

This is not a free clinic:

How the bureaucracy, autonomy, and poverty of community health centers influence their language of expectation

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Synopsis

The community health center program began in the US during the Johnson administration's Great Society program. It was envisioned as a new method of providing primary care to the nation. However, it faced opposition from conservative politicians and the medical and insurance lobbies. After the Johnson administration, attempts were made to dismantle it, and subsequently the community health center program achieved a marginal status in the American healthcare system, which remains dominated by private insurers, hospitals, and practices.

In line with these progressive ideals, there were a large number of academic publications in the years after the program began. Anthropologists, social scientists, public health professionals, and civil rights advocates infused their cursory studies with moral promotion of the health center agenda. By the mid-seventies, however, the marginal status of community health and the changing interests of medical social scientists caused a large drop in the amount of research being performed about community health.

I spent ten weeks interviewing a variety of employees at Philadelphia's city-run community health centers. I asked them questions about how they came to be employed at the health centers, what their co-workers and patients were like, how they interacted with managers, and what they saw as inadequacies and benefits of the health centers.

I began my research with few hypotheses. I thought that the experiences and opinions of community health workers were politically relevant and academically ignored. My interviews presented a few findings. First, I noticed the prevalent social structures of autonomy and bureaucracy. That is, every employee I interviewed (regardless of their position on the chain-of-command) emphasized how independent they were in their day-to-day job. They also emphasized the inefficiency of the city-wide bureaucracy and the lack of funding and staff for the health centers.

These social structures are factors in the way employees speak about patients. The way employees interpret patient behaviors and expect patients to act in these clinics will influence the care they provide. Through the language employees use, I claim that my informants expected patients to accept and adapt to the bureaucracy and inadequacies of the health center. This is

surprising because employees readily admit to many of the flaws that they admonish patients for complaining about.

No-cost clinics are a different environment from private practices and hospitals. Patients and employees face unique challenges. These challenges and the social norms of these health centers will in some ways be reflected in the way employees speak. Of note is the linguistic concept of the *free clinic*, which I am able to describe here because my informants frequently and consistently made use of this concept in their interviews.

My analysis is humble, because I feel that respectful and productive sociolinguistic methods are far from established. However, ethnographic study and unstructured interviews present a valuable window into the motivations for why employees would work in a community health clinic and how patient care can be improved. This study has only been exploratory, but I believe it justifies an emphasis on ethnographic linguistics in the study of healthcare systems.

Chapter 1: Methods

A. My background and identification

Research for this thesis was conducted between my junior and senior year at Swarthmore College through a Starfield Student Research Grant. I am a pre-medical student and have taken courses in both the natural sciences and the medical social sciences. I have also been a practicing Emergency Medical Technician for three years. A previous summer I received a grant that enabled me to spend time in a hospital, mostly in its community health department.

With these experiences in mind, I sought to identify myself as both a future medical student and current researcher in the social sciences. In addition to addressing my research questions, I gave informants the background described above and explained that the Philadelphia area is my home. I had hoped that we could find some shared experiences as I am both a local resident and a future member of a health profession. I was honest about my experiences and expectations and attempted to answer any questions about my personal background (my resume, family, religion, etc.) that informants took an interest in. I hoped that these shared experiences and openness would allow informants to trust my motives.

Informants I had contacted initially, namely Directors, were provided a written description of the project and my resume. Most others came to be informants either through my asking them (usually a request in-person) or through a Director asking them if they would interview with me. While I made available my written project description and Swarthmore's Institutional Review Board (IRB) approval through reading an approved oral consent script, most informants took little interest in these written materials.

When I requested interviews with employees, I was usually accompanied by a higher-ranking employee, such as a supervisor, HCC, or Director. This method garnered many interviews but at times during an interview it was apparent that the pressure of having a boss request they participate outweighed an informant's interest in talking with me. Throughout the research process I tried to minimize this pressure on informants while still allowing management

to feel they were participating in and understanding what I was doing in the health centers they managed.

Professionals, particularly nurses and physicians, appeared to identify with me on the level of my career aspirations. They took an interest in where I would attend school, which speciality I wanted to practice, etc. and offered advice on these types of career decisions. I honestly identified primary care and public health as possible career interests. While our large age and educational differences no doubt affected the register used when talking with me, professional informants addressed me as an interested student researcher. I am in the midst of an undergraduate education professional informants can recall themselves completing and in the future I hope to mimic many of their medical experiences. The register we spoke, then, probably differed from a register informants might speak to someone deemed a complete outsider (e.g., a patient or a journalist). This is in contrast to the way some managers and allied health professionals addressed me. I felt I was being addressed as an investigator trying to find faults or a sensational story, and thus I was seen more suspiciously and possibly as an outsider.

In the ways of age, race, ethnicity, religion, and immigrant status I shared very few of these identities with my informants. In addition to differences in career aspirations and informants' lack of interest in my research goals, this likely exacerbated my being seen as an outsider. A few informants took an interest in my hometown, my family, and my religion, so I hope my discussing these details eased their distrust of me.

Managers (Directors and supervisors) initially approached me tentatively, again wary of my being an investigative journalist and of any negative things I may write. They were also concerned with my receiving appropriate permission from their bosses so that there was no threat to their job standing. I attempted to take any measure I could to assuage these fears. Over time some managers saw me as a conduit to promote their own managerial accomplishments and addressed me in this way, focusing on their managerial philosophy and specific advancements they had made in their centers.

I had mentioned during my oral consent script that I had an interest in possibly publishing articles in the future. Toward the end of my research, motivated by the encouragement of some health center employees, I actually sent to a couple of managers a draft of an article about the city's municipal unions that I had written in order to seek their input. This reignited fear and distrust in some employees, but I communicated openly with city administrators and health

center managers to ensure my research methods were approved and understood. I have not attempted to write or publish any articles after it became clear this would make some informants uncomfortable.

B. Selecting informants and receiving administrative approval

I decided to research Philadelphia's community health centers for both practical and sentimental reasons. Practically, Philadelphia is a large city with a diverse population of immigrants and the entire spectrum of socio-economic classes. It has a well-developed network of community health clinics, most prominently the city-run clinics, but also privately-run and specialized clinics. The city's healthcare sector features multiple medical and nursing schools, prominent hospitals, and biomedical research universities and companies. Philadelphia, then, is a good starting point for understanding how community health clinics integrate into the rest of the healthcare industry. Sentimentally, I was raised in the Philadelphia area, and I have a great concern for the well-being of its community members.

An initial letter describing my project's goals and procedures was approved by Swarthmore's IRB. This letter and my resume were sent out to the Directors of all of the city's eight health centers and to a number of privately-run health centers. Employees from a few of the health centers contacted me (by email and phone). Some employees declined participation in the research.

Most of the health centers did not respond to the initial letter, which was expected, and so a few days later I called the Directors of the health centers and left them messages asking if they would participate in my research. Two Directors called me back and indicated a willingness to participate. They also suggested that they would be unable to participate without the approval of Philadelphia's Department of Ambulatory Services. I contacted this department and received a call back indicating that my research would be permitted.

With this permission secured I began to schedule interviews at two city-run health centers. However, toward the end of my ten-week research period, a representative from the city government contacted me to request that I gain IRB approval from the city before continuing my research. I completed the procedures they requested and the city also granted me IRB approval to continue my research without modification.

Research took place in two health centers because these were the centers that returned my calls and expressed interest. But these health centers serve as comparable examples since they are located in different geographical regions of the city and serve different populations. I decided not to pursue research in more locations because becoming more knowledgeable about the particular centers and gaining rapport with the employees is a long process and research was only planned to take place over a few weeks. I wanted my descriptions to cover the overall operation of a single health center and this requires that I talk to many employees and learn the procedures and histories particular to a given center. Interviewing informants at two centers has provided me with some cursory ability to compare differences and similarities across the health center system, but the goal of this thesis was never to describe trends that occur in every health center but instead describe the personal experiences of particular employees.

The selection of employees within the health center to interview was similarly non-deliberate. I wanted to interview any employee who was willing, and hoped to hear from a number of professions. I followed the “snowball sampling” method (Schensul 1999) by using the social networks of current informants to find new informants. I introduced myself around the centers and asked employees if they would be willing to interview with me or could suggest someone else who would be. Some managers identified employees that they felt would be willing informants. I scheduled specific times for interviews and returned during this period. Missed interview appointments were common but I attempted to reschedule interviews and accommodate employees as much as possible.

By the end of the ten-week session, I had conducted thirty formal interviews with nineteen employees across two health centers. Informants came from the following professions: physicians, nurses, supervisors, social workers, insurance (benefits) counselors, dentists, dental technicians, and managers (with Masters degrees in various fields). I had also been given tours of the centers and informally chatted with other employees. I intentionally had very little interaction with patients since I did not want to make patients uncomfortable or worried about breaching of their confidentiality. Occasionally I would observe in the lobby (by standing in line or sitting in chairs as patients do), but I did not converse with patients.

C. Conducting and recording interviews

When scheduling interview sessions with informants, I found many informants were worried about the length of time the interviews would take since interviews were always done “on the job”. I allowed the informant to allot as much or as little time as they wished, but found that once the interviews began, informants were much more willing to talk for longer periods or for additional sessions. Most interviews lasted between thirty minutes and an hour. I chose to end some sessions when I could see informants fatiguing but other times interviews ended because an employee was interrupted with an important task. If I felt that informants still had interest in speaking with me, I attempted to schedule another interview session at the end of the first one.

During the first couple interviews I asked if employees would be willing to be audio recorded, and I explained my security and confidentiality procedures. I received very hesitant responses from these first informants and I felt that audio recording would hinder the comfort and honesty of informants, so I did not try to record subsequent sessions. Instead I took written notes as informants spoke. I transcribed paraphrases, small exact quotes, interesting words or phrases, and the general questions I asked. A sample of my interview notes is available in Appendix A. This method is much less detailed than recorded transcription and accordingly I am modest in my interpretations. In retrospect, however, I still believe that having audio recorded interviews would have yielded less interesting data and made informants far more reserved.

Initial interviews took an open-ended, unstructured form (Schensul 1999; 121) and follow-up sessions were usually semi-structured (Schensul 1999; 149) based around my general research questions, the informants' interests, and what I felt were topics that could be clarified by further questioning. I usually began interviews with questions related to an informant's personal background and general job description: what their daily job is like, how they were hired, where they grew up, etc. A list of some of the open-ended questions I asked is available in Appendix B. I would modify the exact wording of my questions based on what I already knew about an informant and what I felt was socially appropriate for each interview. If an informant expressed interest in discussing a certain topic, I would only ask cursory questions about their background and then proceed to topics they were interested in so they felt more enthusiasm toward my research. I had what I considered essential background questions about their education, how they obtained their job in the health center, the day-to-day tasks of their job, etc., and I would ask

these questions in between discussing whatever other topics the informants expressed an interest in.

D. Anonymity of quotations

In order to prevent identification of individual informants, when I quote an interview I will remove or change identifying details (specific job position, gender, personal background) to such an extent that no informant should be at risk for losing their confidentiality, even if a co-worker were to read this research. If it is relevant for the reader to attribute multiple quotations to the same informant, I will provide indexing of the quotations, but the label used does not represent any personal information or identification. While it may have been more informative to the reader if I had indexed all quotations, an individual health center is not a large organization, and employees of these centers might be able to identify informants if all quotes were attributed. Out of respect for my informants' privacy, I have chosen instead to only index when it is necessary to follow a conversation. This has also made me more confident in sharing utterances that employees may not have said if they hadn't been assured anonymity.

E. Methodological assumptions and theoretical outlook

Briefly stated, I am taking a historicist and pragmatic approach in my analysis. In understanding social practices and demographics, I assume that the historical context of US community health and Philadelphia's health centers in particular is crucial. Additionally, I believe that subjective states and intentions do matter in analyzing social action. A subjective orientation both admits us self-reflective control over our actions and understands social structures as reproduced only by individual action. Toward this end I report and give some credence to the stated values and motivations of my informants, but I also look at broader structural justifications for certain actions.

In my sociolinguistic analysis, which mainly looks at cognitive concepts and discourses, I focus on the pragmatics of the interviews, and what my informants' utterances meant in the context of our conversation. I also make the assumption that language change is both unconscious and conscious. Employees of the health center may use certain linguistic structures

unconsciously because they have become normalized in that culture, but they may also consciously modify their style because of personal beliefs or by the request of outside authority. I believe that proper sociolinguistic method is far from obvious, and I will explain my methods and assumptions in more detail as they become relevant.

Lastly, my research is grounded. Although I have surely been influenced by my previous reading of sociological and linguistic theory, I did not begin my interviews with specific hypotheses in mind. I wanted to let my informants express what was most important to them. My expected audience includes social scientists and linguists, but I am also writing to the employees and administrators of Philadelphia's community health centers. I try to take the time to explain theoretical jargon and my assumptions so that these descriptions of my interviews can be useful for the self-reflection and policy-making of the health centers.

Chapter 2: Literature Review

A. A short history of the community health center program

Alice Sardell (1988) has written the most comprehensive treatment of the history of the community health center program, placing it in both a historical and political context. The narrative I present below has been gleaned from her seminal treatment.

By the 1960's it had become clear that the American healthcare system did not provide adequate care to the poor. Some reasons for this were philosophical; many people didn't believe that poor people deserved free or low-cost treatment. Other reasons were political; the private system gave few incentives to physicians to treat patients for free. The political lobbying groups for physicians (and later insurance companies) were influential and any "safety net" for providing low-cost care to the poor was opposed by these professional groups as a threat to physician autonomy and financial security. By the 1960's, then, charitable care was provided by public hospitals and low-cost clinics run at the discretion of private physicians. In addition to being underfunded and understaffed, these public hospitals and clinics provided mostly acute and inpatient care. Primary and preventive care was hard to provide in the hospital setting. Individuals with the financial ability could see a physician before they got sick, or at the onset of an illness, instead of waiting until an illness reached an advanced stage. The poor, in general, could not do this.

The Johnson administration saw many systematic problems with the way America treated its poor and racial minorities. The administration's policies sought to counter these inequalities through federally-funded programs to provide low-cost resources and education. During the mid-1960's, congress was generally amenable to Johnson's progressive goals and passed "socializing" programs in many areas, including healthcare. By the 1960's, most individuals paid for their healthcare through insurance plans. The Medicare and Medicaid programs enacted by the Johnson administration sought to provide affordable insurance to the country's poor and elderly so they too could take advantage of private hospitals and practices.

The Johnson administration and congress had lofty goals for healthcare reform. They saw that simply subsidizing health insurance did not encourage the use of primary and preventive

care, which was thought to be cheaper and would produce better outcomes. The community health center program, which was first called the neighborhood health center program, was initially intended to fill this gap and provide primary care to not only the impoverished, but eventually to a large portion of the US population. The model of providing local, stable clinics in communities was seen as beneficial to everyone.

What we see today is not a widespread use of a community health center model. Although there was initial support by democrats in congress and the white house, professional lobbies and political conservatives both opposed the community health center model. Physicians saw the model as a threat to private practice, which in many ways it was. In order to garner enough support, congress limited the program to mainly target those who were too poor to afford private care. In this way it became yet another “charity” service. Additionally, the Nixon administration disliked the program and tried to defund it. Congress was able to pass legislation that prevented the white house from defunding the program entirely, but this political damage was long-lasting. Community health centers still exist throughout the country, but they survive not just on federal funding. State and city governments also providing funding and some clinics charge sliding-scale fees or receive donations.

The American healthcare system has always favored private practices and hospitals. Professional groups and politicians alike have promoted a for-profit system first through individual payment and practices and then through private insurance and HMOs. Any movement toward a more socialized model of healthcare, where the society as a whole sponsors the healthcare of the population, has been resisted by most political actors. Even group practices and insurance pools, now staples of our still-private healthcare system, were initially opposed as leading to socialized medicine. Howard Waitzkin (2005) claims that the failure of our health safety net can be attributed to an overemphasis on privatizing all aspects of healthcare. As I describe in this section, even though the community health center program began as public model providing “free clinics”, charitable care has since become more heavily integrated into our private system of insurance and hospitals. Waitzkin claims that this emphasis on privatizing even our social safety net ends up ultimately providing less care to those in need. Waitzkin says that funneling of government funds for safety net programs into private hospitals ultimately makes community health centers and other public models financially unsustainable. However, as I

describe in this section, the community health center program has always been in a tenuous position, and today does indeed stand marginalized as an anomaly within our healthcare system.

