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Stephanie C. Eken
*University of Richmond*

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By

Stephanie C. Eken

Senior Project
Jepson School of Leadership Studies
University of Richmond
Richmond, VA

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Last summer I was a first-hand witness to the failings of America's current medical system. All too often people who were referred to the Cardiac Rehabilitation department of Stuart Circle Hospital could not benefit from preventive medicine due to insurance reasons. Patients who are enrolled in this program have experienced some form of cardiac disease during their lifetime. The health program provides patients with counseling concerning nutrition habits, lifestyle choices, such as smoking, an aerobic fitness program, and exercise equipment. These factors - nutrition, fitness - combined with inherited genes are major determiners of an individual's predisposition to cardiac disease or further complications of existing conditions. Even those who did qualify for this preventive program for cardiac disease, often were only eligible for partial care. While I served as an intern in this program, I frequently left work with a sense of disillusionment and disbelief. However, my faith in the medical field was not lost forever because of a certain group of patients who visited the Cardiac Rehabilitation department.

These people came to the Cardiac Rehabilitation program through Cross-Over Health Clinic, a community health clinic established in the southside of Richmond. This clinic, which has religious foundations, provides care for those who do not have the financial means to obtain health insurance or traditional care. People who live in poverty and possess no ability to pay can use the services of this clinic. In my mind, this clinic and its personnel appeared to epitomize the concept of servant leadership and brought to life the character of Leo in Journey to the East. In this story a band of men set forth on a mythical journey accompanied by Leo, the servant to the party, completing their menial chores. The journey is smooth until Leo disappears, which it then falls into disarray and the journey is abandoned. By the end of the book, it has been discovered that Leo is the
head of the Order who sponsored the journey, its guiding spirit, a great and noble leader (Greenleaf 18-19). Cross-Over Health Clinic was acting as a servant leader in the community as it had a mentality of serving the needs of the people.

My internship was part of the Community Problem-solving Seminar (COMPs), which also served to open my eyes to isolated populations in decaying cities, especially in Richmond. Field trips throughout the city of Richmond reiterated the stories we were reading in class and revealed a tough reality contrasted to the isolated world of academia. We visited homeless shelters, saw projects aimed at urban renewal, viewed schools educating children in low-income neighborhoods, and met key leaders trying to bring about real change for Richmond citizens.

After these experiences, I am determined to help build communities as I pursue my goal of becoming a doctor. By providing access to primary care for underserved populations, one day I hope to help raise the standard of living for individuals and consequently help prepare them to address other issues in their lives. Community health organizations, through grants and private donations, are helping people to gain this care on a daily basis to help raise their quality of life. In a country which is still fluctuating in determining the proper methods to deal with the skyrocketing medical costs and expensive health insurance, these organizations are leading the way in providing service for the uninsured. However, little research exists pertaining to the individual leadership occurring within such organizations.

Community health organizations provide a unique context for the study of leadership. There are many community-based initiatives in Virginia which are seeking to help neighborhoods with large populations of uninsured residents. The Virginia Health
Care Foundation (VHCF) has 49 model programs in which public-private partnerships are built around strong community support. This foundation is dedicated to delivering primary care services to uninsured and medically underserved peoples of Virginia. In 1996, 40,000 such people received care through VHCF projects (VHCF Annual Report 3). These numbers show that community-based health organizations can be one effective, although partial, answer to the problems of the current health care system. However, community-based projects take a significant amount of work and time to be successful.

Most of the scholarly work pertaining to these clinics concerns empowerment of community members and its effectiveness concerning the residents of the community. Leaders within this context have largely been ignored in the studies. Hence, future research of leadership in community health organizations will provide new information for leadership scholars, especially concerning how leaders maintain hope in desperate situations and how they cope emotionally on a day-to-day basis with such a demanding job. It will also serve to alert health professionals of needs within community initiatives and enlighten them as to some effective methods and characteristics for successful leadership in this context.

**Research Purpose**

The purpose of this project was to analyze the characteristics and motivations of leaders in community health organizations and determine if they were initiators and collaborators in bringing about real change in providing health care for their own neighborhoods. To date, there has been little research concerning leadership in the medical field and even less addressing leadership in community health organizations. Yet, everyday there are “ordinary” people making significant changes in the lives of Virginians.
through community-based health promotion. Their efforts and accomplishments in community health care can provide new insight into leadership in an evolving context and in everyday life.

Although many theories exist to explain the phenomenon of leadership, the concept of leaders as initiators working in a web of participation for change and the theory of collaborative leadership provide the strongest perspective for analyzing the nature of leadership in community health organizations. Change is a component in numerous leadership theories and applicable in the context of community health care as well. According to James MacGregor Burns, “Change occurs when someone, perhaps in midstream, decides not to be ‘controlled by events’ -- i.e., by others -- but to take action on her own, for her own purposes” (Burns 17). Leaders in community health have an understanding of the problem and become determined to change the status quo, no longer accepting the inaccessibility of health care to their community.

Established clinics are the fruition of the efforts by the community to address the health needs of its people. Most often the clinics are located in areas of high need, in which there are desperate needs for improved health care. The people of the community are usually underinsured or uninsured in the health care sector. Usually, though, one person cannot fight the expensive health care system, but the cooperation of influential community members and organizations is necessary. Thus, a diverse group of people must learn to work together in order for their voice to be heard and changes to be made. Several leaders within this context were used as case studies to gain a better understanding of the defining characteristics and actions of those who chose to help their communities gain access to health care.
The questions addressed in this study include: (1) What compelled these leaders to take action in the area of community health? (2) What qualities enable these leaders to motivate the community into a collaborative effort? (3) Does gender or gender-related qualities of the leader play a role in the success of community health organizations? (4) In the context of community health organizations, factors exist such as overwhelming work hours, emotional involvement with patients, working with public policy, and forging a cooperative relationship among the corporate sector, the community, and the non-profit world which make it unique. Thus, the question arises, what are the inherent processes, activities, and events with which community health leaders must contend? (5) Are there unique differences or circumstances that distinguish community health leaders from other leaders who have acted as initiators of change or brought about collaborative efforts? (6) What real changes occurred in the communities from the establishment of a community health clinic and the efforts of those who organized it?

**Literature Review**

There is a considerable amount of literature concerning community health organizations, however it tends to focus solely on empowerment strategies and the roles of physicians and nurses in an evolving medical field. A number of scholars are convinced that individual communities must take responsibility for their own health needs. Although no definite solutions have been found for the crisis occurring in health care today, it is becoming clear the health of America's people cannot solely be the responsibility of traditional health-care institutions. There have been several proposed solutions which include health management organizations (HMOs) and community health organizations. The ultimate purpose of both of these types of organizations is to provide health care to
people in an affordable manner. HMOs are for-profit organizations which provide millions of Americans with health insurance at reduced rates. They are able to offer lower rates due to the business partnerships they form with hospitals, doctors, and other health-related organizations in communities throughout the country (Ginsburg 15). However, their agenda does not include a specific strategy to make medical care accessible to currently marginalized people who cannot afford health insurance, but do not qualify for Medicaid. On the other hand, community health organizations are typically non-profit agencies focused on providing primary care and health education services to uninsured populations (VHCF Annual Report 3). The Healthcare Forum, an organization devoted to fostering healthier communities, claims, “A healthier community is not something any single-group - including those devoted to health care - can accomplish alone. The community has to do it” (“Creating Healthier Communities” 3). Thus, it requires the involvement of all peoples of a community in order to effectively address health care needs. It cannot simply be those whose sole purpose is to provide health care. Community health organizations are more likely to include and require the help of people in the community as they address problems; whereas, HMOs have monetary goals which are not always conducive to extensive community involvement.

Recently, community health organizations have become numerous due to the increased availability of financial assistance from both government and private sources and the growing population of uninsured. However, not all community health clinics have been successful due to reasons such as poor financial management, loss of financial assistance after a period of time, lack of community involvement, and poor leadership.
Those community health programs that have proven to be beneficial to their surrounding community can eventually serve as models for future programs.

While there is a shortage of academic work concerning leadership in community health organizations, there is a definite recognition of the need for leadership in health care, especially in community-based projects. However, most of the writing and research have only discussed the needs of community health organizations and not provided an assessment of those people already acting as leaders. As in the academic field of leadership, there are many definitions of leadership in the context of health care and there has not been a clear distinction between leadership and power. In Merry’s article, “Shared Leadership in Health Care Organizations,” he expresses the need for shared leadership in the 21st century in order for the health care system to survive its current crisis. He claims that true visionary leaders are needed to formulate a new order from the current chaos and defines leadership as “that process in which one person sets the purpose or direction for one or more other persons, and gets them to move along together with him or her and with each other in that direction with competence and full commitment” (Merry 27).

Hence, Merry proposes a definition of leadership to be used in a changing national health care system, which includes characteristics of a visionary leader providing clear direction to people. However, others have differing views of leadership in this context.

Others in health care do not subscribe to individual or outside leadership, but seek community-based leadership. This idea of leadership relies on community action which involves the deliberate organization of community members to accomplish some objective or goal (Brown 446). Implicit in this theory is the idea that those who are directly affected by the problem will take more initiative and care in rectifying it.
The Nursing Institute recognizes several academic definitions of leadership. One is Hershey and Blanchard’s, which states, leadership is “the process of influencing the activities of an individual or a group in efforts toward goal achievement in a given situation” (Trofino 44). Also, the institution gives credence to James MacGregor Burns’s theories of transactional and transforming leadership as well as Robert Greenleaf’s concept of servant leadership. Burns defines transactional leadership as occurring “when one person takes the initiative in making contact with others for the purpose of an exchange of valued things”; while, transforming leadership occurs “when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality” (Burns 101). According to Greenleaf, the servant leader is servant first and demonstrates a form of leadership in which “care is taken by the servant first to make sure that other people’s highest priority needs are being served” (Greenleaf 22). The two theories of transforming and servant leadership are distinct because they are based in ethics which provides a type of moral leadership.

One study which claimed social concerns in a community can be addressed successfully when key local leaders support change, defined community leaders as “those individuals who could be attributed to influencing constructive change in some dimension in the county” (Sutherland and Cowart 249). Another study did not define leadership, but recognized the existence of power in female community leaders who initiated a prenatal care program for women in a community in Texas. The study identified the power of the women as nontraditional because they subdivided responsibilities and used the “power of unity,” whereby the group shares responsibility for decisions and actions in the community (McFarlene 475). The notion of sharing is once again identified when Merry states in his
article that leadership between nonclinical and clinical workers should blend individual creativity and energy with a value of team effort (Merry 33). Thus, it is evident the medical field is searching for workable definitions of leadership. However, no definition other than the references to transformational and servant leadership includes ideas of ethical leadership.

A major focus of the literature concerns the empowerment of communities and individuals within them to promote health education and programs. Many of the articles describe the “how to” aspect of empowering communities, rather than providing information on past leaders who have successfully empowered communities through providing health care and educational programs.

The women of the De Madres a Madres program in Texas, though, is one study that focuses on empowerment through building individual’s personal strength and ability to grow. This occurs through their system of support groups, which give personal attention and advice to expecting mothers, and nurtures an ability to cope and work within the health care system and give respect to cultural differences (McFarlene 474). Another study which shows empowerment to be a multi-level construct (individual, organizational, and community) refers to the process as “the development of understanding and influence over personal, social, economic, and political forces impacting life situations” (Schulz 310). It claims empowerment of community-based organizations is an indicator of health status and quality of life (Schulz 309). Similar views are expressed by health educators who seek a comprehensive approach to health promotion through social and community action in order to change environmental conditions by giving people a greater sense of power to make changes in their lives (Brown 441). Finally, the Nursing Institute espouses
the new primary role of the leader in the changing health systems environment will be to empower others to be their own leaders, including co-workers and patients (Trofino 46).

Another definition of empowerment, used for grassroots organizations, involves "a combination of psychological and political factors: the development of a more positive self-concept; the development of more critical or analytical understanding of a political or social environment; and the development of collective resources for social and political action (Keiffer 31). Thus, the issue of empowerment has been discussed extensively among those working in community health settings, but no work has been done on those whose efforts focus on helping to empower others.

Although community leaders often play large roles in developing community health organizations to address the needs of their neighborhoods, doctors also have been crucial leaders and non-leaders in this context. Doctors have long been part of a culture of tradition which essentially empowers them to act in what they determine to be the best interests of their patients. Thus, they are respected for their expert knowledge, but they are often perceived as "defending physician prerogatives generally, and institutional dominance specifically" (Merry 30). Physicians have not been viewed as moral leaders due to those doctors who usurp power from their patients by using medical jargon which is unintelligible to the average patient. Hence, for doctors to be effective, moral leaders in a community setting they must help people to understand their personal health needs and work to educate and empower them.

A study of doctors in Quebec found evidence to dispute the notion of doctors as informational power-wielders. Two primary care networks have been established in Quebec since the early 1970s - "the traditional one [is] characterized by private practice..."
remunerated on a fee-for-service basis, and the public one comprising 15 percent of physicians and characterized by salaried practice within publicly funded local community health service centers (CLSCs)” (Pineault 49). Compared to the private practices, CLSCs, analogous to American community health clinics, give more importance to prevention and to the adoption of a more comprehensive and global approach in the provision of health care. The study found physicians working in CLSCs to be younger, more often women, and more often graduates of innovative primary care training programs (Pineault 49). Also, physicians who practice in CLSCs hold different attitudes from their colleagues in private practices. CLSC physicians are more sensitive to the multi-disciplinary nature of health care, they express ideas in favor of greater demedicalization of health care, and they are more favorable to patient education and patient involvement in medical care (Pineault 51-54). Thus, the study does not claim physicians are definitive leaders, but provides research concerning the characteristics of these professionals working in community health organizations.

Bennett’s article directly addresses physician leadership in directing the health care of the local community. It claims physicians have lost their decision-making power, objectivity, and autonomy as recent changes have occurred in the health care system. In order to be effective physician leaders, Bennett states several essential actions which must be taken by physicians within the community. For example, two such actions are “(1) they must educate the hospital board members, business leaders, political leaders, and patient advocates that physicians can creatively provide more affordable, more accessible and more efficient health care through better organized office-based settings. They must emphasize that the high cost of health care is generated by hospitals, and (2) they must
learn to use patients as their best allies in order to effect change. Patients can be a potent political force” (Bennett 324-325). However, it seems more like a rally cry for distressed physicians to regain power through manipulation of different groups of people, rather than moral leadership. Bennett encourages doctors to inform people they are not responsible for the high costs of health care and manipulate others to understand and comply with the perspectives of doctors. However, no one is blameless in the health care system, which has become elitist; thus, leaders must be responsible and accountable for real changes to occur.

Other material addresses the clinical worker, namely nurses, who will have new roles as medicine proceeds into the 21st century. Joan Trofino in “Transformational Leadership in Health Care,” claims there will be an elimination of total physician control of health care, which will provide the public with choices of provider, allowing nurses and others to practice more independently (Trofino 43). Thus, these new leadership roles are addressed in a community setting for nurses, although there are no specific references to current leaders within the field of nursing.

It is evident there is a dearth of material directly concerning leadership in community clinics. Although several articles focused on the necessity to empower communities to initiate community health centers, no article directly addressed actual leaders in this context. Thus, the goal of this project was to apply academic leadership principles to leaders in community health organizations. The concept of empowerment is essential to viable community health clinics, but research on leaders who initiate the community action is necessary to gain greater understanding of the successful models.
James MacGregor Burns’s article, “Empowerment for Change: A Conceptual Working Paper,” defines a leader as an “initiator, who because of certain motivations of her own combined with a certain self-confidence, takes the first step toward change, out of a state of equilibrium in the web” (Burns 3). This project sought to find whether leaders in community health organizations are initiators of change as they seek to recognize and address health issues in their neighborhoods. Research was conducted to understand why and how they risk initiating community action.

The projects are built around community action and thus require relationships to be formed within the community. This can be likened to the previously mentioned “web” in Burns’s work. This web is an equilibrium of internal relationships and a routinatization of personal interactions which lead to a form of stasis, or stability. Another view of the web is “as potential collective leadership arising from certain behaviors, in the form of neighborhood associations, union locals, art alliances, local party caucuses, consumer associations, teenager gangs, militias, etc.” (Burns 2). In his new work, Burns challenges the traditional “leadership-follower conundrum” and proposes a web with many participants, as he writes,

In any web of some size . . . there will not be a simple division between so-called leaders and followers, but a more complex differentiation, as follows:

Initiator, who because of certain motivations of her own combined with a certain self-confidence, takes the first step toward change, out of a state of equilibrium in the web;

Partners, (collaborators, co-leaders) who respond positively to the initiators original message;

Opponents, who respond negatively;

Passives, who initially do not respond but may be drawn into participation by the above actors;

Isolates, who share the motivations and attitudes of other persons in the web but who may stand aside because of apathy or anomie (Burns 3-4).
A.J. Schulz’s study of empowerment as a multi-level construct in community health organizations recognizes this web which is created through interactions. Schulz states, “perceptions and actions, at both individual and collective levels, are associated with empowerment, individuals are embedded within social networks (e.g. friend and family), organizations (e.g. voluntary organizations, churches) and communities (geographic or affiliative), which in turn are components of society” (Schulz 310). Schulz’s social networks are analogous to Burns’s collective leadership in its various forms previously mentioned. Thus, society is composed of webs of people and relationships, which have to be effectively utilized to have a strong community-based effort in organizing around problems.

The principles of collaborative leadership are citizen and civic leaders across the country addressing complex public issues in collaborative ways, which can be directly applied to community health care. “By creating constructive approaches to help diverse citizens with disparate interests interact, they are finding ways to meet the broader needs of the community, resembling citizen leadership” (Chrislip and Larson 1). Richard Couto, a professor in the Jepson School of Leadership Studies, adroitly describes citizen leaders when he writes, “The citizen leaders I have in mind facilitate organized activity to improve the conditions of people in low-income communities and to address other basic needs of society at the local level” (Couto 12). These citizen leaders have certain qualities, which Cheryl Mabey claims are sometimes different from traditional types of leaders. “While others have addressed the importance of developing judgment, problem-solving and critical-thinking skills, a frequently overlooked skill for citizen leaders is learning to ask effective questions and to listen well” (Mabey 317). Listening is important to all types of
leaders, but citizen leaders appear to spend more time with the people in the community and oftentimes listen more closely since they too are affected by similar problems. Mabey sees traditional leaders as possessing more expert knowledge so that they do not always need to listen to their followers to address problems and are concerned with problem-solving in an individual manner. However, collaborative leaders often act as citizen leaders as they attempt to bring about community support for change in neighborhoods.

Currently, several states have started initiatives for community-based, collaborative approaches for developing health-promotions projects in which collaborative partnerships among agencies, institutions, and citizens to understand health challenges are being created to establish more systemic and holistic responses to needs that lead to healthier cities (Chrislip and Larson 10). In Chrislip and Larson’s collaborative leadership theory, they explain these community-based efforts for addressing the health needs of people, “These responses are pragmatically driven . . . The responses are visionary; they go beyond coordination or cooperation to create relationships of trust among diverse organizations and people who recognize the need to share responsibility and accountability for the well-being of the community as a whole” (Chrislip and Larson 11). Leaders are seeking to create a web of relationships among people to effectively meet the needs of individual communities. Not only do they want the physical health needs of people to be met, but also through collaborative efforts for people to gain fresh emotional and mental perspectives. Collaborative efforts require a distinctive process “of shared decision-making in which all the parties with a stake in a problem constructively explore their differences and develop a joint strategy for action (London 1). This approach truly helps
the people in communities to become healthier as they work together and give of themselves.

Thus, the fresh concepts of Burns and the theory posed by Chrislip and Larson were used as a foundation for analyzing leaders within the context of community health organizations. Each one, in its own right, deals with leaders as initiators of change working in a web of relationships to empower communities through collective actions.

**Methodology**

The case study method was employed to research the proposed questions and to analyze the collected data. This method requires direct observation, systematic interviewing, and examination of a variety of evidence (Yin 20). It utilizes analytic generalizations to interpret data, thus expanding and generalizing theories, not enumerating frequencies as in statistical analysis (Yin 21). Consequently, previously developed concepts and theories are used as a template with which to compare the empirical results gathered from the study, as was done in this project.

There are five components to the case study research design including, (1) a study’s questions, (2) its propositions, if any, (3) its unit(s) of analysis, (4) the logic linking the data to the propositions, and (5) the criteria for interpreting the findings (Yin 29). Thus far, the study’s questions were posed in the description of the purpose.

Currently, VHCF has 49 model projects with directors at each site. From this pool, five people were selected to provide data through an interviewing process. The basis for selection among these people included the success of their project, the location of their project, and the professional background of each one in order to obtain a diverse group. Although this does not seem like a large sample size, case studies do not employ
statistical analysis. Thus, it is not the number of people interviewed, but the data gathered from the cases that is used for analysis.

Some of the people interviewed were "Unsung Hero" award winners. This prestigious award is given out annually to those involved in VHCF projects as employees, volunteers, or donors who demonstrate "Heroic Efforts Reaching Others through local service. As role models, Unsung Heroes heighten public and professional understanding and recognition of the mission of the Virginia Health Care Foundation" (Annual Report 7). Thus, the unit of analysis for this multiple-case study was the individual and his or her career while serving at one of the VHCF model projects or other Virginia-based community health organizations.

The interview process proceeded under a guided approach. This method was selected since open-ended interviews, in which participants are asked the same questions in the same order, may constrain and limit the naturalness and relevancy of the response (Schumacher and McMillan 427). While the guided approach has topics selected in advance, it allows the researcher to decide the sequence and wording of the questions during interviews. A real conversation between the interviewer and the interviewee allowed the individuals to "tell their stories" and fully describe the context in which community health leadership occurs. Also, each person interviewed was asked to draw a picture of their concept of leadership. This served to provide more insight into the stories of the leaders. Hence, this type of interview presented a more realistic picture of the people.

The interviews were recorded in two different manners. First, permission was obtained to record the interviews on micro-cassette. The interviews were recorded in this
fashion so that as much information as possible could be obtained from the conversations with people interviewed. After the interviews, the conversations were transcribed and are included in the appendices. Key points by the interviewees were also recorded on paper.

Some information was gathered through newspaper articles and relevant background information provided by the interviewees. These materials provided information on the missions of the clinics and how they originated. Also, organizational charts, some financial records, and clinic program brochures were used to gain a holistic picture of community health.

In the case study method, replication procedures should be employed so they can be applied in other similar situations. Through using techniques which can be replicated by others, a researcher must state the conditions under which a particular phenomenon is likely to be found as well as the conditions when it is not likely to be found. For this particular project, the same questions were not used for each individual interviewed, however, similar probing topics were used. Also, there was an attempt to spend the same amount of time with each of them in an effort to attain a form of replication.

There is no precise way of setting the criteria for interpreting findings from a case study. Thus, case studies are often questioned as to their rigor as an effective research method. A problem of knowing whether a study’s findings are generalizable beyond the immediate case study constantly exists (Yin 43). Therefore, the research must strive to generalize a particular set of results to some broader theory, such as the pattern-matching method. With this method several pieces of information from the same case can be related to some theoretical proposition. In this study, the notion of leaders as initiators of change and the theory of collaborative leadership provide the conceptual base for interpreting the
findings. If the findings are compatible with these concepts then it could make them more valid and generalizable according to the pattern-matching method.

Two basic methods of analysis of data were employed for this project. First, a content analysis was performed on all of the interviews. This method requires a search for keywords, trends, or ideas in the transcribed interviews. Repeated ideas served as a basis for generalization and a profile of community health leaders and their environments. Similarities and differences among those interviewed were also analyzed through this technique. Thus, the enumeration of key concepts from the interviews may demonstrate difference in leadership styles among those interviewed.

The second method of analysis used the theory created by leadership scholar Howard Gardner as a lens with which to view the stories of the leaders and how they reflect a particular leadership style. He states, “the ultimate impact of a leader depends on the particular story he or she embodies, and the receptions to that story on the part of audiences (or collaborators or followers)” (Gardner 14). In his work he places a strong emphasis on the strong individual leader, while establishing a link between the leader as a storyteller and the process of community building. This link is established through their stories which have the primary purpose of binding together the community (Gardner 42). Although the stories are primary, they are not always related as words, but in action. “Leader’s embody those stories. That is without necessarily relating their stories in so many words or in a string of selected symbols, leaders such as [George S.] Marshall convey their stories by the kinds of lives they themselves lead and through example, seek to inspire their followers” (Gardner 9-10). Thus, leaders may tell stories through nonverbal communication.
The most compelling story of those interviewed was analyzed to determine its innovation and the effectiveness of the leaders involved. The one story determined to be the most compelling illustrated a community stereotyped by society for years finally uniting to complete a project considered impossible by outsiders. There were numerous participants engaged in a long-term effort to bring medical services to the community. It was unlike other stories because it was not a group of professionals implementing their wants and needs for the community, but truly a project "from the people, for the people."

