

Community and Professional Participation in Decision Making at a Health Center

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CREATION of a design for investigation of the content and process of community participation in a neighborhood health center is a challenge. We shall describe the methods used in a longitudinal study of the participation by the community and professionals in decision making at one health center. First, the history of community participation and some relevant theoretical considerations will be reviewed. Second, the impact of the particular study setting on the

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selection of study methods will be analyzed. Finally, the ways in which the relevant data were obtained and how these data were categorized will be described.

In previous reports on community participation, numerous problems have been identified, including those emanating from the interaction of the community and professionals. Davis and Tranquada have reported on areas of conflict at the Watts health center (1). These authors emphasized the conflicts arising from differences in goals, the difficulties in joint decision making, and differences in perceptions of reality. Goldberg and co-workers have mentioned problems arising from the interaction of members of the community and professionals, as well as from the degree of representativeness of participants and the degree of control to be exercised by the community (2).

Zurcher, in "Poverty Warriors," describes in detail the stress and strains on the Economic Opportunity Board of the Office of Economic Opportunity of Topeka, Kans., resulting from the interaction of the poor and near-poor (3). He repeatedly

emphasizes the impact that the process of participation had on all members of the governing board. Zurcher further states that "... the dynamics [of board meetings] reflected a fission or fusion of world views and the travails of socialization." Articles on the growth and development of individual health centers include stories of difficulties and disagreements, as well as of the learning that goes on as the community becomes involved in the administrative aspects of the center (4-10).

In order to understand more clearly the factors and forces at work in the participation of the community and professionals, it is helpful to identify the elements of the situation and their interrelationships. Briefly, persons with different backgrounds, personalities, and goals become part of a health center because they are serving with a particular group (board or council). Each group, under specific conditions and constraints, evolves a way of behaving within that group and toward other elements of the health center. This group interaction, across time, provides a particular

experience for the group members and produces specific outcomes or results, which in turn affect future events.

We analyzed over time the relationship of three major variables to the perceptions and participation of members of these groups. The first was the status of the participant, specifically, whether professional or nonprofessional. The second variable considered was the setting in which participation occurred, that is, as a member of the board or the advisory council. Traditionally, the board, being located at the apex of the organizational hierarchy, has the final and most authoritative voice on policy matters. The advisory council, in contrast, is given a consultative role, as the name implies.

The outcomes of interaction were an important final consideration. Participation in a successful group experience has been shown to have a positive effect on group members (11, 12). In our study, participation was defined as interaction on allocative decisions, that is, on decisions affecting resources. Therefore, it could be hypothesized that the more decisions a group made, the more meaningful would be its interaction; also, that the increased decision making would lead to an increase in perceived satisfaction, influence, and competence among the group members.

Hypotheses

The following hypotheses were framed:

1. Professionals on the board or advisory council of a health center perceive themselves as more competent and influential than do nonprofessional group members.

2. Professionals on the board or advisory council will report

more satisfaction with their participation than will nonprofessionals.

3. Participants of the group (board or advisory council) which makes more decisions to allocate resources will report more competence, influence, and satisfaction than will members of a group making fewer allocative decisions.

4. Participants of the group which makes more allocative decisions will report more consensus on goals and view other group members as more supportive of their views than will members of the group which makes fewer decisions.

The Setting

The study was conducted from October 1968 to March 1970 in a health center that had been established by the prolonged, persistent efforts of a group of mothers from the community. Lengthy negotiations with numerous organizations resulted in the creation of a community corporation to establish and run the health center. A tripartite arrangement provided equal representation for a community agency, a local university, and a group health organization on a governing board of 12 members. The board was expected to perform the traditional duties of a board and was the final authority on policy and other matters.

An advisory council, composed of 10 professionals and 10 community residents, was created because no community member of the board qualified as a "consumer" as defined and required by the Office of Economic Opportunity. The role of the advisory council, never specifically delineated, was to provide a mechanism for communication with, and involvement of, the

community. Although the health center's bylaws of incorporation did not provide for an advisory council, the grant application showed such a council as reporting to both the medical director and the board.

Methods

Data for the study were obtained from interviews, observations and reports of meetings, and other written communications. The investigator interviewed all members of the board and council and three key members of the staff in early 1969 and again 1 year later to collect descriptive data on each person and elicit his views on selected aspects of the health center.

The investigator obtained data on the content of board and council meetings by direct observation and detailed notation of the proceedings. For meetings that she was unable to attend, the official minutes were analyzed. A tape recorder was not used for two reasons. The advisory council objected to its use at its meetings. Moreover, use of a tape recorder at community meetings in another neighborhood had proved completely unwieldy. Background noise was high, identification of speakers was difficult, especially during lively discussions, and the tape recorder frequently jammed or failed.

