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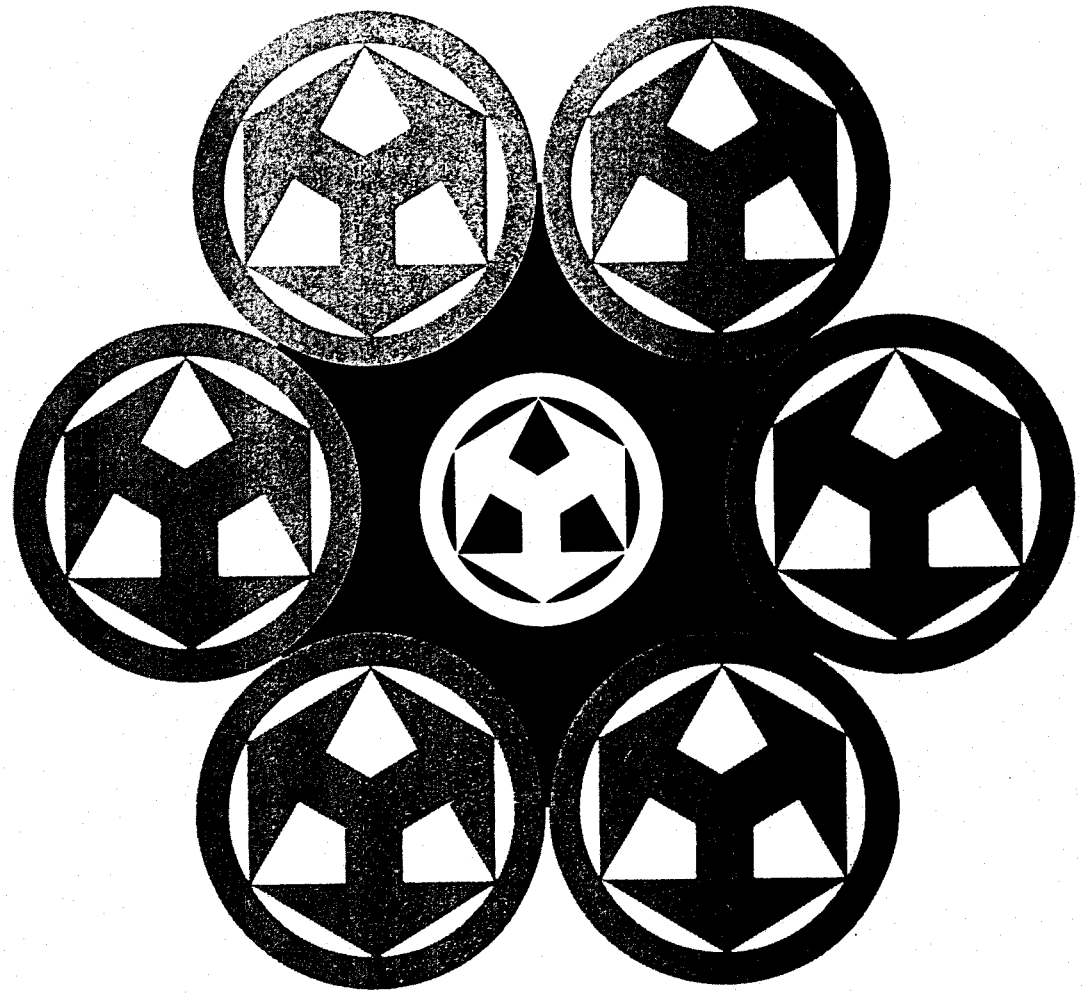

GREATER NEW YORK STUDENT HEALTH PROJECT

summer 1968

THE STUDENT HEALTH PROJECT
OF
GREATER NEW YORK
Summer 1968

Sponsors

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FOREWORD

While medicine in this country advances by giant steps in the area of increasing scientific and technical knowledge, it plods along in extending the fruits of these benefits to all Americans. Today comprehensive community health care is an idealistic pipedream, compared with the realities of a stopgap system of health care which is scanty, episodic, and fragmented. A major reason for these deficiencies and inadequacies is the lack of incentive and interest among health professionals in attacking these problems. In their formal curriculum the vast majority of students in the health professions do not gain an appreciation of the needs of the medically underprivileged or the difficulties that are faced by health practitioners and health facilities in poverty areas. The patient is observed by the student merely as a disease or clinical entity—as a fragment of his society being distinct and separate from his environment. The health student by spending his long years of training isolated from the community which he will serve loses his social idealism and remains blind to many of the basic causes of ill health: environmental deprivation, loss of income and jobs, and poor housing. Tomorrow's health practitioners must understand these causes if there is to be any large scale improvement in standards of health care. First hand experience with the urban community and the urban health problem is the best way to gain this understanding.

The purpose of the Student Health Project of Greater New York was twofold: to increase the education and understanding of health professionals by providing experience in dealing with the social problems and health needs of the poor, the social conditions which engender these problems, and the difficulties in alleviating them; and to engage students in beneficial projects that will have immediate and long term effects on the community, on the educational process, and on themselves. Such long term effects can be achieved only through the fostering of resources within the community and through encouraging flexible student attitudes necessary to develop the new health models needed to define and improve the delivery of health services.

PREFACE

This report represents a distilling of the hundreds of thousands of words written as biweekly or final reports or transcribed from tape-recorded meetings and interviews during the course of the 1968 Greater New York Student Health Project.

The 1967 Bronx Student Health Project report and similar reports of other Student Health Organization summer projects have tended to be compendia in the truest sense of the word, with essays by the participants printed in their entirety or organized in such a way that the reader has had to search through pages and pages of information, impressions, and opinions for specific points he may have been seeking. An effort has been made here, through judicious editing and organization of the excerpts into specific categories of discussion, to provide a more useful source book of information about the summer experience for future planning of Student Health Projects or similar efforts.

Although perhaps less "readable" than previous reports because essays have been fragmented and stripped of most of the "poetic impressionism" that students tend to write, the format of this report should, it is hoped, enable the reader to go straight to a caegory of interest and get a *sampling* (but not a random one) of student and community co-worker experiences and opinions on that topic without having to read the entire report. Of course, breaking down the material into so many categories produced the disadvantage that some categories overlap in content. We tried to assign excerpts as precisely as possible, but in some of the larger excerpts (especially where the writer's flow links several related topics), it was necessary to assign the category on the basis of the "main thrust" of the entire excerpt rather than its specific points. (Many of these papers will appear at the front of discussions as "position papers" that set a tone for the rest of that section.) Thus, the reader should be aware that although he may be primarily interested, for example, in student views on "patient advocacy," he should also cross-reference himself to related categories such as "white students in black communities" for perspectives on the problem that may be stated in a different context. The "main thrust" criterion was applied also to several excerpts whose significance seemed, upon further consideration, to be more relevant to a category other than the general grouping in which it would seem to belong at first glance, e.g., BW's description of his fund-raising activities for Newark's New Well addict rehabilitation program was finally placed under "Student Health Project Role in Agencies and Hospitals" rather than under "Agencies" or "Drug Addiction" because it seemed a better example of a suitable (and successful) student role than a description of either the agency or the problem of drug addiction.

Another thing that has to be pointed out is that much of the material finally used in the report reflects a mood of dissatisfaction that pervaded

the project throughout the summer, and which caused participants to focus on their problems in meetings, reports, and interviews. Not all the participants were unhappy with their summer experience or with the Student Health Project in general, but it appears that they were not as moved to write about their successes and satisfactions as were those who had bitter bones to pick. Thus, the report is biased in the sense that "usable" material came primarily from the latter group. Overall, however, the editors feel that the report does reflect the conflicts in and among participants as to the meaningfulness of the summer. It should be noted here that those Greater New York area health science students who constitute the regional Student Health Organization "steering committee" voted recently not to sponsor any more Student Health Projects of this kind. They concluded that any future summer projects will have to be locally planned and administered projects growing out of on-going activities of the Student Health Organization or other groups at each medical, nursing, or dental school.

Our apologies to those who may feel that what they had to say has been distorted by quoting out of context, and to those whose observations and opinions could not be used. Even after careful selection of what we felt was the best of the material submitted, the first draft of the four major sections of the report was almost 500 typewritten pages and had to be further cut in a somewhat merciless fashion. Anyone who feels strongly about his views being distorted or slighted is encouraged to consider submitting his ideas to one of the SHO publications such as *Current*.

Profuse appreciation goes to all those who helped pull this report together, especially to Mrs. Marylyn Gore, Project Director, for many helpful suggestions after reading the ponderous first draft, to Miss Jody Williams of Albert Einstein College of Medicine (who handled much of the project's cumbersome administrative work during the summer) for invaluable advice and efficient liaison with the funding agency, to Mrs. Joanna McDonough, our excellent editorial assistant, and Mrs. Ruby Hough, our manuscript typist, who stuck with us through the long winter months and showed patience and understanding even when our demands became overbearing.

W. M. SMITH,
AMY T. SMITH,
March 1969.

Contents

Part 1: THE DREAM

THE TASK

This section contains the project proposals distributed to prospective participants at the Orientation session. They were used by many students to determine which area they finally chose to work in.

Although most of the statements suggest that substantial project planning and preceptor arrangements had been worked out, in fact much of the foundation laying remained to be done in several projects at the time students were expecting to "go to work." That the summer thus turned out to be a "use your own initiative" opportunity was extremely frustrating and discouraging for many students who had expected otherwise, as well as community workers and Neighborhood Youth Corps teenagers, who were probably even more job action oriented than the students.

In general, those projects in which specific task definition and firm preceptor arrangements had been made before the summer began (e.g., Brooklyn's King's County Hospital and St. Mary's Hospital physician assistant projects, and Harlem's school health referral project) were most successful in terms of concrete achievements, whereas more open-ended projects in which students had to "feel their way" proved less successful (e.g., Brooklyn's Model Cities project, Harlem's pediatric care center advisory committee, Lower East Side Medicaid cutback study).

But even good advance planning was not always sufficient, as evidenced by difficulties experienced in Brooklyn's Youth In Action project and Newark's frustrating relations with the Martland Hospital and medical school administrations. Even in Harlem, where good pre-project planning had enabled an early start a month before everyone else began, Student Health Project workers experienced several weeks of frustrating slowdowns of the school health referral activities due to less than enthusiastic cooperation by some Department of Health administrative and school health program personnel.

It should be noted that "concrete task fulfillment" as a measure of project success may not be a valid criterion to judge project achievement since considerable disagreement existed from top to bottom in all the project areas as to what the Student Health Project task was supposed to be: providing an educational experience in community medicine for health science students versus helping a finite number of persons get better health services versus bringing about changes in health care delivery systems in the area. Certainly, however, each project was both successful and unsuccessful to some degree in each of these objectives.

Some subprojects were judged sufficiently successful on a programmatic basis that attempts were made to continue them year-round. At the end of the summer, the students requested that several thousand dollars of surplus funds be reappropriated for distribution to the Bronx project to continue the Unwed Mothers project storefront, to the Newark project to keep their advocacy storefront office open, and to support a benefit show for the New Well, a narcotics addiction rehabilitation agency, and to the Harlem project to buy black children's books for clinic waiting rooms, and to pay salaries to three of the community mothers who had been trained to do school health referrals (the Harlem project leaders eventually obtained a $43,000 grant from the Ford Foundation to keep their program going).

The Lower East Side Project

Students working with the Lower East Side Project will be placed with members of the North East Neighborhood Association, its delegates or subcommittees and the NENA clinic

(a total health care clinic to be run jointly by the medical and Lower East Side communities). As consultants to community members concerned with the problem of health care on the Lower East Side, students will gain a knowledge of community attitudes about health care as well as of existing facilities serving health needs and related areas. There will be no door-to-door interviewing as factual material can be obtained from the various agencies serving the area.

Community attitudes will become apparent as students develop working relationships with community members. Students and community people will develop a program of health education responsive to community needs and priorities vis-a-vis health services in the area. The structure of the program and the type of health education needed to improve health care in a poor community will be determined by students and community members during the summer. The program will stress the role of the professional student as a consultant whose activities are to be directed by the community.

Specific activities will be determined by the needs of the community and prevailing circumstances. Particular assignments will be made on the basis of knowledge of the individual student gained during Orientation. Students will participate as fully as possible in community life, and housing will be obtained in the area for those students who so desire.

Interplay between students with discussion about roles, impressions, and difficulties will be encouraged and the importance of the project as a group activity will be stressed. By the end of the summer, each student will have a good knowledge of health problems and community life on the Lower East Side, of the community members they will work with, and of each other.

The Newark Project

During this past summer's 1967 disorders, Newark City Hospital had the distinction of being the only hospital in the United States to be fired on by snipers. These shots were indicative of the general dissatisfaction with the care given Newark citizens by the hospital. The New Jersey College of Medicine has just assumed the control and management of this hospital. The College's goal is to improve the health care delivered by the hospital. The Newark Project will attempt to upgrade local health care and community opinion of the hospital through (1) "patient advocacy," (2) clinics, and (3) improved student understanding through exposure to the needs of the community.

(1) *Patient Advocacy: Emergency Room—Outpatient Department:*

Students will work here (*a*) assisting the patients who are receiving health care and other social services which may be available; (*b*) helping achieve total patient care which may not always be immediately possible because of the mechanics or the attitude of the hospital operation; (*c*) obtaining complete, meaningful records of accidents and the conditions which produced them.

(2) *Clinics: Student Health Organization Evening Clinic for Chronic Diseases:*

Members of the Student Health Organization have already organized an evening clinic at the NCH outpatient department. It is staffed by five internists and two surgeons as well as several students who do the initial history-taking and screening and also necessary lab work. This will be expanded during the summer to a nightly or weekly schedule.

(3) *Student Exposure: Community Obstetrics*

Development and use of a questionnaire for maternity patients at Newark City Hospital. Prenatal death rate in Newark is three times that of the State of New Jersey—some of the reasons are: (*a*) Out-of-wedlock children get less care; (*b*) Care may be unavailable.

The questionnaire will investigate:

family size,
living conditions,
problems of pre-natal care,
nutritional problems.

In conjunction with the information obtained by the questionnaire, the students will focus on environmental problems. An outcome of this might be establishment of a storefront prenatal clinic or some realistic health-care facility.

The Brooklyn Project

The Brooklyn project for this summer involves working through five different agencies or institutions. Participants on the project may be able to work with more than one of these agencies.

(1) *Pediatric Outpatient Clinic of Kings County Hospital:*

Students will act as physician-assistants to help save physician time. Specific duties will include: (*a*) Interpretation of instructions for patients; (*b*) relaying of information on nutrition, hygiene and accident prevention to the patients; (*c*) performing routine medical procedures; (*d*) history-taking, with the aid of a questionnaire to determine the entire medical status of each family. A major responsibility will be the training of community persons for paramedical positions.

(2) *St. Mary's Hospital:*

Students will act as physician-assistants as in (1). In addition, they will work with the Crown Heights Health Council in developing a Health Rights and Resources Handbook for the community residents.

(3) *Bedford-Stuyvesant Youth In Action:*

With the assistance and supervision of the organization's professional staff, students will interview clients with problems related to jobs, medical care, legal aid, housing, job training, and nutrition. They will help secure the necessary services from existing agencies and perform follow-ups on all patients. Involvement in family counseling and group discussion sessions will also be an integral function of this project. Tutoring and homework study programs are also planned.

(4) *Brownsville Community Council:*

Students will assist doctors in counseling on contraceptive techniques, showing films and conducting discussion groups. With the aid of Neighborhood Youth Corps teenagers, programs of hygiene instruction in the community, a health cleanup program, and a survey of existing medical facilities are anticipated.

