

CONFERENCE
ON
COMMUNITY HEALTH PROMOTION
AND THE HOSPITAL

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able to do. They ran the Health Center day and night and proved to me that the Health Centers have more patients between 5 P.M. and 10 P.M. than during the day. Also on weekends, particularly Saturday afternoons and Sunday mornings.

And so they proved that it was possible to develop a completely new aspect of medical care. They showed also that the Health Center was more than just a center for medical care. It was the center of the community, it was a place where there was a phone, a place where people could hold meetings, it was a place where there was somebody available in the middle of the night. It really became the true center of that community. The community was right; the Center had to be open day and night. And the community proved to me that they had a better understanding of health than we doctors learn in many medical schools.

And what is happening here today, in Montefiore, is the same. We have learned so much from the community that I think we will never stop. Now, I am the student and every day I have the opportunity to talk with some of the members of the community. I am amazed at what they really do and know. We, the doctors, have a lot to learn

from the community, and today let's use this opportunity to talk with these wonderful Health Coordinators because they have a lot to say to us and, for me, it's a pleasure to be with them. Thank you very much.

Sally Kohn

I'm pleased now to introduce our next speaker, John McKnight.

John McKnight

You have people of such great experience here. Dr. Behrhorst is the person who, I think, first got me interested in thinking about health. I'm so glad to see him here. I hope many of you will be able to join him in his workshop. In fact, I'm supposed to be in charge of a workshop and I wish I could close mine down and go and hear him.

Now I want to distinguish anything I say that may be useful from what my two predecessors said, because it seems to me they talked about exemplary kinds of activities. I want to talk about the other side of the coin. I am not a public health worker, I am not associated with a hospital, I don't have anything to do

with medical systems, but I've spent almost all of my life working with neighborhood organizations in cities. And so I'd like to describe a little what the health system looks like from the vantage point of the neighborhood; a health system of any kind of dimension - a responsive one or an unresponsive one. Looking at health helpers, health workers, there seem to me to be three things that are most important from a neighborhood perspective. And they are the three problems, as I see it, that health workers bring to neighborhoods. And it's a very, very difficult issue to deal with because the problems I want to describe may be almost inherent in the situation that a health worker is placed in. Let me then try to explain this with two stories: each I think related to each one of these problems. The first is a story about a little experiment that we tried with a group of case workers in Chicago, who had the responsibility of dealing with children who needed to be helped in some way. This was in a department of Children and Family Services. The children needed some kind of help from the government. They weren't delinquent, they weren't mentally ill, but they might have been abandoned, abused, neglected, whatever. And what we did was this - we took a group of these case workers, community-related case workers, and we

gave them little descriptions of ten children, case studies, and asked them if they would develop treatment plans. We asked them to develop treatment plans based on the system within which they worked, based upon the forms that they used, and then we analyzed the plans. Two months later we went back to those same case workers, gave them essentially the same descriptions of these ten children and said to them "Will you write down the single most important thing that this child and/or family needs?" And then we looked at what happened the first time and what happened the second time. And the most important thing is that the second time 40% of the responses said "This child and/or family needs a better income." The first time nobody mentioned income. Same people, same children, two radically different responses. So we asked ourselves, why is that? And I think the reason is that the system within which the case worker works defines the tools that are available to deal with the problem. The tools were therapy, adoption, taking the child away from home, putting a child in an institution, putting a child in foster care. Those were the tools that the system bro-

vided. But the one tool the system didn't provide, an adequate income, was the most important thing that these same case workers could identify as needing to be supplied.

So the first point of importance from a neighborhood perspective is that when somebody comes to tell us in a neighborhood they're going to help us, we have to look at what their tools are. Because it may be that they want to help, but they don't have the right tools and if they have the wrong tools and want to help then they may really distort what we're about and what should be happening. I am not sure that most health workers, for most neighborhoods, have terribly useful tools. And I do know, from a neighborhood perspective, that, frequently, because they want to help and want to use their tools, they can get neighborhoods focused on activities which I think are not inherently important but, nevertheless, absorb the mind, the soul and spirit of the community. So tools and resources are very important in shaping what, in fact, is done to a community. So when I see a health worker, I'm always looking and saying "Now what does that health worker have as a tool? What does that health worker have as a resource?" And I look at these very carefully because my own experience says that those tools and resources may be very, very dangerous. Especially

in the hands of honest people who want to help, because that's so disarming. That's so disarming.

The second thing that health workers sometimes bring that we've got to watch out for at the neighborhood level, is, in a sense, their language. In a good many of the community health projects, the community clinics that were developed in the OEO days, I remember neighborhood struggles to get representatives on community clinic boards and to get community representatives on hospital boards. And those neighborhood people, in that struggle, were talking about empowerment, were talking about community control, and some of those people would get on these clinic boards and they would go on hospital boards. I would see them a year later, these people who talked about empowerment, these people who talked about freedom and liberty and politics, and I would sit with them and they would talk about CAT scans, bed ratios. And I would look at them and say "Is that you. What happened to you?" It has happened so often that most of the community leaders I know who became associated with community-based medical systems are now medical system advocates in the community. Their heads have turned.

They have forgotten why they were there and who they are.

I suspect that there is no community health worker who thinks in terms of words like consumer, even citizen participation, or outreach. Those are terms which tell you that the person is thinking from institution to neighborhood. When you hear people using that language at the neighborhood level you know where their basic interest lies. So it isn't just the language I'm talking about.

I'm talking about how people who say they're health workers understand themselves. Do they understand themselves as caring institutional representatives in the community? I suspect that if they do we have a problem at the neighborhood level, because there is this subtle difference that is the critical difference and that is whether or not you understand health as an essentially community/political question or whether or not, in your language and in your head, what community participation, what outreach really means is that we've got a great big system which is hooked into all the other systems and, now, what we're going to do is hook the little system called the neighborhood into it.

However, you understand it, if you understand that health work is hooking little systems into big systems, you're no friend of my neighborhood.

We are the center, the neighborhood. Health systems are ancillary. They've got to be kept in their place, they have their tools, they have their language, they have their resources, they are always potentially dangerous to us. We must control them, not participate with them. Thank you.

Sally Kohn

The next five speakers that I'd like to introduce are particularly special to those of us who have been working here in the Community Health Participation Program. They are five representatives of over fifty Health Coordinators who live in the neighborhood and are helping their neighbors. I added up the number of years that they've all been living in the neighborhood. Altogether it represents 112 people years of experience in this particular neighborhood. Each person who is going to speak has been trained at a different time and comes from a different group, because we have trained several different groups. Belle Schwartzenfeld, was in our first training program in early 1976. Pamela Logan, whose name unfortunately is not listed, graduated this year. Linda Cadogan