Written communications by, or received by, the two groups under study (including memorandums and letters to and from the project director, the administrator, and chairman of the board) were also reviewed.

While previous research and theories about community and professional participation, in part, dictated the questions chosen for investigation, experience in this particular research setting

greatly influenced the selection of the techniques used for obtaining answers to questions. The factors which influenced decisions on methodology deserve mention because similar decisions are faced each time attempts are made to do research in an action setting.

First, research of this type must conform to the pace of the organization under study. From a methodological point of view, it would have been preferable to delay data collection until numerous methodological dilemmas were resolved. We decided, however, to field the investigation in the first months of the health center's existence so as to learn as much as possible about the initial forces that would affect subsequent community involvement. Consequently, the investigator observed board and council meetings before having answers for many questions on methodology.

Uncertainty about the reception that the investigator would receive also affected the methodology. After 21 months of contact with the health center, it is difficult to recall the initial insecurity felt by participants and investigator alike as to what was going to happen. Although the board and council had formally agreed to permit the research and to cooperate in any way possible, for these groups to experience the presence of a silent outsider or to answer a series of questions without a prior inkling of their content was another matter.

The advisory council, more than the board, expressed doubts and second thoughts about the advisability of participating in the study. Their dilemma was succinctly described by their chairman, who said, "We're still walking through the woods. Why don't you come back and study

us when we've got a role?" Because of the uncertainty felt by everyone, the early months of the investigation were kept as low-keyed and nonthreatening as possible.

Because of these very uncertainties, however, the investigator often needed to be present at the health center. To learn as much as possible about the center and at the same time become a visible, accepted element in the setting, she attended numerous community meetings and talked with many persons connected with the center. Toward the middle of the study period, it was possible for her to reduce contact to only the council and board meetings. By the time of the initial interviews (approximately 6 months after the start of the study), the investigator was known and accepted by many of the council and board members. This acceptance facilitated a more informal atmosphere at interviews and helped in getting complete responses to open-ended questions.

The choice of the open-ended type of questions to obtain key portions of the interview data was also dictated by the study setting. First, in relation to items such as goals of the health center and roles of the groups, the investigator did not feel she could anticipate potential answers well enough to formulate forced-choice questions. Second, it was believed that respondents might give what they believed was an "appropriate" answer on a multiple-choice question, but one which could mask their own feelings. Third, the rapidity of events and the desire to do "before and after" interviews precluded the preparation of a sensitive, closed-ended instrument for the interviews.

Another factor that shaped the investigation was the necessity of preparing a questionnaire for interviews which could be used comfortably both with experienced professionals, knowledgeable in their fields, and with respondents who were new to both health affairs and research. Insofar as possible, therefore, simply phrased questions were used and complicated approaches avoided.

Finally, although the broad rubric of participation in allocative decision making was identified early as the key focus of the study, it was not clear initially what sort of information—in view of research constraints—could be obtained from board and council meetings. Therefore the investigator attended the initial meetings to observe and record as much as possible of the discussion and activities. Only after many meetings and repeated study of their content did the following categorical analysis evolve.

Analysis of Data

Content of meetings. As stated, the essential element in participation in the health center, as defined for our study, was allocative decision making. Raw data on meetings, consisting of almost verbatim accounts of proceedings at the board and council meetings, were analyzed. The first step in such analysis was the identification of each issue or topic discussed during the meeting. Some examples of topics include a progress report from the training director, a discussion of the need for a drug addiction program, and the setting of a date for the next meeting. Often one broad topic subsumed several subtopics which were coded individually.

After separate topics were

identified, it was possible to code several dimensions for each issue—the type of issue, how long it was under discussion, what action was taken, whether or not it was related to health center resources, who initiated the topic, and whether or not the topic was on the agenda. The last two dimensions—initiator of the topic and its status—reflected to what extent different categories of topics were included formally in the meeting format and which were initiated without being on the agenda and by whom.

An important measure of meaningful participation was the percentage of topics discussed that affected resources. A second index of participation was the number and types of decisions each group made. The final disposition of each topic was noted. Alternative outcomes included acceptance, rejection, tabling, assignment for study, and no decision—when one was needed. The last category included issues which were presented to the board or council for a decision, but on which no action was taken.

The crucial element in analyzing the content of meetings was the establishment of a satisfactory coding system for the topics themselves. In the days before community participation, most decisions made within a health center would have been encompassed by the three categories: medical-technical, administrative, and interorganizational relationships. With the advent of emphasis on “maximum feasible participation,” however, lay persons and consumers have become involved so that the topics discussed and the considerations that affect decision making have been altered.