The story was analyzed in light of Gardner's stories of the group, in which individuals who are unsatisfied with their group membership will be on "the lookout for the leader who offers a different set of options with respect to group memberships, including the possibility of creating new groups" (Gardner 54). Also Gardner distinguishes different types of leaders, including ordinary leaders, innovative leaders, and visionary leaders, by the innovativeness of their stories (Gardner 10). Ordinary leaders "by definition the most common one, simply relates the traditional story of his or her group as effectively as possible (Gardner 10). "The innovative leader takes a story that has not been latent in the population, or among the members of his or her chosen domain, and brings new attention or a fresh twist to that story" (Gardner 10). Finally, Gardner states the rarest individual is the "visionary leader. Not content to relate a current story or to reactivate a story drawn from a remote or recent past, this individual actually creates a new story, one not known to most individuals before, and achieves at least a measure of success in conveying this story effectively to others" (Gardner 11). Thus, the leaders in this story were analyzed as to the type of leadership style they used according to Gardner's classification.
Once the interviews were completed, they were analyzed in light of the work of James MacGregor Burns concerning his recent work proposing leaders as initiators of change and David Chrislip and Carl Larson and their work on collaborative leadership. The probing topics in the interviews were focused on the issues in these concepts and theories. These frameworks were chosen for several reasons. Burns, considered the founding father of leadership studies, has recently proposed a new view of leadership in his paper "Empowerment for Change: A Conceptual Working Paper." Although this concept is still being developed, the new ideas are distinct from other leadership theories and are being widely discussed by leadership academicians. Burns’s new concepts of leadership are demonstrated in his writings, "[there is] an existence of webs of potential collective leadership, arising from [people acting as initiators of change], in the form of neighborhood associations, union locals, arts alliances, local party caucuses, consumer associations, teenager gangs, militias" (Burns 2). It provides a good base for interpreting the empowering acts of leaders in community health organizations as they unite people into webs of action. The conversations with the leaders were analyzed to determine whether or not they have initiated with others in addressing the health concerns of their communities. He also identifies these leaders as having an ethical foundation in order to build relationships of trust and honesty (Burns 7). They understand the influence they and those around them possess. Thus, the question arises whether or not these participants in the web exercise mutual restraint as they work towards a goal. Hence, the words of these leaders were analyzed to determine if these qualities were important to their values.

Burns further explains a leader as also demonstrating collaborative efforts, "the initiator may continue as a single and dominating 'leader,' a la Castro, but more typically
she will merge with others in a series of participant interactions that will constitute collective leadership” (Burns 4). Thus, collaboration is a process utilized by leaders which usually produces more substantial results than that of individual effort. As part of the analysis, the webs of people in the communities were analyzed to determine if there were diverse participants, as discussed in the Literature Review.

Finally, the theory of collaborative leadership combines the attributes of transforming, servant, and facilitative leadership. It focuses on citizens and civic leaders, portraying these people as “citizen leaders.” “The role of leadership in collaboration is to engage others by designing constructive processes for working together, convene appropriate stakeholders, and facilitate and sustain their interaction” (Chrislip and Larson 127). It discusses coalition-building among agencies and leaders in a community, which seems to be essential to effective community health organizations. Richard Wellins in Empowered Teams presents essential qualities of collaborative leadership and include:

- Ability to learn
- Business planning
- Communication (oral and written)
- Delegation of authority and responsibility
- Developing organizational talent
- Follow-up
- Identification of problems
- Individual leadership (influence)
- Information monitoring
- Initiative
- Judgment
- Maximizing performance
- Motivation to empower others
- Operational planning
- Rapport building (42)

Thus, the conversations of the leaders were analyzed to determine whether or not they displayed these qualities or whether they valued them.
Thus, both of these ideas of leadership focus on community health leaders as facilitators to meaningful change and served as concepts and theories for the pattern-matching method used to analyze the case studies. The conversations focused on these concepts and they were analyzed to determined whether or not they were applicable in community health organizations. Both of the proposed frameworks appeared to offer a part of the whole leadership picture within this context. It was not presumed that these concepts were capable of a full description of the leadership which exists in community health clinics.

Throughout the process it was recognized that influence and biases affects the gathering and the interpretation of data. Several factors influence interviews including the duration of the session, the number of interviews to acquire the necessary data, the setting and location of the interview, the identity of the individuals involved, and the informant styles (Schumacher and McMillan 430). With the guided approach technique for interviewing, the possibility for interviewer biases is greater since the questions are not identical in each interview. Thus, caution was used when the collected data was interpreted since the direction of the interviews were possibly altered by the interviewer. Other biases included the interviewer’s framing of the questions and the biases of actual people being interviewed. The topics for inquiry for each person interviewed were first formulated and then reviewed by several other parties in an effort to diminish the researcher’s biases, see Appendix 1 for interview form.

When interpreting the data it was recognized that the individual interviewed provided only one perspective. Thus, their bias may have influenced the results. To obtain a more realistic picture of their leadership ability, one would have needed to
interview others within the organization and those in the community. Although the focus of the visits to the community health centers in this project was to gather information from the individual leader, there was an attempt to observe the clinic and those working in it. However, extensive interviews with these people did not occur. Therefore, it is acknowledged by the researcher that some bias exists in the results.

Thus, the goal of the project was to offer a more detailed description of the characteristics and efforts of leaders in community health organizations in their quest for change. The results helped to determine the validity of these proposed concepts and provided a more educated description of leadership in community health organizations.

Data

Five interviews were conducted with people associated with four different community health organizations. The transcriptions of these interviews are in Appendices 2-6. To begin four out of the five interviews, I asked the person to draw a picture of his or her own concept of leadership. Each picture is presented with the description the person offered after completing the drawing.

Myrna McLaughlin, Executive Director of Cross-Over Health Clinic, drew this picture as her definition of a leader,

Figure 1.
Her picture shows a group of people.
extraordinarily large tray. She described as the leader, one ears for listening and symbolize service to The individual has ears and is holding a the unusual character who must have large holding a tray to others.

Dr. Susan McLeod, Director of Thomas Jefferson Health Department in Charlottesville, Virginia, presented the following picture as her definition of leadership, Figure 2.

The leader is the box in the middle. Dr. McLeod described the leader as “drawing people from a lot of different areas (smaller boxes) and pulling them together in a particular direction” (McLeod 1997).
Dr. Art Vanzee, the original and one of the current physicians in the St. Charles Community Health Clinic, made it clear these were only his initial feelings since he only had a short time frame in which to conceptualize his definition of leadership, drew the following picture,

**Figure 3.**

The large stick figure is the leader with many people, represented by the slash marks, surrounding the person. He described the picture by saying, "Somebody who would be a leader would be somebody who comes from within the community group, does not come
from the outside. Basically understands the community as well as respect, and have credibility in the community. It’s very much a two-way street [represented by the arrows pointing towards and away from the leader]” (Vanzee 1997). The squiggle lines above the head of the leader represent doves. Dr. Vanzee explained that the doves symbolize “... something special about some person that becomes a leader and that can be strength of character, strength of will, or intelligence, or a gift with people, or something special about that person that engenders a real respect and a kind of leadership role in the community” (Vanzee 1997).

Judy Knudson, Executive Director of Olde Towne Medical Clinic in Williamsburg, Virginia, discussed her concept of leadership as she drew this picture, Figure 4.

Once again the leader is in the center and is surrounded by agencies of local government and the United Way. Ms. Knudson described the lines going out from the leader as symbolic of being “connected.” She wanted to include in her drawing, but was unsure of how to represent it, the leader as “willing to have an opinion.” Finally, she placed the words “work” and “beliefs” above the leader to indicate the leader must have a “willingness to work” and also have a “core set of beliefs.”
After the leaders completed their drawings, the interviews were conducted to discover information about the leaders and their organizations. The highlights of their conversations are presented as miniature case studies in the following section.

**Cross-Over Health Clinic**

Although I had never walked through the doors of Cross-Over Health Clinic previous to the interview, I was a witness to the services they enabled people to obtain during my work as an intern at Stuart Circle Hospital. Finally this project allowed me the opportunity and privilege to visit the clinic and to interview the Administrative Director, Myrna McLaughlin, see Appendix 2 for interview. During my time spent with Ms. McLaughlin, we discussed the history of the clinic, the purpose of Cross-Over, the volunteers and patients, and with reluctance Ms. McLaughlin, herself.

The clinic began operation in 1982 every other Saturday morning at the Storefront Church on Broad Street. In the initial stages, those who began the clinic were not even sure there was a true need for their services. The purpose of the clinic was not clear to many people in the community, either, due to the religious affiliations it had. Other service providers thought they simply prayed with people and this was not accepted well in the community.

However, Ms. Januzzi, the Cross-Over persisted in serving the people.

McLaughlin and Dr. Medical Director of Health Clinic, their efforts to serve...
Finally, they built trust within the community and in 1990 constructed a building on the corner of Hull Street and Jefferson Davis Highway on the southside of Richmond. They also established another clinic in the Daily Planet, a homeless shelter in downtown Richmond. Although they have not been operating in the Daily Planet for the past few years they are currently contracting with the shelter again and remodeling a space to begin work there once again.

Currently, Cross-Over Health Clinic offers primary care services for no charge, and has a mission to first serve the people and “to connect the talents and resources of suburban Richmond with the needs of the inner city” (McLaughlin 1997). Although it was originally established as a health clinic, it also provides help within its capabilities to help resolve non-health related difficulties people are facing.

Ms. McLaughlin described her own role as a leader to be the “enzyme,” or catalyst for change. Analogous to the rate-enhancing effect of an enzyme interacting with cells in the body, she stated, “I bring people together and I enhance their interactions, make things happen that way” (McLaughlin 1997). Ms. McLaughlin feels she has not only served as an enzyme, but so has Cross-Over Health Center in functioning as a leading organization on the southside of Richmond. She says the clinic goes even further by being the “yeast” for the community, helping it to rise to new levels in many senses. It is obvious from the area immediately across from the clinic

Figure B. Administrative section of Cross-Over

20
that there is a building renewal initiative occurring. Thus, Cross-Over is helping to bring about change in the health of people along with many other aspects of their lives and community.

Other qualities she deemed as important to successful leadership in community health organizations included availability of the leader, experience in the community, a willingness to stand firm in one's values, proving yourself worthy of trust, ability to serve as an avenue for change, and the forming of a network of relationships with those in the community. She felt these qualities were essential in understanding the essence of a community and representing to others as their advocate for better health care and quality of life.

Empowerment was another key point of Ms. McLaughlin's. Too often, people who are most affected by policies, from the government, insurance companies, and the managed care world, in which they have no input. Thus, she hopes to aid these underserved people to take their health into their hands. Cross-Over Health Clinic is helping the citizens of Richmond to gain a better understanding of health issues which effect them personally. Currently, they have a program, the “Lay-Help Promoter Program,” which trains people in neighborhoods concerning health care issues. They teach practical principles such as how to take temperature and blood pressure and educate them about common diseases like diabetes and hypertension. This is especially
important in the surrounding areas where neighborhoods are tightly packed with people because according to Ms. McLaughlin, “People are going to listen to their neighbors.”

In order to tackle such a formidable task as running the clinic, with the deep emotional and spiritual involvement it requires, Ms. McLaughlin finds motivation and inspiration from several sources. She described several poignant stories of patients who had come for services at Cross-Over out of desperation and the clinic was able to provide for them. She enthusiastically claims, “I love what I do... I guess the bottom line is I love to be in the thick of things” (McLaughlin). Not only the unique stories, such as the one she tells of the homeless man who obtained services from Cross-Over and eventually raised himself to have his own ministry and a family, but also the everyday people Ms. McLaughlin sees walking in and out of the clinic motivate her to continue in her role in service to others.

**Thomas Jefferson Health Department**

Dr. Susan McLeod, Director of the Thomas Jefferson Health Department and a VHCF Unsung HERO, was able to give a broader view of addressing health care in communities since her job is in the arena of public health. Thomas Jefferson Health Department is actually the Public Health Department for Charlottesville, Virginia. Dr. McLeod described the focus of the public health as “not just on delivering health care to the individual, it’s on the assessment of the whole population, on developing education services, prevention activities, analyzing what’s going on in the community, and helping it move towards different areas” (McLeod 1997). Thus, there may be a clinical component to some public health departments, but it is not the sole purpose of their existence.
Dr. McLeod in her roles as assistant director and director at the Health Department has been a key player in several community health clinics and programs funded by VHCF to address health care needs for individual people. One of the projects involved a program called CHIP, Comprehensive Health Investment Program, for children. "It is a partnership between private physicians, community action agencies, which are the anti-poverty groups, and Public Health Departments. It provides a team of professional nurses and lay-home visitors to work with families and help kids have a home for their care, a medical home" (McLeod 1997). CHIP helps to educate the parents about the health needs of the children and helps them to learn about using community resources to meet their family's social, financial, and educational needs. The program provides them "access to tools to help improve parenting and help improve the family stability" (McLeod 1997).

The MOS Program, Medical Outreach Services Program, was established in Louisa County from funding provided by VHCF and through efforts of people including Dr. McLeod. A private physician in the county along with churches, people from social services, and a nurse from the Health Department were concerned with "the lack of resources for care for people who didn't have insurance" (McLeod 1997). Due to a lack of space and resources, a free clinic was not established, but instead services were provided to people in doctors' offices with money from VHCF. Also, the money help to fund extra time for a nurse practitioner from the Health Department to do additional work in concert with private physicians in the community and provide more time and services to the people.
A third project involved the establishment of a free clinic in Charlottesville. Medical residents at the University of Virginia began discussing a free clinic after they saw patients receiving care in the emergency room for sickness and injury that should have been addressed at a much earlier stage. They were directed to Dr. McLeod because of her position in the Health Department and she became involved with the steering committee and planning. Although their application for money from VHCF was denied, they were still able to establish the Charlottesville Free Clinic. After residing in rented space in a local hospital, the clinic eventually moved to space in the Health Department.

Collaboration was very important in initiating these three programs. Diverse people and agencies came together to help solve the problem their communities were facing with the health care issue. During the interview, Dr. McLeod reiterated the importance of collaboration and stated, “There’s a responsibility there, in that, to look at needs in your community and help develop partnerships with public and private groups to focus on needs” (McLeod 1997). However, collaboration is not always an easy process. Although there are a lot of people interested in this issue and abundance of resources in Charlottesville, it can be difficult to “pull together so many different ones because of the vested interests” (McLeod 1997). One of the focuses of public health is to “encourage collaboration.” She sees a lot of agencies working on similar projects instead of sharing the burden. Dr. McLeod claims,

People are willing to work together, but when it comes down to really saying can we break down these things and quit doing your part and my part and do our parts together. That’s hard and I know it’s hard . . . because you come with rules and regulations and funding streams and all other kinds of stuff, but they kind of make it difficult for you to just throw it all on the table and say let’s all work together.

Thus, collaboration is the ideal situation, however it is not always easy to establish.
The issue of empowerment has also been “central to a lot of public health principles because education of a person to take care of themselves better to prevent things is sort of basic to everything we’ve been doing for a long time” (McLeod). Through programs at the Health Department, they are “helping pregnant women know how to care for themselves, helping young mothers know how to care for their infants, helping people in food service learn how to do thing right to prevent illness” (McLeod 1997). Although empowerment has a negative connotation to many people, the Health Department is attempting to help people in communities to become healthier through education and connecting them to resources.

In the programs discussed, Dr. McLeod described her role as a background player, claiming, “It wasn’t something I started . . . I was one of several people who started talking about looking at our needs and bringing things together and seeing an opportunity to plug into this particular kind of grant” (McLeod 1997). She is hesitant to label herself as a leader, but understands why she is recognized as one due to the position she holds. The ability to understand other people and needs within the community is one of her strongest assets and she feels communication is also an important aspect of effective leadership. The leadership she exhibits in the community appears to be one of understanding and resourcefulness, enabling others to effectively address the health care needs of individuals as she attempts to focus on the broader population in public health. Her motivation for becoming involved in public health stemmed from her fascination with the concept of prevention and addressing a broader context than individual care.

*St. Charles Community Health Clinic*
During the summer of 1973, a group of medical students working with the Appalachian Student Health Coalition at Vanderbilt University conducted a health fair in the rural coal-mining town of St. Charles, Virginia. The Student Health Coalition “served as a kind of vehicle and a kind of a catalyst for getting those things done. We were just helping people to organize around their health issues” (Vanzee 1997). However, this process was not easy because of “a pretty pervasive, genuine mistrust of outsiders coming into the mountains.” The students, though, did not come in as experts with all the answers for the problems of the community. They were “young, enthusiastic college students” who resided in the homes of local people for several weeks during the health fairs. Open-minded, non-judgmental, and curious, these students were able to build a bond of trust with those in the community after a period of time.

The students examined over 750 adults and children during a two and a half weeks period and increased awareness of health needs in the community. After the health fair ended some of the students stayed behind to help organize a meeting “The community meeting was held on July 26 [1973]. Well over 60 residents came to discuss their medical needs and possible long-range solutions to their problems” (St. Charles Scrapbook 2). During
the meeting they formed the St. Charles Health Council (SCHC), a nonprofit corporation, in order to build a health clinic staffed with doctors and nurse practitioners. "A chairman, secretary, and a committee of representatives from each area were selected to lead and direct the newly formed Council" (St. Charles Scrapbook 2). Charlie Provence, a lifelong resident of St. Charles, was elected as chairman of the council and after their charter as a non-profit organization was completed he became president. Mr. Provence felt he was elected because he "had been involved in a few little projects" for young and older people in the community.

SCHC raised money through local fundraising projects such as bakesales, barbecues, and country variety shows. Most of the funds were derived from local people and organizations, including a $5,000 donation from the Lee County Board of Supervisors. A $30,000 grant from "The Campaign for Human Development, an agency of the Catholic church," was crucial in the construction of the clinic; however, SCHC ran into opposition from some in the community "because people said well the Catholics will take over" (Provence 1997). Once again suspicion of outsiders was ignited, but Charlie and the council helped to calm their concern. Finally, a twelve room clinic was constructed in the summer of 1975 through local efforts and donated materials. It opened its doors on January 26, 1976 staffed with a nurse practitioner and a part-time physician.

The clinic obtained the services of a full-time physician in September of 1976. Dr. Art Vanzee, after completing residency work at Vanderbilt University, came to the community after supervising a second health fair in St. Charles the previous summer. Dr. Vanzee has had to work at building trust in the community. Through establishing relationships and respecting people he has gained the confidence of the residents in St.
Charles. Charlie Provence is convinced the long-term commitment Dr. Vanzee has made to the clinic has been integral to its success. Mr. Provence stated, “He has made a real commitment. I think had he had not stayed it might have been a different story. It might have been a real long time before it was successful. He made a big difference when he came and hung up he shingles.” Dr. Vanzee added stability and validity to a project that was questioned by surrounding communities. His desire to practice medicine in high-need areas where there was a lot of community involvement prompted him to stay in St. Charles. Also, the social and economic problems of the area matched his social concerns he developed in the 1960s.

Along with Dr. Vanzee’s arrival the success of the clinic was driven by the hard-work of the community. Most people did not expect them to succeed in their venture, as Dr. Vanzee stated, “A lot of people in Lee County look upon this part of the county as kind of the ghetto, as people would say in the city, because it was a little poorer than the rest of the county, a little tougher. So, I think there was a sense of nothing good is going to come out of the clinic project up there” (Vanzee 1997). However, the people of St. Charles would not let outside doubt dissipate their goals.
The clinic has a newspaper clippings and which chronicled the entire community struggled to funds necessary to realize articles reflected the hard-

A common need and a effort can work and this is just what is happening at St. Charles. The people of the area have united in an effort to establish a clinic there and their work is bearing fruit . . . The impressive fact concerning this effort is the sincere interest and desire of the people of the community, especially the women. Perhaps they are more aware of the health problems confronting the community than are the men (St. Charles Scrapbook 5).

Another article echoes these sentiments, “The building is not only the talk of the town its the work of the town” (St. Charles 7). Throughout this process, members of the community pitched in to help in any way they could. Electricians, carpenters, brick masons, attorneys, housewives all donated their time and skills in efforts for raising money and constructing the building.
As the clinic was being built, the community gained a sense of pride. The sentiment of the time, according to Mr. Provence was “a sense of achieving whatever they [the community] would like... you know people were willing to work and get involved in it, I mean not just a select few, everybody” (Provence 1997). Not only did the community finish the clinic, but they also came together to begin other projects, such as construction of a community center in which adult education classes are taught, a clothing store, and community college classes. In a letter to the editor, two residents of St. Charles wrote, “It gives you a good feeling knowing that something good is being done in your town, and that you are a part of it. I guess what pleases me most is knowing that we, the people of St. Charles and surrounding areas can do something important as building a clinic building” (St. Charles Scrapbook 13).

In the following years the clinic added more staff, including full-time physicians, and went through two additional expansion phases. The clinic now has a two physicians, two dentists, a nurse practitioner, perinatal care managers, and administrative staff. SCHC has also helped to
initiate clinics and health services in surrounding communities, such as Ewing, Pennington Gap, Vansant, Jonesville, Haysi, and Davenport. SCHC, in 1991, became “Stone Mountain Health Services” and now is an umbrella organization for four corporations in the areas surrounding St. Charles. The mission of Stone Mountain Health Services (SMHS) is “to increase the availability and accessibility of primary health care for people living in the communities we serve, regardless of patient ability to pay full charges” (SMHSP Information 3).

They have increased access to primary care through a sliding-fee payment program, locations in medically underserved areas, and acceptance of public and private insurance. SMHS has helped to build communities through participation in programs of community development and outreach and case management services. It cooperates with other agencies to integrate and extend services and participates in medical and nursing education programs.

**Olde Towne Medical Center**

The Williamsburg Area Medical Assistance Corporation (WAMAC), which operates Olde Towne Medical Center (OTMC), is a public-private partnership which was formed in 1993 by James City County, York County, and the city of Williamsburg to address the needs of the area’s medically unserved and underserved population (OTMC
OTMC is a rural health center with a mission to provide “preventive care and early intervention services to a vulnerable and disadvantaged population with services to children and their families as a priority” (OTMC Background).

As health departments’ budgets were cut, they withdrew services to surrounding communities. In order to obtain health care, the uninsured had to travel to Newport News. However, there was no transportation to this facility and it was not feasible for these people to travel that far of a distance. During this time period local doctors were seeing patients in the emergency room who were extremely sick and who should have received treatment months before these episodes. So, doctors, school officials, government people, and social service agencies came together to help form OTMC.

When it was originally formed, OTMC did not have an executive director. Instead the leadership came from an office manager and the clinic director who was a nurse practitioner. Also, in this first year a doctor agreed to help out with patients and act as Medical Director. As the year mark approached, both the doctor and a man from James City County, who was helping them with the financial aspects of the clinic, resigned. The clinic was in the midst of turmoil as the clinic director and office manager clashed and suffered a lack of leadership. At this point in time, the board asked Judy Knudson, who was serving as chairman of the board, to be the executive director.

Ms. Knudson accepted the position since she enjoyed being involved in the community and appreciated new challenges. She had previously served in numerous leadership roles, including being a member of the James City County Board of Supervisors and president of the Women’s League of Voters. She stated that being a director in the context of community health has commonalities with other contexts, such as fundraising
and building relationships with others in the community. Yet, there are some major
distinctions. According to Ms. Knudson,

The distinction of course is that what you’re doing is so immediate and real
because people are sick . . . I think it’s the immediacy of it. Even though other
things are immediate, I think somehow in health care when people are sick it
changes the level a little bit (Knudson 1997).

She also stated that the focus on relationships and people adds to the context’s
uniqueness. Other factors which affect community health are fighting society’s
marginalization of the poor people the clinic serves and dealing with hard patients “who’ve
been beaten around by the system.”

To be an effective leader, she claims a leader needs to be connected with lots of
resources in the community. Leaders must be willing to take risks and have an opinion.
In order to form these opinions, a person must have a core set of beliefs and truly know
who they are. Many of Ms. Knudson’s beliefs and values originate from her days as a
Peace Corps volunteer. During the 60s, people such as her “were all going to save the
world. We were going to go out there and do good and change the world” (Knudson
1997). She feels she has never lost those values and now views community health as her
own arena to make significant changes in the lives of people. “Now, the nice thing about
this is I can work on my own little corner of the world. I’m not trying to save the entire
universe now, I’m just trying to work on my part. It’s sort of manageable and it’s
endlessly interesting” (Knudson 1997).