B. The sociology of American community health

General trends in medical sociology

The field of medical sociology has been properly overviewed by Renee Fox (1989) in her seminal textbook. Among the main areas of interest for medical sociologists have been how illnesses are perceived and narratized; how medical professionals are educated and socialized; how hospital bureaucracies affect care; and how medical research functions within these systems.

One crucial concept that developed within medical sociology was “negotiated order theory”. Traditional sociological theory posits that social institutions will influence the behavior of individuals. Contemporary sociological theory, however, sees social institutions as being created and perpetuated mainly by the performances of individuals; that is, there aren't external forces creating social rituals, only the repetition of these rituals by individuals keeps them around. In this way, social structures are not static, and by individuals negotiating these rituals in their day-to-day lives, these social structures may change. Negotiated order theory focuses mainly on how different classes of medical professionals (usually nurses and physicians) deviate from officially-prescribed hierarchies in their day-to-day lives. Day and Day (1977) wrote a seminal review of the theory that emphasizes the many case studies that support that the actual practice of medicine is often heavily influenced by nurses and other allied health professionals (who are usually seen as subordinate to physicians).

Fox's textbook and Day and Day's review properly show that for a long period medical sociology focused on physicians, medical education, and hospitals. These are crucial components of the American healthcare system, but not its entirety. I am particularly critical of the focus on physicians, which I discuss in a later section. Medical sociologists and anthropologists became aware of this bias and now also devote research time to understanding the social institutions and behaviors that may influence and inhibit good health habits and careseeking in patients. Social network theory, economic rationality, and ethnomethodology have all been adapted to explain how Americans interact with their healthcare system. For a recent example of this synthesis, I recommend James Kirby's research into why some impoverished people are able to obtain

resources while others are not. Through case-control studies Kirby is able to conclude that social networks play a large role in accessing care (Kirby 2008).

These are general trends in medical sociology, but there is also extensive literature focuses specifically on community health, which I describe below.

Personal narratives and political activism

Much of the literature concerning community health in America was prompted by the initiation of the federal community health center program. Many academics, medical professionals, and politicians had high hopes for the program and were personally invested in its success. However, the articles published shortly after the program's initiation had few data to use for quantitative and longitudinal studies. Instead, early sociological studies of community health centers (between 1968 and about 1979) focused on personal narratives of those working in community health and made heavily use of political and philosophical rhetoric justifying the community health center program (Davis and Tranquada 1969; Elinson and Herr 1970; Torrens 1971; Zwick 1972; Orso 1979).

As more centers became established, sociological focus shifted toward quantitative studies, which I describe below. However, in spite of the methodological flaws and advocacy bias in these early studies, I base my research heavily off of their methods and goals. I too believe that interview and participant-observation based ethnographies can provide valuable information about the real-world functioning of health centers within communities. I also feel that sociological studies can be powerful tools for providing voice to healthcare professionals that may not traditionally have much political input. Unlike these early articles, I do not take such a clear philosophical stance and I am not personally invested in the centers, but I admit I am sympathetic toward them and certainly advocate for better treatment of both community health workers and patients.

I see my study as a reimagining of this early sociological and ethnographic agenda, and I am revisiting many of the themes of these early qualitative studies. A research gap of three decades is a serious flaw in the literature and I can only begin to correct it.

Consumer participation

As I describe above, sociologists writing soon after the initiation of the community health center program had a clear philosophical stance. One part of this philosophy was that consumer participation (that is, patients have a policy-making role) was a clearly beneficial goal. A large number of qualitative and crudely quantitative studies came out describing findings and hopes for consumer and community participation in health centers (Falk 1969; Sparer 1970; Campbell 1971; Hillman and Charney 1972).

It is worth pointing out this theme separately because it shows the clear connection between the community health center program and the civil rights movements of the 1960's. Advocates of consumer participation not only thought that it would produce better healthcare, but that it was crucial in reducing racial and class tension between the poor minorities and immigrants receiving care and the affluent white men providing care.

Quantitative and outcome studies

By the late-1970's and continuing to today, the sociological focus on community health has been quantitative studies analyzing the demographics, treatments, and outcomes of community health on impoverished populations. Studies analyze staffing, funding, patient behaviors, health outcomes, and community health's influence on the hospital system (Morehead 1970; Morehead 1971; Morehead and Donaldson 1974; Gates and Colborn 1976; Breyer 1977; Morse 1984; Dievier and Giovannini 1998). These studies are valuable and draw on a wide variety of sociological and public health theory. They allow us to see how health outcomes correlate to specific procedures, healthcare models, and economic incentives. They allow us to view the health of a population with a wider scope than would be available if we were only using ethnography.

However, quantitative studies by their nature need large amounts of representative data. This means that the research focus will be on the populations and providers where data are most available. This tends to focus research on physicians and physician-based measures of outcomes, which I critique in the next section.

C. Critique of physician-centric research

Most of the sociology of American medicine focuses on the physician, the most lauded of medical professions. Its story is either romantic in describing the physician's exploration of the body and time-consuming training, or highly critical of the immense power physicians wield.

Simply put, both these views are doctor-centric, and doctors only make up a small percentage of the healthcare field. Privileging the experience and opinions of physicians is particularly limiting because physicians have typically been part of the educational, socio-economic, and cultural elite. This gives them the capability to be quite active in shaping the very research performed on them. A physician has the conceptual knowledge and vocabulary to influence a sociologist's agenda more than we would like to admit.

The literature is rife with poetic descriptions of a future physician dissecting a cadaver in an anatomy class or watching a suffering cancer patient in the ward, but writing about medicine with a traditional philosophical, literary, and academic vocabulary is incipiently physician-centric as well. Among the assumptions in this writing style are: a medical worker's experiences and background are far different from those of their patients; unavoidable financial and family matters have not played a significant role in choice of career and work-place; and that medicine is some idealistic career that provides an overwhelming sense of meaning for those carrying it out.

The unquestioned assumptions of many journalists and social scientists writing about community health is that working in a free clinic requires a "missionary zeal" or "loan write-offs" in order to weather losses of income and prestige (Sack 2008). This assumption is physician-centric, as physicians may claim that community health is a "less glamorous" environment (Tilson 1973). As my research indicates, many employees in the health centers consider this job a secure and respected position, and financial benefits are the primary motivations they describe for working in the health centers.

We unreflectively assume that community health, by serving the poor, must require an employee to "give themselves fully" to the job (Tilson 1973). This might be just an extension of the romance surrounding physicians (and to some extent nurses) perpetuated by many anthropologists and physicians themselves. As my thesis describes, community health workers come to the health centers because it's an easier job with better hours and less stressful tasks.

We also assume a certain chain-of-command in medical sociology that places physicians clearly at the top. If we are willing to admit to a "negotiated order" model, we may include nurses as employees with some decision-making ability. While this privileging of certain professions may be codified in the chain-of-command and official protocols of a medical organization, in our research we should not immediately dismiss the possibility that there is clinical autonomy and decision-making that all employees of a medical institution may engage in. A chart review and periodic visit from a physician are far too little to counteract the decision-making of clerks, nurses, and social workers that may affect a patient's outcome. Much of a patient's journey is guided by these employees with the patient's own choices and the physician's authoritative orders sometimes taking a backseat.

Toward this end, I chose to interview any willing employee of the health center. I tried not to make assumptions about the extent of each employee's decision-making capability, the narrative discourse they use to describe their work, or the values and priorities they hold in their personal and professional lives. Instead I interviewed with the assumption that the health and happiness of the patients at this health center will be affected by all the employees, and that it is thus inherently worthwhile to try to understand each employee's personal story, cultural milieu, and the linguistic and social structures that employees use to interpret their jobs.

Chapter 3: The Health Center Institution

A. The official hierarchy of the health center and how it is enforced

There is a codified chain-of-command in each individual health center. The distribution of authority and general operational rules of the health centers fit into a modern bureaucratic model (Weber 1922). Most employees hold a “staff” position and work alongside a supervisor “on the floor”. The general categories of staff positions are medical (which includes nursing, OB/GYN, and pediatrics), dental, pharmaceutical, clerical/administrative, and insurance (benefits). Supervisors over these departments hold the same professional position as the staff (i.e., they are also nurses, lab techs, clerks, etc.) and perform most of the same duties, but hold the immediately higher authority to deal with unanticipated problems when they arise. They also usually carry a few extra administrative duties (restocking inventory, documentation). There are a few employee positions in the health center that do not have a specialized supervisor. Social workers report directly to the Health Care Coordinator and insurance (benefits) counselors report directly to the Director.

Holding authority over these supervisors is the Health Care Coordinator (HCC). The HCC is usually a nurse. The HCC is the lowest-level “manager” whose primary duties are administrative and supervisory rather than medical. The HCCs that were interviewed had maintained their nursing credentials and still practiced during staffing shortages, but their main responsibilities were managerial. The HCC is in charge of “patient flow”. Supervisors report to the HCC, who manages staff schedules, inventory, abnormal lab results, and patient complaints.

Holding both medical and managerial authority over the HCC is the Clinical Director (CD) of the health center. The CD is always a physician and holds ultimate medical responsibility at the health center. The CD sets medical policy, reviews charts, performs evaluations, and is the liaison between the health center and outside medical institutions, such as referring patients to other organizations for outside medical care. (The Director or HCC may take on some liaison responsibilities as well.) The CD is primarily responsible for adult medicine, with pediatricians reporting directly to a pediatric medical director who works outside the health center.

The highest managerial position in a health center is the Director. He or she holds ultimate responsibility for the daily functioning of the health center. The Director is responsible for ensuring equipment and supplies are adequate, documenting and reporting to city-wide supervisors, staffing, overseeing the performance of other managers and supervisors, and is the final authority in the health center for addressing patient complaints. The Director must hold a Masters degree. The degree can be in Nursing, Social Work, Public Health, Business, etc. If the degree is medical, the Director may still be licensed to provide medical care.

There are codified ambiguities and redundancies in the chain-of-command, particularly at the managerial level. One manager emphasized that there was “not a strict hierarchy” at the health centers and that the “lines were blurred” for certain responsibilities. This blurring of lines was literally represented as dashed lines in the official organization chart for the health centers, indicating an overlap between medical authority and administrative authority which must be negotiated. This “strain and potential conflict between” administrative and medical authority is “built-in” to the hospital bureaucracy, and appears to function similarly in the health center bureaucracy (Fox 1989; 145). The HCC, Clinical Director, and Director all hold authority over the supervisors and staff, and all address patient complaints. The Director may hold a higher position in the chain-of-command, but the higher professional position of the Clinical Director (physician) gives him or her the final say in setting medical policy and addressing medical problems. This makes the Director impotent in these matters, even though they occur within his or her health center. Additionally although the Director holds a position higher than the HCC, if the Director does not hold a medical qualification (e.g. nursing degree), then the Director does not hold authority when the HCC makes medical decisions. Without a medical degree, a Director “cannot even write in a patient's chart”, as one informant framed it.

Certain employees at the health centers lack immediate supervisors, which complicate the chain-of-command. There are no on-site dental supervisors, so the Director acts as the dental supervisor. The benefits counselors and pharmacists also lack immediate supervisors, so technically report to the Director as well. When I asked informants why these positions lacked immediate on-site supervisors, they could not provide a clear rationale. This lack of rationale implies that it may be due only to budgetary or staffing inadequacies and other health centers may fill these supervisory positions. Additionally, pediatricians are not under the authority of the

Clinical Director in the same way other physicians are, so the CD's relationship with pediatricians is less immediately supervisory.

In practice the chain-of-command is not strictly followed when addressing patient complaints. The supervisors, HCC, Director, and Clinical Director all make rotations around the health center, so any one of these employees may be addressed by a patient. A "patient flow" question, for example, might be addressed by the HCC before the supervisor, depending on who is present and available. One informant recalled a nursing supervisor contacting the clerical department directly, without going through the HCC, who holds the authority over both the medical and clerical departments. Another example that was recalled by informants was a non-clinical supervisor giving feedback to a nurse when this supervisor had heard complaints about a patient being mis-treated. This supervisor did not need to go through the HCC or the nursing supervisor. One manager did indicate that if someone skips one level in the chain-of-command and comes to him first, he will rebuff the employee by saying "did you speak to your supervisor?" In context this utterance appeared to be a way to avoid burdening himself by too many problems, rather than as a clear show of respect for always following the chain-of-command.

Authority is exerted by management through in-person communication, memoranda, and periodic meetings. Supervisors and managers meet once a week, individual departments (clerical, nursing) have regularly scheduled meetings, and all of the staff at the health center have a meeting once a month. In the weekly supervisor and manager's meeting common topics are: discussing center-wide changes, scheduling and staffing changes, and problems with specific employees and behaviors. The monthly meetings for every employee announce these center-wide changes, and enforce rules such as those for timeliness and professional behavior. Staff input is also requested at these monthly meetings, and staff "always have suggestions". Informants recalled recent staff suggestions like making specific changes to the patient check-in protocol and ideas for computerizing the lab system.

Most of my informants were confident in their knowledge of the chain-of-command, and the Directors I interviewed were able to provide me with the official organization chart for the health centers. I have presented this organization chart as I received it in Figure 1.

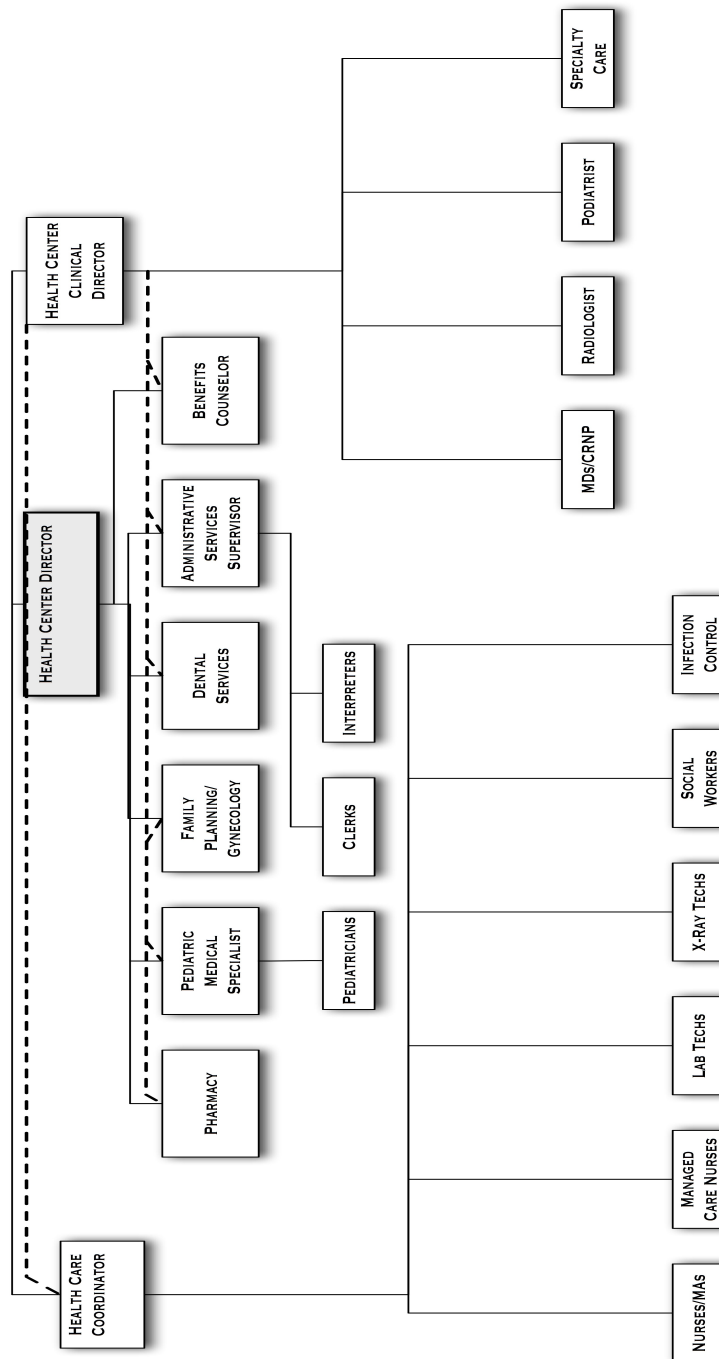


Figure 1. *Organizational Chart of the Health Centers.*

Solid lines represent administrative oversight while dashed lines represent clinical oversight. If an employee has both a clinical supervisor and administrative supervisor, these supervisors must negotiate authority over the employee's actions. The official organizational chart notes that “professional oversight is offsite for Pharmacy and Family Planning/GYN”. (Obtained through a health center Director)

B. “Downtown” involvement and “dual supervision”

A note on methods

I did not attempt to interview any off-site employees who are involved in the running of the health centers. I communicated with them by phone and email only to receive administrative approval for my research, so most of the communication was one-way (sending documents, completing forms). I was able to interview employees from most levels of the on-site chain-of-command, so specific claims about this structure were usually corroborated at multiple levels. This same confirmation hasn’t taken place for my description of off-site supervision; that is, off-site employees have not given their feedback. Without the corroboration of off-site employees, there may be inaccuracies in my description of downtown involvement for which I apologize in advance.

