For the consumer to function effectively in the new roles of adviser and policy-maker in the health field, skills and knowledge are required. This paper deals with the training of consumers serving on policy-making boards of neighborhood health centers and with issues raised in the training. The general issues are raised in the context of a specific demonstration project.

THE CONSUMER AS POLICY-MAKER—ISSUES OF TRAINING

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THE consumer of health services, especially the low-income consumer, is presently assuming an increasingly important role in the rapidly changing system of personal health care. Furthermore, he will no doubt occupy an important future place in Comprehensive Health Planning, whether it comes in the guise of a Model Cities program, in health planning by groups associated with Neighborhood Health Centers, or through designated comprehensive health planning agencies.

This participation has been accompanied by an increasingly insistent request by representatives of low-income areas for a voice in the decision-making process of health programs,[1] and an expressed determination to work for "community control" of institutions serving low-income neighborhoods.[2] It is imperative that health professionals understand the form consumer participation is taking; the manner in which low-income consumers are organized; the organizational structure in which they are working; the advantages and problems for both consumers and the organization when they participate in the planning, development, and management of a health delivery system such as a health center; the skills and knowledge needed to enter effectively into new roles and responsibilities; and the ways these areas of expertise can best be acquired.

This paper will address itself only to the last point—the training needed and desired by consumers serving on policy-making boards of neighborhood health centers and some of the issues raised by this training—by describing a demonstration project carried out in 1968-1969 by the Berkeley Consumer Health Project.

Organizational Background

Neighborhood Health Centers — as first developed under the Office of Economic Opportunity and somewhat later under 314(e) grants from DHEW—are, for the most part, patterned on a basic model, one of the elements of which is consumer participation in the planning, development, management, and evaluation of the comprehensive health services. That this characteristic was included is not surprising since the centers were developed under the mantle of the Community Action Program of OEO that required "maximum feasible participation" of the involved community. Furthermore, the conviction of persons closely involved in the early stages of program evolution, that "participation" by consumers would result in a better designed and more responsive system of health care, assured that consumer participation would receive emphasis.

How community participation was to be accomplished was defined in limited terms in the early period. With few exceptions, the first programs were funded to delegate agencies experienced in the delivery of health care services, and community participation was expected to take place through the mechanism of an advisory council. OEO guidelines distributed in March of 1967 suggest that, through neighborhood councils or associations, "residents of the target area can participate in such decisions as the precise location of the program's services, the time they shall be available, the establishment of program priorities and matters relating to employment policy, and the establishment and implementation of eligibility criteria." Thus residents "can participate in exercising other policy-making responsibilities analogous to those which are ordinarily the function of the lay board of directors of a voluntary hospital."[3] As experience was gained, the functions and activities of the advisory council were made more explicit. Revised guidelines issued in March, 1968, state:

> "The neighborhood health council shall participate in such activities as the development and review of applications for OEO assistance, the establishment of program priorities, the selection of the project director, the location and hours of the center's services, the development of employment policies and selection of criteria for staff personnel, the establishment of eligibility criteria and fee schedules, the selection of neighborhood residents as trainees, the evaluation of suggestions and complaints from neighborhood residents, the development of methods for increasing neighborhood participation, the recruitment of volunteers, the strengthening of relationships with other community groups, and other matters relating to project implementation and improvement."[4]

At the same time, a way of meeting the community participation requirement other than through an advisory council was outlined, i.e., by having at least one-third of the members of the governing board of the administering agency eligible to receive services in the center.[5]

Organizational structures of the presently funded Neighborhood Health Centers have consequently assumed different patterns of consumer participation. The most frequent is the consumer-controlled council, advisory to the delegate agency —whether this be a health care institution such as a hospital, a health department or a medical school, or a new corporation created for the sole purpose of acting as the delegate agency. Less commonly, low-income consumers serve on the legal governing board itself, usually without controlling voice. In a few cases low-income consumers represent the majority and, in at least one instance, only eligible recipients serve on the governing board of directors.

Why Training?

Since the push for consumer involvement in health programs has appeared and since consumer participation has been a requirement of such programs as Neighborhood Health Centers, Model Cities, and Comprehensive Health Planning, there has been a marked increase in interest in training this "new" consumer. This sudden emphasis on training is, to me, an interesting phenomenon. Citizen participation in health programs in the United States is nothing new. As a matter of fact, it is quite traditional to our system. Citizens have joined together in voluntary agencies in the social welfare and health field to promote health legislation, to prevent diseases, and to educate the public. Citizen boards have developed and administered health care facilities and services such as hospitals, visiting nurses associations, and family planning agencies, with apparently little thought on the part of the professional that these were unusual undertakings. And yet it now seems to be viewed as a new phenomenon, and one about which the professional seems unsure and somewhat uneasy.