(5) *Central Brooklyn Model Cities Program:*

Details still to be worked out, but a comprehensive survey of health needs and resources available to the residents of Bedford-Stuyvesant, Crown Heights and Brownsville neighborhoods is contemplated, in addition to other functions.

The Harlem Project

On the basis of last summer's program at Public School 175, a plan for this summer's Harlem Student Health Project has been designed, incorporating the knowledge gained and cooperation began with community residents last summer. The new project will introduce an adequate, readily financed, referral program. Harlem is an area noted for large numbers of inhabitants unconnected with any health agency and for the failure of school health programs even to recognize the health problems of the students. The 1968 Student Health Project will train community people to function on a year-round basis as health workers in the schools and as referral experts within the school community. The backbone of the project is the establishment of small groups of parents who will meet with the health worker to discuss health care as a vital community issue. These health-conscious parent groups will begin to deal with redefinition of health germane to local community needs, will establish babysitting and escort services, will act as a nidus for further community education in nutrition, birth control, and pre- and postnatal care.

Several local elementary schools and their Parent-Teacher Associations will serve as the project population. The PTA's with their active participation will be the sources for the community contacts, for health worker trainees, for homes to be used as meeting places, as guides for answering pertinent health questions, as health committees to evaluate health problems, as guides for SHP workers, and to serve as an advisory group for the Pediatric Comprehensive Care Center. Cooperation with the original PTA group has been expanded during the academic year and additional PTA's have pledged their participation.

The project will be introduced at school teacher-project staff meetings with the cooperation of the principal of each school. An evaluation of the role of the school health nurse—her problems and needs—will be undertaken

with her participation. Communication, with an eye toward improving school health-care programs, will be maintained with the head of School Health Programs of the New York City Department of Health.

Thus, health science students working in the Harlem SHP will work in the community with families, will deal with the referral problems, and will develop with community support the year-round bases for the project. A large proportion of the project staff will be housed in Central Harlem.

The education of the health science student will come from a door-to-door, person-to-person summer involvement in the problems Harlem's health care system, and his contribution will be his effort to deal with these problems in a short-term sense and to help create a long-range plan to solve these problems in ways that will be useful to the community. The opportunity to work and live in the Harlem area should lead toward a contribution to creating a better level of health in the community.

Participating institutions include Knickerbocker Hospital, the Harlem Health Center, Harlem Hospital, members of the Columbia University School of Public Health and Administrative Medicine, and the Harlem Health Council.

The South Bronx Project

(1) *Patient Advocacy:*

Eight student fellows will work closely with community organizers from four storefronts in defining the health needs of a circumscribed slum neighborhood in the South Bronx. The fellows will make home visits, accompany patients to local clinics, monitor followup care, distribute information on health care facilities, and prepare a Health Rights and Resources Handbook. Each fellow will be accompanied in his daily work by a member of the Neighborhood Youth Corps. Special assignments will include a supervised study of medical patients, and planning a biology and medical science course in the newly organized Morrisania Community College.

(2) *Child Health:*

Four project fellows, including one dental student and one nursing student, will organize a child health survey in cooperation with four neighborhood day care centers for children ages 6 to 16. Project fellows will be responsible for arranging discussion groups and films on health issues for community residents and their children. They will also teach first aid to the Day Care Center counselors. The health survey will be made with the help of third and fourth year medical students.

(3) *Mental Retardation:*

Two student fellows will work with a community organization which has been given a grant for a summer day camp for mentally retarded children. They will help organize community support for submitting a larger grant proposal for a permanent mental retardation center.

(4) *Unwed Mothers:*

Two student fellows will work with a community worker at the Neighborhood Medical Care Demonstration to organize a group of unwed mothers for the purpose of obtaining legal rights in housing, education, health provisions; obtaining good health care for themselves and their children; gaining confidence to function as dignified human beings; and furthering educational opportunities. The student fellows will work closely with salaried community preceptors in motivation, guiding, and teaching.

THE MOTIVATION

The application essays of students who wanted to work in this summer's project were important criteria in the selection process. In reviewing the application essays (as well as final reports) of accepted students after the project ended, it could be seen that students came to the project with many different motivations.

Although most students expressed more than one reason for wanting to participate, by far the largest essay category, consistent with what seems to have been a primary objective of the SHP leadership, comprised those students who expected the summer to provide a learning experience, a chance to understand the people of the ghetto and their problems, as an extension of their professional educations.

The second largest category consisted of students who desired to offer specific service-oriented skills (e.g., health education programs) or just had an undefined desire "to help poor people get better health care."

Other motivation categories included those who expected to achieve some degree of self-actualization by "giving of themselves," and those who hoped to compensate for the failings of our society vis-a-vis the poor (or to assauge their guilt in this regard).

Interestingly enough, only a few of the accepted applicants indicated in their application essays an interest in effecting changes in health care delivery systems and institutions through politically oriented activism. Yet, this surfaced as a burning issue early in the summer that split many of the projects right down the middle, and was the cause of much of the frustration experienced by project participants that was expressed at the Final Conference and in their final reports. Only one applicant mentioned a need for the $900 stipend, but this too turned out to be a matter of considerable concern to many of the students as the summer progressed.

The following excerpts illustrate not only the variety of motivations, but also the range of sophistication regarding the summer's possibilities that participants brought to the project.

Participation in a Student Health Project seems to me to be crucial in my education * * * a unique opportunity to learn what I otherwise never could.

* * * I would hope to learn a new perspective on health care: a little insight into what life is like for the urban poor, some understanding of where health fits into the priorities of the community.

I want to build my education during medical school along relevant lines * * * and I want to work closely with a community before professionalism puts too much distance between us * * * I want to make sure that community health is the foundation of my education, not the capstone.

My own education is the primary reason I want to work on a project this summer, but not the only one. I want to do something that will be of service to the community.— K.B., *Medical Student, Bronx.*

The experience will help me become a better individual and perhaps enable me to understand my environment better. I will learn from working with other members of the team as well as with the individuals I am trying to help. This will help me in deciding whether I want to go into the field of public health after I graduate.—J.L., *Nursing Student, Lower East Side.*

Besides bringing to the people my background and knowledge, I will be learning much from them. I will learn much about myself and others. It is one thing to read and hear something, but another thing to actually know what it's like to be poor. It will be quite an experience and the personal satisfaction I hope to get out of it will be exactly why I went into nursing—not for the money, but to help people.—J.O., *Nursing Student, Newark.*

Working in such a project should be very valuable in formation of my personality—broadening my understanding of life and awareness of problems of others. My primary goal is having some effect on the poor living conditions and inequality problems of the people on the Lower East Side.

* * * I believe there is a great need for showing people how to help themselves, rather than taking the attitude of condescension by "helping" them, which has been proven unsuccessful.

Aside from the vast intangible benefits, the financial aid would be of great assistance in the coming school year.—B.G., *Nursing Student, Lower East Side.*

My main reason * * * is to learn—about the ghettos and the people there, about the power structures presently in existence and ways to change those structures, about health services in the city (or lack thereof), and how those served would like to see health care changed. —I.B., *Medical Student, Bronx.*

I felt the job afforded one of my last opportunities for a "dose of liberalism," so to speak.

It potentially offered insight into the problems of the disenfranchised that a hospital setting will never offer. The desirability of working as part of a community health team also caught my imagination. I felt that the role of a medical student in a project might, in some small way, differ from that of a nurse, social worker, lawyer, etc. This too, I thought, would broaden my outlook concerning possible solutions to community health problems. A third lure of the position was the opportunity the job offered for community contact, though I must admit that my concept of my role in community interaction was nebulous even before I began.—J.R., *Medical Student, Brooklyn.*

* * * I have not had the experience to know what real poverty is. I feel that I should have the experience of working in a poverty area and becoming more familiar with what cultural and racial factors prevent individuals from living a healthful life. I want to come to the level of these people to see their problems more clearly, discuss these problems with the people and other members of the health project, and work on possible solutions to the problems. I think I will be able to have a fuller understanding of how I, as a nurse, can help these people achieve the standard of living they deserve. * * * I would be able to share my experience with my classmates in nursing school when I returned in September, so they too could learn more about how to help the poor with their health problems.—L.D., *Nursing Student, Newark.*

Medicine is a full-time job in its strictest sense. Yet, to turn away from the full man (i.e., in and affected by his society) is too strict a definition of medicine. Consequently, I wish to study, observe, and "get the feel of" what affects man. This, I believe, will enable me to diagnose the cause and alleviate the effect.—J.C., *Medical Student, Lower East Side.*

The Orientation had impressed on us the importance of the job. We couldn't even call it a job; it was more of a mission in understanding. Our goals were many. Some of us wanted to find out what life in the slums was really like. Some of us wanted to find out what was ailing our society and try our hand at curing our "social disease." My goal was to give of myself and in doing so find out what I was really made of. I wanted people to tell me how I could be of some use; I wanted to understand the people of the community and wanted them to understand and believe in me.—D.Y., *Medical Student, Brooklyn.*

There is nothing worse than a hypocrite or martyr in the ghetto. Bad enough I'm white and middle class. I'm enthused by the idea of really offering these people something concrete, of doing something they can't now do for themselves, or working with them to begin something that won't end with the summer.—P.G., *Sociology Student, Harlem.*

I like working with people and caring for the sick. However, I feel that hospital nursing is too confined for the kind of care many people require. * * * By going into a person's home you can see the type of problems he has to face every day. * * * I would like to try to help in finding a solution to a few of these problems and I feel I could be of some service because I want to help. On the selfish side, working with people in poverty areas would benefit me. It would enable me to once again see the nursing profession as I did before I chose to enter it. Finally, as a Negro, I have a strong desire to help my own people.—A.C., *Nursing Student, Newark.*

It has long been my goal to assist less fortunate persons in obtaining human dignity by helping them to secure equal justice under law and a decent standard of living, which includes all necessary medical care as a right not a privilege.

* * * I consider this project an opportunity to help and not a job or a task.—N.W., *Law Student, Newark.*

When I found out that I had been accepted for a second summer with the Student Health Project, I was both excited and optimistic about the summer to come. I was anxious to build upon last summer's experiences, using my knowledge to accomplish something definite. Last summer I had not expected to accomplish anything, and I was pleased with what

little I was able to do. In contrast, this summer I had higher expectations, partly because of my experiences last semester in leadership and group dynamics * * *—V.V., *Nursing Student, Bronx.*

Working in the SHP last summer was an enlightening and exciting experience for me. I learned more about the reality of medical care as it exists for the majority of Americans in those few short weeks than in my 2 years of medical school.

* * * I felt that perhaps this summer, with some of the initial learning process * * * behind me, I might be able to do a lot more than last year.—M.M., *Medical Student, Brooklyn.*

I have a brother-in-law who is a "social work" minister * * * and who has effected significant change * * * through similar grass-roots activities * * *

I feel that the SHO projects are significant efforts to bring about important changes in the health care people in these communities have been receiving. I want to be a part of this effort.—W.S., *Medical Student, Halrem.*

I think I should be a part of this project, not because I am any more qualified than other applicants to do community organizing, or to work with poor and minority groups in the solution of their particular problem, but because as a law student I am trained in "social engineering"—the ordering of institutions of society under the law. I want to do more than simply alleviate suffering for a summer. I want to change the institutions that have so far been unable to do the job.

* * * I want to hasten the day when such projects are no longer necessary, and working on this project will provide me with invaluable practical experience, which I hope I can utilize to help bring about long-run changes in the law.—R.H., *Law Student, Brooklyn.*

The present medical curriculum at Cornell places little emphasis on ghetto problems and solutions, so as an SHO participant I would be filling a gap in my medical education. Furthermore, I might be so affected by the program that I could work effectively toward changing the curriculum to include instruction and experience in community medicine.

* * * I am concerned with health problems of the poor and uneducated. SHO asserts the right of every man to comprehensive health service; I completely support that assertion and I consider it my duty * * * to do everything to provide effective health programs for all people.—L.B., *Medical Student, Harlem.*

* * * My experience would also enable me to encourage Stanford to set up an SHO summer program of its own to serve the needs of the Palo Alto community.—B.W., *Medical Student, Newark.*

* * * I feel the commitment to offer assistance to that part of the population which has generally gotten the nation's digested foodstuffs as daily fare. * * * The experience I would get from this project is of the sort that I would be able to use in my day-to-day contacts with other fellow students and attack their motivations and purposes and try to interest the great uncommitted. In my professional role I believe this summer's experience would be a big step in defining for me exactly what I want to do in the health field.—D.T., *Student Coordinator, Newark.*

As a white person, I share with my society the guilt of having manipulated the "poor." * * * I want to give all the life I've got to unravel the tangled mess that exists.—B.M., *Nursing Student, Bronx.*

* * * I felt quite hypocritical since my political and social convictions were distant from our nation's practices and I was not doing anything to express my dissent.

* * * SHO filled this discontent that was growing more and more in me. The work I am doing seems to be at least a step in the right direction.—L.K., *Medical Student, Brooklyn.*

For me, working directly with the underprivileged would be one small way of putting good intentions into action.—V.S., *Dental Student, Bronx.*

I am aware of the sad fact that my profession has devoted its energy almost entirely to

middle class patients, and as a psychologist I hope eventually to move things out into the communities where help is most needed.

* * * The main reason for my wanting to be part of this program is simply that I would like to do something worthwhile this summer * * * I have not felt particularly effective this year, sitting in the library studying while so much immediate concrete work has to be done. I also cannot help but feel totally frustrated with the condition of this country today. At a time when positive action is needed I would be particularly grateful to get out and do some tangible and helpful work.—M.I., *Psychology Student, Harlem.*

I have long been disturbed by the relegation of the individual to a mere cog in society's gargantuan machine. Indeed, in an age when we tend to appreciate humanity only as an amorphous mass, medicine should reassert the need for appreciation of the individual's worth. Yet, it appears to me that organized medicine has often lost sight of this goal. Poverty may be an abstraction, poor people are real. Medical school can be a terribly discouraging enterprise for a student who sees medicine as more than a mere "profession." * * * I would like medicine to be a means for deepening my understanding of people and for my rendering a genuinely useful social service.—D.S., *Medical Student, Lower East Side.*

Part 2: THE REALITY

INTRODUCTION

After 3 days of "Orientation" to the summer ahead (held at an upstate New York resort), the SHP student fellows and community workers officially arrived in the five ghetto communities of Greater New York City on June 27, 1968, eager to begin implementing their formidable task proposal.

Bedford-Stuyvesant, typical of the communities in which the Brooklyn SHP was located, has a population of 190,000, 85 percent of whom are black. The median family income is far below that for the city as a whole and the unemployment rate of 7.2 percent is more than double the national average. The usual slum pattern of inferior, inadequate housing, schools, sanitation, and recreation facilities prevails. The majority of inpatients are seen in the massive, 3,000-bed Kings County Hospital, outpatients using any of the hospital's 32 overcrowded clinics. There are woeful shortages of community practitioners, dentists, and home care services. Essentially similar statements could be made for the Brownsville community, served by Brookdale Hospital, and the Crown Heights community, served by St. Mary's Hospital.

Newark, a city of 405,000, can claim the highest of any national crime rates, the highest national incidence of tuberculosis, alcoholism, venereal disease, and drug addiction. Its health profile reflects the ignorance, bitterness, and despair of a large segment of the city's population which had hoped to escape the blight of the decaying rural South. Newark has proven, instead, to be a blind alley whose only exit is often through inward self-destruction of explosive violence of varying degree. Health services in Newark are provided mainly by Newark City Hospital (Martland), which lies in the center of the Central Ward, one of the city's largest ghettos. The area has lost almost all of its neighborhood practitioners.