One of her responsibilities as a leader in community health is to connect people to
resources. The clinic is situated in a community that is rich in resources, but many people
do not know the avenues to take to use these resources. In order to connect the patients,
Ms. Knudson must herself understand the surrounding community and be involved in it,
constantly building relationships with key leaders. She proposes that a possible reason that health care is undergoing so many changes is due to a lack of leadership displayed by the doctors. Many physicians simply want to treat patients and do not want to spend time building necessary relationships.

Analysis

Sample Group

Ideally the people interviewed for the project were supposed to be representative of community health in the state of Virginia. Although a perfect representation is practically unachievable, certain criteria were established in order to obtain a representative sample, see Methodology section. In the end, the group of five community health leaders did not have as much variety as I anticipated; however, those interviewed included three women and two men with four having professional training. Two of the people were doctors, one a female and the other a male. All of the interviewees were involved with community health clinics at one point in their life, while only three are directly involved in clinics at the present time. Currently, Dr. McLeod is involved with public health. In this role she not only helps in initiating community health organizations, but she also takes a broader view of health and the population as a whole. Charlie Provence no longer has daily responsibilities with the St. Charles Community Health Clinic or the St. Charles Health Council, but played a vital role in the early stages of establishing the clinic to meet the needs of the community.

The western side of the state was represented by Dr. Art Vanzee and Charlie Provence. Each are associated with the clinic in St. Charles, located near the state lines of Tennessee and Kentucky. Olde Towne Medical Clinic in Williamsburg is located in the
eastern part of the state and headed by Judy Knudson. Myrna McLaughlin is the director of Cross-Over Health Clinic which is situated on the southside of Richmond, representing the central section of Virginia. Also located in the central part of state is Thomas Jefferson Health Department, although it is toward the western side. Dr. Susan McLeod is the director of this Health Department in Charlottesville.

The three clinics I visited were each very different in the type of population they addressed. Cross-Over Health Clinic is located in urban Richmond and serves a predominantly African-American community. The clinic is a small gray cinder block building sitting next to an unused church and numerous row-houses. There seems to be a mix of run-down and modern buildings near the clinic, but the atmosphere reflects a community in need of renewal. The clinic in Williamsburg, Olde Towne Medical Clinic, is housed in the same county building as other social services and reaches a more suburban population. The majority of their patients are women and children. In contrast to each of these is St. Charles Community Health Clinic. It is situated in a small rural town in the mountains of western Virginia in a region known for the coal-mining industries. The residents there are mainly Caucasian and reside in dilapidated homes along the mountainside. Thus, each of the three clinics offered a distinct view of community health in their varying contexts.

Content Analysis

After completing five interviews, content analysis was performed on each transcribed interview to determine key ideas and words which were common among those interviewed. Although each person did not use identical words, many of them had similar concepts in our conversations. In the following tables, examples of the phrases and
general ideas from the interviews are given in one column, while the other column
indicates how frequently they were used.

First, there were common and themes and characteristics associated with leaders
among the pictures that were drawn by all four of the people, see Table 1.

Table 1.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leader in the center</td>
<td>4</td>
</tr>
<tr>
<td>Surrounded by people &amp; agencies</td>
<td>4</td>
</tr>
<tr>
<td>Connecting arrows</td>
<td>3</td>
</tr>
<tr>
<td>Leader originates from group</td>
<td>3</td>
</tr>
<tr>
<td>Connection to resources &amp; people</td>
<td>2</td>
</tr>
<tr>
<td>Two-way street between leader and followers</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics of Leader</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Servant</td>
<td>2</td>
</tr>
<tr>
<td>Respectful</td>
<td>1</td>
</tr>
<tr>
<td>Credibility</td>
<td>1</td>
</tr>
<tr>
<td>Strength of character</td>
<td>1</td>
</tr>
<tr>
<td>Core set of beliefs</td>
<td>1</td>
</tr>
<tr>
<td>Listener</td>
<td>1</td>
</tr>
</tbody>
</table>

Collaboration, the development of relationships with people and agencies in the
community to address needs, specifically health care, in the community, was the concept
discussed most frequently. Table 2 gives the phrases used in discussing the idea of
collaboration. During the five interviews, collaboration was an idea used 38 times among
the five people interviewed.
As discussed in the literature review, empowerment is a key focus of community health organizations. Educating people about their help and connecting them to resources and tools to help make them self-sufficient is the latest focus of Public Health and a key issue among community health clinics. Empowerment was discussed in the interviews along with programs the clinics offer which help to empower people in the community. Although the word empowerment was not always used, the concept was used 34 times during the interviews, see Table 3.

These community health clinics were started by people who saw needs in the community. They attempted to address the issues of physical and monetary accessibility
to health care in their own communities. Leaders of this process were described as initiators of change, those who served as a catalyst in beginning the projects of addressing health care. The concept of those who initiated change as being leaders was discussed 31 times during the interviews, see Table 4.

Table 4.

<table>
<thead>
<tr>
<th>Phrase</th>
<th>Frequency</th>
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</thead>
<tbody>
<tr>
<td>Initiation of ideas</td>
<td>6</td>
</tr>
<tr>
<td>Organizer</td>
<td>4</td>
</tr>
<tr>
<td>Catalyst</td>
<td>3</td>
</tr>
<tr>
<td>Vehicle</td>
<td>3</td>
</tr>
<tr>
<td>Raise interest</td>
<td>2</td>
</tr>
<tr>
<td>Jump-start</td>
<td>2</td>
</tr>
<tr>
<td>Impetus</td>
<td>2</td>
</tr>
<tr>
<td>Enhance interactions</td>
<td>2</td>
</tr>
<tr>
<td>Enzyme</td>
<td>2</td>
</tr>
<tr>
<td>Creative thinker</td>
<td>2</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

Leaders were described as initiators, but the interviewees also mentioned other characteristics which they deemed essential to effective leaders. Among the five interviewed the most important quality appeared to be a sense of commitment and stability displayed by the leader. Other qualities which were used frequently include good listening skills, wisdom, resourcefulness, persistence, trustworthiness, and several others. The following table lists the characteristics mentioned by the five interviewed and also displays the number of times they were discussed.
Table 5.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Frequency</th>
<th>Characteristic</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deeply committed, stability</td>
<td>7</td>
<td>Visionary</td>
<td>1</td>
</tr>
<tr>
<td>Good listener</td>
<td>4</td>
<td>Spiritual basis</td>
<td>1</td>
</tr>
<tr>
<td>Wisdom</td>
<td>4</td>
<td>Representative</td>
<td>1</td>
</tr>
<tr>
<td>Resourceful</td>
<td>4</td>
<td>Genuine</td>
<td>1</td>
</tr>
<tr>
<td>Availability</td>
<td>3</td>
<td>Reflective</td>
<td>1</td>
</tr>
<tr>
<td>Persistence</td>
<td>3</td>
<td>Enthusiastic</td>
<td>1</td>
</tr>
<tr>
<td>Trustworthy</td>
<td>3</td>
<td>Non-judgmental</td>
<td>1</td>
</tr>
<tr>
<td>Relishes intense atmospheres</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core set of beliefs</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsible</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community member</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good communicator</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action-oriented</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respectful of others</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Along with characteristics of leaders, those interviewed also talked about actions and responsibilities of leaders. Understanding the complexity of a situation and the difficulties it encumbers was the most frequently discussed responsibility of a leader. Interestingly, serving people, an idea brought up frequently in the Jepson School, in the community was also discussed quite often. Other responsibilities and actions of leaders are listed in Table 6 along with the number of times it was used.

Table 6.

<table>
<thead>
<tr>
<th>Action</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the situation</td>
<td>11</td>
</tr>
<tr>
<td>Serve people</td>
<td>9</td>
</tr>
<tr>
<td>Work in the community</td>
<td>7</td>
</tr>
<tr>
<td>Learn about followers</td>
<td>5</td>
</tr>
<tr>
<td>Work appropriate amount of time</td>
<td>5</td>
</tr>
<tr>
<td>Take risks</td>
<td>4</td>
</tr>
<tr>
<td>Coordinate events &amp; people</td>
<td>2</td>
</tr>
<tr>
<td>Fundraising</td>
<td>2</td>
</tr>
<tr>
<td>Make decisions</td>
<td>1</td>
</tr>
<tr>
<td>Meet people's needs</td>
<td>1</td>
</tr>
<tr>
<td>Make root changes</td>
<td>1</td>
</tr>
<tr>
<td>Make a stand</td>
<td>1</td>
</tr>
</tbody>
</table>
The demanding job of working in a community health clinic would deter most people from attempting to tackle such an important and exhausting task. However, each of these leaders discussed their own personal motivations for working to address the issue of community health. All of the leaders were alive in the 1960s, with four of them being impressionable young adults at this time. Many claimed their motivations are rooted in the social concerns of the 60s. Some of the interviewees discussed their idealized mentality of “saving the world.” Another frequently espoused motivation was to serve the patients of the community. These and other motivations are listed in Table 7 along with the frequency of use.

Table 7.

<table>
<thead>
<tr>
<th>Motivation</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social concerns of the 60s</td>
<td>6</td>
</tr>
<tr>
<td>Serving patients</td>
<td>5</td>
</tr>
<tr>
<td>Filled a void in life</td>
<td>3</td>
</tr>
<tr>
<td>Love of work</td>
<td>1</td>
</tr>
<tr>
<td>Admiration for people fighting adverse conditions</td>
<td>1</td>
</tr>
<tr>
<td>Prevention of sickness</td>
<td>1</td>
</tr>
<tr>
<td>Community involvement</td>
<td>1</td>
</tr>
<tr>
<td>Work is interesting</td>
<td>1</td>
</tr>
</tbody>
</table>

Community health is a context with influences which make it emotionally and physically exhausting as well as unique. An issue leaders in the clinic must struggle with on a daily basis is society’s marginalization of the poor people. The clinic not only serves these people who must fight this stigmatization, but also the leaders of these clinics must take a stand for these people in a world which does not always place the same value on the worth of these people. Another influence which looms over the clinics and health care in general is the future effects of managed care. There are other influences which make this context complex and are listed in Table 8.
Table 8.

<table>
<thead>
<tr>
<th>Contextual Influence</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marginalization of poor by society</td>
<td>7</td>
</tr>
<tr>
<td>Perceived effects of managed care</td>
<td>6</td>
</tr>
<tr>
<td>Financial difficulties</td>
<td>4</td>
</tr>
<tr>
<td>Fundraising</td>
<td>4</td>
</tr>
<tr>
<td>Focused on people</td>
<td>3</td>
</tr>
<tr>
<td>Mistrust of people</td>
<td>3</td>
</tr>
<tr>
<td>Rules and regulations/govt. policy</td>
<td>3</td>
</tr>
<tr>
<td>Immediacy and reality of sick people</td>
<td>3</td>
</tr>
<tr>
<td>Limited access to national policy-making for health</td>
<td>2</td>
</tr>
<tr>
<td>Welfare system</td>
<td>1</td>
</tr>
<tr>
<td>Long hours</td>
<td>1</td>
</tr>
<tr>
<td>Upset, difficult patients</td>
<td>1</td>
</tr>
<tr>
<td>Evolving setting</td>
<td>1</td>
</tr>
<tr>
<td>Frustration with endless paperwork</td>
<td>1</td>
</tr>
</tbody>
</table>

Those involved in community health are usually civic-minded and are aware of other problems which effect the communities in which they reside. Thus, several of the leaders in community health organizations initiate other programs to benefit the community which do not necessarily deal with the issue of health. Some other programs they have to benefit the community include the training of medical students, adult education classes, literacy program for children, and others, see Table 9.

Table 9.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training of medical students</td>
<td>1</td>
</tr>
<tr>
<td>Adult education classes</td>
<td>1</td>
</tr>
<tr>
<td>Consignment shop</td>
<td>1</td>
</tr>
<tr>
<td>GED classes</td>
<td>1</td>
</tr>
<tr>
<td>Community college classes</td>
<td>1</td>
</tr>
<tr>
<td>Black Lung Program</td>
<td>1</td>
</tr>
<tr>
<td>Geriatric Outreach Program</td>
<td>1</td>
</tr>
<tr>
<td>Literacy Program</td>
<td>1</td>
</tr>
</tbody>
</table>

Interpretation

Leadership Drawings

The four pictures drawn by the interviewees offered interesting insight into the ideas of leadership each person held. The only person who did not draw a picture was
Charlie Provence due to time constraints. Everyone who participated drew the leader in the center of a group, differentiating the leader from the followers. This did not appear to represent any sign of sheer dominance by the leader, but the leader was distinguished due to their responsibilities and their ideals. Three of the drawings had arrows or lines connecting the leader with people and organizations, while one of these had arrows pointing in both directions. These lines were important to the artists because they represented their beliefs that leaders need to be connected and involved in the community in which they work. This was a major theme in all the interviews.

In the drawings, the leaders were given certain characteristics as previous displayed in Table 1. These characteristics portrayed the leader as a servant, a listener, being respectful, having credibility, having strength of character, and having a core set of beliefs. These characteristics give a profile of a leader who may have some distinguishing characteristics which make him or her suitable to a responsible position, but they also have evidence of a moral leader connected with the people he or she serves.

In Ms. McLaughlin’s drawing, she drew a leader with extraordinarily large ears, see Figure 1. With her drawing she explained listening, as did Cheryl Mabey in her description of citizen leaders, as a crucial quality of a leader when she said,

As a leader you have to listen. You can’t just tell people what to do. I think a leader in the community health organization . . . they have to have their ear to the ground, so to speak, just like in the old movies when the guy put his ear to the railroad tracks to see if the train was coming. I think you have to be alert in hearing what people say. It’s not always what people say they want is what they need, but I think you have to try to see what they’re trying to say within what they’re saying (McLaughlin 1997).

Myrna thinks its essential to spend time with those she serves to hear their needs. She spends time in the community to gain a better understanding of the daily struggles they
face and aims to be a patient listener, but also a critical one so she can determine what the people are really saying. This is important for a leader who represents the people of a community in many decisions concerning their health care.

Dr. McLeod’s drawing showed a box in the center, representing the leader, with circles around the leader, representing various agencies. Together they were headed down a funnel, see Figure 2. The circles are the followers and the leader is “drawing people from a lot of different areas and pulling them together in a particular direction” (McLeod 1997). The efforts of the leader are collaborative in addressing problems and reaching goals. It is recognized though for true collaboration to occur, people must not just be coordinated in their efforts, but relationships are created “of trust among diverse organizations and people who recognize the need to share responsibility and accountability for the well-being of the community as a whole” (Chrislip and Larson 11). Later in the interview, Dr. McLeod demonstrated through her efforts at the health department that true collaboration and sharing of responsibilities is one of their primary goals, but also hard to achieve.

Although collaboration appears to be an important concept in community health, networking is also vital. Judy Knudson illustrated the importance of networking to leaders in her drawing, see Figure 4. Her leader was also in the center of the picture, but she was connected to numerous agencies with lines. As she drew she talked about the leader and stated, “I think what you need is to be CONNECTED with lots of resources in the community. . . You don’t necessarily have to be a member of all those, but you have to know people” (Knudson 1997). Her background in local government has made her well-known to others in the community and she understands it is important to cultivate those
relationships. There have been numerous instances in which she has been able to help the clinic simply by knowing someone. For example, she told a story in which she received a grant for $25,000 for the clinic with a simple letter. She was able to avoid paperwork and “red-tape” because of a relationship she had with a person at the foundation. Thus, networking can also be crucial to the success of community health clinics, especially as they battle financial struggles.

Dr. Vanzee also provided an interesting picture of leadership in which he defined the leader as originating from the community, but also having a special characteristic represented by the doves above the head of the leader, see Figure 3. This special characteristic ranges from a person’s strength of will to intelligence, but nevertheless is “something special about that person that engenders a real respect and a kind of leadership role in the community” (Vanzee 1997). Couto states a similar notion when defining a citizen leader. He writes, “Whatever their titles, citizen leaders have a deeper sense of responsibility and higher sense of authority that comes from trust others have bestowed informally upon them to act on behalf of the group” (Couto 13).

The arrows in the picture indicated a “two-way street” between the leader and the follower. The leader must be “in-tune” with the followers, which means being involved in the community and understanding its hopes, fears, and problems. Although the leader is an integral part of the community, he differentiated the leader when he said,

Obviously, there are many people in the community and only a few become leaders and there’s something special about some person that becomes a leader and that can be strength of character, strength of will, or intelligence, or a gift with people, or something special about that person that engenders a real respect and a kind of leadership role in the community (Vanzee 1997).
This definition distinguishes the leader, but it does not portray a dominating person determined to solve problems in his or her own manner. He makes sure to distinguish the person does not have to be a Ph.D. or have any type of formal education, but leaders must have strong convictions and will so the community will respect and trust him or her. Thus, it is not reflective of the Great Man theory a theory, which asserts “that leadership qualities are inherited, especially by people from the upper class. Great men are born not made” (Kirkpatrick and Locke 133). It simply describes an individual who has the characteristics and determination to serve the people.

**Collaboration**

The concept of collaboration appeared most often in the interviews conducted. During the interviews, references to collaboration were made 38 times according to the analysis of the transcriptions of the conversations. The word “collaboration” was only used five out of the 38 times, but the idea of building meaningful relationships to address the health care needs of the community was conveyed frequently. Phrases such as “community participation”, “uniting those with vested interests”, and “developing partnerships” were used with regularity in speaking of successful community health clinics.

One of the primary goals of in health departments is collaboration. It seemed to be important to Dr. McLeod in public health, while networking also seemed to be a key in community health. Community health organizations continually struggle in financial ways and networking helps them to receive more donations and more funding. Public Health departments supported by the government do not have an overabundance of money, but fundraising is not as essential. Thus, people in public health have time to build more
altruistic relationships in solving problems that communities face with health care issues.

Dr. McLeod stated,

> The Health Department has been uniquely situated because being sort of a public agency and not really in competition with either one [managed care or community organizations], we’ve been able to be sort of a place to bring folks together to work on community projects (McLeod 1997).

Thus, there are many factors which make collaboration difficult, such as the vested interests of people and organizations and strict rules and regulations from funding sources. Yet, the Health Department seems to be better suited to do collaborative programs since they do not have to compete for people or funds with other agencies as community health clinics do.

**Empowerment**

Another consistent concept in the interviews was empowerment. Both Ms. Knudson and Dr. McLeod referred to a project each of them are involved in called CHIP, Comprehensive Health Investment Project, for children. It is conducted in approximately 14 sites across the state with an aim to help children obtain good health care and help parents to learn more about using community resources to meet families’ social, financial, and educational needs. Home visitors provide this assistance by meeting with families and discussing resources to help address problems with housing, social services, education, employment opportunities, and other community services (CHIP brochure 2). The hope is that parents will learn about basic health care and take advantage of educational opportunities in an effort to build their knowledge base and self-confidence. With a sense of achievement, the people are more likely to become active in helping to address the health care needs of their families and to address other problems within their communities.
Community health mainly addresses the issue of empowerment through educational programs. These programs were a major theme in the content analysis. As previously discussed in the Literature Review, health educators have a comprehensive approach to empowerment through social and community action in order to change environmental conditions by giving people a greater sense of power to make changes in their lives (Brown 441). Consequently, places like Cross-Over help people to find employment and other things necessary to their lives so they can begin to develop a sense of pride and self-sufficiency. A sense of achievement and self-sufficiency were mentioned often in the interviews, see Table 3. These leaders felt serving as a connection to such resources was an important responsibility of leaders in community health.

Initiation

The idea of initiation was discussed 31 times in the five interviews. Leaders were described as providing “a jump-start” in the community and an “impetus” and “vehicle” to real change. All three of the community health clinics were initiated by people who saw a need in the community and decided to take a risk to address it. Judy Knudson in her definition of a leader directly stated that leaders must have “the willingness to take risks” in order to stand up for the core set of beliefs by which a leader lives his or her life. Myrna McLaughlin characterizes herself as “a catalyst or an enzyme.” Her responsibilities include “bringing people together and enhancing their interactions, make things happen that way” (McLaughlin). However, the leaders in the clinic do not just stop at being initiators of change, but she also describes them as the “yeast” for the community, helping it to rise to new levels through improvement.
St. Charles Health Community Health Clinic is a direct result of a collaborative effort initiated by a young group of students. They helped a community take a risk to solve their desperate need for health care. The Vanderbilt Student Health Coalition and residents of St. Charles played key roles in initiating the construction of a health clinic. Thus, it was not just one leader, but several who helped raise the interest of the community and initiated the St. Charles Health Council which has blossomed into Stone Mountain Health Services. These initiating ideas, a recognition of the problem and possible solutions, were mentioned the most frequently when discussing leaders as initiators, see Table 4.

Olde Towne Medical Clinic was initiated due to a downsizing in health departments and concern from doctors who were seeing patients severely ill with very treatable problems if they were examined in the early stages. Certain people in social services and local government "could see what was happening in the Health Department. They understood what was going on." This is essential to leaders, especially to initiating change. Burns writes,

"Drawn from both personal experience and education, these [information] resources can become encoded in multiple knowledge structures that leaders can draw from as guides to initiation and subsequent actions. But possessing information is only a first step; much more depends on the ability to search long-term memory, transfer or retrieve information, encode, analyze, evaluate, make attributions and make decisions (Burns 17)."

After they gained the knowledge, the leaders in the community came together in collective action to solve this problem.

**Characteristics of Leaders**

Many leadership scholars have argued against the trait theory posed in the early 20th century. This theory "asserted that leaders' characteristics are different from non-
leaders” (Kirkpatrick and Locke 134). Some are dependent upon heredity, while others are dependent on experience and learning. This theory was questioned for a period of time during the mid-century, but recent research has “made it clear that successful leaders are not like other people.” (Kirkpatrick and Locke 134). However, these traits do not guarantee success, but it simply means that when these traits are combined with certain actions success is more likely. The research has shown six qualities on which leaders and non-leaders differ, including: drive, the desire to lead, honesty/integrity, self-confidence, cognitive ability, and knowledge of the business. There is also less substantial research that demonstrates leaders have more charisma, creativity/originality, and flexibility (Kirkpatrick and Locke 134-135).

Drive has five aspects including achievement motivation, ambition, energy, tenacity, and initiative. The people interviewed mentioned persistence, i.e. tenacity, three times in the five interviews. In fact, Kirkpatrick and Locke write, “Leaders must be tirelessly persistent in their activities and follow through with their programs” (136). Enthusiasm and enjoyment of intense atmospheres were also mentioned and could be likened to energy.

Leadership motivation involves the willingness to assume responsibility, which was mentioned twice during the interviews. Honesty and integrity are also crucial to leaders as it is the foundation for trusting relationships. Being trustworthy was a characteristic explicitly mentioned three times during the interviews, while being genuine was also mentioned. Cognitive ability is important in making decisions as a leader. This does not just include intelligence, but common sense and learning from previous experiences. The interviewees discussed wisdom as an important characteristic and was mentioned four
times in the interviews. Thus, the people interviewed recognized many of the characteristics that leadership scholars claim are most often present in leaders.

However, there were many others which they associated with effective leaders in community health organizations. The most often mentioned characteristic was a sense of stability and a deep commitment to the organization. Charlie Provence is convinced the clinic in St. Charles would not have the success it enjoys today if Dr. Vanzee had not made a commitment to stay in the town and work to address their health care needs.

Another frequently mentioned characteristic was a leader as a good listener. Ms. McLaughlin feels listening to those in the community is so important that she put large ears on her leader when she drew her concept of leadership. Ironically, Robert Greenleaf writes, "Persons who achieve high leadership positions are generally not good listeners. They are too assertive. They have to learn to listen" (Greenleaf 303). He goes on to say, "Listening is as important to a mother dealing with her children as it is to the head of a state" (Greenleaf 303).

Other important characteristics of leaders, according to the people interviewed, include: resourcefulness, having a core set of beliefs, respectful of others, non-judgmental, good communicator, see Table 5. Thus, an argument could be made that there are characteristics which are more beneficial to leaders in community health organizations than in other contexts. Another way to view this is that people with certain characteristics, as previously mentioned, are more inclined to work in this context.

Responsibilities/Actions of Leaders

Leaders also have certain responsibilities and actions which make them effective in community health organizations. The most important responsibility of a leader is to
understand the situation or problem which the organization is attempting to address. This issue was discussed 11 times during the interviews. Closely behind was serving people in the community. Thus, these leaders appeared to have the attitude of servant leaders. Greenleaf states a necessary condition for servant leadership is the people grow while being served. They “become healthier, wiser, freer, more autonomous, more likely to become servants” (Greenleaf 22).

It seemed those actions and responsibilities most integral to work in community organizations had a common theme of understanding the problems in the community and working selflessly with the people to solve them. Working in the community and learning about the people they serve were high on the list. Other important actions and responsibilities included: working long hours, taking risks, coordinating events and people, fundraising, see Table 6.