One may ask why this is so. Why does the present participation seem different? Why is the professional unsure about the path it will take? Why is he seemingly reluctant to consider the possibility of consumers serving as policy-makers for neighborhood health centers when no second thought is given to consumers serving as board members of a comparable institution—the voluntary hospital? Why is training thought to be necessary now when there has been little past attention paid to training boards of hospitals or other voluntary agencies. especially at the national level?

I believe the present consumer participation is seen as a change for the health system for three basic reasons that might be characterized by Verba's comment on the crisis in democratic participation which he says is occurring in the United States today:[6]

> "New people want to participate in relation to new issues and in new ways."

Let us first look at what the "new issues" are. For the most part, the health institutions in which consumers are participating today are either involved in the delivery of primary health care services or in the planning of comprehensive approaches to health problems. Since planning is such a new task for the professional as well as the consumer. there seems to be common agreement that both need training to carry out their new functions.

But what about the delivery of primary health care services? Citizen involvement in the provision of primary ambulatory care has been somewhat limited in the past—confined usually to organizations providing one small segment of health care such as visiting nurse services or a family planning program, or to the relatively rare consumer-based health plans such as the Group Health Association, Inc., of Washington, D. C., and the Group Health Cooperative of Puget Sound. In these organizations or in voluntary, nonprofit hospitals providing outpatient services, there seems to have been an implicitly made and accepted "gentlemen's agreement" that board members would not encroach into what was considered the professional sphere. This lack of encroachment allowed the traditional pattern for the delivery of ambulatory care services—that of making it a private matter between the professional and his patient—to be followed. The privacy of this transaction has been so honored that even fellow professionals have not moved into it, as witnessed by the dearth of review mechanisms for quality control in the ambulatory care field whether it be in the private practice or clinic setting. The "new" consumer is entering a field, therefore, where the private transaction has been a predominant theme. The traditional consumer knew the rules, but the professional may well wonder whether this is the case with the "new" consumer.

Also, health care services, when delivered through an organizational structure such as a health department or an outpatient clinic, have been distinguished by a professional elite (equaled perhaps only by that of the law) prepared and expecting to make all decisions. Local control when requested or demanded in the school setting, with its long tradition of citizen control, has been seen as a threat to the professional. How much more shocking it appears when applied to the health care system in which the professional sees himself as the sole decision-maker.

Next, let us look at the "new people" who are participating. Because health centers have been placed in inner-city ghettos or other pockets of poverty, consumers assuming responsibilities in the new health care delivery systems are generally persons eligible for care or "representatives" of low-income groups (a very ill-defined term which usually means a person who, because he shares an ethnic or cultural background with recipient groups, believes he can speak for them).* These consumers differ from those considered typical "volunteers" working for a voluntary health agency or serving as a member of the local hospital board. Board members bring to their new job a set of values, a set of perceptions, a set of relationships, a body of knowledge and skills, a way of working and relating to others, a feeling about volunteering their time—which are perceived by the professional as different from those to which he is accustomed. The professional cannot, as yet, judge what this means to him and the institutions in which he serves, and he is therefore uneasy and unsure.

What about new ways of participating? My experience as a health professional working with community boards and councils has taught me that a "new way" of participating *has* appeared in the health system. I would characterize it as a method that generally involves an unusual directness of approach to a problem; a speaking out on issues in a manner unfamiliar to the health care professional; a low level of tolerance to the professional's method of doing business. To the "new" consumer, this often appears ambiguous and confusing. He has an intolerance of words that do not seem to solve the immediate problem or seem to avoid the issue; an intensely strong and personal involvement and commitment combined with the feeling that the health system has dealt unfairly with the low-income consumer; a suspicion of the health professional coupled with a distrust of his basic motives.† Once he feels he possesses some power to influence change, he has a belief in his own ability to create this change properly and effectively. This kind of approach can lead to a productive interaction between the consumer and the professional and can be an exciting and rewarding experience. But it is a different way of operating and one that the professional must understand and to which he must adjust.

