to the OEO. Community participation is one of the requirements of funding. The community itself rarely initiates the project.[18] Thus, during the planning stages, or worse, shortly thereafter, the sponsor goes looking for community representatives. There is a readily available group of indigenous, important people (*e.g.*, ministers, teachers, active parents or tenants) who have internalized the community and who stand up and say, "Here I am," when the physicians start to search for "the community." Although it is not readily apparent, these people generally, in fact, have only a small constituency, but their feeling of self-importance obliges them to assume the leadership role.[19] Their real qualification is that they have some sophistication in the institutions of the wider policy and have identified with it, even though previously they had not been accepted by it. These attitudes at the same time facilitate their acceptance by the professional reformers. Happy with the status their association with the sponsor provides, perhaps conversant in administrative style, but ignorant of the specifics of medical care, and impressed by the wealth and power of the sponsor, these people become the passive Community Board and a symbiosis develops. The sponsor proceeds as planned.

Insigh

Invariably the innovating medical center must, in the process of concretizing its plans, examine its motivation. Real community concern, represented by an unselfish dedication to patient service as determined by their own perception of need, is rare. Often the health project is the manifestation of a new focus of academic research and education promoted by the availability of federal funds and articulated by liberal professionals developing their own identity. This insight is made explicit only by the participation of the community. The Community Board by now has discovered it is a rubber stamp and has little power over finances, personnel, or general policy. Their ego is no longer inflated by the mere illusion of power and they begin actively to challenge the establishment for what they thought was their due. Both the Board and the professionals are soon confronted by other angry community voices, from the Mission Rebels (San Francisco) to Mothers for Adequate Welfare (Boston). Each vocally and critically represents aspects of the neighborhood, at least wanting a piece of the action and at most articulating the new self-esteem of the "other America." Except under unusual circumstances (*e.g.*, Newark),[20] the vast majority of the community remains unconcerned and alienated from this whole process. Nonetheless, the confrontation between the sponsor and the self-chosen community representatives over power initiates the real process of community organization for health.

Disintegration and Cooperation

During this period of strife, angers flare and threats are made. The responsible community representatives demanding real responsibilities and power and the young militants demanding recognition threaten to sabotage the project through boycott or even violence. The liberal professional sponsors, encouraged by the OEO, on their own behalf, or representing the community's desires, carry the challenge to their fiscal agent. The committee of the medical school or the board of the hospital or university, neither wholly convinced of the virtues of the experiment nor

in this respect altruistically motivated, and never before asked to share their governing control in this fashion, are understandably reluctant to cooperate. The relatively insignificant project suddenly appears to become a threat to their own autonomy. Meanwhile everyone's attention is diverted from patient care. After a longer or shorter period of arbitration, if the project survives, a new order can evolve. The sponsor and the community work together, not out of love for each other, but with an orientation toward the task at hand. This then becomes a very constructive period of mutual education. The medical professionals are introduced to the needs and desires of the community and the lay community is tutored in the problems and techniques of both health maintenance and administrative organization. Slowly mutual respect develops and, hopefully, broadened support evolves on both sides.

Constituency and Service

While the preceding evolution has been taking place, hopefully, actual creation of some medical service facility has also occurred. This may now begin to function in a favorable environment to solve the problems at hand. Further problems will continue to arise, but the project and its participants have reached maturity and are capable of dealing with them without threatening the project's existence. The purpose of the OEO demonstration has been fulfilled and the medical professionals and their constituency can now concentrate on the quality of service and contemplate mechanisms capable of rendering the project financially sound and independent. The real task of creating a facility which promotes and provides compassionate, comprehensive, family-centered care can now be explored. It should be noted that no project has yet evolved into the last stage.

Sources of Conflict

March and Simon[21] have observed three important conditions which explain inter-organizational conflict: 1) the existence of a felt need for joint decision-making, 2) a difference in goals, and/or 3) a difference in perception of reality among the parties. The first condition posits that the parties to the conflict are in the same action system. The problem is relevant and cannot be abandoned. In addition, in this case, both the community and the OEO demand a joint-decision process where none existed before; the medical profession must acquiesce. The second and third differences are inherent in serious intercourse between professionals and lay people, especially the so-called "culturally deprived" subculture. As Wilson[22] explains,

> low income . . . people are more likely to have limited time perspective, a greater difficulty in abstracting from concrete experience, an unfamiliarity with and lack of confidence in city-wide institutions, a preoccupation with the personal and immediate. . . . Lacking experience in and the skills for participation in organized endeavors, they are likely to have a low sense of personal efficacy in organizational situations. By necessity as well as by inclination, such people are likely to have what one might call a "private-regarding" political ethos. They are intimately bound up in the day-to-day struggle to sustain themselves and their families.