Motivations of Leaders

Although millions of people in America understand there is a crisis in health care, one in which people are being denied care because of financial reasons, few chose to become involved in such a complex and demanding situation. Few would give up the monetary gains from private health care practices in order to help a marginalized population gain access to primary care. However, the leaders interviewed have made great sacrifices to aid those in this desperate situation. Acting as citizen leaders they feel a moral responsibility to help meet the needs of a deprived group (Couto 15).

Four out of the five people interviewed were at impressionable stages in their lives during the 1960s. Several of them explicitly mentioned the social concerns they became involved in during the 60s as having a profound effect on their lives. They have carried
these concerns throughout their lives and have chosen community health as a forum for them to actively address both social and medical issues.

In congruence with these social concerns is the willingness to serve the patients with whom they work, which was mentioned five times during the interviews. Through their service and sacrifices they have actually become leaders to their respective communities emulating Leo, the servant leader in Journey to the East. They serve people and work long hours in order to fill a void in their lives, to satisfy their need to go out and “save the world”, according to Judy Knudson.

Some of the other motivations they mentioned were the love they have for their work, an admiration for people fighting the health care system, a need for community involvement, see Table 7. All these motivations focus on the people whom the health care system has denied access to. Couto maintains that citizen leaders “act from fairly simple motives” (Couto 14). Citizen leaders “speak in simple terms about the basic dignity of every human being. They act from a conviction that we, as a society, are responsible for redressing the conditions that undermine and understate the human dignity of every human being” (Couto 15).

Along with motivations many of the leaders mentioned their role models or events that occurred in their lives which helped lead them toward the path of involvement in community health. An interesting point was made by Ms. McLaughlin, who claimed the leadership of Cross-Over “comes from a spiritual basis” and she mentioned one of her role models to be Jesus Christ. She acknowledges her own human failings, but she looks to Jesus because “he was in the midst of people and knew their names and tried to meet their needs and was always available” (McLaughlin 1997). Other role models that were
mentioned included mentors during different points in their lives, spouses, and other leaders in community health. Judy Knudson also described the League of Women Voters as being influential in her life and a role model since they work according to a consensus model.

**Contextual Influences of Community Health**

Throughout the interviews, a picture of community health organizations was painted, illustrating a world of emotional frustration, ceaseless working hours, and determined persistence on behalf of the leaders. It is not easy to work with a group of people who are continuously neglected by society and its government. Ms. Knudson stated, "This is a population that people have never bothered to do that [treat them as a person] because their poor and their marginalized and you don’t think about them" (Knudson 1997). This attitude of society is something that people in community health must deal with everyday as they try to treat patients or find funding from numerous sources. However, the leaders in community health realize that they are working with a population which has known so little hope and this drives them to work more diligently.

There is a continually focus upon people in this type of work. There is a distinct atmosphere of immediacy that distinguishes community health from other contexts. There is always a sense of immediacy in the medical field; however, in community health many patients have suffered for long duration’s of time because they cannot afford the care they need in private medicine. Ms. McLaughlin told a story of a man who was literally dying from tooth decay. He rode a bus across town to Cross-Over because he heard he could get free care and he had no money. After suffering through a 104° temperature and other ailments, he was stabilized and survived. Although it is gratifying to know people knew
where to direct him to receive care, it is also emotionally frustrating to see a man in such
dire conditions because he could not afford proper dental hygiene.

Leaders in community health often “go out on a limb” in order to get their patients
necessary treatment. A situation occurred while I was interviewing Ms. Knudson in which
a nurse practitioner was unsure whether or not to send a man to the hospital because of
his lack of insurance. She stated that a person with insurance would definitely be
admitted, but she asked Judy’s advice. Ms. Knudson told her to send him to the
emergency room and she would deal with the hospital later because there were potential
problems. However, complications with the hospital were not her primary concern, it was
a minor risk as she wanted her patient to receive proper care.

A foreboding influence in community health is that of the perceived effects of
HMOs. During the interviews this subject was discussed six times. Although most of the
leaders do not feel managed care will effect their populations of underinsured or
uninsured, who pay on the sliding-fee scales, some are concerned with the potential effects
on their Medicaid population. Olde Towne Medical Center is a Medicaid provider and
Ms. Knudson stated, “What’s going to happen is our revenue is going to drop. We get
more from Medicaid than from other places” (Knudson 1997). As far as the majority of
her other patients, who are uninsured, she resoundingly claimed, “I mean there isn’t going
to be an HMO to take care of them” (Knudson 1997). Dr. Vanzee echoes the sentiments
of Ms. Knudson and does not see managed care as a threat to the vitality of community
health clinics. Approximately 15% of his patients are on Medicaid, so that population will
be affected; however, there is no proposed managed care system that will grant
accessibility to those who cannot afford private insurance and do not qualify for Medicaid.

Dr. Vanzee stated,

I don't think they're [HMOs] going to solve the problems. They don't really have anything to do with increasing access to people who don't have resources. I don't feel that community health centers are going to be threatened by any managed care system. I think there's going to be more and more need for St. Charles and places like it all over the country because I think there's going to be more and more people who don't have resources (Vanzee 1997).

Thus, he does not feel they are significant threat to community health clinics, but thinks there will actually be more need for them.

Another real dilemma in community health clinics is financial. Many clinics do not survive because of funding problems. Financial difficulties and fundraising were each mentioned four time during the interviews. The clinics provide services and receive payment through sliding-fee scales and are left to find money either through the government or private sources. Cross-Over does not receive government money, but generates operational money strictly through private grants and donations. The other two clinics do receive federal funding and struggle through frustrations with the paperwork.

Other influences in community health include: government policy, the welfare system, the evolving nature of the context, see Table 8 for others.

**Community Benefits**

Not only do leaders in community health attempt to address the health care needs of the community, but they also initiate programs to help meet more diverse needs. Cross-Over clinic welcomes students from all over Richmond to participate in the work at the clinic. Ms. McLaughlin described this mutually beneficial relationship with the schools,

"We're providing a good service to the people of the city that they don't have to pay for and we train so many students here at no charge. MCV [Medical College of Virginia] benefits from us. We train dentists here, we train Masters of Public
Health students, and J. Sergeant Reynolds nursing students, MCV students. So
everyday we have students here from all different disciplines . . . We’re providing
for the future and bringing people in here. We realized we can’t do it all so we
need to bring other people in to go out and do their own serving . . . “

Thus, community health clinics hope to train others and encourage their participation in
community health.

Education is one of the major focuses of programs in community health. Often
times the populations that community health organizations serve have not had extensive
formal education. Dr. Vanzee claimed “there’s probably about 40-50% of the people that
don’t have a high school education” although he pointed out most of them are from the
older generation. However, this is not surprising since most of these people have more
immediate needs they must meet and do not have the time or money for more formalized
education. Hence, community health organizations offer adult education classes, GED
programs, and community college classes.

Other Findings

Another interesting aspect find in community health and during the interviews was
the high prevalence of women in the field. While trying to determine the people I would
interview for the projects and speaking with Debbie Oswalt, I noticed the astounding
number of women who were directors of VHCF projects. Although there have been
conflicting results in determining if there are real difference in male and female leadership
styles, several studies have shown women to be more relations-oriented and men as more
task-oriented (Bass 724-725).

Ms. Knudson addressed the issue of women leaders in community health. We
discussed the prevalence of women in directorship positions in community health versus
private care. She believes there are several reasons to explain that phenomenon. First, she
feels people gravitate towards money and there simply is not as much money in community health. However, there are skills she feels women possess that make them better-suited for the job. She stated, “Women are much better at compromising, at trying to figure out as consensus building . . . Dictators don’t work very well in this kind of setting and a lot of men aren’t willing to take the time to do consensus building.” In a context which is dependent upon building relationships, she has seen too many men, especially doctors, not cultivate them adequately. The ability of women to compromise and to do consensus building enables collaboration to occur, which is essential to this context in her estimation.

Women are socialized early to make sure everyone is satisfied, according to Ms. Knudson. However, Dr. Vanzee and Charlie Provence are evidence that men can be effective in the field. It appears to be more an issue of values and beliefs rather than a gender issue.

*Leaders as Storytellers*

Gardner claims there are three kinds of stories that leaders tell: stories about the self, stories about the group, and stories about values and meaning (Gardner 50). These stories are created in response to “the pervasive human need to understand better oneself, the groups that exist in and beyond one’s culture, and issues of value and meaning” (Gardner 50). Different types of leaders have different ways of telling stories, as discussed in the Methodology section.

For years the story of St. Charles sounded like this . . . “The economy of Southwest Virginia has been ruled by extractive industries since huge deposits of raw materials were accessed by developers during the last decades of the 19th Century” (SMHSP 9). Land
companies purchased the mineral rights on vast tracts of mountain land, often paying as little as 50 cents per acre for the rights (SMHSP 9). This outside world has exploited the land and the people for years. "Enormous amounts of wealth have left this region to power homes, storefront windows, air conditioners in New York and Connecticut, Detroit with very little being left to the region," according to Dr. Vanzee. Thus, there is "a pretty pervasive, genuine mistrust of outsiders coming into the mountains" (Vanzee 1997).

This is a stigmatization the Vanderbilt Student Health Coalition had to overcome when they asked to visit St. Charles to conduct a health fair. Because of their values and beliefs, though, they were determined to bring a new story to the people of St. Charles. They did not come in as experts, but as "young, enthusiastic college students . . . being very open, non-judgmental and wanting to know about the culture . . ." (Vanzee 1997).

The Health Coalition, of which Dr. Vanzee was a member, was able to reactivate beliefs and values that had been dormant in this small rural town. Back in the prosperous days of coal-mining and unions, people believed they deserved to be treated in a certain manner and have access to certain services. However, with the money disappearing from the region people became more accustomed to a life of poverty. According to one resident, some people held onto the belief that they deserved medical care. In a letter she wrote, "Right today some of the men that helped organize the union years ago, are back on the picket lines trying to get back their medical benefits and their pensions that have been taken away" (St. Charles Scrapbook 20). The Health Coalition helped to reestablish these concerns for services necessary to a higher quality of life.

Gardner writes, "In capturing the glory or innocence of an earlier era, in the face of rival contemporary currents and counterstories, these innovative leaders may succeed in
reorienting their times” (Gardner 11). Thus, even though the larger American society had marginalized and stereotyped these mountain people as they portrayed an image of the region filled with “poor children almost without clothing sitting on the standard front porches of the shack, Appalachia in the sixties,” the Student Health Coalition saw people of worth, deserving of proper medical care (Vanzee 1997). Even people in the county saw S. Charles as the “ghetto” of Lee County and had a “sense that nothing good” would come out of building a health clinic there. In spite of these obstacles, the Coalition involved the community to successfully challenge the stereotype and construct a health clinic.

Unlike some innovative leaders who are uncertain whether their legacies will continue, the Coalition helped to foster a sense of community spirit and pride (Gardner 241). One news article stated, “The people of the area have developed a sense of pride that has made a big difference in their lives” (St. Charles Scrapbook 8). It continues today, long after the efforts of these innovative leaders have gone, as the community addresses other needs through programs such as GED and adult education classes.

Conclusions

Leaders as initiators of change

The existence of congeries of persons in more or less autonomous arrays, variously connected internally by sets of common needs, hopes, grievances, expectations, despair, and other attitudes — unemployed coal miners, aspiring young actresses, hungry Parisian women, tenant farmers, millenarians, parents of school children. In short, the human condition. Physically unconnected with one another within these array, perhaps inarticulate, and unled, these persons exist in a condition of stasis. But some individual in an arrays of acts — shouts out her grievance in the street or pub, scrawls a message on a wall, writes a letter to the editor, calls a protesting meeting, demonstrates at a funeral. The act may go unheeded, or it may lead to a flurry of contacts among the affected and the public venting of grievances (Burns 2).
This is leadership as initiation of change, recognizing a problem and then finding the
courage to make an effort and determine a solution. This concept may be newly
recognized in the world of leadership academia, but it has been occurring in the “real
world” for centuries.

The St. Charles Community Health Clinic is the fruition of the efforts of leaders
providing the impetus for root changes in a community. The Vanderbilt Student Health
Coalition and one of its student directors, Nancy Raybin, recognized the health care needs
in the Appalachian region in which the people had suffered through tough economic and
emotional crises. The coalition conducted health fairs in many of the communities and
served as a catalyst for community participation in addressing their own health concerns.
After the health fair in St. Charles, Nancy Raybin stayed in the town to help organize the
people and aid them in finding ways to construct a health care facility.

At a meeting of over 60 residents, they protested the conditions they had been
living in and resolutely decided they would no longer tolerate their health care needs being
ignored. As previously mentioned, this helped in the formation of the St. Charles Health
Council. President Charlie Provence and his board members raised money and performed
manual labor as they engaged the community in building in their own health center.
Although the people had little money in their small community and had been exploited by
many outsiders, they became determined to meet their goals despite skepticism from
surrounding communities.

The Student Health Coalition, out of concern for a population of people being
denied proper medical care, set out to initiate change in various Appalachian communities.
The past and current residents of St. Charles became participants in the quest for a
solution to the problem. Each exercised mutual restraint in the process. The students did not come in as experts and attempt to manage the entire process, although they possessed the knowledge to do it. They encourage the residents to become involved and make it a true community project. Also, the residents, even with their legitimate mistrust of outsiders, allowed the students to come into their homes.

Olde Towne Medical Center is the second among numerous examples, in which a leader recognized a problem with his community and organized people to challenge the status quo. Ms. Knudson recognized the director of Community Resources in James City County Community Development as “the guiding principle” in organizing doctors, social service agencies, and school employees to help those in Williamsburg who were not receiving the medical care they needed. As health departments were having their budgets cut and consequently cutting their programs, he saw the resulting problems as people in the community did not have the means to travel to Newport News for medical treatment. Thus, he communicated this need to other key people in the community and through their efforts they initiated the formation of Olde Towne Medical Clinic. Another example, Cross-Over Health Clinic stems from the efforts of a few individuals who decided that the urban population of Richmond deserved better health care. Their concerns for these people were formed from religious convictions and drove them as they offered free medical care to those who needed it. They have grown from a Saturday morning clinic in the front of church to the an established clinic serving the city through its diverse programs and medical services. These leaders have displayed the necessary qualities as initiators of change. Their values and ethics drove them to become involved in community health. Through this they have built relationships based on honesty and trust. Ms.
McLaughlin feels because of Cross-Over’s commitment and availability the “community trusts us.”

Burns claims these leaders must have information and have the ability to analyze it and the willingness to take a risk and act upon it (Burns 18). The initiators had to understand there was a need in the community. The Student Health Coalition in St. Charles, the government worker in Williamsburg, and Ms. McLaughlin and Dr. Januzzi in Richmond displayed their perceptions of needs in their communities.

In all these situations, it is hard to identify one individual as the leader and the one responsible for the change that occurred. Such major projects required the work of numerous people in the community. Burns identified a web of participants in the leadership process which includes: initiators, partners, opponents, passives, and isolates (Burns 3–4). This multiplicity of roles can be seen in the developmental stages of all three of the community health clinics and the programs that Dr. McLeod helped to initiate.

The student coalition from Vanderbilt, as a group, served as initiators of change, playing a key leadership role in the establishment of the health center in St. Charles. According to Mr. Provence they helped to “jump-start” the community in this project. In the beginning stages, the St. Charles Health Council served as partners, who responded to the message the coalition revealed to the community. Thus, a web of collective leadership began to form, instead of the leader-follower dichotomy. The initiator did not continue “as a single dominating ‘leader,’ a la Castro,” but instead “merged with others in a series of participant interactions that constitutes collective leadership” (Burns 4). There were even opponents in the web formed in St. Charles, those who did not trust “outsiders,” as there were in the beginning years of Cross-Over. Yet, most of the residents rallied around the
idea and their collaborative efforts were realized in the construction of a small brown building.

Dr. Susan McLeod herself, provides an example of the web of participation through which leadership flows. Although she was not a key player in several of the projects which she has been involved in, she has been a partner in initiating change. As Director of Thomas Jefferson Health Department, she is uniquely positioned to be involved in numerous projects which the Health Department serves. She has responded and been played a significant role in gathering resources to help those who recognized problems in their communities. Although she may not have been the one to “write a letter to the editor” or “scrawl a message on a wall,” she has been instrumental in bringing about real change in numerous communities in her role as a partner in the web of leadership.

Thus, leaders in the beginning stages of addressing the health needs of a community are initiators of change. The web of participants is also prevalent in this context because it involves diverse community members. However, as the organizations become established in the communities, the role of the leader becomes somewhat altered. They still work in a web of relationships and initiate programs to help address the continuing health care needs of the community, but this role as initiator does not appear to be as monumental.

Collaboration

Collaboration is a distinctive process in communities, different from networking and cooperating. Collaboration “is a process of shared decision-making in which all the parties with a stake in a problem constructively explore their differences and develop a joint strategy for action” (London 1). On the other hand, cooperation simply involves
preestablished interests while collaboration involves collectively defined goals (London 3). Even further from collaboration is networking, which is an exchange of information for mutual benefit and requires little commitment from participants (Himmelman 2). During the interviews it became evident that collaboration, cooperation, and networking are all important to community health leaders. However, their most successful endeavors were the result of collaboration of diverse people from the surrounding community. Chrislip and Larson note that successful collaborations “involved participants from several sectors -- for example, government, business, and community groups -- as opposed to few participants predominately from one sector” (52). Olde Towne Medical Center (OTMC) originated because of collaborative efforts among private physicians, local government employees, social service agencies, and key community leaders. Their goal was to pool their resource in order to address the health care needs of a disenfranchised population in their community. Government employees were able to see the political changes occurring which effected the local Health Department and understood this would seriously effect those in the surrounding area, while the doctors were seeing sick patients who should have been treated months earlier. In the end they were able to establish a unique organization aided financially by three separate local governments which provided medical services to these people. Judy Knudson, Director of OTMC, continues to collaborate with others in the community to provide programs to meet the needs of her patients. However, she also notes the importance of networking. Her background with the Board of Supervisors along with her husband’s work as a professor at William & Mary, has allowed Ms. Knudson to become acquainted with numerous people in the community. She understands
it is important to cultivate these relationship and occasionally “do lunch” because people have resources beneficial to the clinic. Whether it is money, information, or influence, these people she has become connected with can provide substantial assistance. It can be a mutually beneficial exchange also because helping people in need of health care is a good reflection upon a party who helps such clinics.

Not only do these leaders in community health become part of collaborative efforts, but they help to initiate them and exhibit collaborative leadership. Richard Wellins discussed 15 essential qualities of collaborative leadership, as mentioned in the Methodology Section. Of these 15 qualities, the leaders discussed and demonstrated eight of them, which included: communication, identification of problems, initiative, rapport building, individual leadership, information monitoring, judgment, and motivation to empower others. These were all defined as characteristics or responsibilities of effective leaders by those interviewed. These leaders have initiated collaborative programs, such as CHIP; they have built rapport, or good relationships with other agencies and community leaders; they have identified problems latent in the community; and demonstrated other facets of collaborative leadership. A study by Scott London claimed, “An effective [collaborative] leader must guide and coordinate that [joint] decision-making process” (London 5). Thus, it is not about power and dominance, but it is helping to initiate and facilitate collaborative processes in order to bring about real change. Thus, community health leaders do demonstrate many of the characteristics necessary for collaborative leadership. However, there are other processes important to effective leadership in this context.
Empowerment

Empowerment has been semantically and politically twisted over time. The definition bearing the most similarities to its conception in community health is "a combination of psychological and political factors: the development of a more positive self-concept; the development of more critical or analytical understanding of a political or social environment; and the development of collective resources for social and political action (Kieffer 31). The leaders, through the services and programs they offer, act to provide ways to connect their patients with tools and resources for self-improvement in an effort to help them become self-sufficient.

C. Wright Mills claims that empowerment continues "if people act upon the common grounds they find among themselves to discover previously unacknowledged competencies among them that help them deal with a common condition" (Couto 11). Thus, the aim of many leaders in community health is to empower people to recognize and fight battles that effect them. In my conversation with Dr. McLeod, she addressed this issue of helping people attain skills to advocate for themselves. People in community and public health are attempting to "help them develop and become more self-sufficient or better able to advocate for themselves and to do for themselves" (McLeod 1997).

Obtaining health care for those who have no means can be very complicated and people involved in public and community health are "trying to help them learn how to navigate their way through without having to just be told how and taken by the hand or not do it because they throw up their hands [and say] I don't know where to go" (McLeod 1997). This sense of powerlessness is one explanation of why patients can be difficult to deal with in community health because they have been mistreated by the system.
Through the interviews and their subsequent analysis it became evident that empowerment through proper health care and education are focuses of leaders in community health. The programs they offer reflect their goal to help enable people to be independent.

Profile of a Community Leader

It has been shown that leaders do act as initiators of change in community health; however, the initiation process is most significant when the health care problems of the community are first addressed. The web of participants which is formed during the initiation is a foundation for successful collaboration for real change in the community. The web is illustrative of collaboration. In this web the leaders, partners, and other members work in a state of equilibrium, all exercising restraint so that all can be involved in the process.

It was found in this study that collaboration is an important process for community health leaders to initiate and encourage, but it not an easy process. Since people have vested interests, which may keep them from working toward a common goal, other processes exist prominently in community health organizations. Networking is a common process with which leaders can connect their patients with available resources. However, the leaders in this study demonstrated characteristics and skills essential to collaborative leadership.

These leaders oftentimes act as storytellers, exhibiting different types of leadership through the stories they tell. Generalizations cannot be made to say all community health leaders are innovative leaders, but many have brought dormant stories in communities to the forefront and have told it in their way to bring about change.
The profile of a community leader, determined from this study, includes:

- characteristics necessary for collaborative leadership, such as relations-oriented, good communication skills, and motivation to empower others;
- the ability to listen and analyze what people say;
- a deep sense of commitment;
- serve the people, displaying characteristics of servant and citizen leaders;
- involved in the community they serve;
- motivated by medical and social concerns; and
- respect the dignity of human beings.

**Recommendations**

As I reflect back on the study and the processes it entails, I feel it is a topic worthy of more study. The context is unique and complicated and could add greatly to the study of leadership. However, I would recommend the study be conducted on a larger and more diverse group of people, perhaps on a larger scale than only statewide.

Also, there is rich information to be gathered if a researcher were to spend more time with the leaders and those they work with including employees and patients. How they are perceived in the community would also add to the depth of such a study. This would allow one to delve more into the web of participants Burns proposes. Such information would be innovative as the leadership-follower dichotomy has become somewhat archaic.
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Appendix 1
Date: __________________
Name: __________________

Key Points
1. Explain illustration of "leadership."

2. Key to leadership - initiation of change.


4. Success of CHO depends on empowerment of community members.

5. Factors which influence CHO.

6. Role models - explain.
Appendix 2

Myrna McLaughlin  
Crossover Clinic  
March 3, 1997, 11:30 AM

Stephanie: Ms. McLaughlin to begin the interview, could I please ask you to draw a picture of leadership according to your own personal definition with these markers and this white piece of paper?

Approximately 2-3 minutes were used for her to complete this task.

Stephanie: Okay, could you explain this picture? (for picture see Appendix 3)

Ms. McLaughlin: Well, the leader is in the center of things. She has big ears for listening and she has a tray for serving and she’s surrounded by people.

Stephanie: That’s a wonderful concept. This is what we were faced with the first day of our leadership class, too. We had to draw a picture of leadership and people came up with so many versions.

Let me explain to you the basics of what I’m doing for my senior project at the Jepson School of Leadership. I’m very interested in community health organizations because I want to become a doctor and hopefully work in a similar setting once I get through medical school. Actually, next year I will be working with a professor to write a book on community health organizations. It’s Dr. Couto, you may know him.

Ms. McLaughlin: Yes, I know him.

Stephanie: He’ll be the one I’m working with, but let me give you more explanation about this current project. Two theories that I’m using, that I think pertain to leadership in community health organizations, and this is very much an outsider’s view so I could be off base, but one is that leaders are initiators of change. Through their actions they help people to become active and to care about their own goals and destiny. But it takes some person to “get the ball rolling.” Along with this theory, not only after initiating changes, empowering the people to be able to go out and work on their own. Another theory I’m working with is collaborative leadership which deals mostly with coalition-building, working with the community, working within the political constraints and with the different types of people, and with public policy. However, that’s just my initial view of it after I’ve looked at literature. Now, I would like to look at what you do and how you perceive yourself as a leader in this setting and other people within this organization. Please comment on the theories I proposed and tell me your opinion.