The general structure and feedback of dual supervision

The health centers function under a system of “dual supervision”, as one Director termed it. Under the ideal formation of this system, every employee should have a supervisor present on-location at the health center and also another supervisor in an off-center location. These two supervisors hold relatively equal authority. Off-site supervisors usually address job-specific issues (e.g., related to the practice of nursing or social work) while on-site supervisors usually deal with center-specific and patient-specific problems. Only one employee mentioned difficulty in navigating this dual authority, so the negotiation of on- and off-site authority is likely cleanly performed for each employee and job position. The only mention of confusion to me was one social worker’s complaint that “sometimes it can be confusing who to talk to first, since you get accused of violating the chain-of-command”. Other interviews by this and all other informants, however, expressed confidence and comfort with dual supervision, so this is probably not a salient thought of the social worker or other health center employees.

The off-center location is usually at the city of Philadelphia’s Department of Public Health, located at 500 S. Broad St. Informants usually referred to this location as “500” and also made reference to “downtown”, meaning either the Department of Public Health, or another

office in or around Philadelphia's city hall. Off-site, there are dedicated supervisors for most of the professions and job positions. My informants mentioned off-site nursing, insurance, dental, social work, and pediatric supervisors, and we can infer there are similar supervisors for the professions I did not interview. Managers in the health center have off-site managers that hold a position of immediate authority. Directors, for example, report to a regional manager, who then reports to the Department of Ambulatory Services. The Directors I interviewed, however, indicated that in practice they usually consulted the Department of Ambulatory Services directly rather than going through the regional manager. There are also off-site committees that have some administrative authority. For example, there is a quality-of-care committee that is able to provide feedback of physician performance and clinical policies.

The authority of off-site supervisors is exerted through periodic meetings, memoranda, one-on-one communication (usually by phone or email), structured electronic reports (both automatic and manually written) and evaluations, and off-site scheduling. Clinic visits by off-site supervisors are rare. Employees will travel out of the centers for the periodic meetings.

Employees in the health centers do not generally consider off-site supervisors "out of touch" with their needs. Off-site supervisors are usually in the same profession (e.g., nursing supervisors are nurses, dental supervisors are dentists), and some are still practicing in the clinics, just not perhaps in the same clinic as my informants. The only repeated complaint by employees was regarding off-site scheduling. Multiple informants expressed the opinion that those off-site employees who scheduled patient visits were out-of-touch with regard to how much time to schedule for a particular patient or procedure, and off-site scheduling made it difficult for patients to have a say in setting their own appointments.

Any decision that may impact the health center budget (replacing or requesting supplies, replacing or firing staff, salaries and benefits, providing new medical services, etc.) is generally controlled by off-site city administrators, who are themselves bound by city, state, and federal budgets controlled by their respective governments. While not holding the responsibility for many of these decisions is widely seen as a benefit of employment (see The Health Center Employee chapter), it has also created a culture of bureaucracy and limited resources in the health centers, which will be discussed in the following sections.

There is a culture of bureaucracy

As I will discuss in The Health Center Employee chapter, many employees joined the health center to avoid the “paperwork” associated with private, insurance-funded practices. As a salaried employee with benefits working normal business hours, a health center employee hopes to avoid much of the decision-making responsibility and complexity associated with private practice. Giving up this administrative authority will also produce at times dissatisfaction and a feeling of powerlessness by employees.

There are many levels of reporting and evaluation at the health center, typical in a bureaucracy (Weber 1922). Employees submit both manually-written and automatically-generated reports to their supervisors periodically. They also undergo performance evaluation by administrators. These bureaucratic elements do not cause much stress in my informants. I asked employees if they worried about any repercussions from a bad evaluation or missed report, and no one indicated that they feared losing their job. When I asked a Director if performance evaluations were stressful for employees, she also didn’t believe they were.

Other aspects where employees lacked immediate control over the health center, however, did cause stress and dissatisfaction. One staff employee noted that her perception of her managers was that they were “always frustrated with the city”. Off-site administrators control restocking of supplies, for example, which can cause a long delay in the availability of what staff perceive to be much-needed supplies. Multiple on-site managers discussed finding ways around the standard channel for requesting supplies. If a supply is not costly, an employee may concede and pay the cost out-of-pocket. One informant bought tissues and water for fellow employees because the city had not provided new stock for a long period of time. Larger purchases, such as new medical equipment or new signs, are sometimes donated by outside sources at the request of on-site management. Out-of-date or unrepaired technology can particularly cause stress in the informants I interviewed. One informant complained that a vital computer system needed to look up patient records was broken for a long period of time, even after a complaint had officially been submitted.

Managers also complained about the process utilized to fire employees and hire new ones. The same job security felt by employees (see The Health Center Employee chapter) can be frustrating for a manager if he feels the employee should truly be fired. One informant said “it’s a

process” and it’s “time consuming”. Replacing staff that have quit is also slow, because staff cannot officially be replaced until their accumulated vacation and sick days expire. So a long-time employee with many accumulated vacation and sick days may not even be eligible to be replaced for over a month, regardless of any additional budget constraints.

The effect of perceiving the health center as bureaucratic and unresponsive to immediate needs has been previously discussed in an article written soon after the federal community (then called neighborhood) health center program began. Torrens’ article, titled “Administrative Problems of Neighborhood Health Centers” (1971), spends a good deal of its space hypothesizing what effects a disorderly bureaucratic structure could have on the success of the institution. Torrens’ main claim is that the overlapping bureaucracies of the health centers produce widespread “administrative uncertainty”. Since replacement of supplies, technology, and employees are dependent on an off-site administration who are themselves dependent on budgets controlled by various levels of government and non-governmental organizations, Torrens hypothesizes that “it is sometimes even difficult to determine which body has the authority to make a final judgment that is binding on all the others” (Torrens 1971).

The immediate effect of this “administrative uncertainty”, which was independently asserted by my informants, is that “approval procedures can take weeks to complete and can absorb a tremendous amount of administrative time and energy” (Torrens 1971). This could easily contribute to stress and “burn-out” by employees, but Torrens also claims that there are more systematic problems with “administrative uncertainty” on the “policy- and the decision-making level” (Torrens 1971). Uncertainty with regards to budgets can produce cultural effects that can inhibit the success of these health centers. Given that Torrens’ claims about administrative bureaucracy and uncertainty still appear to be supported by my informants, it is worth reflecting on whether Torrens’ claims about budgetary uncertainty also hold in today’s community health centers.

There is budgetary uncertainty and a culture of limited resources

As Torrens put it in 1971, “most neighborhood health centers have problems with money”. Today this sentiment is still corroborated by my informants. Informants could readily

recall staffing shortages, out-dated technology, long wait-times, and unavailable services that were associated primarily with a lack of money. While I conducted my interviews, the municipal unions (of which many health center employees are members) were negotiating with the city and threatening to strike. This indicates widespread dissatisfaction with the salaries, benefits, and working conditions of city employees. However, the city itself lacks ultimate control over a large portion of its budget, which is provided by the state of Pennsylvania. As Torrens puts it, “the final authority *really* rests with the governmental agency providing the funds for the center” (1971) and the Pennsylvania legislature has been untimely and misleading in describing the budget it would hand to Philadelphia (Hurdle 2009). This caused Philadelphia's mayor Michael Nutter to create “doomsday” threats of closing at least two community health centers in an attempt to garner some authority (Gelbart 2009).

With health centers having well-acknowledged inadequacies compared to private clinics, employees threatening to strike, and state and city budgets being late and unpredictable, it is clear that Torrens claim of budgetary uncertainty still holds. When “budgets must be resubmitted, defended, and reapproved” constantly, “the administrative staff never *really* know how much money they will have to use in the future” (1971). Informants I talked to could not predict whether they would be asked to go on strike or whether the health centers would even remain open in the face of a budgetary crisis. One employee said that she felt like she was “in limbo”. My informants certainly did not expect an increased budget to improve all the inadequacies they mentioned. Budgetary uncertainty and a culture of bureaucracy serve to “discourage the development of any detailed or concrete long-range plans” (Torrens 1971). The community health center program began idealistically as an attempt to be “innovative, aggressive, and sensitive to local opportunities for change” (Torrens 1971), yet budgetary uncertainty and a culture of bureaucracy effectively tempers any idealism in the employees I interviewed.

Budgetary uncertainty and bureaucracy have been a part of the community health center program since it began (see The Literature Review). This has produced in my informants what I will call a **culture of limited resources**. Due in-part to long-term budgetary uncertainty and limits and in-part to the “practical” employees who chose to work at the health centers (see The Health Center Employee) a tempering of idealism has not created widespread despondency. Instead, employees are simply happy that they've “gotten what they need to function”. A culture of limited resources affects the expectations employees have for themselves and for their

patients. It is even present in the cultural discourse of my informants (see The Language of the Health Center chapter).

C. Presentation of autonomy

Philadelphia's community health centers bring together a variety of medical and non-medical employees, professionalized and non-professionalized jobs, civil servants and contracted employees, and a government bureaucracy controlled by city, state, and federal authority. There is a codified chain-of-command that employees know. In practice it could be possible for there to be noticeable constraints on both the medical and non-medical duties that employees perform. Part of the appeal of a bureaucracy is a clear delineation of responsibilities (Weber 1922).

Instead, my informants consistently presented their jobs as autonomous from much of the bureaucracy and chain-of-command we could predict. Staff employees consistently presented themselves as autonomous from both on-site and off-site management. A benefits counselor was happy that management “is not on top of you” and that “employees don't need to be micro-managed”. He claimed that when previous Directors micro-managed, “it annoyed people”. This benefits counselor doesn't usually need to consult supervisors, instead choosing to talk to doctors or nurses directly. He also doesn't need to consult other benefits counselors often. They may contact him for help, but he rarely communicates with them outside of scheduled meetings. Another benefits counselor supported his claims. He said he may “touch base” with the Director to “say hi” or ask for time off, but that his job is “very independent” and “no one is watching over his shoulder”. He also agreed that he rarely needs to consult with other insurance counselors. Additionally, while he is in touch with his off-site supervisor through emails and monthly meetings, when I asked him about the feedback he received from his off-site supervisors, he said “no news is good news”.

A social worker informant expressed the same feeling of autonomy. He said that while “some Directors are very hands-on and micro-manage, others close the door and you don't see them”. This informant preferred when managers “delegate”. The social worker's on-site managers were “generally trusting” and “available when you need them”, but he is “usually independent”. The off-site social work supervisor performs chart reviews and quality control, but he usually only needs to consult with the off-site supervisor for administrative help.

Dentists I interviewed claimed to be very autonomous because the HCC and CD are “medical” managers that don't have authority over the dental clinic. They said their clinic did not interact much with the rest of the health center (even being somewhat physically isolated), and that they'll only consult with the Director if a patient is complaining (see “Handling” Patients). One informant said that while dental employees will attend center-wide meetings, they “rarely talk about dental” in these meetings. One dental tech said he was “by himself”, regularly interacting with only the dentist. The dentists and dental techs I interviewed said that they were “all experienced, so don't need direct supervision”. Aside from monthly meetings, my informants said they didn't talk much with their off-site supervisors either. Dentists are particularly expressive of this autonomy, then, claiming separation from the “medical” chain-of-command in the health centers in addition to not being carefully managed by off-site supervision.

Managers independently agreed that their employees had a high level of autonomy by saying that they try to “create an atmosphere where they don't have to micromanage”. They also presented themselves as autonomous from the city administration. One Director said that the Department of Ambulatory Services allows the health center to run autonomously, and that while the Director will have periodic meetings and phone calls with the Department, he doesn't need to consult them before making most decisions, he only needs to inform them afterward. Another Director agreed that he only needs to go to the city “if there are major problems” and doesn't generally receive much feedback from his reports. One manager said that while “suggestions do trickle down from the mayor and health commissioner”, it only mostly happens “if something goes wrong”. The HCC and supervisors are also given a good deal of authority from the Director and CD. Informants in this position also said that while they need to inform the Director and CD of their decisions, they don't usually need to consult them before making the decisions.

Which medical services are provided by the clinic is determined by a (limited) budget and the city government. Individual physicians in a health center are aware of the list of medical services the city will pay for and may only request changes to these covered services through a yearly request process, rather than on a case-by-case basis. The city, due to budget constraints and bureaucracy, is seen to be unable to respond to most of these requests. While this contributes to the culture of limited resources, medical professionals still surprisingly express feeling autonomous in this environment.

I was interested in whether medical professionals in this “single-payer” environment felt like they had to compromise in specific medical decisions they made. In a private practice a physician is mainly limited by a patient's health insurance and personal resources. In these health centers, all care is free to the patient, but is itemized by a city budget. One physician said that she did feel autonomous compared to a private practice. She said that “patient care decisions always go to the physician” and the city respects this relationship. I asked her what happened when she felt that a patient needed a service that the city would not pay for. She said that she “learns to work around the protocol and get the patient what they need”. She admitted that with “in-between cases”, such as when a patient has cataracts, it's harder to get the treatment funded through either the city or outside insurance and that “there is sometimes a feeling where you wish you could do more”. She said that other physicians probably felt the same way because what the budget does and does not cover is part of a physician's official training at the center, but so are methods of getting around the limitations. She said that the protocols she is given by the city can affect her decision-making when it comes to surgery, but she doesn't feel like it affects “day-to-day or primary care.”

Chart reviews and performance evaluations of the medical staff also take place on-site, off-site, and by managed-care insurance providers. In fact, one CD said that he feels the health center is reviewed “pretty heavily”, possibly more than in a private setting. These reviews and evaluations also don't affect decision-making according to my informants. No one expressed fear of repercussions from reviews and one CD, who performs many of these chart reviews, said that he does not “have a ruler in his hand”. He sees himself more as “an extra set of eyes” that “covers a physician's back” in addition to being a benefit to patients.

Nurses are an interesting profession from the standpoint of autonomy and decision-making. They have gained more professional autonomy in Western countries (Fox 1989; 59), but both academics and members of the profession have expressed the opinion that nurses are still given too little autonomy compared to physicians (Fox 1989; 146). Nurses and physicians must negotiate their autonomy in each new medical environment, and I discuss in more detail professional negotiation in a later section of this chapter. However, nurses discussed themselves as autonomous in much the same way as other employees did. While the HCC is one of their

main supervisors, one nurse informant said that while the HCC and nurse supervisors decide on a nurse's weekly tasks, she doesn't feel they expressly exert authority, choosing instead to physically post the assignments on a board so they don't need to be handed out face-to-face. One nurse said that she only needs help from the HCC "maybe twice a month". She compared this to a hospital environment where "everyone is telling you what to do". This is an explicit claim that the community health centers provide more autonomy for nurses than a hospital environment.

Whether or not the idealistic foundations of the community health center program produce more authority in employees and freedom to express dissent is discussed by Torrens in his analysis:

"Since the neighborhood health centers attempt to make all employees feel equally important to the success of the program and attempt to encourage free expression of opinions among the center personnel, there will frequently be questions and challenges addressed to the administrative and supervisory staff concerning actions that they have taken or decisions that they have made."
(Torrens 1971)

Most of my informants did not talk about open dissent and criticism of managers by staff, instead choosing to focus on how they aren't being closely watched and "micro-managed" by managers. This is a proactive framing of autonomy (an informant can make his own decisions) rather than a reactive framing of autonomy (an informant can easily criticize administrative decisions). The codified chain-of-command likely has many of its traditional effects, providing official channels for dissent in order to prevent less-controlled criticism. In fact, I did not get the impression that my informants frequently "question[ed] and challenge[d]" the administration in the way that Torrens describes. I am sure that my status as an outside investigator did not allow my informants to be very comfortable criticizing their superiors, however, so this will temper the responses I received. Some managers I interviewed did mention employee complaints, which they had dismissed, and the managers' expressions of autonomy (described above) probably correspond in-practice to dismissing many staff complaints. Managers will also be affected by my outsider status, however, and will try to portray themselves as perhaps more responsive as they are in reality.

