Health Agencies and the Tower of Babel

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A STRIKING ANALOGY exists between the story of the Tower of Babel and the situation of many community groups which concern themselves with closely related health and welfare matters. The ancient people in the Biblical account had tried to work together to achieve a common goal when they suddenly discovered that they could not communicate with one another. Recognizing this, they relinquished the common goal and each group went its own way pursuing its own goals.

Unfortunately, this happens only too often in our communities today. But we would like to think that we are somewhat more sophisticated now. We are aware that there are differences in objectives, in interests, in points of view, and even in language between the community groups, organizations, and agencies concerned with community health and welfare. However, unlike those ancient people, we need not throw up our hands in despair over problems of communication and cooperation. We understand these difficulties better and can find ways of bridging many of these differences and of achieving cooperation.

New health organizations are usually born of the enthusiasm and leadership of one or two men who are dedicated to meet certain needs with which they are particularly concerned. At the beginning these groups are loosely organized and flexible. They respond to needs as they arise and search for the best ways to accomplish their objectives.

As time passes, certain routines evolve in the functioning of these organizations; procedures become standardized and positions with specified roles, duties, and responsibilities become established. As the organization discovers what it considers the best ways to accomplish its objectives, these ways become fixed and institutionalized. In a young agency, for example, a staff member who wants something done simply telephones Joe or Mary or perhaps the director of the agency himself—whomever he thinks to be the best person to do it. But some years later, under the same conditions, a memorandum goes from his desk through strictly prescribed channels (which must never be violated) to a particular person to whom the responsibility for such a matter has been delegated.

As the organization grows and matures, it develops a complex system which includes a particular philosophy, particular standards, norms, regulations, procedures, and working patterns, as well as its own terminology and jargon. It comes to have a subculture of its own. New members must adopt these characteristics, much as immigrants to the United States must adopt many of the American ways of speaking, thinking, and acting. By the same token, members of one organization will find the ways of another organization different and sometimes strange and inexplicable. Again, this is similar to the reactions of persons from one country when they deal with citizens of another. Of course, differences between organizations are not as pronounced and obvious as differences between countries. In fact the differences are often so subtle that occasionally only the most sensitive persons are really aware of them.

The relationship between welfare and public health agencies in certain States serves as a good illustration. Welfare workers in these States work within the framework of rather strict and

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detailed State and local laws and regulations. These prescribe fairly specifically when welfare workers can do what, with whom, and how, often allowing them relatively little leeway when dealing with individual cases. In a sense, they have to find out if the case fits the rules. Health workers such as visiting nurses, on the other hand, tend to have relatively greater freedom to adapt their actions to individual cases. Where this situation exists, it may cause friction when the two groups need to cooperate.

Both the public health nurse and the welfare worker may be equally disturbed by the other's approach. To the former, the welfare worker's approach may seem to demonstrate a bureaucratic attitude and a lack of appreciation for individual differences in the needs of persons and families. To the welfare worker, on the other hand, the nurse's approach may appear to be inconsistent and to fail in applying existing laws and regulations equally and equitably to all people.

There is often on either part a lack of understanding or tolerance for the fact that the other works in a different subculture and within the framework of a different set of organizational and professional rules and standards. This poses a mighty barrier to cooperation, not only on the operating level but also in the interaction between these agencies on the top level.

In addition to developing a procedural, legalistic, and philosophical framework of its own, the maturing organization also undergoes certain changes in respect to its objectives.

In a young organization, almost all its activities are geared to deal with the very objectives and purposes for which it was created—nothing matters as much as its self-avowed mission. Later, however, increasingly strong concerns develop to maintain and strengthen the organization for its own sake, to expand its activities, to stake out a scope of goals and activities, and to protect this domain against intrusion by other agencies. The existence, strength, and welfare of the organization become important goals in themselves in addition to its more basic health goals.

Occasionally an organization has been so effective that the problems for which it had been created have largely been solved. But it will not regard its mission as accomplished and dissolve itself. Rather, it will find a new mission to justify its continued existence. It may do so by making its services available to different or larger population groups than it had served heretofore, or by extending its scope to new problems and issues. The latter is well illustrated, for example, in the shift from poliomyelitis to other health concerns in the history of the National Foundation and, more recently, in the National Tuberculosis Association's broadening of its objectives to include respiratory conditions other than tuberculosis. This, of course, is often a very desirable development because it allows a large, now efficiently functioning organization to make its already established machinery available to meet new needs. Otherwise, a new and inexperienced organization would have to be built.

In any case, it is natural and necessary for an organization to do everything in its power to assure its continued existence and to justify this existence. And the best justification is that the organization meets some real needs, and that it is the only organization that meets these needs. Therefore, no organization or agency or professional group can tolerate too much overlap of the objectives, activities, and jurisdictions of other competing groups with its own.