Ms. McLaughlin: Well, yes, I think that leaders are the avenue for change and impetus. I would characterize myself as a catalyst, or an “enzyme.” I believe that’s what I do. I bring people together and I enhance their interactions, make things happen in that way. I
think a leader has to have a vision, a clear vision, of what they have heard. I think it’s really important to listen. As a leader you have to listen, you can’t just tell people what to do. I think a leader kind of evolves from being available as well. I think a leader in a community health organization, they have to have their ear to the ground, so to speak, just like in the old movies when the guy put his ear to the railroad tracks to see if the train was coming. I think you have to be very alert in hearing what people say. It’s not always what people say they want is what they need, but I think you have to try to see what their trying to say within what their saying. What are the main points of what their saying? Somebody could tell you, for instance, in community health what they want is a pill to get rid of the pain, you know, but a leader doesn’t give a pill to get rid of the pain. The leader finds out what’s causing it and makes root changes. I think that’s what a leader has to be looking for are the root causes so they can make the changes. With a lot of experience being in the community, you can often hear and know what the problems are.

I guess the other real thing about being a leader is that you have to sit at the table. You have to put in all the time to go to the meetings, to go out into the community. It’s a tremendous effort, but you cannot . . . you have to be at both tables in community health, you have to be in the community and you have to sit where the decisions are made. That is a very hard role to play because so often the people that are up making the decisions don’t know. So, time after time, we have groups on top who don’t work because they have no clear understanding. A good example, is people getting jobs. You know when you’re not in that community you think, well, they just need to get a job. We just need to offer them jobs. But, no, you need to offer them child care, you need to offer them transportation, you need to buy them a phone. You know, it’s all those other things. Another example is, when I first started this work, I thought we should be open in the evenings and on Saturdays because we wanted to be where people could come, when they didn’t have to work. However, the real scenario is people work seven days a week - morning, evening or whatever. So out in the boondocks and out in the suburbs, you think, gee, we need to have it available on Saturdays so people can come in, but it has no real connection here at all. People do day work, they do evening work, they have to work on weekends, at lot of them work at Burger Kings. So, does that give you an idea of what I face?

Stephanie: Can you tell me how you get people in the community to work together? Do you bring leaders from other areas, from other organizations in the community, to help you in your service? Do you have to work with public policy?

Ms. McLaughlin: You have to do all of that. We do a lot of collaboration. We don’t . . . I don’t believe we go head-to-head with anybody. We don’t fight for money. We don’t do all those things that often happen in the corporate and in the non-profit world. Ours is a different type of organization. We are a ministry first. That oftentimes doesn’t become real obvious, overt, because we don’t walk around saying you need to do this or you need to do that and pray with everybody. We look at things differently. Our leadership comes from a spiritual basis, so often times we are at odds with what the prevailing sentiment is. The other thing about it, that makes it easier for me, is because I know the results are
really up to God. So I just do what I think needs to be done, try to follow his leadership and the leadership of the community. People are needed, though, and they need leadership, the needs of the community. There is a certain freedom in realizing that. The results are not up to me. So, I can almost... almost, not have a vested interest. If it doesn’t work, it doesn’t work. You just do what you do, what you feel, but collaboration is very important. The way we have done collaboration at Crossover Health Center is we have just been available to everybody... anybody who wants to come in. They can use our population, our statistics, we work with anybody because our goal is for these people to be taken care. We really don’t care how. I mean if it’s us or not.

**Stephanie:** Do you know, I don’t know if you’ve been here since Crossover Clinic first began, what was the response of the community when it first came in? Did people come in here a lot or were they a little hesitant?

**Ms. McLaughlin:** Well, it started in 1982. I’ll give you some information you can take with you. It started as an every other Saturday morning clinic at the Storefront Church on Broad Street. So, there wasn’t even really any understanding, this was in the early 80s, if there was a need. And we went through a period from ‘89-‘91 or ‘92 where the establishment of the city, the religious establishment in particular and service providers in particular, thought that all we did is pray with people and therefore people just turned their backs on us, literally. They didn’t want us to be involved in anything. Dr. Januzzi and I just felt like all the stuff that was being said was false and we if just keep doing what we’re doing, then eventually someone would see that it wasn’t true and that’s exactly what happened. Of course the reason when I talked about carrying the tray... we were available to whoever, we were just available here to serve. There is a book called *Servant Leadership* and I haven’t read it, but I love the title. That’s what we have done.

**Stephanie:** It’s by David Greenleaf. It’s one of the major theories, actually, taught in the Jepson School. It’s somewhat implicit in the theories, the collaboration theory... being able to serve others. It’s very civic-minded and community-oriented.

**Ms. McLaughlin:** Of course here we serve, we feel like we’re serving the city too. We’re providing a good service to the people of the city that they don’t have to pay for and we train so many students here at no charge. MCV benefits from us. We train dentists here, we train Masters of Public Health students, and J. Sergeant Reynolds nursing students, MCV students. So everyday we have students here from all different disciplines. We don’t charge then anything. So, we’re providing for the future and bringing people in here. It was a while before we decided to do the students because they can slow things down and our first thought was to serve the patients. We realized we can’t do it all so we need to bring other people in to go out and do their own serving and this is a wonderful place for them to come because the community trusts us. The reason they trust us, to get back to you, people would just start... sometimes they would come in, they would see our signs. Most of it was that patients who came in and they would say, “Listen you can go there and you don’t have to pay. If you don’t have money they’ll still see you.” So that... and I’m think you saw them as you came in. We’re very busy
all the time. So the city of Richmond and surrounding areas, the people, I like to say this is . . . I say two things, this is Richmond’s premier “recycling center” because everything we have has been donated. Also, I like to say this is what the people of this area think about their poor neighbors. It’s a very nice building and it’s done very well. It’s supported by private donations for the most part.

**Stephanie:** It’s very nice as you walk inside.

**Ms. McLaughlin:** People don’t expect that.

**Stephanie:** When you say the area it’s in, automatically they get an image in their mind.

**Ms. McLaughlin:** Of course we’ve branched out. We had been at the Daily Planet then we came in 1990 and established our own clinic and we’re now back in contracting with the Daily Planet to provide all the care for the homeless with the same concept. We’ve put new tile in . . . it’s [the Daily Planet] a horrible building, but our part at least is nice. The point is to . . . we wanted people to walk in here and feel that they were worth every bit of it.

**Stephanie:** I was really impressed when I walked in. I had never been here and I wasn’t really sure what to expect at all and I was truly impressed. Do you think that by helping people with access to primary care and helping them to live a more healthy life . . . do you think that empowers them in a way to do more about the community?

**Ms. McLaughlin:** They came after we were here. We are the, I’ll say the enzyme, the catalyst, but I also think yeast. I do believe we have been yeast for this area. I think things were going to happen. I have had people say to me, we have no idea what plopping down in the middle of this area said to people. It wasn’t even what we did, but the fact we came with them. We came in their area and we brought this area along. I think it will improve and be better.

We also have a program with the lay-help promoter concept Virginia Health Care Foundation helped to sponsor for us. That’s where we are training people in the neighborhoods concerning health care issues. That is my favorite of everything we’ve done. I wanted to do it for a long time. I started thinking about it about 1989 or 1990 and we began it in 1994. We have, at the present time, 73 people who have gone through our program. It does not cost. We train people in the neighborhoods, not just this one, but wherever in basic health care issues. Right now we’re in our second class at the jail, women’s jail. So we’re training those women in basic health care knowledge. And it’s very empowering and that was the whole purpose of doing it because we thought, “People are going to listen to their neighbors. They do listen to Dan and I, but it took a long time and it’s because they finally realized we weren’t going anywhere. They will, though, in the general scheme of things, people will listen to their neighbors. So we teach them to take temperature, blood pressures, how to take responsibility for health and diabetes,
hypertension, breast exams, testicular exams, immunization, prenatal care . . . all those things so that these people will be links to the health care system for their neighbors. So that is definitely empowering.

Stephanie: It sounds like an incredible program. So you do this for people not just in the surrounding areas, but all over Richmond?

Ms. McLaughlin: Right, we have one in Fairfield Court, we’ve had one in Essex Village, we’ve had one down in the Sacred Heart Center. We’re always looking for places.

Stephanie: We went to the Sacred Heart Center this summer. I was in a program called COMPS, Community Problem-solving Seminar, with Dr. Couto. We went and visited a lot of places in Richmond. It was very educational experience. The woman at the Sacred Heart Center seemed to be a strong leader. Can you tell me some of the factors which influence you on a daily basis to run this community health organization?

Ms. McLaughlin: Do you mean why?

Stephanie: That and also just what . . . are there any public policies that you have to work around or is there anything like that which influences what you do?

Ms. McLaughlin: Absolutely, managed care. That’s what I meant when I said you need to sit at the table. People that are making the managed care, and the health care, and the Medicare, and the Medicaid decisions are making it, for the most part, from book studies and what other people say and not from experience. So, one of the things I have found is this is a very experiential job. You really . . . it’s the experience that makes a difference and my experience is that all these people here without insurance their lives are being controlled by people that make the decisions on insurance, access to care, and other things and these people [the uninsured] have no place at the table. So, yes, that is a factor we have to deal with and that’s what I meant by sitting at the table. I try to do that if I’m invited and have been invited to some things to make my voice. I hope . . . I hope I’m not being arrogant when I think that my voice represents them. So I feel I represent the disenfranchised and therefore a number of times decisions have been made that effect us that we have no knowledge of and no input in. It’s extremely frustrating, so it’s very much the experience, what these people feel on a daily basis. They have no input into the decisions that are made that greatly effect their lives. That to me is one of the moral evils of our day.

Stephanie: Do you at all deal with having to raise the money for this clinic?

Ms. McLaughlin: Yes, I do, but I have people who help me. Yes, I write grants, I present our experience and our needs to people so that in my contacts we bring in a good deal of money. We also have other people who are out in the community, who have a fine reputation. Edgar Fischer is a retired gentleman, he’s 57, and he’s still fundraising for Crossover because he believes in the concept. His history is that he headed the Virginia
Health Council on . . . I can't remember, but it was one of the early harbingers of health care in our area. He brought, for instance, he brought the first physician to Tangier Island. So his whole life has been involved in bringing health care to people without. So many people give because Edgar’s involved in it and you know he’s a man of integrity. I do the other area. I go out to churches all the time. I was down in an old church on Sunday at an old Episcopal Church, Emmanuel on the way to Tappahannock. So I give talks to churches and I go and give talks to students.

Stephanie: Are you affiliated with a specific church?

Ms. McLaughlin: No. We go to all churches. Whoever calls us and asks we don’t solicit to go. They’ll call and say could you come to our missions committee or could you give us a talk about people in the inner city. It’s good people that are trying to find a way to reach out their neighbors and don’t know how. Our mission statement says, “To connect the talents and resources of suburban Richmond with needs of the inner city.” That is the most important. So, to us, the people that come through the front door needing help are no more important than people who come through the back door wanting to help. It’s giving people a chance. It’s why we have so many volunteers and so many students and so many donors.

Stephanie: Do you have a Board of Directors? Are people from the community on the board?

Ms. McLaughlin: Yes, more on our lay-health promoter advisory board. We have a lot of the lay-health promoters, but we have some people who represent this area. We have a small board, our board is only 12. We have dentists, doctors, businessmen basically, but we’re not like a community health center where we have someone from this community of the board, not particularly. We’re not opposed to it either. We do have people from the inner city on the board.

Stephanie: This question is directed specifically at you, not at the clinic. The question is who do you look to as a role model as leaders or for inspiration in helping you with the work you do?

Ms. McLaughlin: I will probably give you an answer that sounds really corny, but I really try to role model my life after Jesus. I’m a poor, poor example, but he was in the midst of people and he knew their names and tried to meet their needs and was always available. So, that’s my first. I don’t say that very often, in fact, you’re probably the first one out in the community that I’ve actually said that to. Because that almost sets you up because you know you’re such a poor sinner. If you say you’re trying to represent Jesus, people will tell you every time you’re not. Believe me there is a lot of time I’m not. In some ways, another role model for me, who came after I’d been here a while is Dr. Jack Linear at MCV. He’s the head of the Department of Preventive Medicine and Community Health. He’s now the vice-president in charge of something or other there. He’s a man, who’s African-American, who has risen, but also tried to bring his people with him. I see
him as person who tries very much ... elevating his own people, but not trying to separate from them. Dr. Januzzi, who’s our Medical Director here, his soft and positive manner, and his intelligence have been something I’ve fought against and role modeled. We have a wonderful relationship and he’s been a good role model for me. Some books that I’ve read Deitrich Von Hoffer’s book, *The Call to Discipleship*. And I’ve taken a lot of inspiration from our patients and people who I see come through under very adverse conditions and keep their peace and keep their positive attitude. One of the things that people would say to me here that I forget to do, but I keep trying to ... you’ll ask people how their doing and they all say, “I’m blessed.” So I’m trying to remember that because you’ll look at them and ask how can you say that?

Stephanie: I wanted to ask you, how do you maintain hope, day after day, working in the clinic? Is it the people you see daily? What are your motivations and your hopes?

Ms. McLaughlin: These are not questions I’m used to answering, so I it might sound dumb. One day I had a man come in who saw my picture out there [in the lobby]. I remembered he had been a homeless man in 1988 when I was at the Daily Planet. He went out and came back in and he asked to talk to me. He said, “I know you don’t remember me, but I went up to the Daily Planet and I was homeless. You treated me so much like a human being. I want you to know I have raised myself up. I am married. I have two children and I have my own little ministry. THAT is what keeps me going! And a man who came in last, a week ago Monday, who rode the bus ... he had a 104 temperature. Someone had told him he could come here and get care if he didn’t have money. He was desperately ill from tooth decay. He did live, but we were not at all sure he was going to. It was a true medical emergency. The fact that someone knew they could come here and get care ... that’s very important. I guess the bottom line is I love to be in the thick of things. This is the most adventurous job I’ve ever had. Anybody who would want to feel like they could ... I am never bored. If you look at the statistics, most people would tell you that their not motivated by money so much, their motivated by enjoying what they do. I love what I do. I love being able ... you know it started out just Dan and I, now we’ve got all these people who are employed and helping others. So, it’s things like that. But its mostly the everyday person coming in ... one of the biggest compliments I have, to me, is there are so many people who know my name. I don’t know their name, but they know that they can come. I’ll have people come in and sit and see if we can help. So, I guess if you listen to that it’s an ego thing, but I don’t mean it that way. I mean that I do stand for the fact that people get help. That’s real important ... that I can get things done.

Stephanie: What motivated you to get started in Crossover Clinic?

Ms. McLaughlin: When I was a young girl, I went through nurses’ training. I wanted to be a medical missionary to China. However, Mao Tse Tung took over so they wouldn’t allow anyone near there. So then I became Catholic and you couldn’t do any missionary work in those days unless you were priest or a nun and I didn’t want to do that. So, I got married and raised a family. What actually motivated me here was just before I took this
job I had gone to Peru on a mission trip, but not really. A mission trip sounds like a big
deal and it was just a bunch of us who went down there and had no idea what we were
doing. So, my medical mission was basically riding around in the back trunk of a car. But
those people were so poor. I mean they had no water, they had no sewage, they had no
nothing. The average amount of money that a person had a chance of making was sixty
dollars a year, 60 American dollars. Sixty percent of the population had no chance of
work. So when I came back here I felt I had to do something. Of course I’m back up in
administration again, but this job is so wonderful because I can still see the person on the
street. I was walking out one day, I was walking here, and some guy needed help. The
bottom line was we helped him get connected with family who hadn’t seen him in 15
years. They were just delirious to know where their son was. That’s what motivates me.

**Stephanie:** Do you have a lot of connections with other agencies or organizations in this
area?

**Ms. McLaughlin:** Yes, and they refer to us because we’re probably the only one that on
a consistent basis sees people. A lot of other people have a lot requirements. We don’t
have any. We don’t have an intake worker so that means we could get taken advantage
of; but because that’s not our motivation . . . our motivation is to be here to help people
AND without taking a lot of federal money; therefore we don’t have to meet those
bureaucratic requirements. One of the other things we try to say, we try to provide people
with access without barriers. By the time they get here, they walk in the door half the time
furious because they’ve been turned down everywhere. One woman this year came in
asking for us to help her get some heat. We don’t do that at all, but she had a wood stove
and she tried to get some fuel assistance, but at one point she had worked for two weeks
somewhere, she couldn’t find her pay stub. Well, they couldn’t get her anything unless
she proved that she had a pay stub that showed the amount of money she got. So, we
ended up . . . at that particular time right before Christmas one of the people out in the
community always sends me some money to do whatever for Christmas. It was $250 so
we bought her two cords of wood. I mean we don’t talk about that, but the fact is we
really try to meet people’s needs whatever they are.

**Stephanie:** That’s interesting because part of one of the concepts I am using, leaders as
“initiators of change,” it also says for organizations to be leaders they must have a web of
relationships in the community. Without that they are not effective.

**Ms. McLaughlin:** That’s what I place under collaboration. Again, leadership, I think, is
allowing . . . is enabling other people to give their gifts to the community. That’s a big
part of leadership, to empower, not just the poor people, but the people who want to do
something and don’t know how. You know I think you need to be a tunnel, you need to
be a channel, you need to be a . . . make a way for people. That’s my particular way of
doing it.

**Stephanie:** It appears to be very successful.
Ms. McLaughlin: Well, you know I’m sort of at the point now where the success really is everybody’s, all the people, all the volunteers that you see out there. I really believe I’m just the enzyme.

Stephanie: Well, there has to be someone there to be that enzyme. I thank you for your time. I think it will be very helpful to my project.

Ms. McLaughlin: I thank you because it helps me to refocus again. I had to answer your questions and it made me think, “Well why the heck am I doing this?” I would like to invite you to spend a day here in the clinic and see what goes on. If your around looking like you need something to do, don’t worry we’ll give you something to do. This is a great spot for community and public health, just being here. It’s right in the center of what’s happening in people’s lives.

Stephanie: Thank you for the invitation and I’ll be sure to take you up on it. Once again thank you for your time.

Ms. McLaughlin: Just one last thing, I feel the real reason people come and are attracted is because God likes the concept.
Appendix 3

Susan McLeod
Thomas Jefferson Health Department
March 6, 1997, 3:00 PM

Stephanie: To begin this interview, I was wondering if you could take this piece of paper and these markers and draw your own picture, or definition of leadership.

Susan: Sure.

After about 2-3 minutes, she finished the picture.

Stephanie: Can you explain the picture? (see picture in Appendix ?)

Susan: While pointing at the picture) This is the leader, drawing people from a lot of different areas and pulling them together in a particular direction.

Stephanie: Okay. That is similar to some of things we’ve drawn in class. I’ll explain a little bit to you about my project so you can better understand what I’m doing. I am, right now, in the midst of my senior project, my last semester at the Jepson School. We have the opportunity, for this project, to choose any subject that we want to explore further. I am interested in going to medical school and becoming a doctor, so through work I’ve done as an intern at Stuart Circle [Hospital] and as a volunteer at MCV [Hospital], I became interested in community health clinics. I heard of Crossover Clinic, it’s a neighborhood clinic. So, I went to one of my professors and asked what can I do to find out more about what goes on in these clinics and how they’re structured. We came up with this project for “Leadership in Community Health Organizations” and actually the professor that helped me formulate this project ... we’re going to do a national study next year through the Robert Wood Johnson Foundation. He’s going to write a book through the interviews and data we collect next year. This is sort of a precursor to it. Basically, I’m taking a couple of theories of leadership that I’ve learned through my two and half years at the Jepson School and I’m going into this as an outsider, basically. I think these theories begin to explain, perhaps, what goes on in community health, as far as leadership is concerned. I’m not sure, so that’s what I’m trying to find out ... what really happens and how you work, how you define yourself as a leader. You’re name was given to me through Debbie Oswalt at the Virginia Health Care Foundation and she said that you helped to start several projects through them. I was wondering if you could explain to me how you got involved, first, and what sort of projects you were involved with.

Susan: Well, I think one of the first things is, you’ve used the term “community health center” and the way that it’s commonly used is not necessarily the same thing as what a public health department is. Community health center generally relates, or are generally used for a place in the community where people get health care services. Say your doctors’ offices, they’re clinics. Whereas, public health may have a clinical component and may have services like a community health center, but the focus is not just on
delivering health care to the individual, it’s on the assessment of the whole population, on developing educational services, prevention activities, analyzing what’s going on in the community, and helping move towards different areas. So, one of the things as ... I mean I’ve been with the district health department in Charlottesville now for 19 years and I went there first, doing my last year of residency in preventive medicine, which is a different kind of specialty training than any of the other specialties. All of the other specialties are basically clinical training for more individualized patient care; whereas preventive medicine residency involves, not only, a clinical year, which is like the first year, or internship year, but then getting a masters in Public Health. It’s taking what you’ve learned, as far as individual patient care and illness care and moving from one person as your patient to the community as your patient, or the group as your patient. Then the final year, this is when I started in Charlottesville, which is a practicuum year, in an agency providing preventive medicine and public health care. I continued on there as the assistant director for 11 years and now I’ve been the director, well maybe it wasn’t 11 years, like nine years and now it’s been almost nine years that I’ve been the director.

So, there’s a responsibility there, in that, to look at needs in your community and help develop partnerships with public and private groups to focus on needs. Of course one of the big needs is health care for individuals, which is primarily where I became involved with things, with the [Virginia] Health Care Foundation. Back about five years ago now, there was a bill passed in the General Assembly that required all local health departments, all local health directors really, to work with their community to develop an assessment and planning for meeting the health care service needs of the community, primary health care service needs of the community. As a part of that, then there was ... that’s where the health care foundation got its start. There was set up some funding, state funding initially, which was then to be matched by private fundraising to be used to give grants to help implement some of those plans that were developed. So in that first year of that assessment and development, we had three different areas particularly in my planning district, which is the city of Charlottesville and the five counties around the city. We had some connections already going on with other groups and other agencies, so we built on those for the most part.

One of them had to do with a new program that we had just started which was one of the first spin-offs in the state of what has started in Roanoke as CHIP, Comprehensive Health Investment Program for children. They have now replicated that in about 14 sites across the state, but Charlottesville was the first one outside of Roanoke. It is a partnership between private physicians, community action agencies which are the anti-poverty groups, and Public Health Departments. It provides a team of a professional nurse and lay home visitors to work with families and help kids have a home for their care, a medical home. That’s where the partnership with the physicians comes in, as well as helping educate them to best use it and then giving them access to tools to help improve parenting and help improve the family stability giving them educational opportunities, job opportunities and that sort of thing. So that was one that was getting started and we were able to build on that and develop that plan for that. So we made application and received one of the first
Another opportunity that we worked on had to do with... started with a private physician in Louisa County, as well as some of the other agencies, people who... churches, as well as the nurse from the Health Department, some of the people from social services. The different agencies in Louisa County, which is a fairly rural community and this one particular physician who was concerned about lack of resources for care for people who didn’t have insurance. So they were starting to grapple with the idea of a free clinic, but how could they do that, how could they get the resources? They wanted to see about... and at one point we talked about whether or not we could do a free clinic in the Health Department, but there were limitations because we didn’t have a lot of space that we weren’t using during the times that they thought they might need it. So, part of the work out there was the interest in trying to have some kind of services, people screened for eligibility and provide services for that group of people just in the doctors’ offices. At the same time, then, what the focus of our application which also got funded from the [Virginia] Health Care Foundation, was some additional funding to add some time for a nurse practitioner who was already working in the Health Department doing some of our clinics, to let her work some additional hours with some of the private doctors in the community to give more care than the doctors were able to just donate on their own. Also, there was provision of drugs because one of the big things that comes up always with free clinics is the issue of you can see them and tell them what they need, but if they can’t pay for the drugs. So that was another effort so that what is now called the MOS Program, or the Medical Outreach Services of Louisa County, is what developed there. So in both of these situations, you know, it wasn’t something that I started, it was I was one of several people who started talking about looking at our needs and bringing things together and seeing an opportunity to plug into this particular kind of grant.