D. “Handling” patients

There was intentional ambiguity in the responses of administrators when I asked them to describe their day-to-day jobs. Two informants independently responded to this request by saying they merely “put out fires”. One HCC explicitly said that he “can't predict what he'll be doing on any given day”. Ambiguity was most pronounced when I asked about the overall purpose of an employee's job. The HCC, for example, “manages patient flow” according to the HCCs themselves and other employees I asked. This job description doesn't allow for an easy differentiation of duties between the HCC, Director, and CD, however. All of these administrative positions have authority over medical, clerical, and other departments that are involved in “patient flow”.

When I would prompt informants for more specific tasks related to managing “patient flow” or other similarly vague job descriptions, the initial response I would get almost unanimously was about trying to diffuse tensions between patients and staff. As I describe in The Language of the Health Center chapter of this thesis, discussions about “attention-seeking patients” were common in my informants, even when I didn't specifically address the topic, such as when I asked more general questions about job duties.

The autonomous presentation in the health centers could act to undermine the chain-of-command and uniformity of the institution. If a patient were to feel that any single employee had the power to solve his problem, he could attempt to bully this employee into subverting the chain-of-command and making an exception for him. Normally this type of behavior is prevented through codified “channels of appeal” to address customer/patient dissatisfaction that requires appealing “in a precisely regulated manner, the decision of a lower office to the corresponding superior authority” (Weber 1922). At the health centers it is ostensibly no different. There is a codified procedure for patients to voice their complaints. If a patient has a disagreement with his physician, he may approach the CD for a second opinion or to change his primary physician. If a patient is dissatisfied with the way the health center is run, he may move through the on-site and city-wide administrative channels to voice this complaint. With well-documented procedures the patient will feel confident that he has recourse for wrong-doing and the institution will feel confident that only valid complaints will occupy the administration's time.

I assert that although these codified procedures are in place, and are at times inevitably utilized, the staff of the health center seek to prevent use of this official channel through the mobilization of administrative authority within the health center. It has been established that management in the health centers I interviewed is not very “hands-on” and does not “micro-manage”. Consistently in different informants I interviewed, however, they indicated that a time when the administration would intervene in their daily work was to “handle” an attention-seeking patient. When I asked one nurse when she would consult with the Director, she said that “if a patient won’t take no for an answer, I will go to the Director”. Another informant from a different department agreed with this statement by saying that they only consult with the Director if there’s a problem with a dissatisfied patient.

The HCC, Director, or Clinical Director will often address a complaining patient. These are highly authoritative positions in the health center. If a patient is addressed by the Director there is no higher administrative authority on-site and if the Clinical Director talks with the patient there is no higher on-site medical authority. Informants in both of these positions readily recalled addressing patient complaints face-to-face or by phone. I claim the mobilization of this authority has two goals. First, it acts to ostensibly legitimize the patient's complaint. By bypassing the more documentation-heavy, bureaucratic “official” complaint process in favor of face-to-face communication with a manager, a patient may feel his problem is being addressed with sincere concern. However, this first goal supports the second goal of “totalizing” this aspect of the health center. If a patient feels his complaint is being sincerely addressed and redressed to the best of the administration's abilities, and he is intimidated by the use of authority, he will be less likely to continue to be disruptive. He will more quickly feel he has exhausted his channels of redress.

Erving Goffman wrote about such practices in mental institutions (1961), but our community health centers ostensibly share little in common with these in-patient, highly-regulated, and at times oppressive institutions. I do not claim that health centers are “total institutions”; their ambulatory nature alone would prevent this. However, as Goffman has said, “every institution has encompassing tendencies” (1961; 4). “Handling” of patients is one “encompassing tendency” of the health clinics in which I interviewed. The particular tendency in this case is a “barrier to social intercourse” (1961; 4). That is, the staff's goal here is “the control of communication from [patients] to higher staff levels” (1961; 8). By mobilizing the on-site

administration so quickly, the employees wish to keep the complaint within the institution. Goffman calls this type of practice an “obedience test” (1961; 17). By immediately referring patients to a high level of managerial authority, employees engage in a “will-breaking contest” with patients (1961; 17).

Managers I interviewed did not generally give much legitimacy to patient complaints (see *The Language of the Health Center*), and even if managerial informants did discuss a patient complaint as legitimate, they chose to appeal to a culture of limited resources (or lack of medical authority in the case of Directors) in order to claim they were unable to fix the problem. This discourse overpowers both a presentation of autonomy and the innovation and idealism that was originally a part of the community health center program. A selective presentation of impotence is one method to exhaust a patient disruption (break their will).

We could hypothesize that the “innovative” foundations of the health center program could produce responsiveness and understanding of patient complaints by employees, but instead the culture of limited resources causes my informants to try to condition patients against disrupting the order of the health center. As I describe in *The Language of the Health Center*, employees expect patients to learn and adapt to the bureaucracy of the health center with little complaint. Mobilizing authority to condition patients into aligning with institutional processes will increase the day-to-day tranquility of the health center, but it only acts to further distance my informants from the idealism that's often a part of programs that address socio-economic and cultural disparities. “Encompassing tendencies” in institutions traditionally produce alienation between patient and staff, which is antagonistic to the historical goals of the community health center movement. Health centers should try to avoid these “encompassing tendencies”.

I am not criticizing my informants for intentionally silencing legitimate patient complaints. Budgetary inadequacy and administrative uncertainty are actual and significant hindrances to improvement and maintaining institutional order by shows of authority are practical responses to this. A culture of limited resources where employees are happy that the center has merely “gotten what [it] needs to function” and remained open another day is so ingrained that systematic changes are needed beyond individual health centers. Community health centers require more societal and political clout to combat budgetary and administrative limits. One local newspaper wrote an op-ed supporting this (Waxman 2008). The political and media channels that would need to be accessed to address this problem are beyond the scope of

this thesis, however. I am only trying to report that the ultimate outcome of this lack of clout is the “totalizing” phenomenon of “handling” patients.

E. Interactions among the different professions

As I describe in the Literature Review, a concept in medical sociology that has been fruitfully applied to case studies has been how employees both follow and subvert the official chain-of-command in the daily practice of performing their jobs. The actual distribution of authority is often very different from what is described in the bureaucratic code of an organization, and this changing, informal distribution of power is referred to as the “negotiated order” of an institution (Day & Day 1977). The concept of negotiated order has been useful in medical sociology because while the authority and privileges of certain medical professions may be clearly codified, the particularities of different medical institutions (hospitals, clinics, etc.) may redistribute actual medical decision-making and give other employee roles a chance to shape patient care.

An example of this negotiation that has become clear in the literature is the negotiation of power between physicians and nurses. Traditionally nurses are seen as subordinate to physicians, but ethnographic research suggests that nurses are able to “wield considerable influence” over patient care (Allen 1997). Physicians are not actively surrendering decision-making authority, but instead “organizational turbulence” can erode a “rigid division of labor” (Allen 1997). By “organizational turbulence” Allen refers to the fact that the “permanence of nursing relative to medical staff created discontinuities of experience and status” in his case studies (Allen 1997). Nurses spend a longer time in any particular medical institution, and doctors are aware of this knowledge and in practice rely on it “for guidance on details of local protocols and aspects of ward practice as well as the location of materials and equipment” (Allen 1997). In Weberian terms, seniority, then, is not perfectly represented by the bureaucratic chain-of-command, but it is still looked to for authority.

In spite of the fact that nurses may give advice to physicians about the practical aspects of a particular hospital floor, physicians still wield the official authority to make diagnoses and prescribe medical direction. A nurse cannot formally make a diagnosis or prescription; he or she can only follow a doctor's orders. In practice, however, a doctor is willing to approve a nurse's

suggestions or look the other way when he wants to pass a responsibility on to a nurse (Allen 1997). This has been referred to as “boundary-blurring” and case studies found many examples of a nurse blurring conventional boundaries by performing actual medical decision-making that will affect a patient's healthcare trajectory.

The health clinics in which I interviewed present an even more interesting case study for negotiated order than a hospital floor. The heavy use of basic medical skills required for primary and preventative care, in addition to the extensive utilization of the allied health and social work professions, may end up distributing the authority to affect a patient's medical trajectory over many different professions and employee roles. New patients at the health centers will often interact with benefits counselors, social workers, medical assistants and technicians, clerical workers, and even security guards in addition to nurses and physicians. Given the presentation of autonomy that I describe above as prevalent throughout all the different roles in the health centers, we could hypothesize that any given employee could alter a patient's trajectory through the health center. In my interviews with employees, particularly when I interviewed physicians and nurses, I asked open-ended questions to try to gain at least a shallow perspective on how the different professions in the health centers interacted with each other. I asked nurses, for example, what their “relationship” was like with the doctors in their center. Again, refer to Appendix B for more examples of the open-ended questions that I asked.

Many of the important aspects of negotiating an order in an institution, such as the unofficial “boundary-blurring” that might go on, are activities that by their very nature cannot officially be acknowledged. It is better, then, to try to record these activities by participant observation rather than voluntary interviews where informants may not feel comfortable discussing with a stranger the details of how they capture more day-to-day authority for themselves. Aware of this methodological flaw, I also spent my interview time trying to understand the social relations between the professions in addition to professional relations; for example, whether a physician or nurse may become friends, or whether two nurses would become friends for that matter. Informants may be more comfortable discussing these relations. Different roles in medical institutions are often filled by employees from very different socio-economic and cultural backgrounds, and this has been discussed in the literature as a factor that makes certain professions “more comfortable relating to other members of their professional

group than they do with other members of their particular team” (Torrens 1971). Toward this end, I asked my informants if they were friends with other employees, which ones, and how they interacted socially with them, for example, by spending time together outside of work.

Professional interactions

When I asked physicians and nurses what their relationships were like with each other, I would always initially receive positive responses about how doctors and nurses “have a great relationship” (uttered by a physician) and doctors and nurses have close relationships “like a family” (uttered by a nurse). In truth, the interactions are not this simple, and conflicts do arise. My interviews were shallow and this was clearly a sensitive topic for my informants, as indicated by their enthusiastic initial responses, so I am only comfortable presenting anecdotes that hint at certain benefits and struggles in physician-nurse relationships in the health centers.

Physicians officially hold higher medical authority in the health center (as in all medical institutions). They dictate medical orders to nurses, who implement them. As discussed previously, however, in certain environments a physician may allow “boundary-blurring” and give nurses some privileges to make medical care decisions. In my interviews with physicians, it appeared that physicians were aware of their higher authority and supported it. When I asked one physician if he implemented suggestions by other employees, he said that “he [already] knows what works”. He has very rarely taken the advice of employees in lower positions. One physician, in fact, followed up his belief that physicians and nurses “have a great relationship” by saying that “everyone knows their roles”. This indicates that the physician doesn’t actively support boundary-blurring.

Physicians, however, did try to sound respectful of nurses in their interviews with me, and as I previously mentioned, were very positive about their relationships. I believe this is more than an official discourse that is not practiced by the physicians. One physician ensures that nurses and other staff members are always invited to lunch meetings sponsored by outside organizations. He also criticized physicians by saying that their “frustrations” often “get transmitted” on to nurses. Additionally, he complained that some physicians are “more demanding” of nurses than they should be, and ask nurses to perform tasks outside of their official duties. This may suggest that other physicians engage in boundary-blurring, but no

details were provided about what extra duties are performed. Instead, this veteran physician supported a strict division of roles.

The nurses I interviewed also attempted to describe their relationships with physicians. Their responses suggest that relationships with physicians at the health centers are better than those relationships on a hospital floor. Nurses suggested that this was because doctors at the health center are “stable” (whereas in hospitals doctors rotate) and nurses get to know them. By learning the “personalities” and “likes and dislikes” of the physicians, nurses “are not afraid to knock on [the physician’s] door if they do not understand something”. Having nurses confident enough to clarify orders will likely result in fewer mistakes and a less tense environment.

It does not appear, however, that a nurse’s working environment is radically different from a hospital; one nurse described her interactions with physicians as “friendly, short, direct, and clear”. She is able to successfully follow a doctor’s orders without much discussion. And as in a hospital environment, nurses can sometimes be frustrated with a physician’s hubris. One nurse said that she sometimes has to resolve “stupid” doctor-nurse conflicts. For example, some physicians do not like the room that they are assigned to (by a nurse), and complain. Perhaps physicians are uncomfortable with nurses having this authority, but this nurse did not believe that the room choice made much difference, and so was unsympathetic to the physician’s personal preferences. Sometimes physicians also complain about how a nurse has chosen to triage a patient. One informant defended the triage decisions nurses made by saying that nurses make “compassionate” decisions because they hear the whole story from a patient, whereas the physician is more disease-focused in triaging.

It appears as if physicians and nurses hold some respect for each other’s duties, but that there are clear instances where authority must be negotiated (such as in placing physicians in certain rooms or triaging patients). These anecdotes can only suggest certain physician-nurse relationships, and there are likely differences between the discourse used to discuss relationships and the actual practices of employees. Some managers are clearly attempting to implement a cohesive environment, which is discussed in The Language of the Health Center chapter. The language of employees will be influenced by this discourse, but their behavior may not necessarily correspond to this. Only further interviewing and participant observation would be able to conclude what the actual behaviors were for physicians and nurses negotiating authority. In the health center environment physicians and nurses both remain at the health center for a long

period of time; this suggests that physician-nurse relationships may be very different from a hospital setting.

Informants who worked in the dental department presented themselves as isolated from the medical departments in the health center. Informants described themselves as “closed off” and “alone”. They described themselves as rarely interacting with other departments and employees.

Dental informants made a few comments that suggested that there could be some inter-group conflict between the dental and medical departments. Dentists saw themselves as “doing surgery” while medical employees merely “wrote prescriptions”. One informant also expressed dismay that issues important to the dentists were rarely discussed at center-wide meetings.

Overall, my dental informants were consistent in expressing their feeling of isolation from the medical departments of the health center, but this was not explicitly described as negative or antagonistic. Instead, an informant told me that since all the dentists were experienced, they “didn't need direct supervision”. The isolation of the dental department increases autonomy, which we've seen is valued throughout health center employees.

Social interactions

I wanted to know whether employees had close personal relationships, whether they socialized outside of work, and whether employees across professions could have these personal relationships. Close personal relationships could indicate many cultural commonalities between employees, a less-formal work environment, long-time employment and investment, etc. If there are very few close personal relationships between employees, interactions during work could be more bureaucratic and routine. Whether personal relationships tend to occur within certain professions or departments could indicate that either departments or professions tend to share similar cultural backgrounds or perform tasks that facilitate bonding.

When I asked these questions during my interviews, I did not get the impression that employees had many close friendships with each other, in spite of the fact that many employees stay a long time at the health centers (see The Health Center Employee). Employees did consistently indicate that that “everyone gets along well” and “acts professionally” toward each

other. None of my informants chose to describe conflicts between employees that might indicate tensions between employees. Instead, multiple informants indicated that keeping work relationships merely “friendly” was better for “long term survival” and that it's important “to keep a fine line” in order to maintain authority.

One informant contrasted the health center with previous organizations he's worked at. At previous organizations, he said, employees can become “cliquey” and segregate along gender, socio-economic, and professional lines. At the health center he observes friendliness between professions. Most friendships still tend to segregate according to cultural background, and although “the sub-cultures could clash”, they “somehow don't”.

Another informant said that the “friendly” but professional relationships that most employees kept with each other was because “everyone was busy”. There were sanctioned social gatherings at the health center (birthday parties, lunches, barbeques, etc.), but that “there's not a lot of time to get to know people”. This informant did believe that some employees got together outside of work.

F. Contract employees

Some employees are not direct employees of the city (civil servants), but are instead hired by contract and are members of an organization called the Health Federation (HF). I wanted to know if these employees were treated differently or had different experiences from the civil servants at the health center.

I interviewed two employees who were members of the Health Federation and contracted by the city. Their responses about their interactions with the HF were similar. They interact with the HF mainly administratively. That is, the HF provides a transit pass, and is the contact for discussing pay, benefits, and retirement plans. Employees at the health center do no job-related reporting to the HF. The HF doesn't oversee the day-to-day jobs of their employees. As one informant said, he “can't tell he is working for them” and “they rarely step in”.