In addition to these characteristics of the new participation, there is one other fact that needs comment. In the past, a built-in method of socializing new consumer members to the health system has existed. Persons coming on hospital boards have usually come on one at a time. They entered a functioning board relating to an ongoing institution. They learned from their more experienced peers (with whom they shared dominant middle-class values). No such process takes place when new boards, new members, new groups, and new organizations are involved simultaneously.

I believe that out of these factors springs the concern with training the "new" consumer. I believe that training *is* necessary, and the "new" consumer seems to share this viewpoint, but not for the reasons described. He does not envision the task as so new or his approach as necessarily so innovative as it may seem to the professional. However he does recognize it as a new task for him. He is aware of his lack of experience and lack of knowledge about the job before him, even though at the same time he is firmly convinced of his own attributes for success and his own

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* The "consumer" serving on 314(a) and 314(b) agencies is excluded here. In general, he does not as yet represent low-income area groups and I believe the impetus for his training is based on the apparent newness of the task for all concerned.

† This viewpoint that the professional is only doing what he is doing because there is "something" in it for him is often true but in a much more complex way than the low-income consumer may perceive.

expertise in approaching the health problems of low-income areas.

Description of the Berkeley Consumer Health Training Project

The Berkeley Consumer Health Project was funded under P.L. 89-749, Section 314(c), to determine the type of training needed and desired by councils or boards serving in advisory or policy-making roles in Neighborhood Health Center programs. Although not made explicit, it was assumed that the majority of the persons serving on such boards would themselves be eligible for services and would thus fall into the low-income category.

Before the program got under way, tentative guidelines for action were developed as follows:

1. Boards or councils would, together with the project training staff, define their own needs and help to develop their own training program.
2. The training program would involve members from more than one board in order to offer the opportunity to learn from each other's experience.
3. The program would be flexible and contain a feedback process to allow it to change as necessary.

The organizational pattern of the boards and councils in the San Francisco Bay Area that were potential participants in the training program was quite diverse. One was an advisory council for an OEO-funded neighborhood health center administered by a newly created health corporation. Two were legally constituted governing boards of newly created community corporations for the administration of neighborhood health centers, composed for the most part of community residents; one was funded under OEO, the other by a 314(e) grant from DHEW. One board was nominally an advisory council but, in actual fact, had been allowed to and was functioning as the policy-making body of an OEO neighborhood health center grant; another was the health committee or task force of a Model Cities agency.

The three boards who finally chose to enter the program were the three "policy-making" boards. Although a few persons attended from the Model Cities Health Committee, we feel that no conclusions can be derived from our experience about the problems or methods of training for either advisory councils or health planning groups. It seems to me to be quite possible that the task of such groups may differ so markedly from that of an established policy-making body, that the approach and training sequence could be quite dissimilar.* Planning, as well as "advising," is a much more nebulous task than running a center. Organizationally, these groups are also at different stages. Advisory councils, as well as Model Cities task forces, are feeling their way and, in many instances, have not as yet determined precisely what their role is and how they relate to the administrative agency. The three groups that came into our training program were fully organized, knew what their task was, and were already able to see the need for acquisition of further knowledge and skills in order to discharge their responsibilities competently. These characteristics were obviously critical in motivating them to participate.

Three very different communities were represented by the participating boards. One was a "typical" black urban ghetto. All board members came from the community, and most were eligible for services at the center (West Oakland). One was a unique suburban ghetto, separated by the Bayshore Freeway from the affluent university community of Palo Alto. With the exception of two profesisonals, the members were from the community, but not all fell into the income level making them

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* A grant under 314(c) for 1969-1970 will enable us to test this hypothesis.

eligible for services (East Palo Alto). One was a semirural, nonfarm, Spanish-speaking community located about 15 miles from the growing metropolitan area of San Jose. All members were from the community and considered themselves eligible for services. Many spoke little English (Alviso). Approximately 45 persons from these three boards participated throughout the year.

It would be impossible to describe the program as it developed without first describing the project staff, for it was the character of the staff, I believe, that determined the method of approach as well as the success of its operation. In the beginning the staff consisted of three women—an administrator with a background in political science, a health educator with experience in classroom teaching, and a community organizer with long experience in the black community. Because none was Spanish-speaking, a young Mexican-American woman who had recently worked as a community organizer was shortly added to the staff. Although each was chosen because of her special background and skills, each functioned similarly in the actual work situation. All four worked together in reaching community groups, in organizing and developing the program, and in helping to find the desired and necessary resources for training.