Quite often it is assumed that communication and cooperation between two groups should be easy if their respective objectives are similar or even almost identical. Just the opposite is likely to be true. A local heart association and a local tuberculosis association, for example, may be able to establish cooperative relationships fairly easily because they deal with compatible but distinct areas. In contrast, a local society of pediatricians and a health department trying to carry out a joint health program for children may find it difficult to work together because each may perceive the other as a threatening competitor for status and responsibilities in its own domain.

There is another aspect to this issue. Cooperation, no matter under what conditions, always requires that each of the parties give up something—yield some sovereignty or surrender some rights. But, as previously pointed out, every agency and organization must be primarily concerned with fulfilling its own mission and

objectives no matter how public spirited it may be otherwise. Rarely will two organizations cooperate simply because they have discovered a common objective. They are likely to be willing to cooperate only if each one has decided that the other can help it with its own aims and objectives, and even then only if they do not see such cooperation as forcing them to give up too many of their own interests; that is, if they do not see cooperation as a potential threat.

Another difficulty often bedevils attempts to obtain cooperation. It was mentioned that as groups or organizations mature and develop their own subcultures, they also develop certain ways of looking at problems, of interpreting events and words, and of reacting to various things. They acquire a point of view different from that of other organizations. The effect of this on inter-organizational communication can be seen in the following example.

Public health, by definition, is concerned with the welfare of large population groups. Practicing physicians, on the other hand, are concerned with the welfare of individual patients. In 1957 shortly before the Asian influenza epidemic reached the United States, the Surgeon General of the Public Health Service announced the imminent outbreak and stressed that widespread illness would disrupt community affairs, but that, except for certain persons, it would probably not represent a serious health threat to those afflicted. At the same time, he urged community agencies and organizations, including local medical societies, to prepare for the impact of the epidemic by making certain preparations, particularly the promotion of mass immunization programs.

In other words, the Surgeon General stressed what, from a public health point of view, was a real health threat: disruption of community welfare by a widespread though relatively mild disease.

This message did not arouse as much concern among the local medical societies as it did among the more community-oriented voluntary and official health agencies. One reason was that to practicing physicians even only a few cases of serious disease among their patients would constitute a more important matter than a large number of cases of mild and temporary sickness. Consequently, medical practitioners generally were not overly concerned about the epidemic, and in many communities the local medical associations failed to cooperate as actively as they might have with the local health departments' efforts to prepare and protect the total community against the epidemic.

This example illustrates how important it is to consider the other's point of view and the other's interpretation of a health problem when trying to communicate with him for the purpose of soliciting his cooperation.

At least one further problem in this area may raise its ugly head, even when agreements have apparently been reached between agencies or organizations. Good communication depends to a large degree on a common language. But common language is more than just use of common words. It requires that words arouse identical concepts and images in the people concerned. However, each profession and each well-established organization develops its own set of concepts and its own jargons. Words like "case study" or "program," for example, mean something distinctly different to a social worker, a physician, or a health educator.

As a consequence, many of us have had experiences like the following. Members of different types of organizations or of different professional groups sit around the conference table, apparently communicate well, and leave the conference fully convinced that they have reached complete agreement. Yet, some time later, discrepancies begin to become evident. It may seem that one of the participants has changed his mind or is reneging on the agreement. Suspicion is aroused, and this may spell the end of a promising relationship. Yet, it may well be that all parties concerned believe sincerely that they themselves are living up to not only the word but also the spirit of the agreement. The problem may have simply been that each participant interpreted certain terms or words differently in the light of his own characteristic way of thinking and talking.

The various problems discussed so far may help us to look with somewhat more understanding and tolerance at the sometimes puzzling antics of some groups, their apparent selfishness, and what has sometimes been called "organizational paranoia."

But what are some practical implications of all this?

It has been asserted that every agency and organization has at least two sets of goals and objectives. One deals with accomplishing its mission; the other is to assure its continued existence and to defend itself against all threats to this existence.

In a certain city, a health agency tried to get the cooperation of local labor unions to help assure that union members and their families would participate in a community disease case-finding program. After long and painful negotiations, these organizations finally reached an agreement on the top level. But even then there was marked resistance by the union officials, and the cooperation, with some exceptions, was on paper only.

It was ascertained later that (although this never came into the open at the time) the union officials felt that they were just being used to help the health agency accomplish its goals and that they were asked to put in extra effort on a program from which they themselves had nothing to gain. In addition, the unions had prided themselves on their past efforts to promote the health and welfare of their members and their families in many different ways. Therefore, they felt that the health agency really asked them to surrender some of what they considered their own responsibilities.