Additionally, there is a new class of employee called the “patient advocate” that is not hired by the health center directly, but is instead supported through a federal Americorps

program and the Health Federation (<http://www.philadelphiahealthcorps.org/>). There is one patient advocate at every health center, and their job is to contact pharmaceutical companies on behalf of health center patients to request financial support to pay for prescription medications. This may result in discounted or free medications for patients who cannot otherwise afford them. There is only one patient advocate at each health center, and each individual is usually funded for only one year, so they are not ideal informants about health center culture. The one patient advocate I interviewed corroborated the other HF employees' view that the HF does not play an active role in his day-to-day job.

One physician I interviewed split his work hours between civil service and contract. I am not sure how common this is among physicians or other employees, but he indicated that he was able to create this arrangement because he was a long-time employee, and that newer employees may not be able to split their hours. By working as a civil servant for half the time and contracted half the time, he makes more money than if he worked as a civil servant for the full forty hours per week.

G. The Community Board

As I describe in The Literature Review, the involvement of community members and patients in setting health center policies, termed "consumer participation", has been a central philosophical tenet in the founding of the community health center program. The actual involvement of so-called neighborhood health councils was studied shortly after the community health center program began. The methods researchers use to measure consumer participation are to

"attend a meeting of the consumer group; collect copies of minutes of prior meetings; discuss operations of the project with the consumer group, its president or chairman and other members; review lists of group membership and the manner of election or designation of the group"
(Sparer 1970).

I was invited to observe the final monthly meeting of a health center's community board before their summer break, so I took that opportunity to gain an initial understanding of the community board's role in the policy-making of the health center. As previous studies suggest, I

attended a meeting and had brief conversations with the community board members who were present. This process is not replicated or in-depth, but I sought to gain an understanding of whether the community board has resulted “in improved community relations between consumers and institutions purporting to serve them” or whether in practice the community board is “a group calling for control that has nothing to control” (Sparer 1970).

When Sparer (1970) performed a systematic study of consumer participation in health centers, they judged success based on how involved the community board was in policy-making, whether there were strong personalities on the board and in the health centers who were able to particularly exert control, and whether there was conflict between consumers and providers. All three of these criteria come into play in one manager's evaluation of the community board for me: “they think they have a lot of power, but they don't have a say about the way the clinic is run”. This informant is claiming that the community board at this health center doesn't have policy-setting power, that this particular manager is able to set the agenda for the board, and that there are disputes between the board and the employees about the distribution of policy-making power. In the following sections I'll describe my observation of one community board meeting and evaluate its effectiveness with the three criteria established by Sparer.

The community board's policy-making authority

The major topic on the agenda at the meeting I attended was the upcoming addition of co-payments to the health center. The Director informed the board members of how the co-payment system would work (a sliding scale) and when it would begin. She showed the board members a flyer that the health center would post to inform patients of the upcoming change. It did not appear as if the board members had any input about the actual setting of this policy, but they were eager to offer suggestions on how to best inform patients of this change: where to post flyers, how to explain the change, etc. More than policy-setting, the board's task seems to be to facilitate communication between patients and staff. This includes both relaying patient suggestions to the Director and informing patients of new policies.

According to one manager, the main project that is organized by the community board is an annual health fair where outside organizations set up information tables at the health center.

The health fair is funded by the center budget, however, so the fair's practical implementation will be limited by how extensively the government decides to fund it.

Given that the purpose of the community board is mostly limited to feedback of policies that have already been decided and that the meeting agenda is set by the health center management, the actual policy-making power of the board seems to be non-existent, which is corroborated by the managers I interviewed. Community boards in other health centers or other community advisory panels for the Department of Ambulatory Services may be able to offer more input, but this was never indicated by my informants.

The community board's personalities and membership process

To become a member of the community board you must be a patient at the health center. Some attendees were also former employees in addition to being current patients. One member was a retired pharmacist and another described herself as a “health resource specialist” who still worked in this career, but not for the health center. The members I talked to seemed to be veterans of the board; one attendee had been on the community board for 17 years while another had been on the board for five years. There were about five attendees at the meeting I observed, and members said there are usually about 6-10 regular attendees.

I asked the members about the official procedures for running a meeting and electing new members. The members I interviewed were not very confident in describing any official procedures, but indicated that if you were a patient and showed interest, you could participate in the community board without being elected. There were not a limited number of spaces available.

The meeting was informal and disorganized. Although there was an agenda described by the Director overseeing the meeting, members often started tangents about other topics related to the health center, current events, and Philadelphia politics. Given this informality, an assertive member could easily dominate a conversation. Members themselves did not initiate any turn-taking system for speaking, instead relying on the Director to call members back on topic or give someone else a turn to speak. Again, given the lack of formality in the meeting (e.g., there was no explicit list of assignments or actions created) the ultimate outcomes also appeared

personality-dominated, with suggestions only being carried out by those who were self-motivated enough to do so.

This informality is a particularly important aspect of the community board because the members in attendance did not appear to be close friends who collaborated easily. While they had all met before, their relationships did not seem intimate and they often disagreed with each other. My impression was that there might be long-standing antagonism between certain members of the board. One member told me after the meeting that “the meeting doesn't melt together”, possibly referring to these conflicts. Tension between board members probably heightens the provider-consumer conflict I describe below.

Conflict between providers and consumers

The previously-cited quote “they think they have a lot of power, but they don't have a say about the way the clinic is run” is indicative of long-standing conflict between the staff at the health center and the patients. When I asked one member whether the staff and patients had a good relationship, he responded “I don't think we have a good board-staff relationship”.

An anecdote one manager told me about the health fair, which is the main project of the community board, exemplifies the provider-consumer conflict. Due to the financial troubles of the city, the budget for the last health fair was reduced such that the health center could not afford to buy lunch for participants that set up tables at the fair. Since the health center could not afford lunch for participants, one manager wanted to shorten the fair to end by lunch time, instead of going through lunch time and going into the afternoon. Some board members disagreed with this idea and wanted to have the fair continue into the afternoon, as it traditionally did. Members of the community board also offered to help set up tables and be present during the fair to talk with patients about their concerns.

Ultimately the health center staff had the final say in how long the fair would run and they decided to end it by lunch time. They appropriately modified the advertisements to indicate this. The staff told me that on the day of the fair, the health center staff set up the tables with board members absent, even though members had promised to assist. Most board members did not show up until the afternoon, after the fair had ended. They expressed frustration because they had believed the fair would continue in the afternoon as they wished. The health center staff

expressed frustration because they felt the community board had not participated to the extent they had promised. Some of these frustrations appeared to still be present in the community board and staff as I witnessed discussions about the fair during the meeting.

Initial conclusions

Sparer *et al* drew a number of conclusions from their study. I made my observations independent of their previous research, but the conclusions drawn from their study are applicable to my observations. They suggested that

“consumer groups function better when they are better organized. Adequate elections and bylaws are key factors in organizing the consumer group” (Sparer 1970).

The disorganization of the community board meeting I observed and members' lack of knowledge about official procedures probably contributed to its only nominal role in providing input to the health center. Sparer also concluded that

“strong leadership by a member of the group is important, but consumer group orientation on the part of project staff is also helpful and sometimes may substitute for group leadership” (1970).

No member of the community board exhibited a leadership role in the meeting I attended. The Director instead had clear leadership of the meeting, but previously discussed staff-board antagonisms should suggest that a staff member leading the meeting is not effective for allowing consumer feedback. Sparer supported this by concluding that “a strong staff personality has a major input on enhancing or limiting group involvement” (1970).

To reiterate, my conclusions are shallow. I only attended a single meeting of a single community board, and other boards and meetings may function differently. But consumer participation is one of the loftier goals of the community health center program, and the community board in the scenario I observed is clearly not a vehicle for significant patient feedback. There may be other ways in which patients provide feedback to staff members, but I was not told about any other formal mechanisms besides the community board.

As The Language of the Health Center chapter of this thesis discusses, staff members' culture and language exhibit consistent modes of interpreting patient behavior. These modes of

interpreting could possibly be affected by the extent of patient feedback and might also limit staff receptiveness to feedback if they are strongly held assumptions by staff who speak in this discourse.

H. Conclusion: A Crisis Bureaucracy

Although the health centers have a codified bureaucracy, the ubiquitous presentation of autonomy I found in employees was surprising because it seemed to undermine this bureaucracy. My informants did reference times when the bureaucracy would be utilized. Bureaucracy was utilized mainly during serious or politically-sensitive situations. When firing an employee, dealing with a major structural or safety problem (e.g., mercury leaks), or attempting to quickly address (and silence) a patient complaint, the bureaucracy would assert itself. In these situations bureaucracies provide a clear hierarchy of authority to prevent confusion. Bureaucracy also may create more confidence in an organization's soundness by outside observers, who may be present during a politically-sensitive situation.

I hypothesize that these **crises bureaucracies** are common in many institutions, particularly in those that are under-funded or not politically salient. Maintaining strict compliance with official procedures requires a large amount of labor and financial resources. In under-funded institutions, this oversight may not be feasible.

What I don't believe is as common, however, is such an open assertion of autonomy by all levels of employee. One of the primary benefits of a bureaucracy is that powers are delineated, so responsibilities for each employee are limited and predictable. It is not obvious why employees in the health center would be so eager to claim that their institution works so differently. Bureaucracies offer an excuse: one can easily claim a task or problem is outside of his delineated duties. If employees are claiming to have great flexibility and power in their decision-making, they could perhaps be held more responsible by patients and supervisors. This is one possible reason why the bureaucracy asserts itself in the face of patient complaints; employees can avoid the responsibility of handling attention-seeking patients and the possible mistakes that may have brought these complaints about.

One hypothesis is that the feeling of autonomy in employees is simply a benefit of working in the health center, and it has proven useful for recruiting to advertise this autonomy

openly. A second hypothesis is that presentation of autonomy in spite of the existence of a bureaucracy may be a phenomenon specific to the health centers and employees I interviewed. Managers supported this feeling of autonomy in their employees, and we could hypothesize that if managers support this feeling, employees will be more willing to express it. In other environments where managers do not openly admit to employee autonomy and present themselves as powerful micro-managers, staff informants might be less likely to openly admit it to an outsider such as myself.

These two hypotheses can be considered more closely by using the information I present in the rest of this thesis. How employees see the benefits and difficulties of working in the health center is the subject of the next chapter. The discourses that managers and other employees use is the subject of The Language of the Health Center chapter.

Chapter 4: The Health Center Employee

A. Why Demography: Implications for Politics and Healthcare

This chapter provides an initial demography of the employees I interviewed. I will describe their career trajectories; what they perceive the benefits and difficulties of employment to be; their national, racial, religious, geographic, and socio-economic makeup.

As I describe in The Literature Review, the United States has only sporadically embraced socialized healthcare policy. These community health centers are one example of this tentative embrace; they are, as one informant described them, “an island of socialized medicine”. As I write this thesis, congress is debating a healthcare reform bill that moves US policy closer to a socialized model (New York Times, “Checkpoint” 2009). Understanding the characteristics of the employees who choose to work in a socialized center, and the incentives and disincentives the center provides for these employees, will allow insight for how the US should proceed with the socialization of its healthcare system. While we should turn to other countries for examples, these health centers provide the advantage of already existing within the American context.

The clinical practice of medicine is influenced by the demographics and culture of both patient and provider. Particularly in the context of a community health center, which serves many immigrants, the demographics of health center employees will provide both barriers and advantages to providing good care. But even more important than the self-identities of the employees is how they approach the cultural and demographic diversity of patients. In this chapter I ask whether this diversity is salient in the minds of my informants and what their particular methodologies are for approaching cultural and linguistic barriers. Successful healthcare requires navigating these cultural and linguistic barriers, and I hope this chapter will encourage self-reflection by health center employees about how to best overcome these difficulties.

The purpose of this chapter is not to provide a statistically accurate demography (structured interviews should be performed for that), but to present demographic trends, hypothesize why these trends exist, and most importantly, to describe which demographic characteristics were most relevant to my informants' lives. Although the culture of the health

center (linguistically and institutionally) will in many ways be separated from the diverse backgrounds of its employees, the culture and experiences employees bring in will still play a role in how the language and structure of the health center is performed (and thus created and changed) on a daily basis.

B. Methods

I purposely kept my interview format unstructured because I wanted to allow informants to feel like they could discuss what was relevant to them. If I asked too many explicit questions about their self-identity (e.g., “What ethnicity and religion do you consider yourself?”), I believed that I ran the risk of alienating my informants by making them feel as if I were identifying them solely by these demographics. Instead, through the broader questions I asked (again, see Appendix B for sample questions) these demographics would sometimes be considered relevant by my informants. In these cases informants would volunteer such information. Additionally, some demographics have an observable component, and I could make guesses as to my informants' gender, race, religion, nationality, etc. based on their appearance, office décor, and linguistic cues such as accent and vocabulary. These observations are unreliable. Proper demography should not be done in this way. In recognition of that, when I describe various demographics, I present a combination of observation and self-identity and I make clear which is the case for each demographic.

As I will describe later in the chapter, traditional self-identifying characteristics were not particularly relevant to my informants when I asked broad questions, so my demography is limited by this. Additionally, the “snowball sampling” method of my research may have biased the demographics if informants would suggest other informants who shared a similar self-identification.

C. Employee Trajectories

None of the employees I interviewed had talked about community health as a long-time career goal. A variety of motivations brought them to the health center. I discuss such incentives later. Given the fact that most of my informants were medical workers, most came from hospitals

and ambulatory care settings, such as private medical and dental clinics. Employees in non-medical positions, such as social workers and benefits counselors, came from other social work settings or from non-medical administrative jobs in other government departments. One of my informants suggested that clerical and custodial staff applied for a job with the government and were placed in the health centers. I did not interview these employees, since it did not appear as if they chose to work specifically in the health centers.

Some of my informants had already been employed for the city when they came to the health center. One employee described his transfer as a “horizontal move” from a non-medical government agency to the health center. His duties were similar in both jobs. Other employees came to the health center because their new job constituted a promotion.

Of the employees who hadn't worked for the government before, many had been laid off from their previous jobs or were not receiving enough hours. One manager confirmed that many of her employees had been laid off from hospitals and private clinics.

A good number of my informants had studied nursing or medicine outside of the United States. About one third of my informants had spent a much of their careers at the health center – at least ten years. Some informants had spent essentially their entire career at the health center, coming to work immediately after completing their residency or degree. My other informants had begun working at the health centers within the last few years. I attempted not to interview brand-new employees, since they would not be as familiar with the health center culture.

Awareness of the health centers among medical professionals seems to be low. Multiple informants said that a friend had recommended the job to them, and they hadn't been specifically looking to work for the city government. A few informants had seen the job advertised in a newspaper. Some local medical students do short rotations at the health centers, which may raise awareness and provide recruits.

We can see that there is no one trajectory for health center employees. Many were dissatisfied with their previous jobs, others were laid off and the health center was hiring at that time. Some employees said that they were bored with their old job and wanted a change of pace. A couple of employees said that working in the health centers seemed meaningful and helpful, but this was an uncommon statement among my informants. Most of my medical informants said that they had been looking for an ambulatory care position. They had either never been interested in inpatient care or had disliked working in hospitals in the past.

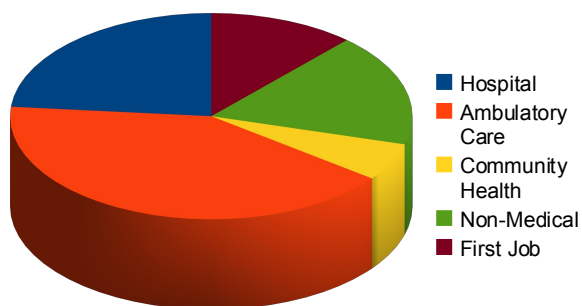


Figure 2. *Where employees worked before joining the health center.* Many employees worked in ambulatory care before joining the health center. Private practices and nursing services were particularly popular. However, some employees had previously worked in community health or had spent essentially their entire career employed by the health centers. Most employees who were engaged in non-medical jobs came from non-medical backgrounds and did not necessarily intend to have a medically-related career.

One informant has not been included. This employee is a one-year intern who applied to the national Americorps program and was placed in the health center.