Certain characteristics of the staff seemed crucial in determining the outcome. First was their total commitment to the need for training and to the group being trained, as well as to their goals and expressed needs. Second was the fact that they shared many of the values and attitudes of board members, especially in relation to the health professional and the health system. They themselves had either not been professionalized or had tried hard not to become so. Third was their flexibility and lack of directiveness. Board members came to rely on them as persons who would help in the training endeavor but who would not insist on the imposition of their own ideas. In this respect, the fact that they were all women may have been of importance. Last was their ability to work together as a closely knit team.

The original plan, as laid out in the project proposal, had been to make the acquaintance of each board and its members; explain the project; ask that two representatives from each center be appointed to a planning committee; have this committee plan the workshop format and timetable; have the committee members take the plan back to their respective boards for changes and approval; and then to hold a short series of two-day workshops—each to be attended by a different multicenter group. Between each workshop, the project staff planned to meet with the planning committee and other board members and, if necessary, to change the next workshop session. We had not planned to work with all centers throughout the year, since we did not think there was sufficient staff to provide this kind of coverage.

Although basic guidelines remained unchanged—i.e., involvement of board members in planning, multicentered approach, and flexibility of programing—our original plan of a short-term workshop program was never carried out. Instead, the project staff worked with the board members over the entire year on a continuing basis, meeting as often as two times per week. The program as it evolved follows.

The Organizational Phase

During this phase, lasting approximately three months, the staff members made the acquaintance of board members and some of the center's professional staff, and became informed on key community issues. Many different methods were used for meeting and getting to know board members. The staff attended board meetings, invited board members to attend other meetings and site visits with them, obtained introductions through mutual friends and acquaintances, and asked certain board members to make a presentation about neighborhood health center activities to the Model Cities Health Committee.

Planning

At the end of the third month, a joint planning session with all three boards was arranged in order to develop the training program. Since key board members had earlier agreed to enter the program only if board members participated fully in planning, all persons were involved at every step and no planning meetings were held until all were ready to go ahead. This first meeting was attended by approximately 40 persons. A second and final planning session was then held with four representatives each from the East Palo Alto and West Oakland boards.

At the first planning session, the following desired workshop topics were distilled from the day's discussion.

(a) Good boardsmanship
(b) Medical-dental administration
(c) Fiscal responsibility
(d) Outside financing
(e) Legal problems
(f) Community organization and support
(g) Culture and medicine.

Alviso had a somewhat different but extremely specific list of topics to be covered.

(a) How to speak before the public
(b) How to conduct a meeting
(c) How to maintain account books
(d) How to prepare a budget
(e) Elementary principles of medical-dental administration
(f) History of social movements (e.g., the farm workers' movement in the U. S.)
(g) Necessary elements of leadership.

Once the decisions about topic areas were made by the group, everyone was extremely anxious to "get going." No one wanted any time for further planning, and all wanted the workshops to start at once.

Workshop Sessions

In the beginning it was planned to have all three groups meet together, but the language barrier between the two English-speaking boards and the primarily Spanish-speaking Alviso board proved to be such that two separate workshop series were held—one shared by West Oakland and East Palo Alto and one for Alviso conducted by Spanish-speaking resource persons. Thus, the planned multicentered approach was not completely achieved. (This changed in later stages.)

Workshops (especially for West Oakland and East Palo Alto) were expected to take the form of group discussions led by persons familiar with the areas under discussion and skilled in working with groups. After the second session, however, this approach was discarded for one which proved highly effective in generating and holding the group's interest. This involved the use of role play and skits around key issues. The role play set up before each session "broke the ice," provided participants with relevant information, and, most importantly, opened up the thinking around the issues involved. In later sessions, skits and the ensuing discussions were video-taped and then played back to bring out important points.

Participants proved to be excellent and enthusiastic actors and felt that this method best allowed them to relate past experiences to present responsibilities, as well as to explore many related and important issues. Once role play was begun, there was no problem of holding the interest of the group. Center boards alternated in driving 50 to 60 miles each week for one year to attend workshop sessions.

In Alviso the role-play method was not used. Instead, group discussions were led by Spanish-speaking consultants (with interpreters to help the project staff know what was occurring). Altogether, eight workshops were held in Alviso on the topics previously outlined. In some of the early sessions it became evident that the center's bylaws were unclear and, for this reason, not understood by board members. The training staff, certain professional staff members of the center, and board members took "time out," over a period of several weeks, to sit down and rewrite the bylaws.