The professional, especially the physician, on the other hand, is not only "public-regarding," *i.e.*, benevolent and civic-minded, but is used to having his opinion respected and instituted with minimal opposition, since he often considers his self-interest synonymous with the com-

munity good. His very cognitive style,[23] intellectual, abstract, deductive, introspective, task-oriented, comprehending wide horizons and long time spans, and operating in a well-structured administrative environment, is in marked contrast to the style of the low-income culture. Racial prejudices only add to this polarization. Thus, conflict is inevitable; goals and realities naturally are perceived differently.

Let us now look at what happens once the process is initiated. Although the health center remains a service project and the people involved in sponsoring and staffing it are concerned primarily with health services, the project has become a political issue, and the sides are joined. Among the six modes of influence —inducement, coercion, rational persuasion, selling, friendship, and authority— relevant to the political process of arbitration,[24] the professionals are likely to rely on two: rational persuasion and authority, while the community tends to rely on coercion.[25] Thus, the sponsor's tactics appear irrelevant to the community and the community's tactic appears outrightly dangerous to the establishment. Thus, conflict is not only a result of a system in disequilbrium, it is introduced purposefully as a variable in that system by one of the parties.

Inferences

If this analysis is correct, it provides a constructive insight; for the first step toward improvement is correct perception of the situation. The service professionals' commitment to "constructive social harmony" has, in the past, allowed him to ignore, deny, or suppress the actual meanings of many types of events which produce disequilibrium and disharmony. Such is the case here. However, viewed as a political process, these circumstances are not so unusual or threatening. They consist of the normal progression of disequilibrium, arbitration, and compromise basic to the political mechanism. As one observer[26] put it:

> Democratic government is the greatest single instrument for the socialization of conflict in the American community. . . . conflicts open up questions for public intervention. Out of conflict the alternatives of public policy arise. Conflict is the occasion for political organization and leadership. . . . Democracy is a competitive political system in which competing leaders and organizations define the alternatives of public policy in such a way that the public can participate in the decision making process.

This controversy has analogies in past community controversies over education, labor relations, urban renewal, taxation, and so forth. Elected officials and lobbyists thrive in this atmosphere of conflicting interests and competition. Accepting the process for what it is, they use it to advantage. Health professionals and others tend to dismiss participation in controversy as "professionally improper," and they have tried to ignore the political dimensions of health care. This attitude should be changed. Once the true nature and importance of the political process is recognized, sophisticated participation will be advantageous.

It is necessary that the organizers of innovative community service projects should be sophisticated not only in their profession, but also in the techniques of political science and sociology insofar as they deal with these situations. Esepcially significant and relevant are Louis Coser's *The Functions of Social Conflict*[27] and James Coleman's *Community Conflict*.[28] Although written with different emphases, these treatises succinctly present analyses which encourage a new constructive attitude toward the problem of conflict. Using these references as sources, let us

examine a few of the consequences of the process of controversy in order to illustrate how a knowledgeable approach can be beneficial.

While provision of medical care is the most important goal of the Healthright program, it must be remembered that health is generally a low-priority concern in deprived neighborhoods. In addition, lower-class areas have very little intrinsic organization for civic purposes. One of the primary problems of the Healthright program is the development of concern for health and a constituent community to express that concern. Conflict creates communities and makes concerns vivid. As Coser puts it:[29]

> Conflict with another group leads to the mobilization of energies of group members and hence to increased cohesion of the group. . . . Conflict acts as a stimulus for establishing new rules, norms, and institutions, thus serving as an agent of socialization (for both contending parties).

Thus, realizing that their innovative attempts are bound to create a certain amount of disequilibrium, the organizers of the service can use themselves as a "straw horse," so to speak, focusing the conflict constructively, first upon themselves to create the community of concern, then transforming the emphasis on opposition into a concern for the problem itself—in this case health—by a sincere and serious appeal (and proof thereof) to common interests.

> Conflict may serve to remove dissociating elements in a relationship and to reestablish unity. Insofar as conflict is the resolution of tension between antagonists, it has stabilizing functions and becomes an integrating component of the relationship.[30]

Thus, Coser, while exploring the ramifications of antagonism and confrontation and delving into the distruptive aspects of conflict, emphasizes what positive functions it can fulfill. These should be sought after and made to predominate.