The third piece of our assessment and plan was something that did not get immediate funding, but has developed since then. At that point, there were some residents at the medical school at UVA who were starting to talk about a free clinic. They had come from places where they had done their medical school training, where they had seen free clinics in operation and they saw, of course, in the emergency room and other places people who didn’t get care until too late and that sort of stuff. So they were starting to talk in the community about developing a free clinic. Several people had directed them to me as the Health Director for the community. So, I became involved with that group early on in sort of a steering committee and planning for what we might do and developing the approach for the free clinic and how it might work in our community. At the particular time, what we were trying to focus on with the grant was how to bring obstetrical care into that and that was the application that we made. Part of the reason that we may not have been able to get the funding for that was because we really didn’t get all of the bugs worked out with the medical school and the training program that was going on, where almost all of the indigent patients in the community needing obstetrical care, prenatal care, went to UVA. There were concerns that even though there were interested community physicians that provide some free care, there were concerns maybe we won’t have enough to teach our residents and that sort of thing.
So that was sort of a lesson in... we had some ideas, but we didn't have all the pieces together, but the free clinic itself did get going and developed. It started off in some donated space that was renovated and served as the free clinic for the first two years or so. Then that space was sold and the new owners didn't want to donate it anymore so there was a mad scramble to find a place. Well, at that point, the Health Department, itself, was in really cramped quarters and was making plans to expand the clinic, but wasn't... that was still on the drawing board. So there was a need to move the free clinic real quickly. Well, they came up with some donated space from UVA at Blue Ridge Hospital, which had been the old sanitarium, but the state had gotten out many years ago and had donated it to UVA and UVA was using. As they were looking at efficiencies and expanding the hospital, they were looking at closing it down at that point. So there was space that they donated for the free clinic and that is where the free clinic has been for a little over a year, but in that interim we had finished the first phase of our building at the Health Department. All this time I had been serving on the board of the local free clinic, Charlottesville Free Clinic. So there came up a need... this is only a temporary situation that we got donated space at Blue Ridge and they started looking around. One kind of problem or another, concerns about having the same problem before of paying to renovate a space and then not having a long-term lease and being kicked out like we were before and the costs of the other thing. At the same time, we had been able to start our building project to expand our clinic in the Health Department, but the focus was starting to turn in Public Health away from providing clinic services to providing more services in terms of education and population services as managed care was starting to take over a lot of the individual patient care and populations like Medicaid were being contracted to managed care. Now that still hasn't come all the way to Charlottesville, yet, it's still in the Tidewater and Northern Virginia areas, but it's still moving towards us. So, we saw new clinic space that we were about to occupy or we are occupying now and yet a need that may be decreasing. Whereas the free clinic still is there talking about serving the working poor, not the lowest level because UVA was able to see them. So, we talked about an arrangement. I made an offer and we talked about it through and within the staff of the Health Department and the free clinic, hashed it out for a couple of months. Basically came down to the fact that in the last phase of our building we were adding on a storeroom area that had gotten kicked out of the first part of the building because we didn't have enough money. So, how about... there was no question that the free clinic could use our new facilities in the evening when we weren't using them because they were operating in the evenings with volunteers. But they needed administrative space and we didn't... we had expanded ourselves, but we didn't have that kind of space to give them. They needed a pharmacy, we didn't have a pharmacy. But what we developed was a plan to raise money for the free clinic to build an addition as part of the addition that we were building for the second floor that would be the administrative facilities that they could use sort of separately, but attached to our building during the day for their daytime services for their staff and so forth. Then at night it would have a connection that could then make use of our clinic. And so that is finally coming to fruition and the move is supposed to be in two weeks to actually get all that going and move out of that temporary space that has
gone on being temporary now for almost 18 months at Blue Ridge because we've had this other thing in progress now for the last year.

**Stephanie:** It sounds like, through all these projects, collaboration is a really large part of what you do. One of the theories I've proposed as possibly describing the leadership in such organizations is collaborative leadership. It is based on coalition building and working with people in the community and other agencies. Do you find that hard to brings together, all the necessary people and agencies to do your work?

**Susan:** I think, often times, it’s hard. I'm not sure that there’s anything that’s happened that I have been the only one or even the prime mover. I think in all of these there have been other people who have been interested and working with them. One of the things that sometimes is interesting in a place like Charlottesville, where there are . . . it’s a fairly small community and yet there are a lot of resources and lot of people interested, a lot of human service organizations and so forth, is trying to pull together so many different ones because of the vested interests. One of the things I’ve been working with for the last couple years is serving on the board of the United Way and I have become involved in their restructuring of how they give funds. At one point, like a lot United Way’s it was sort of the standard agencies and we just raised the money and give them the operating funds. Well, we started seeing decreasing revenues and increasing needs so we transitioned to a program grant approach. One of the focuses with that has been trying to encourage collaboration; instead of several different agencies coming to similar types of things, trying to push them to partner together. So, I’ve been on it from that side, but I’ve also been part of doing it because one of the agencies that is involved has been the Health Department as part of a group of several different agencies working on projects for young children, [ages] 0-3 and their development. Yet, there are a lot of agencies out there and they’re each doing sort of their own little piece of it, but they’re all closely related. How do you break down . . . people are willing to work together, but when it comes down to really saying can we break down these things and quit doing your part and my part and do our part together. That’s hard and I know it’s hard when I’m a part of one of them because you come with rules and regulations and funding streams and all the other kinds of stuff, but they kind of make it difficult for you to just throw it all on the table and say let’s all work together. Everybody has vested interests, I mean the two hospitals, UVA and the private hospital Martha Jefferson, they have been better over the last couple of years of working together. Both have seen the market pressures and realized that we may actually in terms of health care resources, probably, have an overabundance in the Charlottesville area. Everybody knows at some point with managed care things are going to get tighter and how best to position yourself? So then it’s sort of a love-hate relationship sometimes. The Health Department has been uniquely situated because being sort of a public agency and not really in competition with either one, we’ve been able to be sort of the place to bring folks together to work on community projects.

**Stephanie:** Do you find that public policy keeps you from doing a lot of things or does it in anyway help you? How do you work with the rules and the regulations? Is it very difficult?
Susan: Certainly there are times when the rules and regulations do make it difficult. There also are times when the rules and regulations are convenient excuses both for me and for other people. Because you’re not sure you want to make this move so it’s easy to blame something else. You know, I have to resist that. But I also think that sometimes the rules and regulations have helped. I mean there have been some efforts at the state level - the Comprehensive Services Act. Are you aware of that at all?

Stephanie: No.

Susan: It grew out several years ago of the focus on how much money of the hundreds of thousands of dollars being spent on a few kids who had such extreme behavioral and emotional problems that had to be sent to these special schools and all kinds of stuff and how that was growing. So, the state put together a study and then had a bigger group determine how might the system be restructured. I was on one piece of that study group which had several hundred people across the state doing it. What came out of that was a pooling of some funding sources, requirements for each community to set up governing for their so-called community policy and management teams that have representation from, in this case, health, social services, mental health, the juvenile court, and the schools to all come together and figure out how best to use this pool of resources. Now there had been a lot of problems in implementing something new and there are rules and regulations and all this sort of thing about the state dumping more on the localities and some of that’s true. But it also has been an attempt in the rules and regulations to try to bring people and have them work together.

The same kind of thing at the federal level in what’s going on for preschool kids and their handicapping conditions that developed at a young age. There has been a requirement that that be developed on an interagency basis. So there’s certainly a lot of interest and initiative in doing those kind of things at both the state and local levels, the state and federal levels. But how those things actually turn out, that’s where we’ve still got problems, in terms of how the rules are written and how their handle it.

Stephanie: What are your feelings about managed care and how it’s going to effect you in the future. You’ve briefly touched on it, but could you tell me more as far as the effects in the Health Department and in the programs that you’ve helped to start through VHCF?

Susan: Well, of course the VHCF like most other foundations only starts programs, they don’t keep funding them. So, we’ve expired our three years on all of those and we’ve had to go out and try other funding sources. That’s a problem in itself because ongoing projects, once they show they work, there isn’t necessarily the ability to convince a local government or somebody else that they should start picking them up. Not that they’re not good, it’s just that there’s so much other competition for the money.

Managed care, that one is one that is . . . I don’t, again, have as much direct experience as the health departments in the Tidewater area, where they have seen, a lot of them had
developed a lot of clinics and they have seen those... and relied therefore on the revenues that they got from Medicaid for taking care of these patients, they have seen that disappear and had to make cuts in their staff and so forth. As managed care corporations have come in and contracted them and so forth and take those folks out... it should be good that people are still getting the care, the problem is that they don’t always get the connecting pieces and the outreach and other education things that the health department tries to provide. So, we’re seeing that happen and we’re trying to figure out how does that work for us because we never have been, in our area, as heavily into the clinics. Part of that being in our relationship with UVA. We do see that we’re having to change some of the way we’re doing things. We’re having to become more accountable, we’re having to gather better data, both in terms of our cost and our outcomes because if we want to continue to do some of the things we’re doing now, certainly for the Medicaid population, we’re going to have to be subcontracting with whatever managed care organization will be doing that. The other issue always is what about those people who don’t fit into Medicaid and who haven’t gotten the health care reform and are sort of without anything. There’s not a lot of talking about that at either the federal or the state level, about those people right now because of the negative connotations of what happened with the whole Clinton health care plan that was trying to deal with those and now everybody has sort of turned away from it. So, there certainly are opportunities.

One of the opportunities that is being focused on is at the state level and in local health departments with managed care is the possibilities of having some common data system and sharing of those kind of things, to look at the health of the community overall and having better data. That is certainly a primary role, data analysis, for public health. How to make those connections with organizations that are getting started is one of the things I’m having to deal with right now because a big managed care organization, QualChoice, that UVA is a primary owner of, but it is a separate for-profit managed care organization... they are busy doing lots of things like getting a Medicare contract for rural areas and other things and so their interest right now is not necessarily in talking about some of the things we in the Health Department would like to talk about. But there are some connections being made and there are other people who are... we’re sort of talking around different areas right now. So it’s an area ripe for change, it is going to change, some of it you could see, a lot of it you can’t see and it’s difficult to know. Are there other people you will be talking to about this project?

**Stephanie:** I’ll be speaking with Dr. Art Vanzee of the St. Charles Health Clinic later this week and several other people that Ms. [Debbie] Oswalt gave me. I’ll be speaking to about six people for this project. I’m wondering, in these projects that you have and through anything that the Health Department does, is empowerment of the people a concept that is talked about? Is it implemented into your programs? Can you speak about that?

**Susan:** First of all, I can speak to it one way because we have just been almost two years now into... this is internal within the Health Department and the Health Department staff, going through a lot of changes - moving to a team-based organization where
empowerment of individual employees is very important. It started from the interest in Total Quality Management (TQM). What we have tried to do is take some of the principles from TQM and a continuous process of improvement as well as team organization and staff and empowerment. So that is a big thing that our health district has been sort of the pilot for all of the states. We’ve been grappling through a lot of kind of things of training and working out problems and making changes, people not being comfortable with change and all of that going on internally at the same time as people you see on the outside, these other things like managed care coming in and threats. So that’s another piece of what we’ve been working on.

So the concept of empowerment has definitely been there and discussed. It is primary in a number of the things we’ve done, particularly with the CHIP project. I think the focus has been on trying to help the family develop itself to become self-sufficient and doing better parenting and so forth. Too often in the Health Department and Social Service Agencies in general, we start getting into this sort of “welfare mentality” complex - the “revolving door” and the people who sort of are permanently in need of the government to take care of them and all the kinds of things that have been talked about in welfare reform and everything and getting away from that. So the focus has really been to try and say we’re not willing to enroll these people and keep them forever. We’re going to give to them intensely and that is the problem because this sort of thing costs more.

Some intensive work that will help them develop and become more self-sufficient or better able to advocate for themselves and to do for themselves because of course the whole health care system is so complex, has been, and is getting more complex with all the changes. Most of us, even when we’ve got a lot of smarts and a lot of resources have trouble navigating the way through. You can imagine how the other people who don’t have some of those things are . . . trying to help them learn how to do that with some degree without having to just be told how and taken by the hand or not do it because they throw up their hands [and say] I don’t know where to go.

A measure of the issue of empowerment has sort of always been central to a lot of public health principles because education of a person to take care of themselves better to prevent things is sort of basic to everything we’ve been doing for a long time. It’s helping pregnant women know how to care for themselves, it’s helping young mothers know how to care for their infants and do better about that, it’s helping people in food service learn how to do things right to prevent illness instead of having somebody have to come and look over them and make them do it. So the educational component is sort of an empowerment all along.

**Stephanie:** You said that recently you’re focus has been changing to education. Is that correct?

**Susan:** Part of the change of late from clinical care to looking more at population-based services includes public education and prevention.
Stephanie: There seems to be a lot more material about educational services. I did a literature review for this project and it seems in the past two and a half years there is a lot more just on education programs throughout the nation. With different kinds of community health, it really seems to be a focus for a lot of people and that’s why I thought of empowerment for such organizations. Knowledge helps people. So many people don’t have access to it and programs to help them obtain it are empowering.

Susan: There certainly is lots of validity to why that should work. Unfortunately, I think a lot of the reason it gets a lot of press and why you see it a lot in things, its being driven not from the real philosophy of it, but because it’s the same thing with prevention . . . people think about it as a way to save money and all of that will save money in the long run, but it doesn’t save money in the short run because you can’t stop the crisis care or the doing for or whatever. At the same time, you have to think if you’re this group why you’re trying to educate and prevent and so forth with this group so that down the road they may not need as much. Too often it comes across as a quick money saver politically and all of that and that is the unfortunate part about it because it sort of puts you in a box to prove something short-term that isn’t really a short-term solution.

Stephanie: The funny thing is when I was working at Stuart Circle [Hospital] this summer, I worked in the Cardiac Rehab program, it just amazed me how many insurance companies wouldn’t help these older patients receive these services that would help prevent coronary disease. In many ways it would save them money because bypass surgery is much more expensive than to participate in a program on a weekly basis.

Susan: That’s one of the other things in terms of the managed care . . . that at least theoretically and hopefully will have an impact because if you really are having long-term managed care and more stability . . . the problem is right now we’re getting new and what’s going on even in California where it’s been there a while, it’s companies going out of business and buying each other, but if you’ve got the market share and sort of the long-term responsibility then you have a longer-term incentive to do those preventive and money-saving things long term. So if that really works out that may play into it.

Stephanie: On a more personal note, just focusing on you, what were your motivations to get involved in public health? Who are some role models that you look to as influential?

Susan: The motivation, I think, primarily came from the concept of prevention. I went through medical school, my father was a doctor . . . it wasn’t that I always wanted to be a doctor. That really sort of came late in college because I had been thinking about being a teacher, but the medical was always sort of always back there I guess. During my internship year when I was doing some pediatrics and some general medicine and I was seeing a lot of folks through the emergency room because that was really before there was much in the way of the emergency care centers and so the ER was really the drop-in place. You saw a lot of “revolving door” kinds of things and yet I didn’t really get much teaching on prevention or community health in medical school back about 25 years ago when I was
in school. So I just felt like something was missing. So I took some time after my internship, didn’t continue right there with training and wasn’t sure . . . it was sort of a burn-out kind of thing, wanting to know what to do. During that time I talked to some people and they sort of directed me to talk to some other people in the Public Health Department in Tennessee where I was from. It was then that it started coming together about there being some avenues for focusing on prevention and some things that might happen in a social context and a broader context than individual care. So that’s what got me started into it.

The one person I can say, and I really don’t know that I have any specific role models . . . the last year of my training I told you I was assigned to work in Charlottesville and I was assigned to work with someone who had been in public health for a number of years. That person turned out to be the man I married, a number of years older than I. He had had a career working in the U.S. Public Health Service, had worked in international public health with World Health Organization (WHO) before starting to work in the state of Virginia. So that the breadth of his experiences and the kinds of things he shared with me, gave me a different view and so it helped me early on before we developed our other relationship and it continued after that.

Stephanie: My last question for you is, besides the picture you drew, in words could you summarize what you think it takes to be effective, as people have deemed you, as a leader in public health . . . can you specify the characteristics that help you to do your job?

Susan: I’m not sure, I am sure that not everybody would think of me as a leader in public health. I get naturally thought of as a leader because I am in a position that a leader is supposed to hold. So some of it comes just from where you happen to be and the title you happen to hold and that sort of stuff. I do have an interest in communication with all the people involved, other people, other employees, other groups, and that sort of thing. Trying to make sure we understand each other. So that may be an element into it. It’s certainly been one of the things I had some positive feedback say from other health directors across the state. Two years ago I did a temporary six month filling in as sort of the Deputy Commissioner for the state, specifically in charge of . . . sort of filling in as my own boss because there was an administration change and nobody was appointed and that sort of stuff. So I was coordinating things for the people in my position all over the state and I got a lot of feedback for doing that because of sharing things and keep people informed and communication. I don’t know that it necessarily takes new ideas or anything like that, although certainly some of the leaders that I admire are people who seemed to be more creative in thinking about new ideas. An ability to share those ideas and to articulate them to people, I’m not sure that I feel I do a very good job of that at times. That would be something I feel is important to.

Stephanie: It seems to me that you’re a leader because my definition that I’m using for my project is leaders are initiators, initiators of change. So, according to the information I’ve received from others and the projects you’ve helped to start it seems you are a leader.
I want to thank you for your time. I will be sure to send a copy of my final project to you so you can see how much you’ve helped me.
First a tour was conducted through the clinic and Dr. Vanzee spoke about the history of the clinic. The most relevant parts of this conversation are given along with the entire interview.

Dr. Vanzee: They [the community] raised money for expansion of the clinic and built this second building which includes the dental unit. Some years after that, they raised money and they started building the administration part of the building.

Stephanie: The second and third phases of the building, did they do it with a lot of community money?

Dr. Vanzee: We got some grants, but there wasn’t any federal money in the buildings. The first year we got a federal it was to subsidize the care. Underserved areas and poor areas become subsidized so that you have federal grants. Then care is received on a sliding-fee scale. People who have no insurance pay very little according to their income. So some people may only pay five or ten dollars for their health care. I think we have about fifteen percent of people on Medicaid and the majority of people on the sliding-fee scale, these people fall through the cracks. They can’t afford private insurance, but they don’t qualify for Medicaid.

. . . The second year they had a second health fair come down. That year I supervised the medical students, residents, and nursing students. I took a month off as a student. We were in a building with no windows in the month of July, but the kids had a great time.

Walking over to the new dental unit . . . The dental needs are very severe. There are a lot of factors as to why, but I think one of the biggest one’s is that if you don’t have many resources it’s one of the last things you do.

Stephanie: The [dental] equipment, was it bought with the grant money or was it donated?

Dr. Vanzee: No, we bought it with money we raised. Some of it is from the original money raised for the clinic. We used to have one chair that one dentist operated. Now we have two dentists. One of the dentists works here full time and the other just left.

Stephanie: How many doctors work over in the clinic?

Dr. Vanzee: We have two doctors and a nurse practitioner. We had a doctor who was there for nine years and left in January. We’ve had local temporary help.
The actual interview begins . . .

Stephanie: I’m going to ask you to draw your conception of leadership with these markers on a white piece of paper. It can be anything . . . stick figures, anything. This is an activity we’ve been asked to do in some of our leadership classes, so now I’m trying to learn about how others picture leadership.

He thinks for a while and then takes about 2-3 minutes to draw the picture.

Stephanie: Can you explain it to me?

Dr. Vanzee: I haven’t thought about this for more than five minutes, but my initial feeling would be that I would draw many, many, all kinds of stick figures around here. Somebody who would be a leader would be somebody who comes from within the community group, does not come from the outside. Basically understands the community as well as respect, and has credibility in the community. It’s very much a two-way street. They’re very much in-tune with people in the community, are able to give back to what the needs are. Obviously are little tiny doves, as we know [they] are birds of peace, that is only to symbolize . . . obviously there are many people in the community and only a few become leaders and there’s something special about some person that becomes a leader and that can be strength of character, strength of will, or intelligence, or a gift with people, or something special about that person that engenders a real respect and a kind of leadership role in the community. They don’t need to be PhD’s or anything like that, it just has to do with the person. Around here there are a lot of lay-ministers, or lay-preachers, that don’t have any formal education, no form of seminary, but have become leaders through the strength of their convictions.

Stephanie: I think that’s a great definition. That was much better than my first drawing. One of the theories I think begins to explain leadership, and it’s a brand new concept with James MacGregor Burns, he sees leaders as “initiators of change.” That really seems to be something that could apply here to the community because it took people to initiate this clinic. When the people came in from Vanderbilt with the health fair, did they come in because they [the coalition] wanted to or did the people [of St. Charles] want to bring them in? Did they want the change? Were the students accepted well? How did the community leaders go about initiating this?

Dr. Vanzee: I think, you could talk to Charlie [Provence] some about what it was like with the very earliest contacts, but this is not a situation where somebody had an idea that they needed a clinic. Nobody had really thought about that. These people came in with good ideas. I think there was . . . one of the reasons why it was so successful is that there was this pervasive feeling and a need within the community and people knew what the needs were and what they wanted. I think the coalition just served as kind of a vehicle and kind of a catalyst for getting those things done. We were just helping people organize around their health care issues. So the needs and interests and desires and everything
were very much there in the community. I think probably what occurred is initial contacts between some of the people from the coalition looking for places to do health fairs, getting leads on what places there might be for making contacts with communities. Is this something that makes any sense for your community or your area? Is it something that would be helpful? Is there interest and buildings and they just pursued it.

Stephanie: One of the other things that is a part of the concept [for this project] is community building and its importance. Also, the empowerment of the people. I would think that in some communities people would be “stand-offish” towards the students from Vanderbilt, people coming from the outside. Of course there was a genuine need for them. I just wonder how they brought all the people together. It seems like a sense of empowerment came about from them . . . the people building this clinic, but do you know if there was conflict in the beginning? Was it hard to bring the people together to focus on these health care needs?

Dr. Vanzee: There is a pretty pervasive, genuine mistrust of outsiders coming into the mountains. At least it has been historically for years. Of course for some good reasons. The outside world has basically exploited the mountains, pretty heavily. I’m going back to the days where they had money. People coming in from Pennsylvania, Philadelphia, and big cities, developing coal camps here and getting all the mineral rights, getting people land. The region as a whole has been terribly exploited. There’s been enormous amounts of wealth leave this region to power homes, storefront windows, air-conditioners in New York and Connecticut, Detroit with very little being left to the region. There’s lots of poverty, lots of lack of education. There’s not a family hardly around who’s been coal mining family for a long time that hasn’t paid some kind of real personal sacrifice or tragedy and yet the early days of mining were very, very difficult, very, very harsh conditions, dangerous conditions. A lot of people injured, maimed, killed. It would be hard to spend any time in this area, not talking to my generation, but to talk to the older generation, most of which are dying out now, and not find somebody who’s either been killed in their family or serious injuries, or something like that. And these were times and years, pre-union times, when they had no protections and very much exploited and had very little recourse but to work, typically. So, there’s not only that, but I mean whether it was missionaries or church groups or any of the number of the different groups from the North, that came in with the mind set of these are poor, backward people that we need to help and anytime imposing their own view of what is right or what would be helpful among their standards. Of course for decades in the media there’s a general sense of . . . I mean the area’s portrayed in such a stereotypical way. The media goes all the way back to when you saw poor children almost without clothing sitting on the standard front porches of a shack, Appalachia in the sixties. There was some of that there, but it’s been very stereotyped and misconstrued in the media about what the real mountain culture is here and what the strengths are of the people and what the strengths of the culture are. So, there’s been some reason for there to be some mistrust of outsiders coming in to the region and I think it’s like any other region anywhere else. I mean if you’re gonna . . . you live close to Knoxville?
Stephanie: Yes, Ten Mile.

Dr. Vanzee: How big is Ten Mile?

Stephanie: It’s not an incorporated city. It’s tiny.

Dr. Vanzee: Do you have a mayor?

Stephanie: No. There’s no city organization or that type of thing.

Dr. Vanzee: The point would be you would be very skeptical if I came down, but any region you go to is a little skeptical if somebody comes in from the outside, doesn’t know the territory, doesn’t know the people, doesn’t know the particular subculture and seems to think they have ideas about how to answer problems. I think this area has had a little more exposure to that than most areas because it’s been a high-need area and so forth. I think it worked pretty well with the coalition because people came in not as authority figures and not as somebody who had all the answers for what their problems were, but these were young, enthusiastic, college students, medical students who were put up in people’s homes for either a week or several weeks at a time. The people cooked for them and sat around and talked and shared. They really got to know each and that was . . . there’s still a lot of people from around that have kept in touch with the people . . . I mean they get very close to some. Miss Eliza Norton who I talked with a week or so ago was telling me about how she cried and the young student cried when she had to leave for the summer. They got very attached to the people, very involved with their lives. Usually, most student are going to go into a situation like that being very open, non-judgmental and wanting to know about the culture and things rather than coming into a situation that you might have with a 50 year old professional who might come into the situation and have ideas made up about which ways to go. So, I think that was one reason why it [the coalition] could be successful, much more successful than if, you know, Vanderbilt staff talked to some nurses who came in to do health care screening. Much more successful in terms of real community organizing and things.

Stephanie: Are the doctors in this clinic from this area or have they come in from other places?

Dr. Vanzee: No, I’m not from this area. Steve, who was here for nine years, is from North Carolina.

Stephanie: Did you find that to be a problem when you first started practicing?