Action Phase

Toward the end of the training year, the character of the training sessions changed. The East Palo Alto and West Oakland boards decided there were certain things they wanted to do, and they moved into action. At this time they began to include Alviso in their training sessions and in the increasingly frequent social events the boards began to hold for each other and the project staff. Alviso's isolation because of language began to lessen as its board members began to participate in joint action.

During the last month of the training year and the first two months of the new grant year, the staff worked most intensively with board members, focusing on the issue which had developed as their main area of concern, i.e., the creation of a national consumer group (first to meet in the fall of 1969*) that would represent the interests of all consumer-based advisory councils and governing boards in the United States. It was extremely difficult for the project staff members to differentiate at all times between what were clearly training activities and what amounted to action taken in behalf of the consumer boards, but a constant attempt to do so was made. Issues of planning and organization, of relationships with funding agencies and with professionals were raised in planning for the consumer conference, and were used by the staff in furthering training objectives. After the National Consumer Health Conference was over, the training year was formally ended and the project staff moved to new activities, while agreeing to remain available for continued consultation about resources and for further training if this was needed by the boards.

Analysis of the Program

In analyzing the reasons why our original format for training was never implemented, I think some lessons can be learned for future use with similar groups.

Gaining Access to the Group

Originally, the long (three month) organizational phase was not contemplated. It proved to be absolutely essential. It took a long period to reach and get acquainted with board members. It was not possible, for example, just to explain the program to them at a meeting and invite them to participate. The project had to assure them in many ways that this would be their program, and that participation would meet their own needs. It also took some time to overcome the hostility and distrust toward "the establishment" which was characteristic of board members. This distrust included federal agencies such as DHEW and OEO, the health establishment, professionals, and the university—with its reputation for doing research in the ghetto but not staying to solve problems. ("We don't want to be statisticated any more," was told to us early in the program.)

It was also evident very soon that there were certain "gatekeepers" who in some way controlled access to the groups. At first the staff was not aware of their existence, but soon it became

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* The National Consumer Health Conference was held on October 2, 3, and 4, 1969, in Berkeley and was attended by 290 persons representing some 50-60 centers. A steering committee was appointed to develop an incorporated national consumer body.

apparent that certain persons had to be convinced of the validity and safety of the training before the board members themselves could be reached. Each organization represented a different balance between interacting groups, and in each situation persons existed who did not wish the status quo disturbed. This barrier to reaching the boards was overcome in all cases but one. In this one case, the project staff was never allowed to reach the council members directly.

It is apparent that the ease with which a training staff can gain access to board members will depend to a large extent on the perceived threat it poses. If relationships are not expected to change with training, or if the organization providing the training is not seen as a threat, there may be no resistance. But it most cases, from our experience, we would expect this kind of impediment to program implementation to be evidenced, and staff time will be needed to overcome or circumvent it.

Problems Around the Planning Process

Originally it had been thought that the planning process would be assigned to a small committee of persons representing the various centers. Just the opposite happened. No one wished to delegate this responsibility to a committee. Therefore, planning was done by everyone. Formal planning (coming after three months of organizational activity) was extremely short. The group in essence said, "You know what we want. We have given you a list of areas we wanted covered. Let's get to work." And they wished to start immediately—so fast that the staff had difficulty in getting the proper resource persons at such short notice.

The other thing we can note retrospectively is that professional input in choosing topic areas was very limited. The group knew what it wanted and did not want. Most of the areas considered in advance as high priority training areas by the project director were not even included in the final range of topics, and it continued to be very difficult to introduce topics that the group saw as irrelevant to their responsibilities. Only after the relevancy of a topic was convincingly demonstrated were they willing to discuss it with any enthusiasm.

Flexibility of the Workshop Program

Originally, it had been planned that chosen topics would be discussed on a definite schedule. However, sessions developed a life and direction of their own. The extremely flexible, self-directed program that emerged maintained the interest of the members at a high pitch for the entire program. Directions were often changed as new areas appeared in discussions and were subsequently explored in more depth.

At one workshop session, for example, one of the board members, who had worked hard and long for several years in the establishment of the health center, was heard to remark, "I wouldn't take my dog to this center." When questioned by the staff, she said that she had no trust in the aides recruited from the community and working in the center. She fully expected them to disclose confidential material and would not think of placing herself or her family in such jeopardy. The next week the group centered its role play around the problems of confidentiality of patient records and the confidential aspects of board meetings, especially when personnel matters were under discussion. Because of subsequent discussions about confidentiality, the board members proposed changes in bylaws, board procedure, standing orders in the health centers, mail policy, professional education, selection and training of aides, and in the legal resources available to the board.