The extent and manner in

which laymen were to participate in health center matters was never clearly delineated by the Office of Economic Opportunity. As operational instructions, such general guidelines as, “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 . . .” were ambiguous (13). The individual health center—with its professional and lay persons—had to evolve ways of incorporating community input.

Participation of members of the community in the formal health center setting has added new dimensions to the topics and issues discussed at meetings of the board and advisory council. Analysis of the topics and issues discussed needed to reflect these additions. Six major categories resulted:

1. Medical-technical
2. Administrative
3. Interorganizational relationships
4. Community and medical-technical
5. Community and administrative
6. Community and interorganizational relationships.

In addition, two other categories relating to the operation and maintenance of the board and advisory council were set up. The definitions of these topics, because they were critical to our analysis, are explained in detail.

The first traditional category, medical-technical, relates to medical standards of practice. This category, based on the definition of technology of medicine elucidated by Levine and co-workers (14), refers to the medical as-

pects of a professional's role, such as the ability to diagnose illness, to use the proper treatment, or to do surgery. Included were topics such as techniques of treatment, drugs to be carried in the pharmacy, and professional qualifications of applicants for staff positions.

Administrative topics deal with organizational efficiency. Billing procedures, funding, health center construction, staff reports, and the budget are examples of issues which might be exclusively administrative.

An example of the interorganizational relationships of a health center would be its interaction with a health department or with professional organizations. Organizational realities require that an organization relate to the other groups and organizations around it. Topics included under this heading were working with a city-wide coordinating committee, with the health department, or with professional groups.

Any time that a member of the group perceived an issue as affecting community interests, goals, resources, or needs and discussed it in that light, the topic was then categorized as a community topic. The discussant need not have been a layman or member of the community. For example, an administrative topic might have first been discussed solely from a traditional administrative viewpoint, but later in relation to its effect on the community. A discussion of the budget for the health center, for example, might have begun with an analysis of its personnel's fringe benefits (an administrative topic), but have been followed by a presentation of the pros and cons of augmenting the budget of the training department so as to allow more community persons to be trained

(administrative topic in relation to effect on the community).

The medical-technical category in relation to the community might include a reference to the community's preference for injections instead of tablets in treatment. The category of inter-organizational relationships in respect to their effect on the community covered topics such as coordination and interaction of the center with organizations representing the local community.

The interview—open-ended questions. Open-ended questions were used in interviews to elicit the participants' perceptions of the roles of their group (board or council), the goals of the health center. Responses to the open-ended questions were coded into categories based on a study of the responses to both the initial and followup interviews.

Group members were asked, "What do you think the (advisory council) (board) is supposed to do?" Following are the 11 code categories that were created to group their responses:

1. Advise
2. Make policy
3. Represent community needs and wishes
4. Represent the health center in the community
5. Serve as a community watchdog of quality
6. Respond to the community
7. Provide an opportunity for community involvement
8. Help in employment and training
9. Oversee management, the budget, and the achievement of goals
10. Miscellaneous responses about the group's composition
11. Role not clear.

The first two categories reflect the broad, nonspecific views of

each group's role that were given by many respondents. Categories 3 through 9 were for expressions of more specific purposes. Numbers 3 through 7 reflect the liaison duties of relating the health center to the community and vice versa. Varying postures and activities vis-a-vis the community are provided for in each category.

One category was for miscellaneous responses related to the composition of the group rather than to its role, and a final category was for persons who said that the role was not clear or defined. The number of responses falling into these last two categories is one index of the difficulties group members had in understanding their group's role.

Responses to three separate questions provided data on the goals of the health center as seen by the respondents. The questions were: What do you think the health center should do for the people in the neighborhood? What services do you think should be available? What long-term results or outcomes are you looking for from the health center? Eight categories of responses resulted:

1. Deliver health and medical care
2. Provide social services
3. Serve as an economic and social stimulus to the community
4. Teach the community
5. Employ and train people for the center and community
6. Serve people with dignity and warmth
7. Serve as a demonstration project
8. Offer an opportunity for community participation.

The first and most obvious purpose of the health center was the delivery of health or medical

care. Responses such as "get a healthier community," "do preventive care," "treat the sick," and "reduce mortality" were put under this heading. A second category was used for responses related to the delivery of social services, such as welfare counseling and help with a person's social problems.

The third category of goals related to providing a social and economic stimulus to the community. Not only employment was included here, but also intangible hopes, such as creating pride and serving as a nucleus of community organization and spirit.

A fourth category was for goals related to health education and those related to sharing health knowledge and values with patients and the community. The fifth was a role in the employment and training of people, both to meet the needs of the health center and of the community. The sixth purpose assigned to the health center was that of serving people with warmth and dignity. Convenience, accessibility, and concern were cited as legitimate expectations.