Dr. Vanzee: Well, there’s still some people who think I’m an outsider, but very small. I think once people know that you’re there and that you have respect for them and once you establish relationships with people then their . . . they kind of get over the initial feelings, but there’s a tiny bit of that element that is true. My wife grew up in east Kentucky and we’ve been in the county ten years and some people still think she’s an outsider. It’s only
like 80 miles away where she grew up and she spent all her life working in the region and organizing different things, but there’s a small amount of that, but that’s not the majority feeling.

Stephanie: In Dr. Couto’s book *Streams of Idealism* it said in some communities that starting off health clinics helped to start other projects in the community, like improvement of water quality and other resources. Did that occur here in St. Charles?

Dr. Vanzee: I think there was a real vent, I think there was some empowerment. People felt very proud of the clinic. The St. Charles area and surrounding coal camps were always a pretty tough area in the county. A lot of people in Lee County look upon this part of the county as kind of the ghetto, as people would in the city, because it was a little poorer than the rest of the county, it was a little rougher. So, I think there was a sense that nothing good is going to come out of the clinic project up there. Outside this general area people, up here all these people think that, especially after this got going and appeared that it was going to be stable and grow and be a good facility and give good medical care, there was a growing sense of pride about it. In many community meeting you heard people say over the years, “Well if we can do the clinic than we can do this kind of thing…” Other projects that have come up included things like…there’s a community center down here in the downtown, they do adult education classes and a lot of different things, there’s a clothing store, a lot of people don’t have…probably percentage wise there’s probably 40-50 percent of the people that don’t have a high school education, basically older ones. There’s GED classes and there’s some community college classes they’re running out of the community centers. There’s a small sewing factory that was started in the town. I’ve heard that comment a lot that people would say, “If we can do the clinic we can handle that”. So I think in that aspect, as far as pride and empowerment.

Stephanie: On a day to day basis what are some of the factors that affect how you work here and how the clinic as a whole keeps going - working through problems and working with people? What are the daily influences?

Dr. Vanzee: Well, you have the problems in any organization. We’ve had financial problems, a big financial crunch after we built this, we bought this building relatively cheap and the hardware store. It took a lot of money to remodel it and stuff. [There were] difficult times in the organization when a few people were laid off, we went through a close down for a while. The moral of a lot of people was low. We got some leadership and a Chief Fiscal Officer, we got through that real well.

Stephanie: You mentioned the different administration that work here. Are most of them from this area or do they usually come from other places also?

Dr. Vanzee: It depends, the Chief Executive Officer, now, a woman named Karen Northrup, she grew up in the Abington area about an hour from here. She went to high school there, went to college, she got her Masters. She was a nurse and started out as a
Stephanie: What are some of the things that motivated you to become involved in the community health clinic and even, if you know, some of the motivations of the people that work here? What brought you to St. Charles?

Dr. Vanzee: Well, it’s kind of funny because I grew up in a town of 5,000 in northeastern Nevada in a little town named Elko. I couldn’t imagine living in a little town because I thought it was so parochial and I had to get out in the big world. I thought it [Elko] was parochial and conservative and now I look and it seems like such a big town now. I couldn’t imagine I would be working in a town of 200 people. You know I think it’s a combination of a lot of things.

I wanted to go into medicine because I wanted to practice medicine in areas that were real high need areas. I wanted to practice in a setting that had a lot of community involvement because I thought that was real important for the community. I wanted to NOT do private practice because when I was going through there were less options about where you practice medicine, but the predominant model was private practice. I was not a particular believer in fee-for-service medicine because I felt that it excluded a lot of people from getting health care. So, I wanted to be in a setting where you could be sure that money wasn’t a barrier to people getting good health care. I was interested in areas where there were social and economic problems. I grew up in with a Presbyterian background. I wanted to do something with my life that makes other people’s lives better. I had the social concerns of the sixties, so I was very much involved in the social justice and that. So I spent . . . when I was in medical school I had long-term interests of doing something that was useful in high need areas, being rural, I wanted it to be rural. I spent a summer in Alabama, in the Alabama medical school, and spent a summer in Mississippi and knew it was something like what I wanted to do. Then I became familiar with the coalition when I went to Vanderbilt to do my residency. For two years I supervised the medical students in the health fair, I took them up in July and was their preceptor for their exams. I had that particular, specific experience that brought me to the mountains. So, it was the kind of medicine I wanted to be in, it was the kind of area I wanted to be in. At the time I was finishing, the clinic needed a doctor. So, it seemed like a good match. This center has been a good match for me.

Stephanie: Some people are hesitant to call themselves leaders, but Dr. Couto and others have noted you as a leader, and I was wondering if you could tell me what your qualities are that help you to work well with the people and to work in the community?
Dr. Vanzee: I don’t know how much, well I guess there are some qualities... I think the thing that has made this clinic successful is somebody who would come and stay and be here long term. They could make a long-term commitment to staying. That gives them the kind of stability that is needed to grow and develop. A lot of the clinics kind of arose from these similar kinds of backgrounds. There’s one in Dungan, there’s a whole bunch scattered through northeast Tennessee up by Jelico, in Jacksboro. In that area [that you drove] there were five or six clinics started about the same era. They had a lot of turnover, their providers - doctors, nurse practitioners, and that always makes it hard for a clinic to really go. Patients get to know somebody after two years [and] their gone. Long-term makes it go, if you’ve got a person that can stay, will make any program you have... make it work. I’ve been here and that’s one of the main things. I think people feel I have respect for them and the community, a genuine interest in all the people and having a relationship.

Stephanie: As far as the clinic right now, do you have programs that address anything other than specific medical conditions? Do you anything that works with the social aspect of the community?

Dr. Vanzee: There have been a couple of different things. We have a Black Lung Program which does testing for people - a breathing test, nurse counseling in regards to chronic pulmonary problems. We have a guy, Ron Carson, who does benefits counseling for people who are applying for their Black Lung and then of course Social Security. There was a geriatric outreach program for a few years, in which we had case management worker-nurses for patients of their own. They would case manage them and basically try to be their ombudsman for, to try to deal with any problems that they had. We don’t have that anymore, it got cut off in our financial crunch.

We have the case management program for OB’s. Two very good nurses, they basically take patients up in their first trimester and then follow them through. They basically try to make sure they have adequate education about all the issues that you need - about prenatal care, make sure they can get to their appointments, and then they also follow the kids up until about two years old. They have a real good relationship with the parents and the families and there’s a lot of time spent with them. I think it’s been a well established and proven program to reduce low-birthweight babies because I see even private... the private sector is adopting that kind of thing - HMOs, Blue Cross/Blue Shield.

You know the clinic is one of a system, it used to be just St. Charles. Now, the umbrella organization is Stone Mountain Health Services. We are one of seven or eight clinics through this whole region now. So we have clinics in Dickinson County and others.

Stephanie: Do you see HMOs having an effect at all in this area? Or are they really not going to touch the people here?

Dr. Vanzee: Their starting and it’s just a matter of time I think.
Stephanie: What do you see the impact being?

Dr. Vanzee: That’s hard to know. The hospital has basically tried to monopolize the whole health care system because they say managed care is coming and we have to be ready. But the way . . . it’s controversial about the way their approaching it. Their trying to basically monopolize the whole local health care system. It’s hard to tell. There’s been a few private HMO’s in the area now. The Medicare and the HMOs, it’s managed care to some extent now, but their starting in Northern Virginia and moving down. So, in a few years we’ll have managed care with Medicaid.

Stephanie: Do you see it as being positive at all or do you think it will have more negative effects?

Dr. Vanzee: I’m not a supporter of managed care for a lot of reasons. I still feel we’d be better off with a one-payer system like Canada. There are many problems in the fee-for-service model for private practice that the country’s had for years, but their not the problems with managed care. I don’t think their going to solve the problems. In most managed care organizations, people refer to them bleakly. They don’t really have anything to do with increasing access for people who don’t have resources. They have been effective at holding down health care costs nationwide, but the only one that I know of that really made a significant difference was Tennessee’s Medicaid managed care and their intent was to increase enrollment into the program - those who didn’t have access to receive access. I don’t follow that very closely, but it has some problems. I don’t know how successful they’ve been doing that, increasing people’s access.

Stephanie: So it’s possible that a lot of people here may not be effected by it if it’s not going to increase access? I would think a lot of people here don’t have private insurance and you said only a small population are on Medicaid.

Dr. Vanzee: About 15% of ours are on Medicaid. I don’t know, there’s probably 30-40% on sliding fee. We have a pretty good Medicare population. We have a small number of private insurance. A pretty sizable amount are on sliding-fee. There’s not any proposed managed care system that’s going to deal with that population.

Stephanie: The clinic then is still a need here because those people will not gain access.

Dr. Vanzee: Yeah, I don’t feel that community health centers are going to be threatened by any managed care system. I think there’s going to be more and more need for St. Charles and places like it all over the country because I think there’s going to be more and more people that don’t have resources, especially with changes in the welfare system and things like that. More and more people who need places like this.

Stephanie: Well, I want to thank you for answering all my questions.
Stephanie: Where you here at the very beginning when the coalition from Vanderbilt, the student coalition came to St. Charles? When they had the health fair?

Mr. Provence: Yes, in fact I went up and went through it [the health fair].

Stephanie: Okay, can you tell me the feelings of the people in St. Charles when they came? Was there a feeling that “outsiders” were coming in or were people happy?

Mr. Provence: Some people did not want outsiders coming in, but the majority of the people were pleased. Especially since they got some of the services free.

Stephanie: The health fair was there for a week? After they left was there a sense of we want to get a health clinic going or did that take time for that feeling to come along?

Mr. Provence: Yes, they were here for a week. [The health fair] is what got it started. That raised the interest among a few people and it took off from there. Had it not been for the health fair it probably would not have gone, maybe I don’t know, but that jump-started it.

Stephanie: Would you say it was a few people that got it started or was the whole community involved?

(Interrupted by friend of Mr. Provence)

Mr. Provence: Okay, where were we?

Stephanie: After the coalition left was it just a few people in the community that wanted to get a clinic going? What was the atmosphere? What was it like?

Mr. Provence: Well, everybody, except for a few [who said] “We don’t want anybody to come in here” and stuff like that, but actually Nancy Raybin came down here a few days after that. She stayed on here and wanted to organize a group, something you know, to try to get it started. We talked at length about it and just set up a meeting at the lunchroom, I believe, at St. Charles. The building was full when we had it. So, I mean the health fair really, really generated the interest and those people you know would come down from here, run into it now sometimes, for five or six hours to see a doctor. But that, I really think that probably Nancy Raybin was the key in really getting it going after the health fair was here.
Stephanie: Now how did you get the money and all the resources that you needed to start a clinic? How did you even start in that process? It must have seemed really overwhelming whenever you first began?

Mr. Provence: Well, it didn’t really look that big because you don’t have anything so what’s something big? After the meeting we formed a board. They elected me president that night.

Stephanie: Can I ask a real quick question? What do think made them elect you president? Had you held other positions previously?

Mr. Provence: I was a patsy. I was a good fall guy. No, the gentleman I wanted to head it up kind of declined it, but you know I really don’t know. Of course I’m from St. Charles. Born and raised up there. I had been involved in a few little projects that I had you know more or less . . . especially for young people and older people. A few little ‘ole things that we had. Anyway, they elected the president and the board members that night. Then we began to work on, I guess, getting the by-laws and how we wanted to set it up. Then I had a little building up there and we had a nurse practitioner and we just used that little building. I can’t remember it’s been so long if anybody ever came there or not. Anyway, we just had different fundraising events.

Stephanie: Did all the money . . . did you build the building right off or just use one that was already constructed?

Mr. Provence: No, no, we bought the land and built the building. I drew the plans up, if that’s what you can call them on cardboard. Most of the labor was free and we didn’t have to buy much. A fellow at Kingsport took those plans and put them in blueprint form. We had a lot of bake sales. It was just the general run of fundraising things. One of the biggest things we made the most money on ever was a Hee-Haw show. I printed up some little ‘ole ads and made you buy this ad. We made money like that. We had a membership, if you gave us a dollar we gave you a little card. You were a member of the St. Charles Health Council. Anybody could be a member of it, it didn’t matter the amount. One guy gave us twenty-five cents, we were talking about it just maybe two weeks ago when he was by here, but he gave it. With the labor being donated, money you know you get a hundred here and a hundred there, five hundred here . . . well we can build this with that much. Then we had a doctor there for a little while, then Art was still in school at this time. He’d come up and visit. We’d say well you know Art you ought to come back up here. We played basketball a lot. He’s a good ball player. I can’t even remember how long it took us to get the money to even start the building.

Stephanie: How did you, if you recall, how did you get all the people to work together?

Mr. Provence: It was no problem. No, problem. I’d call up there and say I need ten people up at the school at six o’clock, there’d be thirty. It was no problem.
Stephanie: As far as getting the labor donated, was it from people around the St. Charles area? Can you describe the feeling as people saw the building being erected?

Mr. Provence: We had electricians and carpenters and brick masons, people like that. I helped.

Stephanie: So it really was a true community project.

Mr. Provence: Oh, absolutely. Yes, absolutely.

Stephanie: Was there a sense of pride after it was done?

Mr. Provence: Absolutely. Never dreamin’ it would expand out like it is now. I had no idea it’d be like that.

Stephanie: Do you think it helped to start anything else in the community? I’m sure it’s not the first time you worked together as a community, but did it help to address any other problems in St. Charles?

Mr. Provence: I think that it gave, like in any community, a sense of achievin’ whatever they would like to. It kind of jump-started that. But I had been more up there and organized more recreation things. Before this happened, you know people were willing to work and get involved in it, I mean not just a select few, everybody.

Stephanie: What about the people that didn’t like the outsiders? Did they come around?

Mr. Provence: Everybody came around, but one person, at least one that I know of. We had to have some help, what with an attorney, we had an attorney who volunteered from out-of-state. He helped us with the by-laws, get the 501 tax deductible thing. Then we had some people, some business places [who said] well you know if you think it’s going to go then we’ll help you. I said we don’t need your help, with that attitude we don’t need your help. They offered it a time or two afterward, but I said no. They said if it goes real good then I’ll help you.

Stephanie: Have you been involved in any of the other phases? Dr. Vanzee said there was an original part of the building and they’ve had two separate parts of the building added on as time has gone by, have you been involved in that?

Mr. Provence: No. After this thing got going real good there was money available and that’s where it all come from, not all of it, but all these new projects. No, I just kind of felt like they needed young blood.

Stephanie: How long were you president of the board?
Mr. Provence: Several years, I don’t remember. We had it in our by-laws that a board member couldn’t have a relative working at the clinic. I’ve seen to much of that. I had a cousin who was the administrator and I resigned so he could get the job. He was real qualified. He served as the administrator for two or three years, four or five, I don’t remember. He’s doing the same thing now in Michigan. I don’t know how long I was [the president], but I’d have a hard time with the board. We’d have a little something come up and I’d say how do you want to handle it? Well, whatever you think Charlie. So I mean it came to the point that I said well how do you feel, what do you want to do to each one individually. We had a good board.

Stephanie: It was all people from St. Charles that were on the board?

Mr. Provence: I don’t know how it is now, but I felt like we should have a representative from each geographical area, like Bonnie Blue; in fact it turned out at that time that we had somebody representing each community that was part of the St. Charles route. I don’t know how it is now. I don’t go to any of the meetings.

Stephanie: Can you describe to me some of the early setbacks or problems? How did you keep hope and how did you keep working through them?

Mr. Provence: Everyday. Discouraging. Probably just didn’t know any better. Mostly it was with the finances. We’d think should we have attempted this? You’re at a certain point and you don’t want to fold your hands. What am I going to do? Yeah, I had a lot of sleepless nights. I sure did. Basically that was it, just the financial things. Then little problems would come up. They always do and we handled them, took care of them.

Stephanie: Did you, at the time, did you apply for any money from the federal government?

Mr. Provence: No. We did apply, this may have been after the building was completed, I’m not sure, we did apply to a foundation. I can’t remember the name of it. It seemed like they gave us, at that time, maybe fifteen or twenty thousand. I’m not sure about that figure. Campaign for Human Development, that’s what they called it at that time. And we ran into some problems with that because some people said well the Catholics will take over. My attitude was so what if we get it. Who cares, but they kind of smoothed out.

Stephanie: I bet people would be hesitant to apply for even federal money too because it gives them the ability to say more about what you can and can’t do.

Mr. Provence: I believe, I’m not sure if the Board of Supervisors eventually gave us five thousand dollars or if a board member gave us five thousand dollars. I can’t remember which it was. One of them.

Stephanie: I don’t know if you can speak on this since you haven’t been as involved in the board as of lately, but what do you think has kept the clinic going? It seems like so
many have not been able to make it. Do you think it’s the support of the community that helped it’s success?

Mr. Provence: Yeah, some grants they’ve applied for have helped too. I understand they’re buying property across from the clinic now. A house across from them, [in which] a lady died. They’re going to move some offices over there and have a place for visiting doctors to stay. They’re working and the money is coming from somewhere.

Stephanie: They showed us the dental office they put in the old hardware store. The dental offices are really nice. I was really impressed. I wasn’t sure what to expect and it’s nice and it’s big. I’m sure people are really proud of that. Is it something that is talked about a lot still?

Mr. Provence: Not really. No because most of the board members have died. I probably am the only one still living. Most of the people that were involved, not most of them, but a good majority of them, a lot of them were older people. At that time 60 and 70 years old. They since have passed away. Of course, the younger generation growing up don’t care.

Stephanie: Did any of the students stay with you whenever they were here for the health fair?

Mr. Provence: Nobody wanted to stay at our house. They stayed with others in the community. There was one of them she was a nurse practitioner who stayed a long time. People began to like here, she was real sweet and helpful.

Stephanie: I’m sure just staying there helped them trust her more. I would think that doctor’s moving in and out would cause a little bit of mistrust.

Mr. Provence: Kind of like it is now with all these doctors now. I tell you though these ladies that worked at the clinic they worked long hours. They had a building up there so people could get clothes and they were the ones who were really behind this. And Dr. Vanzee comin’ up here was really a big springboard. Of course he had been here several times.

Stephanie: And he had come here with the [Vanderbilt] coalition later in years, not with the original health center, but later?

Mr. Provence: When he graduated he came. He had been here several times.

Stephanie: Do the people in the community really like Dr. Vanzee?

Mr. Provence: Oh yeah. He just like he was born up there about where I was. He has made a real commitment. I think had he had not stayed it might have been a different story. It might have been a real long time before it was successful. He made a big
difference when he came and hung up his shingles. Yeah, he comes to the house and brings food. You don’t have to do that and he’s done it many, many times.

**Stephanie:** Well he thinks you all are very special who started the clinic.

**Mr. Provence:** They were all dedicated when they got into it.

**Stephanie:** Thank you for your time. You’ve been extremely helpful.
Appendix 6

Judy Knudson
Olde Towne Medical Clinic
April 2, 1997, 11:00 AM

Stephanie: Let me explain a little bit about my project and how I got this idea since I didn’t tell you much over the phone. I aspire to be a doctor. I worked in a couple of medical settings, in hospitals in Richmond, so I have an interest in community health. I talked to one of my professors about the project and he suggested I do something on leadership and community health. This is my big project for my senior year. I have interviewed four other people, two over in St. Charles, Virginia and in Richmond at Crossover Clinic, and Susan McLeod who’s head of the Health Department in Charlottesville.

One of the things we’re asked to do as Leadership majors is to draw our own picture of leadership. I know I’m hitting you right off the bat with this. I was wondering if you could take this piece of paper and these markers and draw what you see as your definition of leadership in the context of community health.

Knudson: I’m not a visual person.

Stephanie: That’s okay most of the people I’ve asked to do this are hesitant.

Knudson: (as she’s drawing) This is the leader here [in the center]. I think what you need is to be CONNECTED with lots of resources in the community. These [peripheral circles] are other agencies of people - government, United Way... United Way covers a lot of Williamsburg. I don’t know about other places, but United Way tends to be real central here... business - the Chamber of Commerce kind of stuff - civic organizations. You don’t necessarily have to be a member of all those, but you have to know people. You have to be connected. So, that’s why these lines have to be connected. Then you have to be willing to have an opinion. I think that most people are either afraid or don’t have an opinion. You can’t just know people, but there has to be some substance there. You have to, and I don’t know how to draw this, but you have to have some core set of beliefs for yourself. So, you have to know who you are, you have to have these beliefs out here (as she draws them above the leader).

I thought a little bit about this. I don’t know if Debbie [Oswalt, Director of Virginia Health Care Foundation] told you anything about me.

Stephanie: She told me you were a director of a project in Williamsburg, of a free clinic. We went through so many people that I don’t remember all the details.

Knudson: I came to this center sort of a bleak way. I’m one of these people who’s on their seventh career. One of my careers involved being on the James City County Board
of Supervisors. I was in fact chairman for a year for the Board of Supervisors. So, I’ve thought quite a lot about . . . I’m also am one of these people who tends to be president of every group I’ve ever joined, unless I say I’m not going to do that this year. I think it’s a willingness to work because too many people want this on their resume. It looks really good to be president of whatever, but if you’re not willing to do all the garbage and the getting out the mailing and doing the fundraising and being on the nominating committee. You have to do your homework and you have to pay your dues. You don’t just leap into these things and say, “Okay, now I’m going to be in charge.”

**Stephanie:** Are there certain characteristics that you have that you think make people view and elect you as their leader? Is there something about your personality?

**Knudson:** I think that the willingness to take risks, just the willingness to do it. My husband is a professor at William & Mary and he was chairman of his department for a while. They take turns and he disliked it intensely. He simply, and I think it’s got more to do with his personality . . . they wanted him to be chairman another three years, they liked what he was doing so clearly they thought he was doing a good job. He just hated, perhaps too strong a word, but he was not happy doing it. He’s a scientist, he would much rather be in his lab. Because it does take . . . you’ve got to be able to schmooze with people, but you have to be willing to take risks. You have to tell people what you think and I think a lot of people aren’t willing to do that. One of my friends one time told me that I was a terrible politician because everybody always knew what I thought. She said, “There’s no gray area, Judy, everybody knows what you think about everything.” Politicians aren’t supposed to do that.

**Stephanie:** I think it’s good you’re willing to make a stand. I think it’s important.

**Knudson:** But again it goes back to I think the core set of beliefs. This idea that I know who I am and I also think you have to have a few years on you. It’s hard to a leader when you’re young because you don’t have a lot of self-confidence because you’ve been there and done that and the other issue is that you just don’t have the experience to draw on. I really do wonder about these really young people who are elected to public office because I don’t know . . . it’s the paying the dues, it’s the out-there being the campaign manager and being the fund-raiser and writing the policy. If you’ve never had to write policy, you’ve never worked on bills or things, how can you vote on them because you don’t know what’s happened. Of course being the director here is like being a leader of almost anything. I mean you have the same kinds of issues. I’m not a medical person, I have a Masters degree in political science. I’m not a medical person at all, but there are certain commonalities about being in charge of something. I run around and get money and I do lunch all the time, to the point you get sick of it. There are only four good restaurants in Williamsburg where there aren’t any tourists.

**Stephanie:** You said there are a lot of commonalities between being a leader here and in other places. Can you tell me the distinctions there are about being a leader in community health?
Knudson: Well, the distinction of course is that what you’re doing is so immediate and real because people are sick. I just had a meeting yesterday with the head of the Health Department and we have all these political problems at the Health Department where they have been providing some nurses and all of a sudden they’re not doing it because of some funding issues. My issue is that without the nurses we can’t treat patients. I don’t really care about their money problems. The bottom line is we have people coming to the door and we don’t have enough nurses. I think that it’s the immediacy of it. Even though other things are real immediate, I think somehow in health care when people are sick it changes the level a little bit.

Stephanie: Do you see that you have more emotional investment in a context like this with people being sick, other than say a political context?

Knudson: That’s a really interesting question because, not so much in a political setting, but the United Way directorship which became vacant recently . . . I’ve had a couple people call me and ask me to apply for it. I’ve been thinking about it because it’s more money for one thing and there’s not quite as many problems. This is a new agency and its got a lot of growing pains. It’s [the United Way Directorship] a step removed from people. As United Way director your raising money and your dealing with the community leaders that give it out and you’re not really focusing on people. Well, I don’t see people a lot, I mean I always get the patients who are mad, you know the one’s that want to talk to the director and straighten it out. As other kinds of leaders you’re a step removed and it’s even worse as a political leader because as a political leader you are real removed from it. You can go around and have town meetings and talk to community leaders, but you’re fixing sewers and working on roads, you’re not really focused on the people. So, it really is about relationships. It’s much, much closer to what’s going on. Of course, part of the problem in Williamsburg is that nobody believes there’s anybody poor. You know it’s a pretty little town, it’s got a college, it’s got Colonial Williamsburg, what do you mean they have poor? Well, of course there’s this whole cadre of people who keep the city, who take care of the hotels, do of the lawns and all that kind of stuff, but people don’t want to believe that there’s poor.