This type of approach, almost completely guided by the desires of the group, meant that some areas were not developed in as much detail as the project staff thought advisable. Issues such as the representativeness of the board, the board's ability to work with professionals, the changes necessary at the community level to insure effective delivery of health services—although repeatedly touched upon in group discussions—were never treated in great depth. Attempts made by the staff to have these issues discussed further met with little success. Eventually, after several failures, it was decided not to introduce them "prematurely," but to wait until this kind of information and discussion was actively desired. In several instances, the relevancy of such issues later became apparent to board members.

Length of Training

In the beginning, training was seen as a much more clearly defined and limited process. The desire of the group for a longer program and for help in the development of the Consumer Health Conference kept the training program functioning for over a year. Only when it became absolutely necessary for the staff to devote increased time to other activities were the contacts with the three boards decreased. This decrease of commitment of staff time was seen by some board members as an act of rejection—falling into the old resented pattern of programs created only to be permitted to die.

A program such as the one we carried out involves, of necessity, much mutual dependency on the part of the trainer and trainees. It therefore presents many problems that a more structured training program does not have to face. Since the board's ability to function successfully and effectively in an independent manner was the desired outcome, the staff had to differentiate those activities that would further these goals and those that would not. Since the boards moved to independent action on the Consumer Health Conference some five months before the end of the project, this was sometimes an especially difficult distinction to make.

The Issue of Payment of the Board for Training

This issue was raised by one board when it was first asked to participate. Payment was requested for the training sessions; members insisted that, since professionals were paid, they should also receive a consultant's fee. They said, "We are the experts on health care for the poor, not the professionals. We will not teach the professionals for nothing." On this issue they were adamant, refusing to enter the program officially. Nevertheless, the staff included them in all planning activities and, as the program gathered momentum, the board members became active participants despite their initial refusal. They gave unstintingly of their time without compensation to the training project and to the consumer conference.

This problem of payment to boards is an unsettled problem and one about which low-income board members feel very strongly. It is without doubt very difficult for low-income consumers to participate fully in activities for which there is little or no compensation—especially if this means taking time off from work and paying transportation and child care costs. But it also became clear during the training period that low-income consumers, when they feel their time is spent meaningfully on important tasks which they have designated as their own, will give of their best with no thought of payment, however hard this may be on them personally.

Basic Relationships of the Board and Their Importance in the Training Process

Early in the program, the project staff conceptualized the following basic relationships a board must make and maintain in order to function effectively.

1. Internally between the members of the board itself.
2. Between the board and the organization and staff which it serves in an advisory or policy-making capacity.
3. Between the board and the community it represents.
4. Between the board and the outside health system as well as the larger sociopolitical system.
5. Between the board and the funding agency.
6. The very subtle, variable, and complex internal commitments board members may have with regard to themselves, the board, the institution, and the community.

It was theorized that any action made by the board could either augment or deter the success of the health center, and that an examination and clarification of relationships in which such transactions took place might prove beneficial. Many of the basic relationships conceptualized as a model for board action were subsequently found to coincide with those which the board itself thought necessary to discuss in the interest of running a successful health center.

Our conceptual model also took note that a board would have to consciously recognize its over-all goals, and would have to have made some commitment to reaching them. All three boards seemed to think it self-evident that their commitment was to get the health centers under way in order to deliver personal health care services efficiently. Several times in the discussion groups, mention was made of larger and more encompassing commitments to the community and its health problems, but these were never developed to any extent. However, a commitment to national consumer interests was made clear very early in the program, and was enthusiastically embraced in the development of the Consumer Health Conference.

Many facets of each relationship were raised during training. It is one thing, however, to have made note of a relationship and the problems arising around it, and another to change behavior so that problems are eliminated. It is certainly impossible at this time to do more than estimate the extent to which attitudes and action around these relationships were changed by training.

Here we shall briefly review how the six categories were seen by the participants and what part they played in discussions.

1. *The Board's Internal Relationships—What Is the Board's Own Structure and Organization and How Does It Function?*

This was an area given prime importance by board members during the planning phase. They wanted to know how to perform efficiently and effectively, asking such questions as: What is the board's legal responsibility? Its by-laws? Its method of procedure? Its chairman's function? How are members encouraged to participate? How does the board combat apathy? Lateness? Disruption? Nonattendance? How is factionalism handled? How can board members be helped to function better? How can they learn skills like public speaking, and so on? A large part of the early program was spent exploring these areas.