This story had a happy ending, however. A year later the same program was planned again. This time, the health agency included the local unions in the initial planning. Separate but coordinated areas of activities and responsibilities were delineated. The disease casefinding program was combined with another program that had been of great concern to the unions. And credit for locating persons with active disease in the target population went at least partly to the unions. This enabled the union officials to justify their efforts in the eyes of their members and of their national parent organizations. Cooperation was excellent, the program was a success, and everyone gained by it.

The practical lessons learned from this story point to the need to understand and accept as a fact that every agency, organization, or professional group has, in addition to its official, public, and professed objectives, also some private ones. These are directed, basically, at self-preservation, protection of its interest, assurance of continued resources (financial, legal, public opinion), and defense against the threat of having other parties trespass on its own staked-out domain.

The first implication that can be drawn, therefore, is that in enlisting another group's cooperation, the proposed joint activities should be able to meet that group's private objectives as well as those to be pursued by the joint program. In other words, the proposal should be planned and communicated in such a way that the other party sees that it can gain from cooperation in terms of its own interests, not only in terms of the vague "public good."

Inclusion of other groups early in the planning of a program rather than after a full plan has been developed will prevent them from feeling that they are merely being used for someone else's purposes, that they are being asked to rubberstamp someone else's ideas and decisions. Instead, it will give them the chance to introduce features meeting their needs, and they will feel they have an active part in the planning and a stake in the program. Nothing is more likely to produce a cooperative spirit.

Where organizations differ greatly in their manner of operation it may be a good idea to divide, where possible, areas of responsibility so that each organization can work within the framework of the cooperative program but somewhat independent of one another. This will not force the cooperating agencies into a common mold of operation that may run counter to the custom and preferences of some. Rather, it would allow each one a maximum amount of freedom to follow procedures it has found compatible and effective for itself. This freedom of action would be limited only by the needs imposed by the common objective.

It is important, however, that there are not only clear and distinct reponsibilities, but also that each of the participating groups recognizes from the beginning that it will get full credit for its own activities and accomplishments. Again, I stress the phrase "from the beginning" because it is the promise of this reward that pro-

vides a most powerful initial incentive for a favorable atmosphere for cooperative planning.

Clearly, all these lessons point to the overriding importance to know, understand, and consider the others' viewpoints, concerns, expectations, and interests. How can this knowledge and understanding be achieved?

One way is to review past behavior of these groups. What seems to have stimulated them previously to cooperate or to go it alone? What positions have they taken in relation to various community problems and issues? A great deal can be learned from studying an organization's past behavior. This helps to anticipate what that organization may want to do in the future and how it will probably react to various approaches and arguments.

Unfortunately, little attention is generally paid in planning multi-organizational programs to sociological, psychological, and political factors although they may crucially affect the attitudes, decisions, and actions of the organizations. For example, community health programs are usually planned only after careful analysis of the biomedical aspects of the problems with which they are to cope. However, with few exceptions, no corresponding effort is made to study the sociological, psychological, and political aspects which are likely to determine whether the support and cooperation of key groups in the community will be assured. Yet the success or failure of many health programs rests as much on the achievement of cooperation by various community agencies, organizations, and groups as on the soundness of the medical plans and procedures themselves.

As to inter-organizational communication, one must consider the fact that organizations and agencies tend to interact predominantly through official channels and through formal meetings of their officials. For various reasons such official contacts, especially formal group meetings, often tend to accentuate differences. Opinions, once publicly expressed, become resistant to change. Agency officials tend to be more flexible and more responsive in informal private interactions with officials of other agencies. Therefore, it is often fruitful for officials of one organization to establish informal personal contact with influential members of the other organization and to discuss ideas for cooperative programs in a social and more easy-going atmosphere long before exposing these ideas in formal and officially scheduled meetings.

My final suggestion concerns the difficulty, mentioned earlier, of actual agreements which are, however, more on the level of words than on the level of underlying meaning, and which may therefore be more apparent than real. This stems frequently from the fact that words and even written statements may have different meanings and connotations for different people. To avoid misunderstanding and later accusations of bad faith, one should not be satisfied with general and abstract terms of agreements. One should insist on clarifying each statement, clause, and proposed action by spelling out—and have the others spell out—exactly what they mean in concrete terms of action. This will increase the probability that all parties to a joint program know exactly what they commit themselves to do and what they can expect the others to do or not to do.

Other suggestions or implications could be drawn from an understanding of what makes organizations and their officials tick. But many of them will depend on the specific kinds of organizations, the particular situations and relationships that exist, and the nature of the health issue.

Of course, none of the implications spelled out on these pages will apply in every case—there are too many different situations and special conditions. Still, they should provide some helpful general principles which, when translated into concrete steps adapted to the demands and resources of specific situations and conditions, may prevent many a community health program from suffering the fate of the Tower of Babel.