The seventh category was that of serving as a demonstration project, being a model for other health centers. This category included responses concerning the testing of theories of medical care in real life. A final category of goals related to offering the opportunity for community participation.

This system of categorization made it possible to identify changes in the respondents' views of their health center's mission as well as shifting views among lay and professional subgroups about its goals.

The interview—areas of decision. A second portion of the questionnaire solicited partic-

ipants' perceptions of their ability and influence on 11 areas of decision. Some of these decision areas included topics mentioned in the OEO guidelines for health centers as appropriate concerns for advisory councils. Other topics had been used by Schwartz in his study of community participation in group practices (15). To discuss these topics, varying degrees of professional, administrative, and community expertise were required. The 11 areas of decision were as follows:

1. Setting eligibility limits
2. Handling complaints from patients of the center
3. Formulation of employment policies
4. Deciding which programs were most important—or should have the most emphasis
5. Selection of the medical director
6. Evaluation of the care being given
7. Choosing persons for non-professional positions, such as secretaries, aides, drivers, and so forth
8. Setting fee scales to be charged at the center
9. Working closely with community groups and residents
10. Setting the health center's hours
11. Approval of the annual budget.

The areas of decision were presented as topics which might come before the respondent's group for a decision. The respondent, who was to assume that his group had to discuss each issue and reach a decision, was asked to state the following for each area.

1. How much influence do you think (community people) (professionals) like yourself will have on the final decision?

2. On which topic do you feel most able to make a decision; on which topic do you feel least qualified?

The first question about influence was intended to evoke the respondent's general view of his potential contribution and influence in the decision-making process. The second was designed to demarcate the areas of decision in which the participants might be most predisposed to participate.

Limitations of Data

The data as gathered and conceptualized present a number of limitations. Ideally, information on the participation of the health center's staff in decision making should have been included. Interviews with members of the staff and an analysis of the content of staff meetings would have been revealing. Also, data gathered from meetings of the advisory council and the board present only one aspect of the total decision-making process. Discussions and decisions at meetings are only the tip of the iceberg and do not reflect the multitude of activities carried on outside of meetings to accomplish the group's goals.

In any study in which the data are based on oral sources, such as the notes on meetings used in our analysis, questions arise as to accuracy and completeness. Such questions are even more likely to be raised if the meetings are of the type that are often characteristic of community participation since such meetings may become unruly at times, and the subjects introduced may not be directly related to the meetings' purposes. Use of a second observer, of tape recorders and projectors, or of both, would strengthen the rela-

bility of a study in which notes on such meetings were used. Unfortunately, however, the context of community-oriented studies does not always lend itself to such approaches.

The principal focus of the study was community participation in the allocative decision making of a health center. To evaluate that phenomenon it was necessary to determine what and how many allocative decisions were made and by whom. It was also necessary to identify, insofar as possible, what influence a respondent's status and role had on his perceptions of his influence, competence, and satisfaction. The impact of the respondents' participation in allocative decision making on their perceptions also had to be analyzed.

The data gathered indicated how many decisions were made by each group at each of its meetings and how many of those decisions actually affected the distribution of resources. Shifting areas of interest between the council and board could be identified. It was also possible to see how and where each group came to grips with the task of identifying its role and its relationship to others in the health center situation. Information became available on the shifting membership within the groups and how group members changed their views of their contributions to the council or board and of the potential contribution of their group to the health center. The second round of interviews reflected the impact of a year's experience in decision making on participants' perceptions.

In spite of some limitations, the methodology described appears to produce useful data and insight into community participation at a health center and should

be useful to persons interested in studying this subject. Results of the study in which the methodology was used will be reported subsequently.

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Methods were formulated for analyzing the part that community and professional members serving on a board and advisory council of a health center played in decisions involving the allocation of funds and other resources. The 21-month study began 3 months after incorporation of the health center and 14 months before the center became operational.

The data were obtained from interviews, reports on board and advisory council meetings, notes on these meetings by a study investigator, and other written communications. Open-ended questions were used to obtain key portions of the interview data. These questions sought the board and advisory council members' conceptions of the goals of the center, the role of their groups, the problems facing their groups, and the members' assessments of their ability and influence in 11 areas of decision.

In analyzing the data, the topics discussed at

meetings of the two groups were first identified. Several dimensions for each issue were then coded, such as length of time under discussion, action taken, and whether the topic was on the meeting's agenda. Meaningful participation was measured by the percentage of topics relating to resource allocation that were discussed by each group and by the number and kinds of decisions that each group made with respect to these allocations.

Six major categories were established to code the topics—medical-technical, administrative, and interorganizational relationships, plus each of these categories from the aspect of its consequences for the community. These categories were also applied to written communications.

The results of the study in which the methods were used appear promising and will be reported subsequently.