The South Bronx, which is just a short drive from down-town Manhattan, has traditionally been a rapidly changing community of immigrants. At present, it is a Negro and Puerto Rican area which has few private medical practitioners. Its hospitals and health centers are overcrowded. There is a high infant mortality rate in many health districts, and lead poisoning of infants, rat bites, and drug addiction are great community problems.

Health services in the South Bronx are provided by ambulatory care centers in Morrisania Hospital, Lincoln hospital, and by many new neighborhood service centers for maternity care and mental health. Most inpatient services are provided by the hospitals mentioned above. One of the great innovations in primary medical care for this medically indigent area is the Neighborhood Medical Care Demonstration (NMCD), funded by OEO as a demonstration project. This center has been a great help in changing the pattern of health care delivery. North of Central Park, New York City changes its complexion. It becomes a teeming ghetto of closely packed houses, littered streets, and alienated citizens—Harlem. Summer in this neighborhood means the sweltering humidity and scorching heat of poorly ventilated apartments forcing youth into their playgrounds on the streets. The freedom of summer turns into an endless ballgame or wading pool filled by gushing water hydrants.

Although Harlem has the high unemployment and crime rates characteristic of other depressed areas, one of the most troubling aspects of life is the inability of youth to improve their fate. They receive few aids to improvement and have many chronic health problems, some of which are direct results of their environment.

Harlem is served by Harlem Hospital, Knickerbocker Hospital, private practitioners, and practitioners of folk medicine. This area has one of the highest infant mortality rates in New York City. Lead poisoning and rat bites have traditionally been health hazards for those who live in the ancient housing of this predominantly Negro community.

The Lower East Side has traditionally been the home of immigrants. Puerto Ricans and Chinese now makeup the larger part of the community but there are still many Jews, Negroes, Ukranians, and Italians. The median gross income is approximately $2,000 less than the average for the city. Drug addiction, alcoholism, and crime are the main problems in this neighborhood, where many inhabitants speak little or no English. The public schools have been abandoned by those families who can afford to do so. As much as 10 percent of the total labor force many be unemployed at any one time.

Health services are provided by 106 private practitioners, more than 40 of whom work in the Wall Street area and in effect do not provide medical care to the inhabitants of the Lower East Side. In recent years the Gouverneur Ambulatory Care Unit of Beth Israel Hospital and the Judson Health Center have delivered the bulk of primary medical care. Inpatient services are provided by Beth Israel Hospital and the mammoth Bellevue Hospital.

Although many of the SHP workers had some prior understanding of The Reality of the health care delivery deficiencies in these communities (at least from a professional point of view), the awakening of many participants to the realities of life in a ghetto environment and the circumstances of health care delivery from the patient's side of the admitting desk constituted the first stage of the "learning experience" that was, perhaps, the most significant of the summer.

VIEWS OF THE COMMUNITY

Brooklyn

At the beginning of the summer I had certain ideas about the problems existing in the Bedford Stuyvesant community. For the most part, these views have not been changed but, rather, reinforced. I have come to consider the urban ghetto another country: an isolated colony of the United States, dependent upon the U.S. economy for its essential needs, at the same time not being a part of the mainstream of society nor sharing on an equal basis the wealth existing in this great Nation.

Like most colonies, Bedford Stuyvesant is economically underdeveloped; furthermore, it is exploited by those who have control over its existing economy. This economy is one which is setup in such a way that it takes the small monetary resources which do exist and drains them from circulation in the community. Like other economies of the world, the affluence of the people in an urban community depends upon how much money enters the community and how many times that money exchanges hands within the community. Money can enter in the form of payment for goods and services, wages, interests, and rents.

For the most part, communities like Bedford Stuyvesant are unproductive: no industries exist and no goods are manufactured in the community. Therefore, money does not enter for payment of goods. On the contrary, money leaves in the form of payment for essential goods produced outside of the community by nonresidents. The obvious solution to this problem is to bring more industry into the community. Such industries should be owned and run by residents and should provide essential goods for residents and/or nonresidents. (This is presently being done on a small scale in the clothing industry.)

In the case of interest, we see another vehicle for the exit of money from the community. There are few creditors, if any, in Bedford Stuyvesant; there are, however, a great many debtors.

Rents represent a large drain on the community's monetary resources. I, for one, think that rents should be taxed away, thus abolishing landlords from the face of the earth. Rents in the pure economic sense are money paid in return for which no goods or services are given. (A perfect example of this are rents paid by Nebraskan farmers to individuals or

corporations completely removed from the land.) The land was here long before any landlord came into existence; furthermore, the land will be here long after the last of the landlords has turned back into dust. I believe that no mortal being has the right to claim that he owns so much as 1 square inch of soil on the face of the earth. Rents and the ownership of land is purely a European concept. In Asia and Africa people live on and work the land but the landlord-tenant relationship is unheard of.

Slumlords are the same type of landlords as those who rent land to tenant farmers: they accept rents; they provide essentially no services; they don't keep the buildings in good condition; often they don't provide heat or hot water, proper garbage disposal, or elimination of rats, roaches, and other health hazards. The few services their tenants do receive are provided by the city, not by the landlords to whom they pay rent and from whom they should receive services for said payment.

Article 7A is a law which has been setup in New York to deal with this problem. It provides for the withholding of rents from landlords who fail to supply required services. The rents withheld are used by the city to provide the services to which the tenants have a right and which the landlords have not seen fit to give. At the present time, however, this law is not being applied on the scale necessary to deal with the problem.

Wages are the major route for the entrance of money into the Bedford Stuyvesant community. The problem is that these wages are not enough to support the economy of the community. One reason is high unemployment, another is the type of employment available. The jobs which are available to the population, for the most part unskilled and uneducated, are usually low-paying.

If the economy of the community is to be strengthened, more money must enter. One way of doing this is to raise the total wages of the community, which can be done by creating new jobs to meet the level of knowledge and skill already in existence. At the same time, if education and vocational training are improved, residents will be able to move into better paying jobs. "To get a good job, get a good education." Education and vocational training represent major tools for improving the economy of any economically underdeveloped area.

The rendering of services represents a potential means of keeping money circulating within a community. But this is another area which represents a drain on the community resources. One of the larger services provided is the sale and distribution of essential goods in the community—food and clothing. This service is provided by large corporations and merchants who are, for the most part, nonresidents. These are the men who drive down from the suburbs in the morning and leave at night, often exploiting the community residents by selling poor quality goods at high prices.

In recent years, programs have been started to encourage community residents to enter into small businesses, largely in the merchant field. Such programs, however, will continue to have limited success unless residents are provided with the knowledge necessary to run a small business. Once again, the issue is the need for adequate education.

At the present time there is an attempt being made by residents to provide themselves with a service once rendered by nonresidents, often in a discriminatory manner: taxicab service. The medallion cabs are licensed by the police department—the gypsy cabs are licensed by the people. "Black Pearl means Black Power." Indeed, if Black Pearl, the private cab service association, wins its fight to exist, it will have a beneficial effect on the economy. The existence of the gypsy cabs serves to keep money circulating among residents of the community.

In this report, I've concerned myself with problems other than health problems existing in Bedford Stuyvesant which, when solved, will elevate the community into the mainstream of American society. I cannot deny that health-care delivery is a problem in the community. However, its solution will not upgrade the status of residents of the community. They realize this, and therefore health care has low priority. I recognized this at the beginning of the summer and chose to work in the Youth In

Action education program rather than in a health problem area.

The students working in the YIA homework study program were criticised for devoting their full time to this program. The basis of this criticism was that the project was not oriented toward health. I trust that the people who felt this way are now beginning to realize that health is not of high priority among the problems of the urban ghetto, just as it is not in other economically underdeveloped parts of the world.

In such areas the problems to be solved first are economic ones. Western countries have often solved the health problems of undeveloped countries long before they have even begun to think about socioeconomic difficulties. One result has been a population explosion which makes it that much harder to solve economic problems. Indeed, in most instances the economic progress has been nullified by the population explosion.

Another solution offered by the Western countries has been foreign aid, charity and handouts, all of which have no positive effect whatsoever on the economic development that would eventually eliminate the need for aid and reduce the dependency of the undeveloped areas on the Western world.

The same sort of Christian ethic which has shaped the relationship of the West to the underdeveloped areas of the world has shaped the approaches the Federal Government has chosen to solve the problems of the ghetto. Such programs as medicaid, welfare, and other assorted handouts are all very beautiful ideas, but in the end they don't even scratch the surface of the problems which exist. If all the health problems of the urban ghetto were solved tomorrow, the only significant change would be that there would be a lot of healthy people throwing bricks and bottles at policemen and firemen.—R.J.,*Medical Student Brooklyn.*

In working in Brownsville, one must take into consideration something not found in other ghetto areas; Brownsville is a very unorganized community; there are many deserted houses all over that were burned out and are waiting to be demolished. In Harlem on a Friday night you will see people having fun. In Brownsville people walk along depressed with their heads held low, many nodding from their last fix. There is little spirit in this community and that is why working here is difficult. There are no chapters of CORE, SNCC, or other national organizations Thus these people are not aware of much more than their immediate personal needs.—D.K., *Medical Student Brooklyn.*

Brooklyn

For too long we have been satisfied with charity where rights are involved. The legal profession has been a major offender in this area, but there is reason for optimism in recent decisions of the courts. The problem of the poor is that they do not have enough money. That is not their only problem, but their other hangups are shared with their more affluent brothers. The solution is not to provide the poor with goods and services, food stamps, welfare, or free medical care at special clinics, but to get money into their hands. They should have the same opportunity to squander their money on what many would deem less beneficial services as anyone else, for who is competent to tell another what is worthwhile and what is not? It is paternalistic for the affluent society to decide what is good for those who are not affluent. The poor are not free, for their only choice is between starvation and accepting largess with strings attached. Our welfare laws date back to the Elizabethan Poor Laws, when being poverty stricken was akin to being a criminal.

Paternalism in society has the same consequences as paternalism in the family—the son must rebel against the father before he can feel himself a man. We are seeing the results of this policy in the rising crime rate and urban riots, at a tremendous monetary cost to society. Those who do not rebel become dependent, docile, unwilling to change, lest they somehow run afoul of some welfare regulation and have their relief check reduced. As for the rest of society, it gets its money's worth in the psychological satisfaction of moral indignation, and retains its ability to discriminate against the poor. They are kept in ghetto

areas, in public-housing projects. They do not have access to the same professional, educational, and social opportunity as their affluent neighbors. The legal aid society, the county hospital, and all other agencies which require a means test are separate from the agencies or facilities used by those with money. The Supreme Court has held that separate is inherently unequal in regard to education and race. Perhaps the same reasoning applies to poverty. Discrimination on the basis of rich and poor may violate the equal protection clause of the 14th amendment.

Furthermore, abolishing this discrimination may save tax dollars. If everyone had money, then everyone could be sued and would be insurable, and many crimes could be converted into torts. A burglar, arsonist, or murderer could be sued for damages by the victim, thus killing three birds with one stone: the "criminal-tortfeasor" would be punished, the victim would be compensated, and society would be saved the expense of keeping the man in prison. The few really dangerous people could continue to be dealt with by custodial treatment, but with more due process guarantees—preferably as mental patients. There are other costs that would be saved. The waste involved in relocating slums by urban renewal, sending city dwellers to the suburbs, building freeways to bring them to and from the city, then having to deal with the resulting smog problem, and then watching the same thing happen over again in another place is costing more than an outright gift of a minimum standard of living to every poor person. And the human cost in terms of physical health, and emotional insecurity is difficult to calculate.

Just how this minimum amount of money is provided is a decision for the legislature. It may be done through a negative income tax, or through recognition of a right to employment, either with government or indirectly with private enterprise. The latter should include the choice of quitting and taking another job. An additional means would be to enact legislation requiring full disclosure by merchants, loan companies and landlords, and granting treble damages to any person who deals with them without having the qualities of the product or the terms of the contract fully disclosed. Such a statute is fully consistent with modern theories of tort liability, in which the risk of liability is placed upon the party most able to insure against the risk.

The problem is not with the poor, it is with the institutions and the laws. People, even poor people, can see what is in their own best interests. No one else can do that for them. What one can do is try to educate, persuade, and make available. Certainly there is less need for public health services if everyone can afford his own doctor.—R.H., *Law Student, Brooklyn.*

I don't imagine community people feel very much about health care one way or the other. It's a sort of episodic thing. You go when you need to go. Some people are regulars, according to the nurses. They come to the hospital like some people go for walks or play mah-jong or go to the movies. That is not to say that they are malingerers, but only that St. Mary's Hospital is as much a part of their daily existence as anything else in the Brooklyn community. People want care and do, for the most part, have confidence in doctors as a breed who know their business, but they do not often perceive the professional's ideas on better health care as being great improvements. Taking the time to answer questions on a medical history form may help the doctor, but it is not always welcome to the patient who has to go home to the other kids.—M.H. *Sociology Student, Brooklyn.*

The basic problem I found this summer in Brooklyn is that the medical problems from which the poorer communities suffer are less important to them than problems of survival. A toothache isn't important if you're starving.

Even with medicare and medicaid it is costly for a ghetto mother to obtain care for her kids. Often babysitting services are needed and transportation to the hospital is time-consuming. Accounting for the costs of a babysitter or a taxi can be a big order for many families. The result is that medical care is neglected until a serious problem arises.

In poverty areas, where people are more concerned about money for food and clothes and

things like that, health care has to take a secondary position because it is not as immediate a need. This is the problem in Brooklyn. We find that to a lot of the residents, health care is equated with emergency room care. There is very little concern for preventive medicine.—W.S., *Student Coordinator, Brooklyn.*

Newark

What is this community that we were to reach? They did not respond to radio appeals, personal appeals, or flyers. The "leaders" we attempted to integrate within our local organization did not "produce." A person suggested as a leader by our community worker promised to reach "different folks with different strokes," but when we failed to move our organization into his domain he evaporated. To the outsider, the Newark "community" is apathetic and hardened against any type of appeal to join and march. They generally fear and dislike the treatment that they have received from the city at Martland Hospital, but they will not rally with the white liberals to upset the status quo. What is the community? They are a disparate group of leaders jockeying for power and, perhaps, money, within a cross-section of distorted values (by white middle-class standards). To "them" we are richer, different outsiders who in many cases don't belong.

These are things I feel very strongly about: apathy and what is the community here, who represents the community, who are the community leaders? I don't think anybody knows. We ran into problems with the administration of the hospital and the administration of the medical school because they thought we were upsetting the community, but I think they were entirely wrong. I don't think they know who the community is (though they think they do) and I don't think we know. The administration doesn't feel that these people are representative, these mothers who have been waiting four hours in a clinic or the factory workers who have to be dragged to a meeting.

Another thing is the tremendous disappointment you get when you think you've got community involvement and no one shows up at the meeting, which was pretty normal for us. The question is, how do you reach this community which has a defensive shield around it? P.D., *Medical Student, Newark.*

The people are on the verge of a major revolt. Right now, they are awaiting the election year, but if Newark does not have a black mayor and a black majority council in 1970, Newark will burn. Newark's blacks are not only tired of poor health care but also of the whole political system.—D.B., *Community Worker, Newark.*

Newark-born, I never realized how badly in need my people are. I never knew how disinterested they are in their surroundings, that they don't care to come out and help themselves or to take part in building a better place in which they could get a better outlook on life.

I never knew that a community of people could stand to be content where there are so many disadvantages, not only with housing, clinics, welfare, and schools, but with many other everyday things.