(Momentary interruption by Wendy, a nurse practitioner.)

Knudson: We don’t have any doctors here and Wendy is a nurse practitioner, she’s a family nurse practitioner. She gets all of our chronic adult problems.

Stephanie: It seems very stressful.

Knudson: It is very stressful. I think she should go to medical school myself, but she likes being a nurse practitioner.
Stephanie: One of the ladies I was working with this summer at Stuart Circle Hospital, she was studying to be a nurse practitioner. She was really excited to be involved in that capacity.

Knudson: Well, it is very exciting. I personally think if you’re interested in community health it’s much better kind of care. Doctors tend to treat illnesses and nurses tend to treat people.

Stephanie: That’s what I really like about the community health context. That’s one of the reasons I’ve chosen to study it because I think hospitals and many other situations where I’ve had to see doctors, they just don’t realize the patient is a person. Health is just as much from the emotional and mental side as it is from the physical one.

Knudson: Absolutely. This is a population that people have never bothered to do that because their poor and their marginal and you don’t think about them. We just got a call from the city, we did a physical on a child who was removed from a home by Child Protective Services. We charged more than Urgent Care and the city called and they’re real upset about it. I said well what kind of physical do you want? Do you want how do you feel or do you want a real physical? They’ve got to make that decision. Now they want us to give them a break and I’m thinking right. I don’t think so.

Stephanie: How do you work with other leaders and agencies in the community? Do you find that to be hard? Are they difficult to work with?

Knudson: Well, no because health care is sexy. It is. I mean its really easy to support health care. We are in fact a 501(3)(c) non-profit. Let me give some background about the clinic. (She gives me a packet of papers and some brochures.)

We’re not the Health Department and we’re not a free clinic. There are no other clinics like Olde Towne. We were here because this area is part of the Peninsula Health Department which is headquartered in Newport News. Are you from Virginia?

Stephanie: No, I’m from Florida, but I’ve been in Virginia for four years.

Knudson: Where in Florida?

Stephanie: From St. Cloud, Florida. It’s about 20 minutes south of Orlando.

Knudson: Really? I used to live in Orlando. It’s a small world. Anyway, in Virginia their health departments are divided into districts around the state. We’re part of the Peninsula Health Department, just down in Newport News. What happened when health departments’ budgets started getting cut, they began to withdraw services from the outlying parts of the district. So, people here were supposed to go to Peninsula Health Department to get care. Yeah right, down by Riverside Hospital and there was no bus service. I mean you couldn’t get there. You’re in Toano with a sick kid and you couldn’t
get there from here, basically. So, there was a group . . . a lot of doctors were involved because they were seeing really sick people in the ER who should have had treatment. In fact the OB docs were the first ones involved because they were seeing women who were ready to deliver, no care. I mean nine months later you show up in the emergency room ready to have a baby. So anyway it was docs and school and government people and social service agencies and it took quite a while, but they formed this. It’s a non-profit 501(3)(c) and it’s supported by the three jurisdictions, by James City County, Williamsburg, and, North County. The idea originally is that they would give less to the health department and give that savings to us. Well, that’s what my meeting was about yesterday. That formula’s gone out the window and nobody knows how to count. So, we have fairly good working relationships with them. The fact that I was on the Board of Supervisors doesn’t hurt. Then we also get money from Williamsburg Community Hospital. We have a fairly good relationship with them. In fact the chairman of our Board of Directors right now is the Chief Operating Officer of the hospital. So there are problems with that, but we’re working on it. We’re very closely tied to the hospital. We get a little United Way money and we do fundraising.

It’s an interesting situation. What is even more interesting is we’ve been here . . . this was formed in the summer of 1993. I started in the summer of 1994. Before I came there was no executive director and that in itself is an interesting study on no leadership. What happened, they were really floundering. The way we are set-up (she finds an organizational chart) . . . when they were set-up originally there was no executive director. So what you had was the clinic director who is the nurse practitioner and an office manager trying to work together. They were getting some financial help, budget stuff, from James City County. There was a doctor who had agreed to help out for a year. He was acting as medical director. We have a volunteer medical director now. What happened was this person (clinical director) and this person (office manager) did not like each other. So there was all this conflict about . . . and they were just organizing . . . how to order things, small kinds of stuff. Then the doctor and the financial guy from James City County both decided to leave the same day. They both announced they were leaving. The doctor said, “I said I’d do this for year and I’m going to go now.” The finance guy got another job and he was going to leave.

So, I happened to be the Chairman of the Board at the time. We all sat down and said, “What are we going to do?” The interesting thing was we didn’t know on the Board how bad things were over here. We all thought it was perking along. Anyway, we decided that what we needed was an Executive Director over the strenuous objections of this office manager. She really thought she could do it all by herself if she just had some help. Well, the reality is that a person who is an office-manager type cannot do this kind of job. It takes somebody who’s . . . you’ve got to have all these skills. The interesting thing is you have to have all those skills, you have to be able to do all that, but you also have to have some community background. She just really wasn’t able to do that. She hadn’t been to college and that’s not really much of it, except that going to college means that you have a little broader view of things. She basically had started as a secretary and worked her way up. The sad thing was she didn’t know she didn’t have the skills because
she didn’t know what it was she wasn’t doing. Anyway, that’s what happened when the doctor and the financial guy left that we brought the executive director in and I did it. I moved from being Chairman of the Board to being Executive Director. You get more money this way.

This is an evolving situation. I am not at all sure that that’s the final organizational chart. It’s what we’re doing right now. So it’s what’s out there. We are members of the Virginia Primary Care Association and I asked them for organizational charts from other organizations and they’re all different. It is amazing. People go with what works. I asked somebody in the Health Department and they said, “Oh, the Health Department changes its organizational chart about every three years.”

**Stephanie:** So, a lot of it is by trial and error.

**Knudson:** Absolutely. You’re out there doing your thing. It’s seeing what you can do. The reality is that the Executive Director needs to have a lot of community stuff that I cannot spend a lot of time making the decision I just made (referring to earlier situation with nurse practitioner). I should not have made that decision actually. She should have asked the Clinic Director who’s another nurse practitioner. The trouble is the Clinic Director is probably seeing a patient. That’s probably why she came to me, but the interesting thing about Wendy is she could have done that all by herself. See that’s the difference between she will never be a director of a clinic because she’s not willing to make the decision. She needed me and you’ve got to put yourself out there on a limb. Then if the hospital fusses their gonna come to me. A lot of people fuss. That’s the other thing you’ve got to put it all in perspective. I’ve got a nice husband and two nice kids and those are the important things in life. I don’t really need to worry about these others.

**Stephanie:** You were talking about how the clinic began and how it’s different from a free clinic, is there a sliding fee scale?

**Knudson:** Well we charge our patients. We have a sliding scale. We bill Medicaid, we do do that. More of our patients are working, are not on Medicaid. There are a couple of things going on. One is that we really do sort of have to make some money. The other is . . . I have a lot of background in this, I was in Peace Corps . . .

**Stephanie:** My roommate was just accepted into it. She is going to Africa.

**Knudson:** Wendy [the nurse practitioner] was in Africa.

**Stephanie:** I can’t think of the place where she’ll be there.

**Knudson:** Some strange country I’m sure. I had to go look at mine on a map. It’s really worth it. Does she know what she’ll be doing?
Stephanie: She told me the name of the project and it’s somehow related to community building. It’s something along those lines.

Knudson: Yeah, that’s what I did. They take a lot of liberal arts majors. It’s like go out there and do good. Anyway, I think that people don’t value free things. When you go to the food closet or the clothes closet, we’ve got one of those in Williamsburg of course. I think it’s demeaning. I know people who’ve had to do that. When my husband was in graduate school we qualified for food stamps. I never had to it because we had family that could help, but it really is demeaning. I think that if you just pay a little bit, then you are paying for services. You’re doing just exactly what you and I would do when we go to the doctor - we go and we pay. Of course if there’s anybody who really can’t pay we don’t charge them.

Stephanie: Do you think that HMOs are going to effect these people in any way or are they a population lost in all the policy that’s going on?

Knudson: No, see I don’t [think they will effect the people]. The interesting thing was I had to argue with the director of the Health Department. He thinks HMOs are going to solve everything. All the Medicaid patients are going to go on to HMOs. Most of our patients aren’t in HMOs. Most of our patients are on Medicaid. (She hands me a piece of paper). We do this every month and if you look on the second page, we finally started keeping track of insured and uninsured. Because I said we’ve got to know what’s going on. Basically, the insured . . we have two things going on. We have people who come here because they like to come here. They would rather pay, but we also have some industrial accounts. We do injections for James City County, so that’s what those 92 people are [on the sheet]. If you look at it, we have 194 people on Medicaid and 528, these are visits not people, but still who aren’t insured. So the HMOs, we are in fact becoming a provider under the HMOs for Medicaid. I’m not real happy about it, but I don’t want our Medicaid patients to be out there dangling in the breeze. We get people who like to come here, but it’s those 528 people who don’t have any insurance. I mean there isn’t going to be an HMO to take care of them. What’s going to happen to us is our revenue is going to drop. We get more from Medicaid than from other places. The other things is, and the state . . and this is what Dr. Warren didn’t believe yesterday, the state is trying to get people off of Medicaid. You almost cannot get on to Medicaid unless you’re a child or a pregnant woman.

When Wendy [the nurse practitioner] just came in, I’m sure he [the sick patient] doesn’t have Medicaid. He’s got Medicare, but he probably doesn’t have Medicaid. Because probably he works, or worked I suspect. See most of the people here know Williamsburg is full of all these part-time jobs, 35 hours a week and you don’t work in January, but you do work in August. So I think, I mean our revenue is clearly going to drop from patients, but I don’t think our patient numbers are going to drop because of HMOs.

Stephanie: You said that a lot of people like to come to this clinic. Do you think it’s because of the people you have here or the programs you have?
Knudson: It’s because of the nurse practitioners. The other thing is we get a lot of people saying to us, “You’re so nice.” I think what happens to the poor and Medicaid when they go to really doctors, their hard patients, they’re not compliant and they don’t always take baths like they should, they’re not always nice because they’ve beaten around by the system a lot. I’ve worked really hard with this staff. They treat their patients just like anybody else they would treat. My whole front staff, those ladies you saw when you came in, all came here from private doctors. It’s really interesting, they came because right now James City County is our fiscal agent so we get county paychecks and county benefits which is really kind of nice. They all came from doctors’ offices where they didn’t get benefits. The worst people for paying benefits are physicians and I understand it because if you look at my budget and it’s 30% of the salary budget. It’s real expensive. Anyway, they all came from doctors’ offices where they were in fact nice to the patients. So they’ve just translated those and do the same thing here. I think that for most of our patients that’s sort of a revelation. I fuss if they have to wait a long time. I don’t think they should wait. So we’re working really hard and these are people who are used to going to the Health Department, come and sit all day long kind of thing or going to doctors where they’re not treated very well. We still have that problem. We get some doctors saying, “You’re referring one of those people.” Then all my hackles go off.

Stephanie: I’m sure how you treat them helps them to have a little more self-confidence and respect. Do you have programs that are empowering in a way for them? Or are all your programs focused on the medical aspect?

Knudson: No, we have a program here . . . we have a couple of things. We have a program called CHIP and I put the brochure in here. I don’t know if anybody’s talked to you about it.

Stephanie: Yes, Susan McLeod did.

Knudson: Well we’ve got a CHIP program here. The idea of course is to help the family. First you fix the medical problem the child has and then you fix the family.

Stephanie: It helps teach them about better parenting?

Knudson: We’re trying to connect them with other things in the area. Williamsburg is rich in resources. There are lots and lots of resources here, lots of help, but people don’t know about them. So it’s a question of connecting them to the resources that are out there. Plus we’re trying to do some parenting classes and a bunch of different little programs.

We also have a GYN nurse practitioner whose trying to institute a Women’s Health Program. We feel very strongly about birth control for the world. We really do. We spend a lot of money with birth control and it’s worth it. She’s trying to institute a program for uninsured women. For one fee they can come in all year. They can get their
birth control, they come in for their pap smears, they get their blood pressure, whatever for a single fee. Anyway, that’s one of the programs we’re trying to do. We’re planning for trifle expenses. We’ve been talking about it because it is very expensive because most of the women who come are paying 10% [on the sliding scale]. So we’re getting $25 for this year.

On the other hand, we think . . . now it’s very hard to prove a negative, but we think we’ve had an impact on the unwanted pregnancies. We really do. The number of unwanted pregnancies seems to be dropping and we really do think it’s because as I say birth control for the world. There are enough babies who aren’t wanted with problems. That’s a social problem that we kind sort of talk about. I’m on a group now that’s working with the girls in a local high school who are pregnant. Of course the goal of that program is to prevent the second pregnancy.

**Stephanie:** It sounds like this literacy project that you have is going to be great. It will help children to have confidence.

**Knudson:** We got a little grant to do that with the local library. See that’s the other thing about being connected. I used to be on the library board. So it just makes working relationships really nice. So when Noreen called me about this little grant . . . somebody said to me how did you get this grant? I said, “Oh, Noreen called.” They were thinking who’s Noreen? She’s the children’s librarian. It’s all these connections *(as she points to her drawing)*. You’ve got to make all these connections. You can’t just say, “Oh, this is a wonderful thing I’d like to do.” Too many people try to function in a void. They try to go forth and do something, but you’ve got to bring all these people with you or it’s not going to work.

**Stephanie:** That’s funny because I had to propose a couple of theories that I thought might help to explain leadership in community health organizations. One of the theories I’ve proposed is collaborative leadership. It’s all about building within the community, working with organizations, working with policy. I wanted to ask, do you think government policy restricts you’re work or does it help you in your work? It could be both.

**Knudson:** Well, local government . . . I’m a big fan of local government because I think it’s where things happen and it’s where you can get things done. I always find it fascinating that a lot of people vote for the president and then fewer for the state and fewer for the local. Local, those are the people deciding about your sewers. So, I’ve always found it fascinating. Local government can be very helpful if you can get to them. Now I do have a couple of people around here who don’t really think that health care is the . . . that local government should be doing health care. As I said, my Masters is in Political Science. I would be happy to debate that forever because I think theoretically it probably isn’t. The reality is if local governments don’t do it, it’s not going to get done. Then their going to pay other ways. You wind up paying somewhere if people aren’t taken care of.
The state right now and the feds are, I would have to say they interfere, not on purpose but because of their processes. It’s so hard to get anything done. I’ve applied for one or two federal grants, but mostly it’s not worth it because the grant thing has been fixed. I got $25,000 from a foundation last year with a letter and it’s because I knew somebody who knew somebody. It’s ridiculous to make people jump through all these hoops. I understand that they’re protecting, they’re having to protect the federal money, but I also think that you’ve got people who are making jobs for themselves. You know if you get enough pieces of paper on your desk then you’re doing something and get to keep your job. I don’t know that that’s true, but I’ve often thought if Medicaid could just send the money directly to me, right to the provider instead of going through state. Now they’re going to go through HMOs. There are now going to be four stops for the money before it gets to the person doing the providing. I understand that not everybody’s honest like I am, but there have got to be ways, and this is probably where paperwork starts, the reporting of grants and everything. Sometimes you just get so tired of it.

We make use of the Drug Assistance Program. Did Debbie Oswalt tell you about that? The VHCF piloted this. All the drug companies have programs where they will give away prescription medicine to people who are indigent. I personally believe it’s a big political thing so the drug companies can go and say, “Oh we’re giving medicine away.” Accessing those programs is just, well it’s really hard to access the program because of the paperwork. It’s not just government. The [Virginia] Health Care Foundation developed a computer program to assist people like us to access the program. So we’ve been making use of that. We also have one clerk and three volunteers who do almost nothing but that. We’ve got 400 patients on this program with different drug companies. They make it so hard for people to do what they want to do. I can see it from their point, they want to prove that the person is really indigent, really needs the medicine and then they only do it it’s life-threatening. At one point I was ready to give up trying to do it because the clerk was spending all her time on this. I was paying her $16,000 dollars and I thought I could go buy Medicare with $16,000. Why should we be doing this? Now that we’ve got the volunteers helping her, it’s taken a lot of the pressure off of her. So she’s not spending ALL of her time doing it, just some of the time doing it.

It’s that kind of impediment, it’s not that people are saying you’re doing a bad thing, but you have to prove you’re doing a good thing. The way you prove it is by filling out all these pieces of paper. That’s what I do. Between personnel and filling out pieces of paper . . .

Stephanie: Just think what you could do if you didn’t spend all your time with paperwork.

Knudson: If I didn’t have personnel and I didn’t have all that paper, I could save the world.
Stephanie: Another theory I’ve proposed as a means of explaining leadership, specifically community health, is that leaders are initiators of change. I was wondering if you could tell me about the leaders at the beginning of this clinic, when the idea was first beginning. Were people in the community really involved or was it mainly people who had been involved in Public Health?

Knudson: It actually was a lot of the later. The really guiding principle was the director of Community Resources in James City County Community Development. He’s the guy who handles social services and housing and transportation and all those things in James City County. He’s a very strong, committed black man who grew up here. He’s a real leader, a very strong leader. So he was out there along with the other social service directors because they could see what was happening in the Health Department. They understood what was going on.

But it was the doctors because the doctors were bearing the brunt of the problem. They were getting the people in their offices who should have had help six months before and who would have been much less complicated if they’d gotten there six months before. So they were hunting for some way to get care earlier, to do some prevention and stuff. So it think that that leadership, and it’s interesting because doctors aren’t very good leaders.

Stephanie: As I was doing a literature review for this project, that was a very common theme.

Knudson: Well I don’t know if it takes a different kind of mind-set to go to medical school or if they beat it out of you in medical school. My father was a doctor so I have some vague connection with all this, but I knew one of his friends, most of their friends of course are doctors, and I knew one man who wound up being President of the Michigan Medical Society as a doctor. He was the only one of all my father’s friends who seemed to enjoy the sort of political stuff that you have to do. He was a real outgoing personality. He was an OB/GYN guy and that was sort of an aside a little bit with him. That’s how he made his money, but it was really fun for him to go be on all these boards. My father was on the Geriatrics Board in the state of Michigan for a while, but it was not really his thing. He just wanted to go treat patients and I think that’s part of it. I frankly think that’s why we’re in this mess in this country with health care because the doctors didn’t show any leadership. All my father ever talked about was socialized medicine, the evils of socialized medicine. My druggist said to me the other day that doctors were so worried about socialized medicine that they forgot to watch out for the insurance companies. That’s exactly what’s happened, the insurance companies have taken over and it’s because it’s all so connected. The other thing of course in this country is our love of machinery. So it’s a whole lot more fun to do all this stuff for a premature baby than to take care of the mother to make sure she doesn’t have a premature baby. You don’t need nearly as much equipment, you just need food.

Stephanie: It’s amazing how when I worked at Stuart Circle Hospital in the Cardiac Rehab. The insurance companies and doctors would not support that. Well first of all
insurance companies wouldn’t pay for it. Some doctors wouldn’t even refer them to the program because they said, “Oh I don’t really know if that’s going to help.” They [the patients] had a history of heart disease and this program talked about nutrition, put them in an exercise program. People just do not want preventive medicine.

**Knudson:** It is real hard to measure prevention. People say, “Well how many people have you kept out of the emergency room?” How am I supposed to count that? You can’t quantify a negative. You can say well the emergency room saw this many people in July of ‘92 and this many people in July of ‘94, but of course the population has grown since then. I’m not enough of a mathematician to work that problem.

**Stephanie:** It’s a long process it’s not a short-term fix.

**Knudson:** Getting funding . . . of course it’s all people. That’s the CHIP program. We bought our computers we don’t use anymore, we do not need a cat scan here, we do not need X-ray machines here. I need people. That’s one of the really difficult issues is to get people to fund what you really need.

**Stephanie:** It’s been interesting as I’ve gone through some of these interviews and talked with Debbie Oswalt. Most of the leaders that are directors of clinics are women. Do you think there’s a reason for that?

**Knudson:** There isn’t as much money. The salaries are lower.

**Stephanie:** Do you think that women have different skills that are better suited for this context? Can you tell me what they are?

**Knudson:** Oh yeah. Women are much better at compromising, at trying to figure out as consensus building. I think a lot of this is consensus. Dictators don’t work very well in this kind of setting and a lot of men aren’t willing to take the time to be consensus building. You’ve got to make sure everybody’s gotten a little bit of something. Make sure everybody’s satisfied somehow and again I don’t men do that. Women get those skills the way they’re socialized early. The men who are involved in this kind of thing aren’t viewed well by other men for whatever reason. I know several men through Virginia Primary Care Association who are “wimpy”, one of the words used.

**Stephanie:** Dr. Vanzee, the man I interviewed down in St. Charles, had a very quiet demeanor, but he does a great job. I could see where people might perceive him as not that strong, typical American male. It seems to me that relationships are so important in this context and he has the personality for it.

**Knudson:** When my husband was having problems being chairman of his department, I would say to him things about relationships and he didn’t want to hear it. That wasn’t an issue. So I think that’s probably a large part, it’s not just the money. People gravitate to where there’s more money and there just isn’t that much money in these kinds of things.
Stephanie: With the sliding-fee scale and with the Medicare, how do you pay your bills? Do you have grants from other places?

Knudson: Yes, I have a copy of the budget. (She hands me a copy) The billing is the middle part there. The top is what the governments give us and we have the billings and from there on it’s out there fundraising. Williamsburg Community Hospital does give us money.

Stephanie: Are you in charge of the fundraising?

Knudson: Well there’s a committee on the board. Basically the committee does the local organizations, kind of. I do it, too.

Stephanie: You’re job seems to be quite involved. What motivated you to become involved in community health?

Knudson: As I said I’m sort of on my seventh career. I first came on the board when I was on the Board of Supervisors in James City County. Since the governments contribute they each have a representative. So I was on the board and then after I went off the Board of Supervisors I was asked to remain on this board. I had another job at a local literacy place that William & Mary sponsors. When we decided we needed an Executive Director, they approached me asked me if I wanted to do it. I was getting a little bored frankly. I didn’t need a real job when I was on the Board of Supervisors. I had plenty to occupy my time, but then after I wasn’t on the board this other job was interesting but it was part-time. I didn’t carry it home with me. It just sounded interesting and it was a little more money than I was making there. I like to fill up my time. My children have both left home, my husband works all the time as a college professor. He loves what he does. I keep threatening to go home and do needlework, but I think I would last about three days. Every time I have a problem, I think I should just go home and bake cookies. I don’t need to do this.

Stephanie: Well something has to keep you here.

Knudson: It’s interesting and I was a Peace Corps volunteer. I don’t know about your roommate, but we were all going to save the world in the ‘60s. We were going to go out there and do good and change the world. I guess I’ve never really lost that. Now, the nice thing about this is I can work on my little corner of the world. I’m not trying to save the entire universe now, I’m just trying to work on my part. It’s sort of manageable and it’s endlessly interesting.

Stephanie: My roommate definitely has the “save the world” mentality. She has the energy and motivation to do it.
**Knudson:** An amazing number of Peace Corps volunteers . . . we try to have little reunions. There are a bunch of people in Williamsburg - the guy who’s the Director of Big Brothers/Big Sisters, the person that’s in charge of volunteers at William & Mary, our nurse practitioner, the woman who works at the library, a woman who was doing legal aid before her baby was born. We’re all doing it, we’re all still somehow trying to do this. We’re all crazy of course.

**Stephanie:** Do you have any role models that you look to as leaders or that inspire you?

**Knudson:** Well I had a mentor on the Board of Supervisors, a man who had been on the Board of Supervisors for a long time. He was the one who approached me and asked me to run for the Board of Supervisors. I laughed hysterically. I thought he was out of his mind. He really helped me through the intricacies of local government. The other thing, my other part of my background was the League of Women Voters. I started that when we lived in Orlando, in fact, and I had small children. We were living in a suburb and I thought I was probably going to go out of mind. It was pretty dire. I discovered the League of Women Voters. A friend introduced me to them. It was a combination of leadership training because . . . I don’t know if you know much about it, but it functions on consensus. There are no votes. We don’t vote except for when you go out to vote for whoever you want to vote for, but the organization functions on a consensus model. So not only was there a lot of intellectual stimulation because they do deal with real world issues at an interesting level, but there was also this training. I was the president of the one in Orlando and then I was president of the one up here too. I think the combination of the one gentlemen who helped me plus the League probably influenced me.

**Stephanie:** Well, I would like to thank you for answering my questions and taking time out of your schedule for this interview.