D. Demographics

Demographics and employment stability

It is worthwhile to look at some demographic trends in my informants since this may influence their motivations for working in the health centers and how long they stay. One early study looked at this correlation through more quantitative methods. Tilson (1973) found a disproportionate number of African Americans and women working for the health centers. He also found that employees were more likely to stay employed if they had a high salary, were over fifty years-old, specialized in a particular branch of medicine, and worked full-time for the health centers.

Tilson (1973) hypothesized that younger physicians were not interested in working in the health centers for their entire career, but instead “use it as a spring-board to something better”. Older physicians were more likely to stay until retirement – their careers were “winding down”. My informants supported this view of why older physicians and nurses joined the health centers, though given the fact that some of my informants had spent their entire career at the health centers, there may, in fact, be “stayers” (as Tilson calls them) among the younger workers.

Nationality

About one-third of my informants grew up or were trained outside of the United States. Among immigrants, the most came from India, and other countries of origin included Italy and the Philippines. We could hypothesize many reasons why immigrants would be more likely to come to the health centers. Perhaps the health centers functioned like medical centers in their home countries. The health centers may recruit immigrants. Immigrants may also be more inclined toward the incentives I discuss below. I also think that immigrants are more open to culturally- and linguistically-challenging environments, so this does not become a major disincentive.

Gender

About three-quarters of my informants were female. This statistic is likely skewed by the number of nurses I interviewed (where females are disproportionately represented), but I also interviewed female informants who were managers, physicians, dentists, and benefits counselors. A manager and physician I interviewed both supported the idea that females were drawn to the clinic. Having stable work hours and maternity leave would support raising children. Some of my female informants were in high positions in the chain-of-command (Director, Clinical Director, HCC). Perhaps it has historically been easier for women to gain prestigious positions in the health centers than in private hospitals and practices. I have no direct evidence to support this hypothesis, but I think it is worth further study.

Ethnicity and race

Among native-born informants many were African American and Asian American. In the two health centers in which I interviewed, African and Asian immigrants, African Americans, and Asian Americans constituted a high proportion of the patients. These demographic aspects were almost never mentioned by my informants. One informant referenced the fact that he was black once, but did not spend much time on the thought. Most of my native-born informants made no reference to their race or ethnicity, so I can conclude these weren't conscious motivators for coming to work at the clinics. My identity as a white man may also have influenced this discussion.

Geographic and socio-economic identification

One early study of the health centers proposed that “the staff for the center is usually recruited from the resident population of the area to be served” (Torrens 1971). This was an assertion without much evidence at the time. At the health centers in which I interviewed, you had to live in the city of Philadelphia to be employed, so all employees were local in this way. As I mentioned before, many employees immigrated to the United States, so were not

geographically local. Some of my informants lived in very distant parts of the city and had a long commute to the health center.

Two informants referenced having grown up in the neighborhood that they were now serving in. One of these informants had even come to the health center as a child. These were indeed motivations for working in the clinic.

Socio-economic identification did not seem to be a major motivator either. Most employees did not reference any socio-economic solidarity with the patients, though one employee said that the possible union strike made her aware that she was only “one paycheck away from the patients”.

Religion

Given the fact that many people view the health centers as a charitable service that performs morally-upstanding work, a religious person might be motivated to join the health centers. Most informants did not make much reference to their religion and some specifically denied that they were working at the health centers for moral or charitable reasons. A couple informants referenced their Christianity and their belief that working at the health centers was part of a religious obligation to help others.

One informant made a specific reference to shared religious identity with her patients. This informant was a muslim and was able to recall instances where she and patients exchanged religiously-based greetings. She believed that some patients found this religious identification helpful.

Understanding the patient's demographics

As I describe above, there appear to be some demographic similarities between patients and employees. Most patients are immigrants or racial minorities and so were most of my informants. Some employees shared a religion with patients. These identifications could have been a motivation for joining the health center or been a significant part of an employee's day-to-day job. However, this does not appear to be the case. When I asked informants whether it was

difficult to work with patients from diverse demographics, they mainly made reference to language barriers and the need for translators. A few informants referenced “culture shock” and needing to change the way they spoke to patients in order to be more sensitive to cultural differences, but even when I prompted employees to discuss these difficulties, it did not appear as if informants considered either demographic identification or lack of identification to be major components of their day-to-day jobs. Most informants expressed confidence that they could easily overcome these differences.

Social Science often focuses on cultural and demographic differences in its studies. Given this analytic lens, is hard for me to believe that such cultural and demographic differences were inconsequential. On the surface, it seems to me that an older African American nurse treating a Southeast Asian immigrant who does not speak any English would face some cultural and linguistic barriers. This example pairing is very common at the health centers. Such cultural interactions are certainly worth further study. However, it is not fair for us to dismiss outright what my informants told me. It is clear that they consider these barriers to be minor and surmountable. While informants made occasional reference to respecting cultural differences, the practical barriers, such as an inability to speak a common language, were more salient to them. I think these data further support the idea that informants came to the health centers for a variety of “practical” reasons, rather than with the goal of performing charitable services.

Demographic	Common Identification
Immigration Status	About 2/3 native born and 1/3 immigrant (the most common country-of-origin was India)
Ethnicity if Native-Born	About 1/2 African American, 1/3 white (non-hispanic), and the rest were Asian American
Gender	About 3/4 female

Table 1. *Demographic trends in health center employees.* My informants included a large number of immigrants, particularly from India. Of the native-born employees, most were not white. Additionally, most of my informants were female. Studies early on in the health center program supported the finding that many racial minorities and females would join the health center (Tilson 1973). These demographics may be related to trajectories and motivations for working in the health centers, but this type of correlation should be made with caution. I am only

providing this data to give readers a general impression of my informants' demographics, not to present an accurate census.

E. Institutional Incentives and Disincentives

Benefits and salary

The benefits (health insurance, retirement plans, etc.) were considered a significant incentive for working at the health centers. This may relate to the fact that many employees are older. While the salaries at the health centers are often much lower for medical professionals than working in a private practice or hospital (one informant said her salary at the health center was half of what she used to make), informants suggested that the benefits outweigh such reductions in salary, and become more important as they get older.

Schedules

Having business work hours of 9am-5pm on weekdays was a strong incentive for working in the health centers. Many medical professionals came from ambulatory and hospital settings where shifts were longer and occurred during nights and weekends. Working during normal business hours produces less fatigue and allows better scheduling of an employee's other activities. Additionally informants referenced this schedule as beneficial for raising children. These hours align well with when children are at school, and allow parents and children to spend more time together.

Technical ease and emotional energy

Working in private clinics and hospitals can be taxing for medical and non-medical staff alike. Nurses, physicians, dentists, and benefits counselors all believed that fewer technical skills were required for their jobs in the health center. Although some specialized training is needed, for example in pediatrics if the employee hadn't worked in this speciality before, the ambulatory nature of the clinic and the limited services it provides make the job easier. Working in the health center is also easier because less of a professional demeanor is needed. One informant said that in the health center she “can be herself”. Since the patients are not paying customers, informants seemed to indicate that there has traditionally been less of a focus on a “customer is

always right” mentality. One informant contrasted serving “doctors and lawyers” in a private dental practice with serving patients in the health center. Although this informant said that she treats all patients with respect, there was less pressure to sell extra services and finish procedures quickly.

Torrens (1971) claimed that there were “great psychologic pressures” when working at a community health center, and my interviews seem to contradict this statement. Although linguistic and cultural barriers are present, technical and emotional ease outweigh these difficulties. When I specifically asked about burn out, informants admitted that it occurred, but most managers tried to prevent it and claimed that it wasn't a major reason for staff leaving.

Job security, prestige, and autonomy

Torrens (1971) also claimed that it is “difficult to guarantee professional job candidates that their jobs are secure for several years”. Managers told me it was difficult to fire employees. Not only was there a lot of bureaucracy for it, but periodic evaluations were not threatening or stressful for most staff. During my interviews the city was facing a budget crisis that might cause many employees to lose their jobs, but it seemed to me that this was caused by the economic difficulties facing the entire nation, and was in no way specific to Philadelphia or the community health centers.

There is likely a loss of prestige by working at the health centers. The employees that chose to work at the centers did not seem to mind, but admitted that the job was not “glamorous”. This lack of prestige was more pronounced for physicians. One physician told me that his friends did not particularly respect his working at the health center, but he enjoyed the job none the less and had stayed for many years. I did not get the impression that nurses, dentists, and non-medical staff found the job less prestigious. Prestige was not an explicit incentive or disincentive for my informants. In fact, with prestige can come pressure and subordination, which can be disincentives for some. The high level of autonomy for all employees at the health center probably contributes to the reduction in stress.

F. Conclusion: The health centers are not a “charity case”

My informants made it very clear to me that they were not working at the health center because it was morally righteous. Occasionally this was referenced as a secondary motivator, but most employees explicitly denied any charitable motivations for working in the clinics. Employees also almost never referenced any cultural or demographic identification with patients. Instead, employees told me that the benefits, hours, technical ease, and job security were the main incentives for staying at the clinics.

If the United States is going to expand its offering of socialized medical services, these effective incentives should be taken into account. Both medical and non-medical employees want to escape the stress of hospitals and private clinics, and a primary care clinic can provide such an escape through better hours and technical ease. Of course, economic considerations are also important to my informants, and we should use salary and benefits as incentives as well. Essentially, if the United States wants to create a stable network of primary care clinics, it should pay its employees well, provide good benefits, ensure manageable hours and technical tasks, and allow employees to feel their jobs are autonomous, prestigious, and secure. These incentives are sometimes difficult and expensive to put into place, but it is likely going to be required if socialized medicine can be a viable component of the American healthcare system. What is clear is that with these incentives in place, there should be plenty of professionals willing to work in the health centers.

Chapter 5: The Language of the Health Center: Adjectives, Idioms, and Discourses about the Patient

A. Goals

The goal of this research is to examine broader sociological questions about the culture of these health centers and their employees. I asked informants questions pertaining to the codified rules and bureaucracy of the health centers, how employees felt about the politics of American healthcare, their memorable experiences and feelings, how employees self-identified culturally, and how they interpreted the cultures of their patients. Through many of these topics I sought to learn about the lives that the employees held outside of their work and how their decision to become involved in community health was one part of their life story. But many of my informants had spent decades working in the health centers; some informants had been employed by the health centers for essentially their entire medical careers. Given the amount of time spent in this work environment, a long-time employee will become proficient in a health-center specific culture in addition to the cultures they participate in through other venues in their lives. I have described the various trajectories that may bring an employee to these health centers, and this background is never lost, but work is a powerful influence that given enough time will create a shared code of communication (a speech community) and ritual that in some ways will reflect the values and experiences of its participants.

It is with these assumptions in mind that I will examine some linguistic phenomena that I hypothesize reflect certain values and conflicts in the culture of these health centers. I am providing this explanation in order to be humble in my analysis, because language is a murky representation of thought and tradition, but also to defend my interpretation of a health center culture, or speech community, that is detached from the backgrounds of the employees and homogenous among a diverse group of employees. This culture is not codified formally and not acknowledged as a traditional aspect of an informant's culture in the way that race, religion, or profession might be used for self-identification, but it is codified within the minds of my informants and can be accessed to some extent through their unself-conscious use of language.

In this sense, I am still adhering to the dangerous sociolinguistic myth that “language reflects society” (Cameron 1990). Irvine and Gal (2000) warn that this myth about an obvious connection between language and social structure produces harmful ideological fallacies. In their footsteps, my analysis tries to avoid “iconization” (Irvine and Gal 2000), which means assuming that some linguistic or sociological property of a group represents something inherent or necessary about their nature, and is not merely arbitrary or incidental. I equally try to avoid “fractal recursivity” and “erasure” of my sociolinguistic data (Irvine and Gal 2000), which would mean that I unfairly extrapolate one pattern onto an unrelated linguistic or social pattern and ignore variation within the community I'm studying. More succinctly, I am trying to be respectful of the nuance and variation in my data while not ignoring the importance of any “structured variability” that may provide sociological clues (Cameron 1990).

B. Methods

I had not conducted most of my research with the priority of learning about employees' conceptions of patients. I had primarily been interested in their conceptions of the centers themselves and the government that ran them. But medical workers will inevitably talk about their patients, and when they do, they end up unconsciously expressing a particular method of interpreting a patient's behaviors and motivations (which I'll call a **discourse**). When a number of employees talk about patients using the same adjectives, idioms, and modes of interpreting, it is clear these conceptions of the health center patients are not just formed from an employee's formal medical training and personal experiences but also from a form of socialization in the health center (sometimes consciously but usually unconsciously) that normalizes certain ways of speaking about patients. It is not enough, however, for us to merely “correlate” certain linguistic data with a certain social group (in this case community health workers). This correlation proves nothing sociologically. Introducing “*ad hoc* social theories” to explain this correlation is also no better (Cameron 1990).

Most of the quotes I cite were not uttered specifically as answers to the questions I asked, but as unmarked elements in the answer the informant was trying to craft. When I would follow up on interesting comments and ask for an informant's opinions about patients, the informant usually switched codes toward the way of speaking that had been formalized by the health center

management, the city government, and professional training. Expectations about speaking to patients or customers is a ubiquitous part of formal medical and corporate training, so employees will have a variety of encouraged linguistic routines available and can with probably with little effort repeat these performances if I specifically request it. It is important not to oversimplify the relationship between the beliefs of my informants, their actions, and their utterances, and I do not superficially claim that rote-learned sanctioned response (a **customer-service discourse**) either is or is not a factor in healthcare workers' beliefs about patients. We need to additionally take into account how language expectations are transferred through a culture and the social psychology that governs many group interactions. In the words of Dell Hymes (1986), I will look at “what is possible, what universal, what rare, and what linked” in the way health center employees talk about patients. With these patterns, and the sociological observations I have made previously in this thesis, we can then begin to evaluate how employees expect patients to behave and how that might influence the care they provide.

One significant assumption I am making is to assume that the register spoken to me is the same register my informants would speak to fellow employees (of the same level in the chain-of-command). This is of course not true. My being a young, nosey outsider surely has an influence on the register spoken by informants. I am assuming that because informants identified me as a future medical worker that the register they addressed me with would be more similar to a used with fellow employees than to a register informants would use with patients. In actuality, of course, this will be a unique third register, but I have hoped that my status as “future medical professional” has inadvertently allowed me some of the advantages of participant-observation.

Notation

In this chapter of the thesis, when I present a word or phrase in quotes, I am indicating that a specific speaker uttered this quote in a single instance (though I may not identify the exact speaker for confidentiality purposes).

When I use a word or phrase in italics, I am discussing the broader use of that word or phrase by my informants, taking into account the many times they uttered it and synthesizing an interpretation.

When I use a word or phrase in bold, I am indicating that I am coining a term for a particular phenomenon or using an already-established term in a way that might not be identical to previous use in the literature. I will only bold the term when first defining it.

In this way it should be clear when I am reiterating the exact words of my informants and when I am providing my own paraphrasing of the data.

C. Modifying patients

The initial data that prompted me to examine more closely how informants spoke about patients were which adjectives they used to modify the noun *patient*. Most of the time informants used the noun *patient* with only a determiner. Sometimes an informant would use an adjective in speech that I could find in many official written materials from the health center. For example, a patient may be *undocumented*, which means he does not have fully legal residency in the United States. Other adjectives may come from a medical discourse, such as when a patient is described as *compliant* or *noncompliant*, meaning he either did or did not follow the instructions given by a physician. I'll consider these to be neutral adjectives that don't reflect a health-center specific speech community, though they are certainly part of the overall language of a health center.

Use of an adjective with *patient* was frequently prompted by one type of patient. I will examine more closely the behaviors that cluster together into this type and how informants chose to interpret these behaviors through their discourse. I will call the type **the attention-seeking patient**, since this is my own modifier that was not used by informants. However, discussing this patient type is not unique to my informants. In Goffman's famous studies on mental health institutions (1961) he recorded employees talking about a “persevering, nagging” type of patient that employees sometimes referred to as “worry warts, nuisances, and bird dogs” (9). While the labeling of these patients with particular adjectives is not entirely arbitrary and unimportant, the fact that these previous studies and my study all refer to a similar patient type probably indicates deep interpretational and experiential similarities between healthcare workers in different communities.

The adjectives I recorded in my notes that informants used to describe the attention-seeking patient are: *aggressive*, *angry*, *disgruntled*, *unruly*, *unhappy*, *demanding*, and *dissatisfied* (or *unsatisfied*). I recorded multiple utterances of these adjectives from different employees. The

context of these adjectives is usually to describe a problem that a patient brought to the attention of the employee, who then addressed the problem in some respect. But the experiences are usually recalled as a hypothetical patient type rather than a description of a specific instance. For example, one informant described the path a hypothetical *unsatisfied patient* would take through the health center chain-of-command if he continually remained unsatisfied. This supports my assertion that informants are attaching these personalities or behaviors to at least a segment of the patient population rather than describing idiosyncratic patients.