As a community worker in Newark, I hope, during the next 10 years, that the people will come out and be willing to take part in trying to build a better community in which they can live. It will take time to give the black people back their confidence in any new organization, health or otherwise. The needs are far too deep for a mere 10 weeks of SHP to help them help themselves. They don't know who to listen to: for too many years black people have been lied to by all kinds of so-called do-gooders. I pray that the services that SHP has offered the people of the ghetto area in Newark have not been a total loss, but only a start for better understanding between the hospital and the black community.—K.C. *Community Worker, Newark.*

Newark

* * * The newest and most popular weapon in the war on poverty's arsenal is an attempt to change a common feeling in the ghetto of despair and powerlessness into one of hope and a sense of power over one's life by giving the community control of decentralized local programs and institutions. This approach may have some validity as a line of communication and a peaceable channel for protest which forestalls

or helps to prevent ghetto insurrections. However, the experience I have had in observing the United Community Corporation Area Boards in Newark suggests that the community approach is not very effective in alleviating hard-core poverty. These Area Boards are failures because they do not reach significant numbers of the real poor. In large part, the real poor include those without the time, energy, knowledge, or hope to go to the meetings of the Area Boards, to speak up to and not be intimidated by the clique who run the meetings. The United Community Corporation spends vast sums on rent and office equipment, and very little, if any, money or material goods gets to those who need them the most.

Much better than this approach would be an individual approach to the universal problem of poverty, for example, low income. This would involve an overhaul of the welfare system to provide something like a guaranteed minimum income and other features designed to make it possible for persons to get off welfare, for example, enough babysitting stations so that a mother of dependent children (70 percent of all welfare cases) can leave her children and work. If a welfare recipient does start making money or inherits some, he should not have to give it all back to the Government and thus have to remain on welfare. There must be an incentive to welfare recipients to get off welfare; it should be made possible to earn more by working than by being on welfare by providing that money earned is not deducted from the welfare check. The present welfare system provides no such incentive. In fact, the existing welfare system is producing second and third generations of welfare recipients by such features as requiring children receiving aid to dependent children to give whatever money they earn to the family who then have that amount deducted from the welfare check. Neither the mother or the child have any incentive to get a job because it is almost a foregone conclusion that neither can get a job which pays much more than the welfare check. —N.W., *Law Student, Newark.*

Harlem

The biggest problem I felt in working in the Harlem community was, "who is the community?" Here I was really stumped. Out in the Midwest where I grew up, communities were pretty homogeneous. But in an area such as central Harlem, community is almost indefinable. The community of Lenox Terrace (high-income housing) is infinitely different from the community of the middle and low income housing project across the street, and both differ greatly from the community of brownstone tenements they face. The community of well-kept brownstones in the block of West 137th Street out of which we were working was very different from the run-down brownstones on the same street across Seventh Avenue. Not to mention the multiplicity of self-anointed community leaders and ad hoc community groups working independently toward the same objectives.—W.S., *Medical Student, Harlem.*

Harlem Hospital was presented to me as a place where people go to die. Columbia University and its students were portrayed as an institution that had in some way or another created the woes and hardships of the people in Harlem. The city fathers have been neglecting Harlem, I was told, and a most impressive illustration of this is the beautiful, ultramodern but too long unfinished Harlem Hospital—a structure which seems to tantalize the people. I was told that community control was the only way out and to get this it was necessary to demonstrate. It seems, however, that many a demonstration had gone for nought in the past. As I passed our neighbors day after day, I could sense their confusion, frustration, and contempt. They were vexed.—E.M., *Law Student, Harlem.*

Harlem

The attitudes that people have about facilities, without even using them, are subtle and difficult to document. Nevertheless, there were some things that came up over and over again which had little to do with the actual health care delivery facilities, but which kept people away.

Health is not a high priority issue for many people who live in Harlem; health care often means the alleviation of a medical emergency,

not preventive care or the treatment of problems that aren't causing immediate, severe pain. We ran across numerous cases of people who had not taken their children to treatment, even after referral, simply because they didn't think it was important enough.

Lack of knowledge about health and health facilities is one of the reasons for the low priority; people may not know that a hernia can strangulate and become a serious problem very quickly, or they may not know that there are specialty clinics for problems such as obesity. People seem to think that if a problem isn't causing immediate discomfort then it probably isn't very serious. If someone does impress on them the seriousness of the problem, or if a mother is scared because she thinks the problem might be serious but isn't sure, we found that she would usually take the child to a treatment facility. The lack of knowledge about facilities available was noted but was sometimes an excuse rather than a serious hindrance.

Perhaps the major reason why health does not have a very high priority in Harlem is that there are so many other problems facing people who live there that have more to do with simply keeping food on the table and keeping a decent apartment. Rather than try to describe the galaxy of social problems that afflict people living in Harlem, I will outline a few: Health care is expensive; not only does treatment at a clinic or a doctor's office cost a lot, but it may mean the loss of half a day's salary to go to an appointment. Added to this may be the cost of a babysitter to take care of a mother's other children, and transportation costs to get to the relatively centralized health facilities in Harlem. As a result, checkups or non-emergency problems are often prohibitively expensive. Moreover, people who live in Harlem may be more interested in getting a job with a steady salary than in attending to health problems. Housing conditions or keeping up with payments on merchandise may come before health. Preventive medicine may be impossible in a situation where there is a general lack of a future orientation.—R.C., *Student Coordination, Harlem.*

Going in and among the people, through some dirty hallways to—almost always—the topmost floor, seeing the undelivered garbage on the landings and around the buildings made me wonder why it is that the city does not do something about it all. This left me with an impotent feeling when I realized that we have come and will be going and leaving these people in the same conditions and knowing full well that what we have done hardly began to scratch the surface.

It seems to me that SHP, and through no fault of our own, is really powerless to effect any meaningful change in the lives of these people, except that we can bring the needs of the whole community to the attention of the powers-that-be with the hope that some social change will be effected which will lessen some medical problems encountered in the community.

Let's face it. The incidence of poor eye sight, TB, and rheumatic heart disease bears a direct relationship to the socioeconomic conditions of the environment in which they are found.—J.H. *Medical Student, Harlem.*

In terms of health-care delivery, the most important differences I discerned in Harlem are matters of priorities. Residents of Harlem's Lenox Terrace, and the middle-class oriented mothers with whom we worked, can afford to be concerned about preventive medicine, dental care, and the like, because their physical and psychological environments are more in order than those of the slum tenement families across the street.

Some of the mothers whom I visited had an entirely different hierachy of priorities, and preventive medicine was far down on their lists, below housing, food, and crisis medical care, their major concerns were matters of day-to-day survival in a hostile, uncaring, unresponsive world.

I found it very difficult to convince myself, much less a tired, distraught mother of several children, that one of her kids needed a general checkup "just because" when they were sleeping three to a bed in a dark, smelly, roach-infested two-room hovel for which she paid $90 a month.

I felt that I was in no position (strange outsider, inexperienced student) to address myself to her real problems and that even if I turned her case over to one of our law students, there was little he could do for her either. Should we have come more prepared to direct ourselves to those needs that the people in the community consider more pressing than non-crisis health care? If so, what can we really offer at all except a body willing to do legwork or babysit? (Actually, we don't have that much more to offer!)—W.S., *Medical Student, Harlem.*

Bronx

The mothers' classes in the Bronx were not attended because the mothers did not see attending classes as a priority need. When a mother has unsolved problems with welfare and housing, she really is not too concerned about what happens to her body during pregnancy. I am not suggesting that there is not a need for such classes, but more immediate needs should be taken care of first. A better approach to providing health classes may be to work through welfare rights or housing groups. There is a need for individual health counseling for people facing specific health problems, but hoping to form a group for the sole purpose of health classes is unrealistic.—V.V., *Nursing Student, Bronx.*

I felt out of place forcing the issue of health care when the tenants had many other things they wanted first, especially housing repairs, full welfare benefits, and better police protection. The health care I heard about sounded like all the cliches—poor quality, fragmented, inaccessible, without regard for the dignity of the patient, in the control of external institutions. On the whole, I think the real lack was in preventive measures. The housing code on hazardous and unhealthful conditions is not enforced, garbage is not collected, walls and ceilings let rats and roaches through, diets are often skimpy.—K.B., *Medical Student, Bronx.*

When SHP comes back, please do not ask the community how you can help them because you will hear everything but health problems. They will tell you welfare, housing, play streets. Just let them know you are willing to help them if they have health problems.—M.G., *Community Worker, Bronx.*

Bronx

There is mixed opinion in the community about the health care they are receiving. It is obvious, however, as you go from home to home, which family does its best for its children and which do not even try to secure the care available to them. Mothers are often neglectful except when it comes to themselves. Children are dirty and unclothed and receive no medical attention. Other mothers of equal-sized families in the same area do not live elaborately, but the home and children are clean and they do their best. They are the ones who do not complain too much if asked about medical care, although everyone has some gripes about hospitals such as Morrisania. The neglectful mothers are more dissatisfied, but again are primarily uninterested or despairing. —P.B., *Nursing Student, Bronx.*

I really couldn't state in words the feeling of disgust and the "I don't give a—" attitude that the people in the South Bronx have toward the hospitals and clinics.—
H.H., *Nursing Student, Bronx.*

Lower East Side

Much of our information concerning the Lower East Side community's view of the health care in the area was collected by means of random canvassing throughout the community. As with most methods of canvassing, there are no real instruments to measure the validity of expressed opinion and experience. Therefore, after sifting through generalities, individual misfortunes, etc., we focused upon a number of problems that appeared to be representative of the community as a whole. The two problematic areas to which our group initially directed most of our time and energy were: (1) The recently instituted medicaid and medicare sliding-scale classifications for clinic fees; and (2) the transportation problem wherein people found it an inconvenience to travel to and from the Bellevue outpatient clinics.—E.C., *Medical Student, Lower East Side.*

If we in the Lower East Side SHP regard

ourselves as healers of a chronically ill system of health care delivery, then our treatment of it this summer can best be described as symptomatic. I do not believe that the health care problems of the Lower East Side are related to the methods of health care delivery per se. It is unfortunate, for example, that a patient may have to wait a long time at an allergy clinic for his turn to see a doctor; but if we find that the patient's allergy responds remarkably well to moving him from his dirty, roach-infested tenement to a clean and airy apartment house, mustn't we admit to ourselves that the problem, really, is in the housing? I believe that future Student Health Projects will make more enduring and important changes in the health of the communities they work in if they concern themselves more with social, economic, and political activism, and less with established medical facilities or health-oriented community organizations which are, afterall, dedicated to the maintenance of the status quo. Improved health care in the Lower East Side area in the future depends more on providing more and better jobs, better housing, and improved education in the community than in cleaning up the wards at Bellevue or making doctors become nice people. Not that these latter factors are unimportant but they are luxuries that we can deal with after the basic problems have been solved.—J.A., *Medical Student, Lower East Side.*

HEALTH CARE DELIVERY

Lower East Side

It is difficult to generalize about Bellevue Hospital. The enormity of the physical plant, the complexity of its organizational structure, and the heterogeneity of the hospital's staff defy simple categorization. However, a general impression of the hospital has been imprinted in my mind through certain experiences that tended to recur and through attitudes that seemed to be ever-present.

The physical structure is not well-suited for the delivery of good medical care to the residents of Manhattan's Lower East Side. The hospital is inconveniently located and is difficult to get to by public transportation. The problem of transportation to the hospital is made worse by the scarcity of taxicabs cruising the Lower East Side and the absence of subway facilities in the area.

Bellevue is a huge, impersonal institution; a very easy place to get lost in. The structure is too large, the passageways too cavernous, and the directional signs are abysmally inadequate. These features are especially formidable obstacles to patients lacking a firm command of the English language.

* * * We regarded our group as a community-located action organization working with Bellevue to effect changes that would improve the delivery of health services to the Lower East Side. Early in the summer we developed a productive liaison with the department of pediatrics, whose director served as advisor to our group throughout the summer. We had intended to focus our efforts on the pediatrics clinic, but discovered that this department of Bellevue was very sensitive to the problems of the community it was treating and was already attempting to solve problems that other clinics didn't even realize existed. In comparison to other Bellevue clinics, Pediatrics is a paragon. Therefore, we decided to involve ourselves with problems of the institution as a whole, and not with the particular problems of the department of pediatrics.

To define the existing problems, we first met with doctors at Bellevue and viewed the workings of the clinics. We went to the community to speak to organizations and residents. We followed up patients who were known to use the services at Bellevue. We knocked on doors, spoke to people on the street, and met with community organizations. Our relationships with these people were informal and unstructured, and our conversations were very spontaneous. Certain problems were consistently expressed by the people, and we chose those that we thought we could work with.

An illustrative example of our experiences is our work with the fee system at Bellevue. The predominant myth at Bellevue is that there is no problem paying hospital bills: "Medicaid and welfare pay all their bills"; "They never pay their bills anyway"; "They fool us by giving us a wrong address"; "If they don't pay

nothing happens to them" etc. Quite a different perspective on this situation can be gained by anyone talking to residents of the Lower East Side about this: "I'm afraid to go to Bellevue because I have no money"; "Eleven dollars is too much to pay, I can't afford it"; "Medicaid used to pay for my medical care, but doesn't since the Government took the Medicaid money away"; and "If I don't pay my bill the clerk will embarrass me in front of everyone the next time I go to the hospital."

As of July 1, 1968, a new sliding scale of fees went into effect for all city hospitals. Depending on income and the size of the family, people were to be billed from $3 to $11 for visits to Bellevue's clinics. Most patients from the Lower East Side were in the $3 to $5 category, but they did not know this. The signs at Bellevue still described the old $11 fee for weeks after the system had been abandoned, and little effort was made to notify the community of the reduction in fees. (I was told the newspapers carried this information as a public service. I missed the story, and I suppose many others did, too.) As a result of our prodding of the administration of the hospital and the office of the commissioner of hospitals, new signs in English and Spanish were posted throughout the hospital explaining the new fee system. In addition, we obtained a pamphlet, also in English and Spanish, that described the new fee system and distributed it to everyone on the streets of the Lower East Side. We also placed signs in local storefronts.

We developed the transportation problem with the advice of various community organizations, particularly the North East Neighborhood Association, the United Neighbors Association, the Fifth Street Mothers, and Movimientos Puertoriqueños Unidos. We concluded that patients in acute crisis were adequately transported to the hospital via the ambulance emergency service. However, we thought that adequate facilities for transportation were lacking for clinic patients, for patients wanting to use the emergency room services during the night but who did not consider themselves sick enough to call the ambulance, and for patients brought to the hospital by ambulance but who were not admitted and had to return to the Lower East Side during the night. We did not think that improving the bus service would eliminate these problems because we did not think it sound medical procedure for ill adults and children to walk several blocks to a bus stop and then wait a long time for a bus to arrive, particularly in bad weather or late at night. We thought that either a hospital or community-based car service would contribute to solving these problems. We hope that our efforts in the study of this problem will lead to a greater utilization of a Medicaid-financed private car service by patients unable to reach Bellevue by conventional modes of transportation.—J.A., *Medical Student, Lower East Side.*

Another area we worked in points up the problem of poor communication between hospital administration and staff even more. After talking with the administrator of Gouverneur Hospital, which runs its own transportation service for those who can't use public transportation, we decided to propose that such a service be instituted by Bellevue. Gouverneur pays for private cars but it also uses the services of cars paid for by Medicaid for the use of eligible Medicaid recipients. The patient's eligibility for such a service is determined by the patient's doctor who fills out a request for it; social service handles the rest. Naturally, the funding of the cars and the drivers' salaries was the main issue. As far as the administration at Bellevue knew, that hospital had never used and didn't know that such a service was available under Medicaid.