We feel that this part of the training was quite effective. Members developed a new sense of their common goals and the ways they must work together. Board members noted that factionalism and infighting within the board seemed decreased as a result of the training program. Board chairmen came to see the importance of their role in protecting timid members and curbing aggressive ones in board meetings. New respect for the role of the chairmen was expressed by participants.

2. *The Board's Relationship with the Professional Staff of the Center*

This was the next most crucial issue in the eyes of board members. They wanted to understand what they should do and what the professional staff should do. How should professionals be used? What work should be delegated to them? What was the board's fiscal repsonsibility? How was policy-making differentiated from management of the center? How could communication with the staff be achieved? How could they be trusted? What were the values of the professional staff? How do professionals differ from nonprofessionals?

In this area of board-staff relationships, training could only accomplish a small part of the task. Ongoing continued support is going to be necessary for consumer advisory or policy-making boards, if communication is to remain open, and if boards are not to permanently injure their relationships with center professionals. The degree of misunderstanding and lack of appreciation for the role of the professional is still great. Methods, such as common training programs, must be developed to deal with it.

On the positive side, board members noted that they felt more understanding about the responsibilities of the staff, especially through such role plays as "hiring the project director." They began to ask for information and justification about project activities with apparently unprecedented directness—often to the discomfort of the project directors who, along with the Consumer Health Project staff, were unprepared for the open expression of interest of the board in all phases and aspects of center activity.

3. *The Board's Relationship to the Larger Health-Care System*

This was an area that was of little interest to board members in the beginning. They were so intent on the organization and functions of the board and the center that they saw little reason to be concerned about what went on around them. They did not wish to learn about other resources or other health programs.

About half way through the sessions, the project director pointed out the importance of future Title XIX funding for health centers. This was not picked up at the time; in fact, one board member stated, "We are interested about what's happening now, not in the future." Later, however, when the project staff re-explained how Medicaid funding could contribute to the center becoming self-supporting in the future, members requested further information about Titles XVIII and XIX and about health insurance in general. Nevertheless, it was never possible to develop any deep or continued interest on the part of most board members in over-all health planning or in working closely with other health agencies at the local community level. Most of their attention was focused on the federal establishment, and one of the expressed purposes of holding the Consumer Health Conference was to develop a group that would have some influence on federal agencies and their policies.

4. *The Board's Relationship with the Community*

The project staff, committed to the idea of representative community participation, would have liked the boards to explore their relationship to the community. However, since the subject of community representativeness was potentially a sensitive area—only raised cautiously through such mechanisms as role play and skits—the actual implications of the relationship were left to the interplay between board members. In this way, questions were raised about what interests and groups the board represented, how it was selected, how communication was established with the community, and how the board would respond if the community was not satisfied with its performance.

Relatively little change was noted in this area. Some members already had a well-developed sense of community responsibility—even with an almost missionary zeal. Some wished to continue to function as a closed group, chary of community involvement; in fact, some felt themselves better able to function effectively because the community was *not* involved. However, the project did serve as a vehicle for raising the question of representation, and this may have an impact at some future time.

5. *The Board's Relationship with the Funding Agency*

In the conceptualization of relationships, this area did not, in my mind at least, seem particularly important; I saw the federal commitment as one primarily of program development, whereas the local community and its health system would continue to be part of the environment of the health center for the rest of its existence. However, the federal relationship proved to be the one with which the boards were extremely concerned and over which considerable heated emotion was displayed. To them, it was "Washington" that was the antagonist with which they must battle. It was interesting that they seemed to see "Washington" only in this adversary role. One of the expressed reasons for the Consumer Health Conference was to unite consumer boards in order that they could deal with Washington with enough power so that matters of funding, guidelines, board pay, and eligibility could be solved. They did not see the need to do this is relation to county hospitals, county health departments, comprehensive health planning agencies, regional medical programs, or state health departments—probably because these agencies did not have any direct control over the centers and were therefore invisible at least for the present.

The outcome from this area of discussion is difficult to evaluate, but we think that discussions with resource persons, often representatives of federal funding agencies, enabled board members to see these agencies as somewhat less willful and mysterious bodies than previously. Certainly the boards showed increased confidence in their ability to effect change on the policies of the funding agency, although it is difficult to assess the long-range truth or importance of this change.