The connotation with these modifiers is almost always negative to some degree. For example, one manager said that he “does not tolerate aggressive behavior” in a patient. My first impression upon unexpectedly hearing these modifiers used frequently was that any attention-seeking behavior was considered unjustified by my informants. One physician said that some *unruly patients* are “on the warpath before you even start”. This physician is claiming that he has not even had the chance to make a mistake and that a patient's behavior is not due to any culpability by the physician himself.

Informants rarely separated behaviors from a rationale for a behavior when they described patients. Because of this I claim that the culture of the health center tends to homogenize behaviors around a few specific interpretations of why patients had these behaviors. Throughout my interviews it was clear that **a discourse about responsibility** was prevalent in the language of my informants. Sometimes explicitly, but usually implicitly, an informant would address his and the patient's responsibility for a patient's medical condition and attention-seeking behavior. The next section will discuss this phenomenon in more detail.

D. Discourses of responsibility

A fixture of both the philosophy and practice of medicine has been deciding the extent of a patient's accountability for his own illness. On moral and political grounds we question whether society should use its resources to treat an illness that a patient is culpable for. In the medical realm physicians and public health professionals debate the extent that so-called lifestyle diseases are actually due to the choices of a patient rather than to, say, a genetic predisposition or certain incentives and disincentives within a culture. These are frequently termed “determinants of health” (WHO 2009). It is no surprise that both this philosophical and medical debate could be

present in the community health centers in which I interviewed. These centers were (at the time of my interviews) no-cost clinics that were funded by taxes and spend a significant portion of their resources treating lifestyle or preventable diseases.

But while it is no surprise that these questions are raised at the political level when it comes time to fund the health centers, it is not obvious what role that these questions of accountability play in the daily practice of medicine at the centers. During my interviews informants would sometimes explicitly address these questions in explaining their jobs. When I asked a social worker to tell me what he thought about his profession, he responded that social work was “interesting in a capitalist society” because he felt that American culture valued “pulling yourself up by your bootstraps” and being “self-sufficient”. Social work in his mind was about the government taking an active role to improve people's lives, which may run the risk of certain people “leeching off society” or being undeserving of its resources. The informant admitted that in his personal work in the health centers he “struggles with how much to hold individuals responsible”. During this particular interview, the informant downplayed a patient's own culpability, admitting that “not everyone has equal opportunities” and that “people losing their jobs” and “the healthcare crisis” are “beyond their control”. In the face of these struggles, most patients still “work hard and play by the rules”.

The views this social worker expressed might be termed the **liberal view about patient responsibility**. The liberal view holds that these patients lack advantages such as an education, money, and literacy. A safety net, such as the community health clinic, is an important service that the patients deserve since they've been disadvantaged by society from birth. Opposing the liberal view is what we could call the **conservative view about patient responsibility**. The conservative view believes that a certain amount of initiative is required on the part of the patient. It is as much the responsibility of the patient to raise himself up as it is the employee's job to help him. This view also tends to hold patients somewhat accountable for their lower socio-economic position. One informant expressed this view during an interview. She said that she sometimes “questioned a patient's priorities”. She will treat a patient who cannot afford care at a private facility, but who has “nice cars and tattoos”. The implication is that money spent to acquire these things could have been spent on medical care instead. The informant also suggested that since many of her patients are unemployed in addition to lacking health insurance, they can “exploit the social welfare system”.

The discussions by these two informants are examples of employees of the clinic specifically addressing a patient's responsibility. Oblique reference to patient responsibility, however, is much more prevalent. The liberal/conservative dichotomy is a schematized political construction that does not reflect the nuance of this conflict within the psychology and of an individual and within his culture. In the clinic an employee can choose with each patient and each task to exert more or less effort, and a patient's culpability and an employee's empathy toward a patient will affect this economy of energy.

Therefore, a more realistic method of understanding how an employee's position toward patient responsibility is affected by utterance context and health center culture is to analyze oblique reference that is embedded within the linguistic constructions of my informants. These constructions will be formed in part by active choice of one construction over another, and in these cases we can seek to learn a speaker's intentions and what options were available to him. But utterances will also be shaped by the less-active perpetuation of conventional linguistic constructions through a culture (what we could call **idiomatic expressions**). As Cameron (1990) has pointed out, however, "what determines the expressive resources available" and "who or what produces 'the conventions'" are hard and non-obvious questions. Cameron's proposal is to look at the "actual, concrete practices" that shape a speaker's linguistic options and idiomatic expressions. For this goal I will refer to not only what I've learned about medical socialization in general, but also the particular socialization processes and socially approved ways of speaking in the health centers.

In essence, there is a conflation between cognitive language acquisition and performance and an informant's beliefs and psychology. This combination can be exemplified by an interview I had with a long-time physician at the health center. This physician did not explicitly address the liberal/conservative debate about patient responsibility, instead choosing to speak more about the day-to-day aspects of his job at the health center and providing anecdotes about individual patients. Toward the end of the interview I asked the physician if he believed his patients were satisfied with the care they received. Once again, discussion of hypothetical patients prompted the utilization of a discourse explaining patient behavior that was unmarked to my informant. The physician said that he was particularly happy to provide services to children because they are "innocent". A child, then, is more deserving of care because of this innocence, and thus more personally satisfying to the physician. Implicit in this construction is a conceptual hierarchy of

culpability. *Innocence* is the state of being least-culpable. A child's being inherently more innocent than an adult for his illness necessarily references some concept of patient responsibility. A child might be more innocent because a parent makes many of his choices for him, because he is too young to have made many mistakes, or because he was born into a certain socio-economic position, as the liberal view holds. I cannot be sure what my informant had in mind when he called the children he treated *innocent*. His use of the modifier was not an independent answer to my question, but it came to mind as one part of his answer about patient satisfaction. His word choice in these instances will also be affected by the cognitive psychology of language; that is, frequent cultural references to *innocence* when discussing children that are present in English. The conceptual connection of a child with *innocence* reflects many different aspects of our culture, and the physician will also have these concepts in mind in addition to any concepts he might have specifically about patient responsibility.

It would be an unfair oversimplification of language use to place this physician on the liberal/conservative scale simply because of this single linguistic datum. But it is not unfair to try to understand his discourse about patient responsibility if we take into account the rest of his interview and the interviews of his co-workers in order to understand his personal psychology and cultural milieu. With this background and a careful look at the particular context for each utterance, we can begin to understand interpretational and stylistic norms in addition to belief and intention.

This informant also said that some of his patients are “inner-city kids” who “already have a 'character'” that makes them difficult to treat. The idiom *Having a character* indicates some idiosyncrasy in an individual (in this case a negative idiosyncrasy) but it is a purposely vague construction that doesn't specify any specific character traits. My informant's use of this construction here is a more direct connecting of his personal experiences with patients to a concept of patient responsibility. When we reference people from the *inner-city*, we indicate that they have a certain socio-economic status and live in a certain harmful environment. Here my informant is implying that this environment and socio-economic status are having a negative influence on the “character” of his pediatric patients, slowly turning them into the attention-seeking patient type. This causative implication supports a liberal concept of patient responsibility in the physician.

This method of linguistic analysis not only lets us glean the linguistic concepts within an individual informant, but by looking at linguistic patterns across my informants we can begin to understand how the health center environment has influenced the nature of these concepts within the health center culture. Particularly fruitful for this goal is analysis of idiomatic expressions. These are phrases that are standardized in a culture and are available with little cognitive effort to members of this culture for utterance. Their meanings are understood by their speakers, but their frequency of use implies a different type of understanding, with implicit cultural assumptions probably playing a greater role than in non-idiomatic phrases.

One frequent idiomatic expression by informants was the describing of their health center as a *last chance* for care; that is, if the patient cannot receive care at the health center, he will receive no care at all. This idiom was expressed as “where else can [a patient] go?” , “if we're not here, the patients will get no care at all”, and “the patients have no other place to go” (all uttered by different informants). The ubiquity of these utterances indicates this is a cultural conception at the health center rather than just a belief by an individual informant.

The **last chance culture** of the health center may be one component of the discourse about patient responsibility. It implies some responsibility on the part of the health center and society to provide care for the patients. Uttering a *last chance* phrase indicates that it would be morally wrong if the health center's clients did not receive care. This is at least a partial abdication of a patient's responsibilities to ensure his own health.

So in the case of a *last chance* utterance we can say that the informants are implying that a patient *deserves* care. The cultural discourse at the health center about a patient's deserving care is the subject of the next section.

E. Discourses of entitlement

Related to the discourse about a patient's responsibility is a discourse about the responsibility of society, health centers, and community health workers like my informants to provide care. If the responsibility for a patient's health lies outside of the patient, I will term this **patient entitlement**. A discourse of patient responsibility is one mode of interpreting a patient's behaviors, and through this discourse certain actions and beliefs will be more or less justified. A discourse of patient entitlement (rather than patient responsibility) provides a different mode of

interpreting behavior and yields different possible actions and beliefs for community health providers. It is for this reason that we should understand the discourse being used to interpret a patient's behavior and responsibility.

Western medical discourse supports an entitlement discourse

As mentioned in the previous section, a *last chance* utterance falls under the discourse of patient entitlement. Informants utter this idiom in order to justify the necessity of the health center. It may seem unmarked to an informant that this justifies the existence of the health center, but it is not an *a priori* justification for public health. Instead, this idiom relies on culturally contingent assumptions about the causes of illness. Historically health has been associated with morality, and thus patients became ill because of sinful behavior (Duffy 1991; 99). Depending on the specific moral and religious discourses present in a society, public health may not be justified. If a medical language appeals to miasmatic or germ theories of disease, where certain disease-causing particles can be spread between people, public health measures would be thought to prevent disease. When an informant describes patients as *underserved* or *unfortunate*, he is using a discourse of entitlement that reflects assumptions about how socio-economic inequality and bad luck may cause illness. In these cases, the patient is not entirely responsible for his own condition, as he would be under a moral-religious discourse. Discourses about the causes of disease, then, will affect the responsibility/entitlement and conservative/liberal discourses because whether individual behavior or socio-economic and environmental factors are more influential depends on the causes of disease.

One idiomatic expression supported patient entitlement. Informants would sometimes speak about treating patients like *human beings*. One manager, for example, talked about how certain procedures were discontinued because they “dehumanized” patients. This noun phrase is meant to emphasize the commonality between all people, and thus justify equal entitlement to healthcare. This idiom dismisses inherent differences in people that may justify one person becoming ill instead of another.

Charity care versus moral obligation

It would follow, then, that if patients were entitled to healthcare simply for being humans, then the health center should welcome them with “open arms”, as one nurse told me. This would be in contrast to a self-conception of the health center by employees as a charity service. A charity service represents more the good-will of the providers than the moral duty to provide care. Charity is a benefit to society, but it is not a moral injustice if it is not provided, and patients should act accordingly. Thus, even if a patient is not responsible for his own illness, it may not necessarily be the responsibility of the government to provide free healthcare.

My interviews with informants strongly supported the charity interpretation of the health center's *raison d'être*. The relative prevalence of a patient responsibility discourse over a patient entitlement discourse may influence my informants' charity interpretation of their own work, but I believe that the ultimate discourse that informants expressed to me was also strongly affected by cultural assumptions about the **practical realities** of their particular community health center. These two discourses – responsibility/entitlement and the practical realities of the health center – are synthesized in the health center culture to create a standardized, prevalent discourse about patient expectations, which is the subject of the next section.

F. Assumptions about expectations:

a synthesis of entitlement and practical considerations

The phenomenon I have been trying to explain is the prevalent use of certain modifiers with *patient* in the health centers. It is my assertion that informants were most often prompted to use a modifier with this noun when accessing cultural assumptions about what a patient's expectations should be. A patient cannot be (too) *demanding* unless an informant has assumptions about what a patient's demands should be. A patient cannot be (too) *aggressive* or (too) *dissatisfied* unless he is asking for more than he should have. The primary mode of interpreting patient behavior in my informants, then, is an appeal to assumptions about expectations.

Adjective choice for *patients* falls into a conceptual scale of high versus low expectations. Adjectives that describe high expectations in patients are *demanding*,

dissatisfied, and *aggressive* and adjectives used by informants that describe low expectations in patients are *appreciative*, *satisfied*, and *grateful*. One informant reiterated this contrast herself in the same sentence:

“Many people at this health center are grateful [for receiving care as an undocumented immigrant], while at other health centers patients can be more aggressive.” (emph. mine)

Not all adjectives used by informants fall onto this scale. A patient's behavior was described as *nice* by one informant, for example, and this description could be placed on the scale, but there are other likelier meanings related to the context of the utterance that we should consider before attempting to fit all adjectives into our hypothesized discourse.

Adjective choice cannot be conceptually explained only by quantifying the amount of expectations patients should have. As one of my informants told me, patients can also have the “wrong expectations”. The practical realities of the health center are what determine whether an expectation is wrong or right.

The culture of inadequacy is reflected in the language of the health center

As I described in The Health Center Institution chapter of this thesis, there is a pervasive culture of inadequacy at the health center: there are not enough employees, supplies, or money to meet the demand. This has always been the case and it is expected to be the case in the future. It is this culture that most informs what the practical realities of the health center are believed to be by employees. As was described earlier, employees do want the health center to have more resources, and while they have pride that the care they provide is good, informants also freely admit that care could be better. When I asked one manager what he would improve about the health center, he said that “while the standard-of-care is good, everything is needed.” Another employee expressed the same sentiment when responding to the question: “the budget doesn't match any of the needs”, she said.

How this informs the expectation discourse of employees is not easily predictable. I could hypothesize that employees would be tolerant of patient attention-seeking behavior if they admit to inadequacy. But what has culturally arisen instead is the expectation that patients learn to accept this inadequacy. This is likely informed by a responsibility discourse, but does not

necessarily arise from it; I am not making any claims for why the expectation of accepting-limits has come about.

The ubiquity of the expectation discourse can be exemplified in what I overheard one employee tell a patient in the waiting area: “I’m sorry your legs hurt, but you should have come a little earlier.” In this one utterance the employee expresses empathy for the patient’s pain, admits the medical problem’s legitimacy, but also admits that the health center is too busy to treat him and that the patient should have adapted by coming to the health center earlier in the day. In this way the ultimate blame for the inadequacy lies in the patient’s not expecting the lack of staff.

The connection between the modifiers used to describe patients and the expectation discourse is also at times explicit. One informant said that *unsatisfied patients* have “unreasonable expectations”. These patients “cause problems”, which contributes to physician “burn out”. The informant quoted a hypothetical patient who says “how come I’m not being helped? You guys are doing nothing”. This is an “unreasonable” patient expectation according to my informant, even though he admitted in the same conversation that many changes were made to the check-in process in order to improve the speed at which patients were seen. Referencing the same inadequacy (long wait times), another informant said that “some patients are impatient and don’t want to wait for anything”.

Patients are also expected to accept that while the health centers provide many services, they do not provide all of the medical services that are needed. One employee recalled having to tell patients that “the city scope is limited” and that she couldn’t provide a certain treatment. The employee expected the patient to accept this and act accordingly. If they exhibit attention-seeking behavior, however, the employee will “tell the patient to cool off”.

Demands for more services are seen negatively in the health center culture. One employee summed up this assumption with the aphorism “if a patient is very demanding, he wants percocet [an addictive narcotic pain-killer]”. This exemplifies that the expectation discourse is a method employees use to interpret patient behavior.

The culture of bureaucracy is expressed in the language of the health center

As I also discussed in The Health Center Institution, bureaucratic complication of the daily functioning of the health centers is also an accepted fact in the culture of my informants.

One manager tells his employees “you've chosen to work here, don't complain about what it is” when they complain that the health center doesn't run in the same way a private clinic would. Just as the expectation discourse expects patients to accept inadequate care, patients are also expected to navigate the bureaucracy of the health center. The same informant, after claiming that employees need to accept bureaucracy, also said that “sometimes patients don't like what they hear”. Another employee said that first-time patients are not “appreciative” because they have the “wrong expectations” from not knowing how the long registration process works. This employee had also admitted that they've needed to make the registration process more “patient-friendly”.