A trip to the central Medicaid office at 34th Street revealed that Bellevue did indeed avail themselves of these services—at least, the rehabilitation and orthopedic clinics did. When informed of this, the administrator was, of course, greatly surprised that his initial investigation hadn't indicated that Bellevue used such a service; he said he would make further inquiries. A few days later he reported to us that a supervisor at the same medicaid office insisted that medicaid provided no such service! Thus, we have a case of a phantom car service which neither Bellevue or medicaid knows about, which Bellevue uses and medi-

caid provides!—J.M., *Nursing Student, Lower East Side.*

We found Bellevue's administration to be very receptive and helpful to us. However, it matters little what one supervisor or one individual says, since the hospital's rules and chains of command are so extensive and communication is so poor.

In the beginning of the summer we had serious misgivings about being connected with Bellevue, especially since the Lower East Side community is trying to cut the cord with Bellevue by establishing its own comprehensive health center. An end of the dependence that Lower East Side residents have long had on Bellevue, and which, to a certain extent, has allowed poor hospital conditions to continue, will probably be the best thing that could be done both for the community and for Bellevue. People who have a choice will go to the health facility that offers them the best care.

Bellevue should not make the mistake of supposing that Lower East Side residents are too unsophisticated, too irresponsible, or even too stupid to know the difference between good and bad health care. For what, after all, is good health care? Does it matter if a doctor has won a Nobel Prize if his patient's bed is roach-infested? Or, if a doctor's language "doesn't happen to be Spanish," yet Spanish is all the majority of people in this area can speak? These people are extremely capable of judging the quality of health care they receive. This is obvious because many of them, though complaining about Bellevue's clinics, have nothing but praise for the pediatric clinic. In this clinic there are Spanish-speaking community workers who help with translation, appointments are made for further visits (and they are kept), and, if a patient has a problem at home, the community health workers, nurses (and occasionally doctors) will make home visits to see if further help can be provided. Bellevue personnel must stop thinking that a person's sensitivity to true human concern is dulled because his income is low. If anything, it is heightened.

* * * In our contact with the community, the opinions we heard were many and divergent. I would say that the people seek care in equal numbers at Bellevue, Beth Israel, and Gouverneur. Many had no complaints about Bellevue. Many hated it. The reasons they expressed most often for using facilities other than Bellevue were: Spanish-speaking staff; more courteous treatment; not as long a wait, therefore a day's wages didn't have to be lost.

For those people who missed appointments at Bellevue whom we followed up and visited, it appeared the reasons were usually an inability to find a place to keep their kids or an inability to travel to Bellevue. For many of the patients, the problem is what I believe is *the* first problem in health-care delivery—they can't afford it. They know the hospital will send a bill and they don't like not paying bills so they don't come for help. In one case in which the woman neglected going to the hospital because she couldn't afford the fee, I assured her the hospital would never refuse her service, money or no. She finally came to the hospital and it was found that she needed surgery, which she has now had.—J.M., *Nursing Student, Lower East Side.*

The idea for the NENA health center arose because of the mistreatment of community residents at other institutions and the lack of sufficient health facilities on the Lower East Side. From my own experience, doing clinical practice in a municipal hospital, I find many of their criticisms are valid.

One complaint that I can support, having worked in a city hospital, is the one of depersonalization that takes place in these large institutions. People are not treated as individuals. They are forced, for example, to see different doctors all the time even when a familiar face would make the situation less embarrassing and perhaps less painful. The doctors that see these patients in a clinic do not have time to study the background of each patient, such as the number of people in a family and the conditions they live under and if they do get this information it is not always passed on to the next doctor.—J.L., *Nursing Student, Lower East Side.*

I do not believe that the residents of the Lower East Side community feel that they are

not getting good medical care. Most people do not think about medical care at all until they are acutely ill, and it has been my impression that the residents of this community have found places to be treated that they regard as adequate. The pediatric clinic at Beth Israel Hospital and the pediatric clinic at Bellevue are widely regarded as excellent medical facilities.

Some patients prefer private or union doctors, others prefer Columbus Hospital because of the large number of Spanish-speaking personnel there. Some prefer Beth Israel because it is near, clean, and they don't have to wait long, and some prefer Bellevue because they like the medical care they get there. Certainly there are complaints, especially about Bellevue: the long-waiting hours in the clinics, rude and impersonal hospital staff, dirty and depressing surrounding, etc. I believe, however, that the people have accepted these faults as inherent and inevitable aspects of the system of delivery of health care, and are not especially concerned with complaining or changing the present situation.—J.A., *Medical Student, Lower East Side.*

Newark

Martland, formerly City Hospital, is better known in Newark's Central Ward as "Butcher Shop on the Hill." This hospital is understaffed, underspaced and underfunded, 90 percent of its patients are on welfare. The Board of Health in Newark is inactive, ineffective, and unconcerned.

City Hospital was run on a minimum budget for years. Jobs were political plums and, before the New Jersey College of Medicine took over recently, only a portion of the staff actually worked, others just collected checks. Departments, clinics, and emergency room ran independently with no communication between administration and medicine, nursing, dietary, etc. Even good staff became bogged down and bitter in the medical morass. Result: patients suffer from bitter, tense staff, uncoordinated medical care, failure to be directed to existing facilities. I have seen patients wake up in the hospital, realize where they were, and run out of the door dripping blood fron stab wounds.

Newark is ranked at least second in infant mortality, drug addiction, and TB deaths. People fired on this hospital during the 1967 rebellion. They hate it. They hate the 3-hour waits in clinics; being turned away from clinics without treatment; being misscheduled for clinics; the lack of human concern and the abuse received from all levels of staff; the lack of anaesthesia for delivery; inadequate social services; families being notified 2 to 3 days after a patient has died, or finding out when visiting; filthy and uncomfortable waiting facilities; lack of followup, etc., etc.—A.H., *Medical Student, Newark.*

I particularly don't like Martland Hospital. I was sick once when I was pregnant with my litle boy. Used to have nerve tantrums, and had to get a shot. When my mother took me to the hospital, those people put me on the 10th floor, the psychiatric ward, and I was not allowed to leave until I was examined. My mother told. those people I just had to have a shot, and they kept me there and made me go through all this red tape. I just wouldn't take my dog there. I take my children to Beth Israel in Newark. At Beth Israel, people act like they are concerned. You don't hear smart remarks. The hospital is clean, you don't even know it's a hospital, doesn't have that funny smell, and the food is not food for animals. It's nice, it's so much different, the people there are so nice and when you leave they give you a questionnaire to write what you like about the hospital.

Not many people from this area go to Beth Israel because it is a private hospital. When I was pregnant I had to pay $6 for every visit for an examination, and I had to pay for my pills, and it was $300 or something like that to have my baby and I had to have the cash first. But a lot of people around here don't have that money. I didn't have it either, but I just had to get that money because I wasn't going to the City Hospital.—G.J., *NYC, Newark*

The delivery of health care to the community was ineffective and insufficient. Many of the hospital departments are undermanned. The majority of their present staff is grossly unproductive. This stems from many causes: the

jobs were under city civil service, many of the political appointees are unqualified for their positions; many of the staff believe that good health care is a privilege and not a right. Consequently, the people administering health care have corruptive attitudes about the Newark black community. One of the hospital administrative staff was quoted as saying: "These people are all the same, you have to treat them like animals."

Hospital records were out of order; cases and files were misplaced and lost, record rooms were open only six hours a day and four days a week, and doctors had no way of getting any histories or X-rays during off-hours or off-days.

Clinic patients were forced to wait anywhere from 2 to 7 hours before they could be seen; many were even turned away without being rescheduled. The people were forced to wait in filthy, hot rooms, with no restrooms or water facilities. Many of the clinics are located near food service garbage rooms, which present problems with flies and the smell of decaying waste.—D.B., *Community Worker, Newark.*

In the prenatal clinic at Martland I found many positive things but mostly negative things. The nursing care the patients receive in the clinic is very good. The clinic is staffed by public health nurses who want to give each patient individualized care as much as possible. Most of the nurses' attitudes seemed good and they appeared to be interested in the patient's problems. However, there are only seven P.H.N.s and approximately 125 patients per day. Most of the time the nurses got tied down with paperwork and assisting doctors, and were unable to do as much health teaching as they wanted to do. The nurses do make home visits to try to do some of the health teaching the patients often miss in the clinic.

The physical setting in the clinic is awful. The patients are packed into a very small area. They sit on hard, wooden church pews. For a while there were no fans in the clinics and patients would frequently faint from waiting so long in that hot stuffy room. However, after enough patients had fainted, someone was able to procure fans for the clinic. The clinic is very dirty; the floors look as if they've never been mopped, and there was a lot of useless junk lying around which was finally removed about 24 hours after I called and made the request.

The patients have to wait to see the doctor in these surroundings from 2 to 4 hours, depending on how early they arrive at the clinic. Everyone is given an 8:30 a.m. appointment. The doctors arrive around 9:00 a.m. to begin seeing new patients, but do not see returning patients until 10:00 a.m. Some of this waiting time is needed by the P.H.N.s to take weights, blood pressures, etc., but not 3 hours. However, since there are so many patients and so few nurses, the nurses seem to be very busy all morning. The patients are served on a "first come, first served" basis, so many arrive very early. If a returning patient arrives at 7:00 a.m., then she will be one of the lucky "firsts" to see the doctor at 10:00 a.m.

All the patients seem to be treated equally, except sometimes I have seen certain nurses giving the Puerto Rican patients a bad time because they cannot speak English.—L.D., *Nursing Student, Newark.*

The lack of facilities for good health care are not isolated to Martland Hospital and its clinics. Most of the programs offered by the Board of Health and its drug dispensary are plagued by similar problems. The problems range from improper followup of cases (which eventually become chronic ailments) to useless and cursory initial treatment. Medical people use "lack of supplies" as their excuse. But the fact is that they don't make proper use of the little they do have. As with other services found in the context of our society, the health delivery system in Newark are corrupted by an inherent disrespect for and unconcern for the poor, nonwhite peoples.

There are many members of the Newark community who would rather die than subject themselves to the health care offered by the city. Those who can afford health care privately would much rather do so. For the majority of the people, however, there are no options available. Community people are not as ignorant as many suppose them to be. They judge the value of their health care only after

years of experience. Newark SHP has numerous accounts of conversations with community people in which they usually expressed dissatisfaction with their health care. Their most useful parameter is a measure of discomfort. They will usually tell you that a visit to one of Newark's health centers results in an aggravation of discomfort rather than an easing of it. In general, the Newark population is repulsed by its health care—repulsed to the point of hostility.—R.P., *Community Coordinator, Newark.*

While working in the Martland Clinic, I observed that the people who came to the clinic received good care, but I might add that the community people were very reluctant to come. They often would come to the hospital days, weeks, or even years after they developed medical problems. An example was a boy about 11 years old who came into the emergency room 3 days after he had cut his head on a piece of glass. The doctor told me he could not administer the proper medical care to the patient because a wound of this type must be closed within 8 hours of the occurrence. There were many similar cases where people neglected to come to the hospital promptly.

I found out by administering a questionnaire to the women in the maternity ward at Martland that in many instances they had neglected their health. They did not know about birth control methods; they had dental problems but never went to the dentist; and the same was true of many other medical problems they had. Some women complained of long waiting periods in the prenatal clinic, and other patients said they had received rough treatment in the maternity ward and delivery room. The main answer I got from these women when I asked them why they did not go for medical care when they needed it were, "they didn't know why they didn't go." or, "they were afraid to come to the hospital."—*Anonymous, Newark.*

There are many problems of health care delivery in the central ward of Newark. One problem is neighborhood health examinations. I assisted at one such checkup organized by the city health department. The turnout was not small, but it wasn't near a majority of the population of the area. It seems that more imaginative means of communicating the checkup, such as a sound truck, would have brought a great many more persons. Another problem of the checkups and the free clinics is that the older males almost never come. Women of all ages and children, yes, but hardly ever any males over high school age. This comment refers to city-run checkups lasting until 7 or 8:00 p.m., and free clinics run by Queen of Angels Church between 5 and 9:00 p.m.

Another problem I was told about was that it is almost impossible to get a doctor to make a house call in Newark. For this reason, people who are not in an actual emergency state but do need the services of a doctor call the city ambulance to take them to Martland Hospital. Those who have had a very bad experience with the hospital and do not wish to return have nowhere else to go if they are on welfare. The no-house-call problem undoubtedly will continue, but since the college took over Martland Hospital it is possible that maybe 5 or even 10 percent of the people who have sworn never to return to Martland may give it another chance after learning it has changed hands, and, hopefully, they won't be disappointed again.

I did note two other major problem areas in which improvements should be made. One was the abominable state of dental care of almost all the persons in Newark's Central Ward. I am unaware of what, if any, dental clinics are available. A second more general problem is finding and helping the real poor—the ignorant, despairing, almost helpless person who is hardly being touched by the health and welfare programs. Some referrals to these people may come through the emergency room. A far better source is through people who know them in the community. One such case was a 71-year-old guardian of five great-nieces and nephews and the two children of the oldest niece whose welfare check was going to be cut. This woman's only contact with the social services and agencies set up to aid people was an unsympathetic welfare worker. We were referred to her by a neighbor who was one of our NYCs.—N.W., *Law Student, Newark.*

Brooklyn

The population of the Crown Heights area of Brooklyn is estimated at 225,000 people, most of whom are either black or Puerto Rican. These are the patients that use St. Mary's Hospital.

St. Mary's can be seen as a white fortress in a black forest. It is a voluntary hospital with a capacity of 237 beds, administered by the Catholic Medical Center of the Diocese of Brooklyn. In my opinion, it is a 4th-rate hospital in an area where there is tremendous need. Until several years ago, the hospital refused to provide outpatient services for the residents of Crown Heights. During the last few years, the forest has crept in. There is still a good deal of resentment by staff and employees of the hospital who represent the "old guard," having such attitudes as: people who receive free medical treatment (the Medicaid fiasco has changed this) should not care whether it is administered with dignity or not.—W.B., *Medical Student, Brooklyn.*

Those of us who have observed the workings of the pediatric clinic at St. Mary's Hospital have noted the cursory care given the patients. We identified this not simply as a function of disinterest or lack of thoroughness on the part of the doctors, or as simply a crush of patients in a short time, but rather that the patient does not enjoy what we are accustomed to seeing as the proper doctor-patient relationship. The patient is not seen by the same doctor at each visit, although an attempt is made to some extent to do this. There is no appointment system at the present time and the patients and parents must wait an hour or more. Most important, however, the doctor sees an incomplete chart on each patient. He is expected to treat the symptoms of the episode rather than the patient as an individual. Often the value of knowing past facts about the medical history of the patient proves essential to adequate patient care.—M.H., *Sociology Student, Brooklyn.*

The most common community complaints were about the service in the emergency room and the attitudes of doctors toward patients: Hours of waiting in the emergency room, half-hearted treatment given to welfare patients as opposed to those who could pay, that children aren't cared for unless their parents are there (try to explain the "law" to people who have seen a child refused service when he needed it), that white children get dental care at Brookdale Hospital a few weeks after they apply whereas black children must wait for months—all this has been told to us again and again. Many people claim they wouldn't go to Brookdale if their lives depended on it. The community resident have been asking for better services—a better emergency room, a narcotics program— and Brookdale has been deaf. —E.B., *Medical Student, Brooklyn.*

Health care delivery services in the Brownsville section of Brooklyn are far from adequate.