6. *Relationships of the Board Member to Himself*

One should not overlook a sixth relationship which is real although difficult to acknowledge as a separate issue in the training program. This is the board member's relationship to himself—his self-confidence, his ability to look at himself and explain why he serves on the board, what he contributes, and what he is receiving from this experience. The clarification of these relationships may have been one of the most important accomplishments of the program, and one that could only have been attained in this kind of self-directed program. Great growth was seen in individual self-confidence, in the ability to work constructively with others, in developing a sense of purpose and commitment. This became especially clear after the consumer conference had been held and all members shared a strong sense of accomplishment.

Summary of Training Results

During the organizational and planning phases, board members suggested a wide range of topics for training—from folk medicine to the means to obtain increased federal funding. However, their most basic concern during the training period was to define the role of the board in its relation to the health center operation. All the boards involved in the project were either legally or *de facto* policy-makers. For persons unaccustomed to holding formal institutional power, as were nearly all the board members, the sudden assumption of such responsibility was a disorienting and disconcerting experience which affected them deeply as public and private persons.

One of the most important functions of the training project stemmed from the fact that, by its very existence, it made the consumer board members aware of and confident about the legitimacy of their new roles. Another was to provide a forum so that self-confidence, both for individaul members and for the board as a whole, could be increased. In addition to this legitimization and confidence-building function, the training program resulted in other achievements. It led to an increased ability to work together as a board, as well as with other boards, around common goals.

The acquisition of increased knowledge and appreciation on the part of members about the mechanisms of board action, the role of staff professionals versus the role of the board, and the problems facing consumers as they become health care providers, was clearly apparent. There was increased skill in planning rationally and taking action to carry out the plan. There was little appreciation and knowledge gained about other important parts of the health system as they relate to board action, about basic health problems and their solution, and about priority setting in the health field. Much need was demonstrated for an increased exposure to working with the professional in a controlled training environment which might lead to a better understanding of the professional, his values, and his method of operation. A great need was apparent for more exploration of how community representation could be achieved and assured.

It is important to note that not all members of each board shared equally in these charges. Not all members, of course, felt the same way about serving on the board. Some saw it as a vehicle for increasing community control of its own affairs; some saw it as providing a necessary community service; some saw it as an opportunity for social contact and prestige (e.g., meeting high-ranking personages, having one's picture in the paper, being known in the community).

For certain members, however, membership on the board was a unique opportunity to assert a new sense of self and community importance vis à vis those institutions and officials that were considered to have had a negative effect on both community and personal growth. These members, about three or four on each board, tended to be the most aggressive and articulate persons involved, and they were the most active in the training program.

Implications for Other Training Programs

From our experience in this first year's program, we have learned some lessons that may be helpful to other training programs that involve consumers representing low-income areas. Following are the most important:

1. It is necessary, if training is to be anything more than superficial information-giving, to provide a continuing program over many months in which the staff, after gaining the trust and respect of the trainees, can serve in a supporting, counseling role. If this kind of program is developed, it is imperative that it not be ended abruptly. Trust can be promoted by the staff working as a closely knit team, and by having a staff who share to some extent the values and experience of the consumer group.

2. The organizational base of the training must be such that it does not serve as a barrier. Preferably, it should not emanate from, nor be based in, either the funding agency or the parent center; if it is, it will be seen as the ally of that organization rather than of the board.

3. The content, sequence, and timing of the training schedule must be seen by the board not only as its own and totally relevant to its needs, but it must remain so flexible that, if the board's priorities change, the training program can instantly respond.

4. An informal, primarily verbal training technique including skits and role play is the most effective method to be used. The use of written material should be minimized.

5. The tasks of the groups involved in training should be similar. Planning and policy-making are such different functions that we do not believe that training for them can be carried out simultaneously. (We are interested in finding out during our next year's program whether it is possible to carry out effective training with low-income consumers whose only task is "planning.")

6. The multicentered approach returned such high dividends in learning and individual growth that groups should be trained together whenever possible.

7. The gap of understanding between the professional and the consumer is so great that attention must be paid, in any training program, to its narrowing or elimination. New methods must be immediately developed and made available to overcome this critical problem. These approaches must not only have change in the consumer attitudes as their objective; change in the attitudes of the professional is equally important.

We have come to believe—as have those consumers who were involved in the Berkeley Consumer Health Project—that if such training meets the above criteria it will provide a very valued and valuable experience for consumers assuming new responsibilities in the health care system.

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