Patients are expected to learn the rules initially and keep up with any structural changes. While “new patients are frustrated” because “they don't understand how the system works”, they will be “satisfied” with the health center once they learn. One informant told me that patients “know they have to wait” and “know what to expect”. Another informant proudly told me that the patients adapt to the bureaucracy so well that “patients tell other patients what the rules are”. (This incidental and half-serious comment may hint at a mechanism for propagating social norms in the health center.) Informants tell me that when organizational changes take place patients “re-educate” themselves and that “patients expect” the changes to happen.

How the responsibility/entitlement discourse, the expectation discourse, and medical discourses align with the use of certain modifiers is explained in Figure 3.

*Aggressive, angry, disgruntled, unruly,
unhappy, demanding, dissatisfied*

*innocent, appreciative
deserving, satisfied, respectful,
unfortunate, underserved*

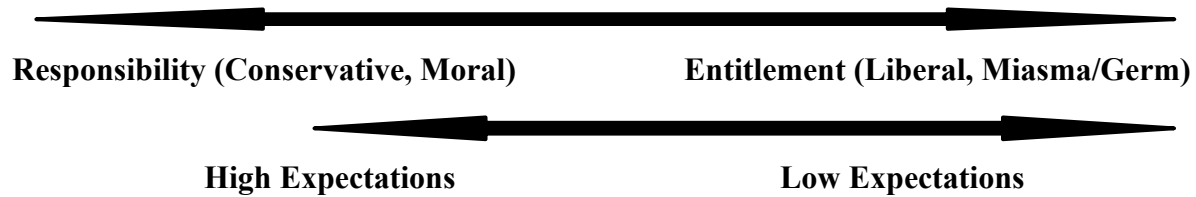


Figure 3. *The two overlapping continua on which modifiers of patient may be placed.* Modifiers that tend to express a responsibility discourse interpret patients as responsible for their own socio-economic position and health status. Modifiers that tend to express an entitlement discourse place the responsibility for a patient's socio-economic and health status in the hands of society, and treat the patient as inherently more deserving of treatment at the health center. A society or individual's conception of the cause of illness (e.g., germ-based or morality-based) also influences the extent of a patient's responsibility. Not all modifiers of patient fall cleanly onto this first scale; we must also take into account a discourse about the practical realities of the health center, which contribute to the continuum of high and low expectations. This scale is placed underneath in such a way as to indicate that even if an informant's discourse doesn't express complete patient responsibility, the practical realities will still indicate that the patient's expectations are too high.

The fact that the center has been no-cost to the patients affects the expectation discourse

Larger cultural discourses in capitalist societies relate the value of a service to the money paid for it. The fact that patients can receive care at the health center for no cost is causing a capitalist discourse to affect the expectation discourse. When I specifically asked one employee what he thought patient expectations were at the health center, he said that patients expected to be treated quickly and that “if people were paying big fees, lines wouldn't be so long”.

At the time of my interviews, the health centers were in the process of implementing a co-pay system, where patients would be required to pay a fee on a sliding-scale according to their income. Informants, then, often hypothesized about whether the co-pay system would help the budget inadequacies or change patient behavior. During these conversations it was clear that a capitalist discourse was present in the language of the informants. The equating of value with cost was present in their expectations for how patients would respond to the co-pays. One informant was in favor of the co-pays, not to raise money for the centers, but to “encourage respect” by the patients. If patients paid even one dollar, the informant told me, it would “create a sense of ownership by the patients”. Another employee also utilized a capitalist discourse, but came to a negative conclusion about co-pays. She said that if the health center started charging co-pay, “patients will probably demand more services” and there would be more attention-seeking patients.

These informants make it clear that an expectation discourse relies heavily on a certain concept of a *free clinic* that is without cost. In fact, patient behavior was frequently explained by my informants through an appeal to how a *free clinic* is seen by patients. While I described the lack of cost is one aspect of the concept, the many uses of the phrase *free clinic* by my informants allows us to see the conceptual nuances in the culture and language of the health centers.

G. The free clinic concept

My informants often justified a patient's behavior or an employee's mistake on the supposedly false belief that “this is a free clinic”. Informants clearly perceived *free clinics* negatively, had a certain mental concept about what a *free clinic* entailed, and why their health

centers did not fit these criteria. Free clinics have a particular social and etymological history, but I will not attempt to describe these. Instead, this section will analyze the *free clinic* concept that is cognitively and linguistically available to my informants, and the conversational implications meant when informants refer to a *free clinic* in relation to their health center.

It is worthwhile to note that Goffman (1961) saw a clear connection between “lack of payment” and total institutions. He said that “there is an incompatibility...between total institutions and the work-payment structure of our society” (11). There are certain capitalist concepts about what consumer-provider relationships entail, and without payment, these structures break down and a totalizing structure sometimes takes their place. In the case of the community health centers in which I interviewed, employees clearly disliked the lack of a consumer-provider relationship, or were resentful if one was assumed by patients without the accompanying payment.

The obvious property of a *free clinic* then is lack of cost. Informants referenced this widespread belief by citing the fact that some workers at the front-desk did not bother to check a patient's insurance, even though it was required, because employees associated the clinic with being no-cost. Benefits counselors I interviewed also said that one barrier to utilization of their services was that patients did not care about getting insurance if the center was not charging them.

The association between cost and quality also makes *free clinics* appear to be low quality in the minds of patients. Employees reported that health centers are seen as illegitimate medical care. One informant set up a conceptual contrast between a *free clinic* and a *healthcare facility* by saying that “this is not a free clinic, but a healthcare facility”. Another informant said that patients will say they're “going to see a real doctor” if they get insurance, since a physician that charges a fee will be inherently more legitimate. One early discussion of the community health center program feared that if neighborhood health centers had no paying members then “they run the risk of becoming stigmatized as 'ghetto' medical programs providing second rate 'charity medicine’” (Torrens 1971). Even early on, then, this property was part of the *free clinic* concept.

Free clinics are also considered government handouts which patients will necessarily take advantage of. By being ghettoized (as Torrens worded it), *free clinics* become conceptually linked to welfare and its abuses. Patients are seen as taking advantage of a service for the needy.

Having the clinics be largely outside of the private insurance system of the United States also delegitimizes them because proponents of private insurance strongly promote their system as providing better care and choice.

Employees unanimously dislike the phrase *free clinic*. I did not record a single utterance by my informants acknowledging that their health centers were *free clinics*. They always claimed that the health centers weren't *free clinics*, and were better off for it. The widespread dislike of *free clinics* by my informants is probably representative of the desire to change the place of the health centers in the minds of Americans. As The Literature Review summarizes, community health centers were seen as a starting point for a large reform of the healthcare system in the US. Instead, through political and financial antagonism, the health centers have been “ghettoized” and turned into providers of “charity” care, rather than providing socially responsible care for everyone. The language of the *free clinic*, then, could reflect the culture and history of community health centers.

But this discourse, so cynical of *free clinics* and holding high demands on patients, is not necessarily looked upon positively by health center management. One high level manager I interviewed was vocal in his attempts to change the way employees spoke and treated patients. This attempt to change the discourse is the subject of the next section.

H. The “customer-service” discourse: an authentic counter-discourse?

Throughout this thesis I have emphasized the social structures and history of the health centers as influencing the language of employees. I have also referred to an informant's intent and conversational context as important. However, it is inaccurate to treat all linguistic phenomena as unconscious or ingrained. Language change often happens without an explicit agenda, but sometimes the way we speak can change due to intentional political action. One example is the widespread change in the way the female gender is referenced in English (gendered professions, pejorative terms for women, etc.). Specific political action by feminist groups initiated this widespread linguistic change (Cameron 1990). The way most Americans refer to specific races and ethnicities also changes in large part due to political groups. I raised earlier the “hard” question of how linguistic norms come about. Acts of “verbal hygiene” (Cameron 1990) are one of these production methods.

There is a verbal hygiene movement that is being promoted by some health center management. The movement has been described as promoting “customer service” and a “patient-first” mentality. Management is essentially promoting changing the discourse about patient expectations. As one manager described it, employees will now greet patients by saying “What do you want?” but he wants employees to say “How can I help you?” This manager has said that employees should “have joy”, “be approachable”, and “be here” for patients.

This manager was clearly influential with the staff. While most employees still seemed to speak the old discourse (I often heard “what do you want?”), some clearly had tried to integrate the manager's discourse, and spoke about customer service. However, it is not obvious how efficacious a top-down approach to changing widespread discourse will be. While I previously mentioned successful top-down changes to language, these changes were part of powerful social movements. Additionally, it is clear that while many managers have strong personalities at the health centers, they do not micro-manage, and the great autonomy of employees could hinder the uptake of this new discourse if staff isn't actively normalizing and promoting it. If anything, managers will produce two different registers of speech, one for speaking to a superior, and one for speaking to others. The customer service discourse will be integrated into the higher register, but perhaps not the lower register used when addressing other staff and patients, which is its intended goal.

The expectation discourse I described is inherently contradictory to the customer service discourse. Take one utterance by a manager. He said that employees should “treat [patients] with respect” because they “already have an attitude”. The adverbial clause here is contradictory to the antecedent. The assumption that patients have “an attitude” is part of an expectation discourse that's dismissive of attention-seeking patients, while “treating patients with respect” is part of the customer service discourse. Thus employees will be required to either integrate or switch between these two discourses, and it would be beneficial to identify more specifically the situations where each is utilized, or if the customer discourse is actually taken up by employees over time.

I. How language may affect care

When individuals make decisions, they use well-characterized processes, which Tversky and Kahneman (1974) call judgment heuristics. They claim that “subjective assessment of probability...based on data of limited validity” is an important aspect of decision-making. However, our subjective assessment of probability is subject to psychological biases. As healthcare professionals are required to make assessments about the probabilities of certain diagnoses, outcomes, and patient behaviors, systematic cognitive biases can clearly influence the provision of care. The discourse healthcare employees use to interpret patient behaviors may play into these cognitive biases. For example, Tversky and Kahneman (1974) discuss representative biases. These involve assuming that one member of a group is highly representative of the entire group. People may also assess the likelihood of something by how easily an example comes to mind (an “availability” bias). They also anchor their estimations around an initial probability estimate, which could have been learned from anywhere and may not be accurate. All of these biases could be influenced by which interpretive modes are frequent and seen as more justified. If negatively-framed discussions about attention-seeking patients are common, these examples may come to mind easily in healthcare employees and skew their probability assessments. Given the fact that many patient care decisions are made by the subjective assessment of a healthcare employee, cognitive biases can factor heavily into a patient's treatment.

However, there are severe limitations in predicting behavior from language. Discourses spread through a culture and lose some of their ideological literalness. Language can be used to signal group identity, and may propagate merely because people are trying to “be normal”. A speaker will not necessarily internalize as belief a literal ideology behind a particular linguistic phenomenon. Of course, we also have to be careful with how easily we appeal to a group signaling explanation and discount underlying ideology. As Cameron (1990) points out, the assumption that language “reflects groups' norms” is a “useful one” because generally “people act to reproduce...the order of things” and are not eager to “subvert the order”. However, we are again faced with the hard problem of where “linguistic norms 'come from' and how they 'get into' individual speakers” (Cameron 1990).

Often sociolinguistic analyses will simply correlate a particular linguistic observation with a demographic, and appeal to group norms as an explanation. Cameron is right to question, though, whether “people really have such fixed and monolithic social identities”. The demographics we correlate an observation to may not be a real social identity to speakers. In this vein, just because we've correlated a certain discourse in health center employees, it does not necessarily mean that employees have internalized this belief system or that they have propagated this way of speaking merely to “fit in” at the health centers. We have to look toward the stated motivations and rationales of employees for why they may speak this way and expect patients to acquiesce to the inadequacies and bureaucracy of the health center.

I also want to make clear that I am not entirely admonishing a discourse that is cynical and condescending toward patients, though it clearly may hinder patient care. In fact, the pressure employees put on patients to lower their expectations may be a coping mechanism that helps to prevent burn out in employees. One employee, when I asked her about difficult decisions she had to make, said it is hard for her “when a patient comes for help, but she cannot give care”. Most employees present rationally-driven motivations about benefits and hours for why they chose to come to the health centers, but at times the socially beneficial aspects of the job are discussed.

The problems of poverty and illness are intractable in many regards, and it would be no surprise if employees sometimes feel this burden. These narrative modes can allow employees to distance themselves from a patient's problems, or even rationalize why the problem exists. Employees are faced with patients who are in poor health and poor socio-economic status. There are also cultural and linguistic barriers to overcome. This would likely alienate an employee from her patients and make it difficult to optimistically see “the way out” for many of these patients. A morbid vocabulary and humor are common among medical professionals, and it may not arise unintentionally from the desensitizing aspects of medical training, but might be an intentionally-implemented therapy for the difficult experience of treating sick people. The discourse I document might be one part of this therapeutic language.

Chapter 6: Conclusions and Future Research

The methods used in my research have been eclectic; I've drawn from ethnomethodology, sociological theory, and linguistics. I've attempted to follow the gold standard of being “thickly descriptive” of my interviews and always considerate of the conversational context and interactional specifics. However, my interviews were necessarily shallow. I was only able to perform follow-up interviews with some employees, and, in total, the interviews only took place over a ten week period. Good sociology, anthropology, and linguistics requires participant observation, and in-depth (preferably audio-recorded) interviews. To gain a fuller picture, analysis of structural and demographic trends should utilize solid research design and quantitative methods.

In these regards, this analysis has clear flaws. I've continued to pursue it, though, because I feel that the lack of attention to community health and non-professional healthcare workers is a serious deficit in the social sciences. Additionally, the political reform of our healthcare system requires the input of non-political actors. Even if medical and nursing organizations have a political voice, individual members of this profession, particularly those engaged in community and public health, do not have much input. More importantly, my informants work in healthcare settings that closely resemble what a reformed American healthcare system could look like.

The sociological research of community health that began in the late-sixties (and ended by the mid-seventies) combined quantitative analysis with politically-invested and critical description. However, this research was necessarily myopic because it was performed shortly after the health center program began. I have attempted to continue this line of research. One current trend in public health and medical sociology is statistical analysis of the economics and demographics of the healthcare of impoverished or unhealthy populations. While it is valuable to look at such structural “determinants of health” and intervention “outcomes”, this research should not be performed at the expense of ethnographic methods and subjective analysis or it runs the risk of disseminating ideas about what it's like to treat “poor people” or “immigrants” that have been imagined by mostly non-poor and non-immigrant academic researchers. I don't believe you can craft effective interventions and incentives without direct and subjective discussions with those whose behaviors you wish to change.

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Appendix A: Sample of Interview Notes

My interview notes were intended to be a record of what an informant said, without much interpretation or verification of accuracy. Toward that end, I try to specify exact quotes (using quotations) whenever possible and paraphrase the rest of what my informant said. When paraphrasing informants, I tried to stay true to the message they were trying to communicate without including my own reflections. My general line of questioning is also included in my notes so I can understand my informants' answers in context.

\$ [Interview number] [Interview date]: [Health Center ID];

Interview with [Initials of informant (XX)] ([profession])

I asked XX about whether burn-out was a major problem at the HCs [health centers]. He said that "sure, a lot of the time it is". There's burn-out in any environment, but he feels more so in this one. Patients here have no insurance, and when it comes to major medical problems, like breast cancer or knee surgery, it is stressful. He said that "we do extremely well" in getting these patients care, but it's hard. Programs and counselors support this effort. Getting supplies such as glucometers can also be stressful for the patient.

A physician here has to be "more involved than in a private practice".

I asked if physicians ever leave because of burn-out. He said that physicians do leave because of this. XX said "I burned out a long time ago" and he left for a period of time. I asked him if his administrative duties provided a break from patient care and reduced his stress. He said "it is and it isn't". He said it's stressful because "his desk is full by Friday" -- from labs, being the default physician, etc. XX must pick up referrals, and the volume at this HC is great -- he claims it's one of the most productive centers for physician productivity.

Appendix B: Sample Questions

- How did you end up working for the health center?
- What is your day-to-day job like?
- What were your training and education? Did you have specific training in community health?
- Do you think staff at the health center have close relationships?
- Do you anticipate working at the health center for a long time?
- What are your patients like? Are there any difficulties in treating them?
- Do you need to consult with your supervisors often? Do you consult with the Director, HCC, or Clinical Director often?
- What are some of the difficulties of working here? What are some of the benefits?
- If you controlled the budget, what would you improve about the health center?