Brookdale Hospital has two new programs —comprehensive child care, and multiphasic screening—both of which in format appear excellent. From contact with the programs, it seems evident that the staff is attempting to deliver total health-care services to the community. The programs have not been successful and the services are under-utilized because, (*a*) the community did not participate in planning the program, and (*b*) Brookdale has had a reputation for many years of giving second-class treatment to Brownsville residents.—L.K., *Medical Student, Brooklyn.*

Through activities in the clinic, I found out how many people felt about the health care afforded the community at Kings County Hospital in Brooklyn. Most people readily admitted that the doctors were quite competent and that they felt their children were in the best of hands. One common complaint had to do with the lack of understanding that the doctors showed concerning the day-to-day problems of the ghetto mother. First of all, most doctors did not fully comprehend the conditions that these people live under. This was one of the reasons why the role of the patient advocate was instituted. We attempted to show the doctors how serious the problem of peeling plaster and lead poisoning was. In most cases the doctors never inquired about the living conditions of the family

being treated. They didn't think to ask whether there was any loose plaster in the house or whether any of the children ingested the stuff.—D.Y., *Medical Student, Brooklyn.*

I was pleasantly surprised at the excellent quality of medical care the people receive at the Kings County Hospital pediatric outpatient department. Before beginning the job there this summer, everyone was telling me what a "hell hole" it was. I found it quite the opposite. The only major problem that I noticed was the very long wait encountered by the patients in the afternoon hours, whereas those patients arriving around nine in the morning usually had little or no wait at all. What most people fail to realize is that with many private physicians, an hour's wait is not uncommon, and with the tremendous volume of patients seen daily at Kings County Hospital, an hour and one-half wait should not be unexpected. Many of the people I have spoken to had very little complaint about Kings County Hospital. Their main complaints were usually against the smaller neighborhood hospitals and private physicians. Invariably many patients first went to these two before coming to Kings County Hospital.—S.P., *Dental Student Brooklyn.*

I found the poor delivery of health care in New York City to be well-documented, and the people painfully aware of it. The question was, what could be done about it. I believe I found a partial solution, legally.

I found a newspaper clipping which related that some months earlier the Commissioner of Hospital had testified before the State Investigation Commission that none of the city's 21 municipal hospitals met the requirements of the Federal Medicaid law or the State Hospital Code, with respect to physical facilities. I went to the Investigation Commission office in Manhattan, read the 200-page manuscript, and we decided we had a case under article 78 of the New York civil practice law and rules, which provides for the issuance of a court order against any public official to compel him to perform a duty to see that the city hospitals meet the requirements of the law.

I described the case to a 21 year-old black man who had come to the SHO office at Downstate complaining of poor treatment at King's County Hospital, and he undertook to bring the suit. The suit, *Moore v. Terenzio,* et al., Index no. 12459/68, was filed with the Manhattan Supreme Court on August 6, 1968, by Mr. Hanft, an extraordinary lawyer on the Lower East Side. There will probably be a hearing on the order to show cause sometime in the Fall. —R.H., *Law Student, Brooklyn.*

Bronx

A young boy in that neighborhood had been treated at Morrisania Hospital in the Bronx for a puncture wound of the knee, caused by a rusted iron bar. His treatment had consisted of X-ray and a damp bandage; no antibiotics or tetanus shots had been given. He came back to our storefront complaining of pain. His knee was red and swollen and he could bend it or bear weight on it. I took him back to Morrisania and spoke to the head doctor. It took 15 minutes of arguing and debate about who I was and whether or not I had any medical authority before the doctor consented to treat the boy.—M.J., *Nursing Student, Bronx.*

Many feel that though health care may not be perfect, it is good enough to be a major reason for staying in New York rather than returning to rural areas. Everyone mentions the long waiting periods before the doctor gets to see them. I found no agreement in the Bronx about the quality of health care. The most common accusations were against the obstetrics ward of Morrisania; no one who had been there once wanted to return. Bronx-Lebanon Hospital was felt to treat patients condescendingly; there was a fair amount of bad feeling towards it from Medicaid patients.—N.A., *Medical Students, Bronx.*

The health care which the residents of the Bronx receive does not seem as bad as some would believe. Fordham Hospital, while not the most luxurious spot in the city, seems to give effective service. The hospital is, of course, plagued by the problem of all the city hospitals —over-crowding, too much red-tape, and not enough personnel. But stories that it was a butcher shop seemed from my point of view to be unfounded. The people in the community will

all say that the care is horrible and degrading, but many have had actually no specific reasons for feeling this way. Either they have heard stories which may or may not have been exaggerated, or they feel they will get the bad side of things wherever they go. Upon taking a survey of 60 Head Start mothers and talking to them more and more, many conceded that their health care, while not ideal, is adequate.—J.W., *Nursing Student, Bronx.*

Health care attitudes were determined from a questionnaire administered to 60 Head Start mothers and from a sampling of community attitudes. Since Fordham Hospital was serving our area of the Bronx, most of our responses dealt with this hospital.

A majority felt that Fordham was not a desirable place to seek care. Long waits, poor care, disinterested doctors, etc., were given as reasons. Sentiment ran the gamut from mild endorsement (usually from those who had had the least involvement), to outright anger. Women expressed feelings that they'd sooner have babies at home than suffer the indignities at Fordham. Several complained of miscarriages due to poor obstetrical care. Many avoided health care for all but emergencies because of such unfortunate experiences.—V.S., *Dental Student, Bronx.*

The people in the Bronx community in which I worked receive health care that is unbelievably bad. Some of them said that they would rather die than go to Morrisania Hospital or to Bronx-Lebanon because, once they go there, the substandard care, the abuse from staff, and the interminable waiting would probably kill them anyway. Besides these two hospitals, Montefiore Hospital's Neighborhood Medical Care Demonstration Health Center also offers service to the area. This facility is highly regarded by community residents but unfortunately it can accommodate only a limited number of patients and it has definite geographical boundaries which exclude many of the residents in the area I serviced.

I feel that the community residents who go to Morrisania and Bronx-Lebanon Hospitals should document each case of poor health-care delivery and insults received from the medical personnel, especially the initial contact at the main desk, in order to press for reform. Students can do nothing in one summer because these institutions put up a front of cooperation for the 10-week duration of the SHP. Educating the residents is necessary.—B.B., *Student Coordinator, Bronx.*

The people would rather go to private doctors in the area, any place but Morrisania, Lincoln, and Bronx Hospitals. The people describe these hospitals as the "dog pounds." Three women I know delivered their own children because Morrisania and Bronx Hospitals don't have enough clean sheets for the patients * * * so the people feel they can keep themselves cleaner at home.—M.G., *Community Worker, Bronx.*

The delivery of health care to the community residents of the South Bronx ranges from excellent to poor. I feel if people really want to get good health care, it can be found with a little effort on their part, but unfortunately many people are not motivated to try. If they hear rumors that this city hospital or that clinic is not doing the job, they fail to complain or search out better medical care. Laziness is much of the problem. It is easy to blame it on discrimination or lack of money, but if some of the population can get good care and they have the same problems, why can't others? The projects I worked on showed that there are many service being offered to the slum areas if people are willing to ask for it instead of shrugging their shoulders and saying nobody cares. —E.F., *Community Worker, Bronx.*

Harlem

After working for 9 weeks on school health referral problems, we can draw some conclusions about why people don't use the health facilities available in Harlem.

The most obvious and most frequently cited reason for not using outpatient facilities at Harlem Hospital and other clinics in the area is that the time spent waiting in line is often prohibitively long. Most of the clinics are open only during the daytime and appointments cannot be made: the waiting time varies but can

be as long as 4 hours. People simply cannot afford to take time off from work or leave other children and their homes unattended for that long. Also, sitting and waiting in noisy, uncomfortable waiting rooms is not a very pleasant way to prepare oneself or one's child to see a doctor.

Compounded with the long waits, the clinic procedures and personnel are often insensitive to the needs of the people who use the facilities. We found that the procedure for registering at a clinic and for Medicaid was often confusing and exasperating, particularly when questions were asked in front of a long line of other people waiting to register. We found one clinic for eye and ear problems where the staff was downright rude and hostile to the patients waiting. Another frequent complaint was that doctors did not take time to explain to the patient or the mother what actually was wrong and what prescribed medicine was supposed to do. It seems that the feeling that health care is a right that people are entitled to is just not operative. Health personnel seem to consider their work a nine-to-five job, and patients, especially, lots of patients, are a hindrance to the many bureaucratic duties they may have rather than people to be dealt with in an efficient, gracious way.

A problem that was a result of the Medicaid legislation last spring was the institution of the $11 clinic fee for any visit. This was a hardship until a sliding scale was set up for non-Medicaid patients, but it still represents another obstacle: the patient must again tell how much he earns. Needless to say, the people who were covered by Medicaid before the cutbacks are now getting less adequate health care than they were getting when they were covered. We found that most Medicaid patients preferred going to a private doctor to waiting in the clinics; many non-Medicaid patients would rather risk paying a higher fee to a private doctor for a non-emergency problem than having to go through the inconveniences of a clinic visit.

A significant problem is the lack of adequate psychiatric facilities for the people of Harlem. In a survey of child psychiatric facilities, we found gross inadequacies in coverage. All the facilities in-and-out of the Harlem area had long delays before diagnosis and even longer delays before treatment could be started.

* * * An important reason why people don't avail themselves of facilities bears directly on Harlem Hospital; the reputation of the hospital in the community is abysmal. People say that they have heard nothing but bad things about the treatment people get there and refuse to put anyone in their family through it.

Part of this reputation comes from a time when Harlem Hospital was one of the two or three worst in the city. Many doctors appear to have cared very little for the people who use the hospital and left it to others to improve services. The house staff had been largely foreign-trained and this led to problems of communication with the patients. The list of grievances is long and familiar for large urban hospitals with poor facilities. The significant changes and improvements that have taken place recently have not been communicated to the people who might use the hospital. The improvement in quality of the house staff since the Columbia University affiliation (the fact that all the interns are now American trained, for example) has not filtered down to the people and the reputation continues to be just as bad as it ever was. The efforts of all the dedicated doctors (not just the results of the affiliation) in recent years should be made known in the community. Demonstrations of community frustration and dissatisfaction like the one that took place this summer following the death of a child who was misdiagnosed need not occur.

Whether or not these community attitudes are fair or even rational is not the issue; the fact is that they are real. The challenge to the doctor, black or white, is to understand the mentality and life styles of his patients and to deal with them as they are, not as he wishes them to be.

I will list our recommendations for improving health facilities in the Harlem area which we think would lead to more frequent and more satisfactory use by patients:

(1) Clinics in the Harlem area should be made more convenient for the people who use them; there should be appointments made, waiting rooms should be made more comfortable, and babysitting should be provided. Clinic hours day and evening should be scheduled for the convenience of the patients, not the staff.
(2) There should be health workers hired from the community who can do case-finding and home visits, and who can act as patient advocates in the hospitals or large clinics.
(3) Attitudes of doctors and staff should be screened and standards of courtesy and cooperativeness should be maintained. Patient complaints should be solicited and acted upon.
(4) The New York State Medicaid program should be reinstated in full.
(5) There should be an attempt to establish more psychiatric and counseling facilities immediately; the need is especially critical in the area of child psychiatry.
(6) Health education through all the communication media and with community groups should be continued actively and new bases should be sought.
(7) Harlem Hospital should establish a community relations department on a formal basis which would concern itself with more than just the writing of press releases; it should actively try to reach the people in the community and involve them in the hospital.
(8) Community participation in the setting of priorities for health and the running of health facilities should be institutionalized. Responsiveness of health facilities to the needs of the community can and should be guaranteed in this way.

These recommendations may not solve all of the health problems in Harlem, but unless these eight points are addressed, we see no chance for an improvement in the health care delivery situation.—R.C., *Student Coordinator, Harlem.*

There is an acute shortage of health professionals in Harlem. One school nurse must serve up to five schools or more; some schools have a doctor only 1 day a month; school children are commonly not examined between first grade and high school; there would appear to be virtually no specialists in private practice in Harlem. Parents *are* concerned. When informed their children need care they endure long waits, dreary waiting rooms, rude clerks, and frequent double standards for paying customers versus Medicaid and welfare patients.

What seems to be lacking is proper preventive medicine. Harlemites tend to wait until they are noticeably ill before seeking medical care. This is due, to a great extent, to the people's mistrust of the medical institutions.

Harlem Hospital has a terrible reputation in the community. The building is old and overcrowded, while a new building stands next door, unfinished, overdue many years, and many months short of completion. One wonders whether the city is giving the new building the priority it deserves. I suspect a similar project in the East Sixties would have been completed on time. The people of Harlem agree.

The people of Harlem are not blind. They realize that decent housing, proper nutrition and adequate jobs are necessary for health. Is the American system as presently constituted able to deliver these? Doubts are multiplying.

It is to belabor the obvious to say that to improve health care more doctors are needed—young people from Harlem who will return there must be trained as doctors, nurses, etc. Pediatric screening programs in the schools could be expanded; hospitals can be made more relevant to the community by placing them under community control. It is stupid to speak of anything short of billions of dollars spent in all areas of human life when considering health care.—L.B., *Medical Student, Harlem.*

At present, the most important way to improve care in the Harlem area is to lobby for the speedy opening of the new Harlem Hospital. Also, I would try to get more board-certified group practices involved in the area. At present there are only two.—J.H., *Medical Student, Harlem.*

There is need for a followup service as an extension of health facilities in Harlem. People often do not return for appointments or seek referred treatment. By having individuals go out into the community to follow up school health referrals, we have managed, temporarily, to deal with part of this problem. In order to secure a more permanent solution, on a small scale, we are in the process of funding permanent jobs for our five community workers. In these positions they will function as extensions of the school nurses and will follow up the school health referrals year-round. —S.G., *Medical Student, Harlem.*

ATTITUDES

Brooklyn

The doctors must know the community that they serve. They must be acquainted with the customs and beliefs of the patients. They must know their patients and respect them as fellow human beings. In order to treat someone with compassion, one must understand this person and look on this person as a comrade in pain, not as a stranger who cannot be understood.

There are a variety of problems about communication between the patient and the physician. The patient or the mother of the patient often viewed the doctor as competent but unconcerned. They often felt that the doctor didn't care about them. On the other hand, the doctors viewed the patients as being hostile and unreceptive to the care they were delivering.

There is a definite lack of communication between the members of the community and the hospital as an institution and as a representative of the white man's world.

What is needed is more community involvement in the running of the city hospitals and more effort on the part of the hospitals to make their services known to and accepted graciously by the community.—D.Y., *Medical Student, Brooklyn.*

Bronx

The following two experiences illustrate the problem of routine medical care delivered without concern for the patient and his specific needs.

Gladys is an 18-year-old girl who has a little boy and is expecting her second child. Gladys made an appointment to visit the Morrisania prenatal clinic and I decided to accompany her. She misunderstood, or was not told, that she would not see a doctor at this time. The purpose of this visit was to obtain a clinic card and to have the preliminaries before seeing an obstetrican. During her interview with the clerk, Gladys said that she had been going to the N.M.C.D. and that they had referred her to Morrisania. She said that she was told that she no longer lived in the N.M.C.D. district. The patient had never been seen prenatally. An appointment had been made for Gladys, but she did not keep the appointment. With this bit of information the clerk asked Gladys why she had not seen a doctor sooner. Gladys appeared very hurt by this question because she said she had seen a doctor. The clerk told Gladys that she was old enough to be her grandmother so she shouldn't try to tell her that she had seen a doctor when she hadn't. I was irritated with the clerk for making a judgment without trying to clarify with Gladys as to how she saw the situation. It is possible that Gladys saw a medical doctor and thought that she had seen an obstetrican. Gladys did say she didn't keep an appointment to have some blood drawn. This one encounter left Gladys with an unfavorable first impression.

Gladys was told, or rather I was told, to take her to have blood drawn, her teeth checked, a chest X-ray, and, finally, to see a social worker.

The lab technician did not say anything to Gladys when she went to have her blood drawn. The technician was very hurried and a bit gruff. Gladys was frightened and did not receive any psychological support or instruction, such as to look away or to grasp something to make the experience easier for her.