Coleman's exploration of community is an excellent guide to the pitfalls of the normative political process of dissent over social and civic goals. For instance, in order to make constructive use of the conflict situation one must be aware that certain tendencies are likely to be manifest, *e.g.*:

> A dispute which began dispassionately in a disagreement over issues, is characterized suddenly by personal slander, by rumor, by the focusing of direct hostility.[31]

In other words, one's vanity should not be disturbed by personal attacks in the midst of a controversy. One should be even more guarded against this in conflicts with a lower-class community where less distinction is likely to be made between the character of a man and his activities than other groups may make.

One must be aware of new demagogic and irresponsible leaders in opposition.

> New leaders tend to take over the dispute; often they are men who have not been community leaders in the past, men who face none of the constraints of maintaining a previous community position. . . . The new leaders . . . are seldom moderate; the situation itself calls for extremists.[32]

The militant Black Nationalists are a present example of this phenomenon. A practical implication of expecting their rise to power would, for example, have been to promote more moderate, but nonetheless sincere, opponents to one's own programs.

Coleman observes that the structure of authority may affect the course of conflict. The device of a community advisory or policy board is an approach to this realiza-

tion. Nonetheless, anticipation would insure that these channels of power and communication were real in order to better structure the conflict and its results. Mention must also be made of the technique of cooptation (bringing the opposition inside to voice its criticism with or without real influence on the course of events) in order to warn against its premature use. True community support does not grow from cooptation of its leaders; it is preferable to maintain the confrontation until accord is reached through mutual concern.

Finally, Coleman mentions the importance of the mass media of communication, although with a slightly different emphasis. Nonetheless, it becomes important to remember the value of propaganda and the right publicity in shaping the course of events to advantage, remembering that the ghetto dweller has different exposure habits, including a very active word-of-mouth grapevine for important events.

The aforementioned considerations are just a few examples of how political sophistication can be brought to bear on a problem to good advantage. These approaches are not panaceas, nor formulas for success; rather, they illustrate the kinds of concerns which have been ignored in the past, thus mitigating against the success of socially-innovative community service projects.

Conclusion

Although there has been considerable local and national publicity about the OEO Healthright program, it has tended to overlook the considerable difficulties being encountered in the creation of these innovative services. Until now, no comprehensive perspective of the problems has been undertaken by any of the parties involved. The unofficial impression is that many obstacles have prevented the fulfillment of many of the program goals. Although some people have been provided with medical care that is of better quality or would not have been available otherwise, in many health centers services are underutilized; community participantion is not powerful; the support of the medical establishment is tenuous; social innovation is minimal or inefficacious. One aspect of this failure has been the inability of the programs to face up to the political problems involved. This paper has been an attempt to define the nature of those problems and to illustrate how their comprehension may be used to advantage. Obviously, some of the suggestions posed demand very skillful and nimble political maneuvering and some risks of failure. However, in view of the many barriers to social change, the situation demands these skills and risks if any lasting improvements are to come from these innovative projects.

Footnotes

(references included)

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5. Dr. Paul O'Rourke, Director, East Palo Alto Health Center (August, 1968; April, 1969); Dr. Rodney Powell (November, 1968).

6. Columbia Point and Roxbury in Boston, St. Luke's Riverside in New York City, Mission District and Hunter's Point in San Francisco and East Palo Alto, West Oakland, King City, and Watts in California, and Mound Bayou in Mississippi.

7. Davis and Tranquada, *op. cit.*

8. *Cf.* Spiegel, H. (ed.): Citizen Participation in Urban Development. Vol. I. Washington, NTL Institute for Applied Behavioral Science, National Education Association, 1968.

9. Also see Moynihan, D.: Maximum Feasible Misunderstanding. New York, Free Press, 1968.

10. This impression was reinforced by Max Weber's classic analysis, The Protestant Ethic and The Spirit Of Capitalism, (New York, Charles Scribner's Sons, 1930): "[Protestant] asceticism looked upon the pursuit of wealth as an end in itself as highly reprehensible; but the attainment of it as a fruit of labour in a calling was a sign of God's blessing. . . . The religious valuation of restless, continuous, systematic work in a worldly calling . . . [was] the surest and most evident proof of rebirth and genuine faith." Conversely, poverty was the stigma of personal incompetence and sin.

11. *Cf.* Moynihan, *op. cit.*

12. The recent acceptance of the neighborhood health center concept by the AMA and the sponsorship of several projects by local Medical Societies is a definite change in attitude and thus is one indication that this process has had some success.

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14. *Preamble to Constitution* of World Health Organization, July 22, 1946.

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18. For an important exception see the experience of the West Oakland Health Council, a spontaneous indigenous organization.

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29. Coser, *op. cit.*, pp. 95, 128.

30. Coser, *op. cit,* p. 80.

31. Coleman, *op. cit.*, p. 10.

32. Coleman, *op. cit.*, p. 12.