Our next visit was to the dental clinic. At the registration desk I had tried to tell the clerk that she had seen a dentist within the last 6 months, and that maybe it wasn't necessary to see a dentist again since it was so close to the time of her delivery. At the dental station I was told that the X-ray machine was broken and that she would have to make an ap-

pointment for another day. At this point I said that it was hard for this woman to get to the clinic and unless it was absolutely necessary that she see a dentist at this time, that I preferred a new appointment not be made. The clerk, somewhat confused, called the nurse. The nurse checked the records and found that Gladys had seen the dentist at the end of March. She arranged for Gladys to see the dentist without coming back to the clinic.

Next we went to the X-ray department. After waiting about half an hour Gladys was seen. The technician did not smile and appeared very tired and bored with what she was doing. She made no effort even to acknowledge the patient's presence.

Our last visit that afternoon was to the social service department. She was the only person we met that day who appeared interested, and we felt she had the time to speak with us.

We came back that evening for the prenatal clinic. The doctor started asking questions, and Gladys became confused and appeared frightened. He got irritated because she was not responding to his questions. The nurse then informed me that I was not supposed to be with the patient while she was with the doctor because I was violating her privacy. I did not leave so she sent in another nurse to inquire if I was translating for this woman. Even though the head nurse did not object the other nurses did not want me there speaking with the doctor. It was not their routine.

The doctor also followed his routine. He did not interject any personal comments at all. In the examining room I could hear him bawling her out for using salt because of her high blood pressure. I'm not sure any doctor had told her this before. He then told her she was to have a Pap smear. I could hear Gladys saying that she had just had a Pap smear, and I know she had because I had read the letter she received stating that the results were negative. Maybe the doctor did have reason to doubt Gladys, but he didn't take much time to listen to her.

Our last visit was with the nurse. The nurse was very pleasant, and did not appear to be rushed. Gladys did speak up to ask about the problems she was having with her leg. Th nurse explained that elevating her legs woul help. She suggested that Gladys elevate he legs while reading a good book. I had to chuckl at this because Gladys only has a 9th grad education and has difficulty reading and writ ing. The nurse did some diet counseling whic was very inadequate for this patient. Sh handed the patient a diet sheet and said t avoid salt and greasy foods. No inquiry wa made into Glady's eating habits.

Rebecca is a 64-year-old Negro lady who wa referred to me by a dental student because h felt that she needed more comprehensive car than just seeing that she get some dentures.

I decided to take Rebecca to Morrisania t have a checkup. This was to be my first ex perience with registering a new patient. I firs asked a clerk processing new patients what th procedure was for bringing an elderly patien to the clinic who hadn't seen a doctor in som time. She said to bring the lady to the emer gency room. I replied that there was nothin acutely wrong with this lady and asked if there wasn't some other procedure. "No, you mus take her to the emergency room". I didn't ac cept this as being the solution so I asked at the information desk on leaving the hospital. She suggested that I speak with the nurse at the screening clinic. The nurse said that the screening clinic was perhaps the best solution.

We returned to the clinic the next day. We arrived at 8:15 and were seen by the clerk by about 9:00. Shortly thereafter we were seen by the doctor at the screening clinic.

The first question he asked was, "What's the matter, why did you come." After a pause with no answer he said, "Well, what's wrong with you, you know that this is a hospital." At this point I answered by saying, "Nothing is the matter with this woman in particular. She just hasn't seen a doctor for some time, and I think it is advisable. She had poor vision, she is hard of hearing, she needs dentures, and has had problems with her heart in the past." By this time I was disturbed by the lack of dignity and respect the doctor showed this patient. After a very brief examination, he discovered high blood pressure and decided she needed a car-

diac series. He was very impatient with Rebecca. He would get irritated when she did not understand his questions. He even tried to tell her how to talk. Rebecca answered some of his questions with a "ya." He told her to say yes, not "ya." What particularly irritated me was his being more interested in my being a student nurse than in Rebecca. I think it would have been much more beneficial for the patient if his interest had been directed toward her. The doctor said to make an appointment for the medical clinic for Rebecca. I asked him about the eye clinic. He did not mention the E.N.T., dental or G.Y.N. clinics. This would seem to indicate that this doctor is not providing comprehensive care, or is even considering preventive medicine.—V.V., *Nursing Student, Bronx.*

Lower East Side

The biggest obstacle to the delivery of good medical care at Bellevue Hospital is the pervasive atmosphere of what I have heard referred to as "Bellevue Paranoia." It is an attitude composed of varying degrees of lassitude, obstinacy, and covert hostility. It is personified by the elevator operator who will not tell you what floor a certain clinic is on because it is not his job to give information; by the clerk who will not admit you for a clinic appointment because it is 10:10 a.m. and registration for the clinic stops at 10:00; by the perverse administrator whose decision it was to man the information desks with personnel who do not speak any Spanish; and by the physician who can just walk away from patients waiting to see him in a specialty clinic because he thinks it's time to go. These attitudes are accounted for in many ways: overworked doctors who must see too many patients in too little time, frustrated clerks frozen in positions with little upward mobility, etc. Regardless of the excuse, it is an attitude which exists throughout the hospital and which the hospital has failed to deal with.

Bellevue has, for too long, enjoyed the position of being the only center in the area offering extensive facilities. That it has also been one of the most notorious is often not considered. It was interesting to observe, in the process of speaking with community people, the repetition of a few common complaints about Bellevue's services. It would be a conservative estimate to say that 90 percent of those persons we asked cited the lack of courtesy to be their main complaint about Bellevue. Medical care, they say, is fine, but "the clerks are rude and we're treated like dirt."

Bellevue must refocus its attention from medical education to that of service to the community. This is, of course, difficult to do. I was told by a resident in pediatrics at Bellevue that he cares about his patients and their continuing welfare, yet if Bellevue's census continued dropping as it had in recent years, and the "interesting cases" no longer were seen there in such quantity, he would promptly leave and so also would most of his colleagues. "Let's face it," he said, "what I'm most concerned with at Bellevue is my education. Sure I care about my patients, but that's not what I'm here for; primarily I'm here to learn." As long as the patient remains in this secondary position in the physician's list of priorities, no amount of new buildings, equipment, or famous names will lure patients to Bellevue Hospital.

Bellevue's pediatric clinic has serious "competition" from Beth Israel Hospital's "I Spy" clinic, which also handles children. There, the doctors speak Spanish, as do all the health-aid workers on the floor. These health workers make regular home visits and followup care on their own patients. The "I Spy" clinic does actual soliciting and canvassing in its area, actively trying to get people to come.

This active community action on behalf of the health care facility is the essential feature. It is what's lacking at Bellevue and seems to be what Bellevue still refuses to do. More than one doctor has said to me, "I don't know what our job is in respect to the community any more; should we go out and get them, or should we let them come to us? I don't know." For a hospital whose census has dropped in recent years and which faces an estimated 75 percent loss of its outpatient department patients to the new NENA health center, is there much of a choice? They must reach out actively to the community if they expect to see an increase in their patient load. A new building

alone isn't the answer.—J.M., *Nursing Student, Lower East Side.*

Newark

Generally, postpartum patients felt their prenatal care was satisfactory; their one common complaint was the long waiting time. * * * It is not unusual to see 150–200 pregnant women come to prenatal clinic at Martland Hospital in one morning, nor to see them wait 3 or 4 hours to see a doctor who gives them only 5 minutes. There is little personalized attention because there is no time to give it with such inadequate staffing. Little wonder that mothers wait until their delivery date or near before coming to the hospital.

Many of them were dissatisfied with the treatment they got from the nurses in the delivery room; they felt that the nurses were giving them very little emotional support; that the nurses conveyed an "I don't care" attitude. I quote a young mother: "I delivered the baby all by myself; they (the nurses) only stood there watching." The general complaint about the postpartum floor was the attitude of the staff; many patients felt they were rude.—*J.Q., Nursing Student, Newark.*

* * * Besides the decrepit, dirty, and dingy conditions of community health facilities in Newark and the poor quality of health care administered, the ultimate crime is the complete insensitivity of most health care personnel to the patients whom they have supposedly dedicated their lives to serving. The patients are treated like cattle, herded in, thrown out if they dare to speak or question, and herded out, usually with a few harsh words of condescension. The obvious reasons for the conditions are lack of funds, lack of staff, and ultimately lack of concern. Hopefully SHP fostered concern if nothing else.

The people of the community are completely disgusted with the deplorable health care offered them. However, only an exceptional few will speak up to the hospital staff. The majority of the community people I've had contact with feel like puppets on a string—if they don't jump when the hospital personnel says jump, they get no health care. Obviously changes are necessary fast, but I didn't accomplish them and SHP didn't accomplish them.—K.S., *Nursing Student, Newark.*

People do not like being treated like dogs at city hospitals; they do not like to be kept waiting for hours at a clinic; drug addicts do not like to be considered criminals when they seek medical attention. In short, the people of Newark's Central Ward are just like people everywhere—they want to be treated with respect and dignity. This does not seem to be an unreasonable request, but in Newark it is far from a reality.—B.W., *Medical Student, Newark.*

The hospital is contracting a psychology institute to begin sensitizing staff to needs of the patient, and to coordinate and improve communications between various levels of supervision. This idea for a sensitization program was sold to the administration by speaking with enlightened members of the administration on all levels. It is hoped that staff will begin to function as a whole towards patient care.

An in-service sensitivity training program now running in the nursing department will continue weekly until I leave in October. I am using tape recordings of community people talking about the hospital and working with staff reactions to this stimulus material. This program is serving in the interim preparatory to the more general program.—A.H., *Medical Student, Newark.*

Harlem

We received many complaints about the "nasty attitudes" of the personnel in the clinics at Knickerbocker Hospital, poor treatment, long waiting periods and frequently a lack of communication between the patient and doctor due to a language barrier. The Harlem community feels that the comprehensive pediatric health center that Knickerbocker is trying to establish is fine but that it will be some time before the center is completed. They would like to use Knickerbocker's facilities since it is in their vicinity, but generally refuse, except in the case of dire emergency, to tolerate the treatment they presently receive from personnel at this hospital.—P.J., *Nursing Student, Harlem.*

MEDICAID, MEDICARE

* * * The pharmacies are another bone of contention in the Harlem community. The people on Medicaid feel that they are not being given the same kind of service that non-Medicaid people are getting, especially if their cards are not "filled out properly." Also there is no drugstore in Harlem which is open 24 hours, or even late in the evening.—J.H., *Medical Student, Harlem.*

We've run a couple of experiments on a Harlem drugstore: we got prescriptions for the same drug for Mrs. X. who has a Medicaid card and Mrs. Y. who doesn't have a card. The store gave about the same service to each customer in terms of time. The drugs sold were different, the Medicaid drug being generic, and Mrs. Y. had to ask for a bag to carry it in. Also, when Mrs. X. asked how much the drug was going to cost Medicaid she was told, in effect, that it was none of her business.—R.C., *Student, Coordinator, Harlem.*

It takes longer for a Medicaid patient to get his prescription filled. There seem to be legitimate reasons, or are they legitimate? Many are clerical in nature and could be avoided. One wonders if these professionals are excessively jealous of their independence and excessively, almost cruelly, preoccupied with resisting a "government takeover." And who finally suffers if the prescription is left unfilled?—L.B., *Medical Student, Harlem.*

These past 2 weeks revealed a problem which was not entirely surprising. We found that most holders of Medicaid cards regarded themselves as recipients of a gratuitous act from any agency, doctor, or pharmacist that delivered services to them. They felt as if they were obligated to put up with any indignity. However, this does not derive from the fact of Medicaid, but from a general feeling on the part of many of the community of being second-class citizens. The situation is compounded when the person slighted does not know how to have redresses made, or does not have any place to appeal. I see the role of SHP as middlemen between the community and the deliverers of health care, acting both as advisors to and trouble-shooters for the people of this community.—JH, *Medical Student Harlem.*

DENTAL HEALTH

Nowhere was poor health care brought home to me more than in the dental clinic at the health station. Being a dental student, I was able to observe and question the dentists as they treated the Head Start youngsters I brought from St. Joseph's. From the equipment which was antiquated, to the techniques used which were criminal, to the attitudes which were racist, to the ability which was low, to the knowledge which was minimal, the entire service epitomized the worst in health care. I will not proceed further into a detailed analysis of the care here but I can summarize what I saw by saying that, by comparison, Fordham Hospital was a model of health care, and that the city has no justification for allowing outright malpractice to exist within its service. At the conclusion of the program, I recommended that this health station be boycotted by the Bronx community.—V.S., *Dental Student, Bronx.*

A particular deficiency of health care delivery on the Lower East Side can be seen in dental health services. There is no dental clinic in the neighborhood and the people are oblivious to the effects of poor dental hygiene on overall health of body.—B.G., *Nursing Student, Lower East Side.*

Since one child out of eight gets dental service in the community, the need for dental education for the parents and children, and also the need for more and better dental services, is absolutely imperative in the Lower East Side community.

The parents frequently said that they can't find good dental services in the community (no dentist or clinic was apparently satisfactory), and others told me they could not afford it. Morally, I feel this is one of the most terrible things that could happen in the wealthiest country in the world. Everyone I talked to was disgusted with the lack of dental services and financial aid for the underprivileged. Something must be done in these two respects and I will certainly try to do what I can in the fu-

ture to alleviate such a situation.—G.L., *Dental Student, Lower East Side.*

LEAD POISONING

In the course of our survey of lead poisoning incidence in the South Bronx (and, to a limited extent, in Harlem), we came in contact with a wide range of community institutions, most of which were of an Establishment-type nature. First reactions to our requests were guarded until we had explained our purpose and our procedures, at which point we found people most willing to aid us. We found, for the most part, that dealings on a personal level were more profitable than when we were forced into a head-on encounter with a bureaucracy.

In terms of concrete results, our group came in contact with 1,200 households and informed them of lead poisoning dangers. We collected and analyzed 500 urine samples from small children, and our results will soon be made available to the general public.

We found that a good many asymptomatic lead poisoning cases had not been to a hospital recently, nor received medical care, nor sought it out.—I.B., *Medical Student, Bronx.*

Two suits were filed this summer having to do with lead poisoning. Acting on a suggestion from Paul DuBrul, Mr. Hanft asked for the court, under article 78, to order the New York City Health Department to compel the removal, pursuant to section 173.13 of the health code, of lead-based paint from the walls of two apartments in which children have suffered lead poisoning from eating chipped paint and plaster. In one of these families, three children have been treated for lead poisoning, one seven times. One suit asks that the court order the removal of lead-based paint from all apartments in New York City.—R.H., *Law Student, Brooklyn.*

The Central Brooklyn Coordinating Council and our group are working on the problem of lead poisoning. The hope is that we can get a group of people from all over Brooklyn—parents, doctors, and people in other fields—interested in the problem to meet after SHP is gone, and maybe take some action or at least make demands.

Brooklyn has the highest incidence of lead poisoning, and it is increasing. A lot of people don't know that children can die or get permanent brain damage from it. Say there are 600 cases of lead poisoning a year found in the city: well, if these 600 cases were diphtheria or polio, everyone would worry about it because it would spread. But lead poisoning is just in the poverty areas, and does not "spread," so no one is concerned about it.

Our purpose is to get the community interested, to get them to realize that no one is listening to their problems.—W.S., *Student Coordinator, Brooklyn.*

The Brooklyn Community Council SHP workers coordinated the Brownsville and East New York activities of a campaign throughout Brooklyn against lead poisoning. This involved contacting parents whose children had had lead poisoning in the past 2½ years, distributing flyers and posters, and speaking to community organizers and workers, in order to encourage attendance at a mass meeting we were holding. A door-to-door canvas was conducted explaining the effects of lead poisoning and how it was related to poor housing conditions. A bus was arranged to take area people to the meeting.

The meeting was attended by approximately 80 people, 10 of them from Brownsville. In the estimations of most people involved, the meeting was successful. However, the effectiveness of communication techniques, which involved so many man-hours and netted such a small attendance, can be questioned.—L.K., *Medical Student, Brooklyn.*

DRUG ADDICTION

In taking steps to establish a narcotics center in the Brownsville section of Brooklyn, we met with people from the Governor's Office, Ramirez, Narcotics Addiction Community Center and C.C.V.N. This meeting was quite enlightening: the State people couldn't account for the placement of funds and had no idea where the appropriated money went; the money that was appropriated to private addiction rehabilitation centers was never given to the centers. Moreover, the State programs

weren't servicing the real addict population: 75 percent of the addicts in the city are black, but only 15 percent of the addicts in the Ramirez program are black.

We found that Model Cities had money for health facilities and that the Multi-Service Committee, which was supposed to make the funding decisions, was not functioning. We acquired the directions on how to write a proposal, and spent several days at the Addiction Rehabilitation Center in Harlem with our NYCs, speaking with ex-addicts and addicts. They helped us in writing the proposal for a Brownsville narcotics center. We presented the proposal to model cities and the leaders of Brownsville. The response has been very favorable.—E.B., *Medical Student, Brooklyn.*

The narcotics problem is a big one with no good answers at present. Everyone in the Brownsville community knows people that are "shooting" and that kids at nine years of age or younger are turning on by glue sniffing, reefers, and goof balls. In talks with two of the NYCs working with us, it became evident that they were interested in working perhaps in a preventive sense with youngsters and drugs. In order that we would not duplicate other programs, and to avoid some of the previous mistakes, we contacted and spoke with all groups working with drug abuse in Brownsville, including:

(1) Addiction Services Agency (ASA), part of the Phoenix Program of New York City. They have a storefront which is an induction center and meeting place for A.W.A.R.E .and R.A.R.E.

(2) Narcotics Addiction Community Center (NACC). They have a fairly formal and traditional approach as part of the New York State program. Their preventive measures consist primarily of films which can be loaned to any group, and staff members occasionally will answer questions with film showings, or go to the schools. Unfortunately, none of the films are directed towards the "ghetto" children or towards children around the age of nine years. The NACC takes a limited number of addicts into detoxification and rehabilitation programs run by the State.

(3) Interfaith Hospital, owned by N.E.G.R.O. and located in Queens. The hospital maintains a twenty-one day detoxification program. Most addicts come in from referral from other organizations, but any addict can walk into the center. Some minimal rehabilitation work is done.

(4) Brookdale Hospital, whose psychiatric service has a newly formed narcotics program. They are doing some methadone treatment; they have no preventive program.

(5) Brownsville Community Council Narcotics Committee, a group of interested community people who want better treatment and preventive facilities in Brownsville. They have attempted to improve the effectiveness of police control and arrests of addicts, and they are presently undergoing some training with the addiction services agency.

None of these groups really reaches the youngsters or does anything with the glue sniffing problem, so we decided to canvas all stores which would possibly sell glue, carbona, or other toxic substances. We visited 80–100 stores, informed the owners of the law and discussed the problem with them. We presented them with a copy of the law against the sale of glue for the purpose of sniffing, and attempted to get them to attend a meeting we had planned. (We were surprised that so many of the storeowners were Puerto Rican, and regretted not having copies in Spanish.) The meeting was conceived as a way to make a small attempt to change attitudes, rather than just forcing people to comply with demands or rules. At the most, we had expected five storeowners to come, that would have been a success—but none showed.

Shortly after this meeting, we had a discussion with three NYCs, who were requested to do some protesting at stores selling glue. They discussed the drug problem and fairly freely described various encounters they had had with drugs. One in particular, who is a gang member, had very strong feelings about drugs since

he had seen two of his uncles and a cousin hooked. The NYCs noted that most of the drug usage is in the evening: the kids either work or hustle all day and then get high at night. It is more or less the thing to do. From the discussion emerged the idea of organizing some evening activities, an idea which will be further developed.—L.K., *Medical Student, Brooklyn.*

As a part of the Brownsville project, we canvassed the area to inform storeowners of the dangers inherent in glue sniffing. We handed them literature concerning a meeting at which storeowners would confront members of the community and discuss this topic. It is of interest to note what transpired in one hardware store in the area, where a man behind the counter claimed: "I hope kids continue to sniff glue; they will get sick and die and stay off the streets. * * * You are stupid to think that these kids don't know it's dangerous. * * * I will continue to sell it to them."

The next week, in conjunction with the Brownsville Community Council, a plainclothes narcotics officer waited outside the store as two young children entered to ask for glue and bags. After the man sold them, the policeman came in and issued him a summons, which he refused to accept. The policeman called a squad car and he was arrested.

Perhaps if this incident were made public, through news media, a greater public awareness of the problem would follow, and the people of the area would pressure storeowners not to sell glue and the police to make more arrests. The problem at present is so great that you cannot walk down the streets without seeing young kids sniffing glue.

The meeting on glue sniffing was a failure because not one of the 100 storeowners informed about it showed up. At the meeting the topic digressed from glue sniffing to gun-control legislation, etc., and members of the community claimed that glue sniffing was not such an important problem that such priority should be given it. Our activities were, in essence, called useless.—D.K., *Medical Student, Brooklyn.*

We spent 2 days driving our NYCs around Brownsville from store-to-store, attempting to buy glue. Happily, our earlier campaign seems to have had some effects: only one store that we visited was still willing to sell glue. We returned to this store 2 days later with 20 not-so-eager pickets, and left about a half-hour later with the druggist's total supply of Duco Cement. Picketing is apparently a very effective prod.—J.T., *Medical Student, Brooklyn.*

My feelings and views about the problems of the ghetto have changed since the summer began; I am less optimistic and more depressed over it all.

Tuesday afternoon an addict walked into Action Center 3 in Brooklyn; he had two friends with him who had agreed to drive him to Interfaith Hospital. He has been an addict for 8 years. A girl friend who was maybe willing to marry him, and a growing fear that the next rock he tossed through a shop window would be the last, had convinced him to call Interfaith on his own and make an appointment to be admitted on Wednesday morning. From us he wanted pajamas, soap, and cigaretes, since he had no possessions of his own. We took him to Action Center 5 since I'd heard that they had a good program there. The lady there called the welfare center, then informed him that he could not get pajamas and soap and cigarettes until the following afternoon. She asked him why he had waited until the afternoon to come in, since he must know that "in offices things have to be done in the morning." He walked out. I followed and begged him to go the Interfaith anyway with his friends, and promised to get pajamas and soap and cigarettes to him the next day if he couldn't get them through the hospital. He wasn't so sure he wanted to go anymore, and after 2 hours of waiting around for nothing was quite angry and confused. So was I. I begged him some more, shook his hand and wished him luck. On Wednesday afternoon, Interfaith Hospital had no record of his arrival.—J.T., *Medical Student, Brooklyn.*

The official Newark City narcotics bureau is a division of the Police Department. Lt. Kenney of Newark's Narcotics Squad was friendly and informative but I was horrified at his attitude toward drug addiction. He and his staff

under her circumstances has stamped on her record, "13P", which means out-of-wedlock pregnancy. The stigma follows her throughout her life. The final decision to accept a girl back into school is left up to the individual school principal; for reasons cited previously, the principal is usually not anxious to have such a girl in the school, and permission to return to the girl's original school is often denied.

If the girl tries to remove the social stigma of her out-of-wedlock pregnancy by marriage, she is denied an education because she is now considered a married woman.

There are only seven centers in all of New York City that offer educational facilities for teenage mothers; three in Brooklyn, three in Manhattan and one in the Bronx. These centers offer both educational and health facilities while the young mother is out of school and living at home. However, they can only accomodate 40 to 70 girls at one time, which means that 85 percent of the unwed mother population is not being reached and is therefore not being educated.

Other resources offering educational and medical facilities are "shelters for unwed mothers." These shelters only accept girls who are planning to give their babies up for adoption, or girls who have no home or cannot cope with their home situation. These shelters range from $40 a week, up. Ninety percent of the Negro and Puerto Rican girls do not go to the shelters because, either, they live at home, are unwilling to give up their babies for adoption, unable to afford the shelter, or lack information about such shelters.

I found that in certain instances these centers and shelters were not able to fulfill the educational needs of the girls either: most of the educational facilities already set up do not have full-time teachers; and subjects such as advanced math, languages, and commercial subjects are not taught because they require special teachers and equipment. This means that it is only token education; and the girl may also require classes in child care and nutrition, personal hygiene, social services, family counseling, and psychiatric counseling.

These girls usually lack parental support and personal motivation. If total rehabilitation is to take place, their families must become involved. Society has spent thousands of dollars to help rehabilitate the drug addict, high school dropouts, and people coming out of our penal institutions. Why hasn't something been done for the unwed teenage mother? Perhaps it's because she is not seen as a threat to society like the drug addict and ex-criminal!—M.J., V.V., *Nursing Students, Bronx.*

Mornings weren't too busy in the emergency room any more so I began to give a questionnaire (concerning prenatal care) to patients on Martland's postpartum floor. The actual question and answer session was slow, but in talking with these women I was appalled to learn that: (1) Most of the women had very little prenatal care, partly because they dislike the long waits in the prenatal clinics and partly because they didn't think that prenatal care was very important; (2) too many were unmarried and under 16, and very few (young or old) knew much about birth control—they received pamphlets for family planning, but most had not bothered to read them; (3) most of these women accepted their poverty, ignorance, and degrading surroundings (24-bed wards with paint falling from the ceilings) because they knew of no other existence or did not know to whom to protest; (4) most importantly, many of these women could not read or speak above a grammar-school level, even those who had graduated from high school, and some could not even construct complete sentences or understand words like abortion. That lack of ability to communicate was not just a problem of the black mothers; it also applied to many of the white mothers I interviewed.—K.O., *Nursing Student, Newark.*

HOUSING

Article 7–A is a "rent strike: law passed in 1965. It is the most effective means of getting slum dwellings repaired ever passed in New York. It provides that if specified conditions dangerous to life, health or safety exist for more than five days in an apartment building, then one-third of the tenants can sue to get an administrator appointed to collect the rents

and make the needed repairs from the rent money. The law is not a flawless piece of legislation. Among other things, it requires an architect's estimate of the cost of repairs be made at the expense of the tenants bringing the suit.

In connection with various community organizations, an extraordinary lawyer on the Lower East Side, Mr. Hanft, has brought about 75 article 7–A suits in the last year or two, and has had adverse decisions in only two, and in those two cases the repairs had been made by the time the decisions were made.

The law has received little publicity, and Mr. Hanft believes it has been downright censored in the press. For instance, on May 27, 1968, the *New York Times* wrote a long article on slum problems including tenant legal remedies, without mentioning article 7–A; the New York Post wrote a feature on a slum building in which Mr. Hanft had an article 7–A suit pending, and failed to mention that fact; when picket lines were organized to picket large department stores which advertise in these papers, the television stations refused to cover the story.—R.H., *Law Student, Brooklyn.*

We found that the Crown Heights Neighborhood Improvement Council was very quick to respond to our report of dangerous housing conditions. In one instance, they sent out an inspector the same night that the complaint was called in to them.

One of our complaints was at 1018 Park Place in the Crown Heights section of Brooklyn, where there was loose plaster falling from the walls and garbage and dead vermin in the alleyway between their building and the next. The pressure that was put on the landlord by our organization and the Crown Heights Improvement Council resulted in a new plaster and paint job for three apartments in the building, and a thorough cleaning of the alleyway.

We found the RESCU agency to be the most cooperative and productive of any of the organizations dealing with housing conditions. The role of this agency is to make emergency repairs in cases in which the conditions are so detrimental to the welfare of the occupants that these conditions cannot be allowed to continue for one more day. One of the flaws of the program is that certain conditions that could be disastrous to the health of the children are not deemed emergency repair. Despite the threat of lead poisoning, the presence of falling or loose plaster is not now considered a reason for emergency repair. Our studies on the incidence of lead poisoning from ingestion of loose plaster and paint have shown us that this condition leads to a sick and often critically ill child in too many cases.

Even though Project RESCU is a city agency that is part of the superagency, the Housing and Development Agency, it has managed to cut out a lot of the red tape that was formerly involved in getting needed housing repairs. It has shown many people that repairs can be done without having to go through the entire "mishmosh" of housing agencies and administrators, and it has gained the confidence of the community. This was clearly shown in the demonstration for RESCU in the fall of 1967, when the agency was threatened with a funding cutback: 1,500 people attended a rally on behalf of the agency.—D.Y., *Medical Student, Brooklyn.*

The "channels" we had expected to set up for the follow up on housing complaints discovered through our hospital social history are becoming bogged down in red tape. By trial and error, we have nearly reached the end of all the agencies who have passed the buck. The latest system for housing and health violations is to type up a resume of each case separately on a memo. One copy is sent to the Department of Buildings for the Borough of Brooklyn. A carbon is sent to the health commissioner. The third is kept for our files. A cover letter with the seven memo cases was sent out today to each agency. The question is now what to do if no answer to received.—M.H., *Sociology Student, Brooklyn.*

The real problem is housing. The community knows that housing is not only an urgent problem, but is also a central one; many other problems, particularly health, are dependent on it.

My first approach in handling housing problems in the Bronx was to work with each person individually; call the landlord about the tenants' complaints; help a tenant look for a new place, and so on. It's the wrong technique, but the right problem. One-to-one work is probably the only way of doing good patient advocacy, but it's not a productive technique for improving housing. Housing is much more directly a community problem than health is: all the tenants in a building are inherently a group with common problems.—K.B., *Medical Student, Bronx.*

I worked as a community organizer in a dilapidated apartment building on Monterey Avenue in the Bronx. After working as a patient advocate for four of the families in the building, I had decided that an effort should be made to confront the landlord and to make him pay for his negligence. We held two meetings, at which the tenants chose a captain and treasurer, and during which tenants' rights and violations were itemized. A lawyer was recommended to us by a representative of "Little City Hall," and the tenants decided to hire him. The treasurer was able to collect a $5 fee from nine of the 13 tenant families. During the last week of the project, an architect who works with the lawyer in a group called the 7–A Associates made a systematic inspection of eight of the worst apartments. Article 7–A specifies the following sequence of action:

(1) Landlord summoned to court for apartment violations. Specific repairs ordered.
(2) Landlord obtains one week adjournment, during which he must indicate specific progress on repairs orders.
(3) If these repairs are not initiated during a prescribed period, the building ownership is transferred to a court administrator and rent is payable only to this administrator.
(4) The landlord does not receive ownership back until major repairs requested are on the way to completion.

I intend to be present during the first court action in September. Arrangements have been made with a community organization for similar court actions to be taken against landlords in all the buildings on the same block of Monterey Avenue. These efforts may contribute more to the good health of the community than all of the screening, physicals, and referrals that could be made for this same neighborhood.—J.G., *Medical Student, Bronx.*

LEGAL SERVICES

Legal services are about as adequate as medical services. The Legal Aid Society is an establishment organization that will really fight like - - - - to get you a divorce but if you want to sue a landlord, look elsewhere. They do an excellent job on family problems. I don't want to downgrade the importance of this, but they by no means offer a full range of capable legal services. As far as the criminal division goes, they are a fine outfit if you are guilty. The criticism has been leveled that they plead everyone guilty. From my summer contacts with them, I believe this to be true. This problem is compounded by the fact that The Legal Aid Society is the only organization offering legal counsel on a wide base to persons involved in crimes.

The legal services provided by the NAACP are mostly (if not exclusively) for what they consider landmark cases. If you can't get into a trade union, they might take your case, but if you are a petty thief they won't. Most of the other organizations are interested in rendering aid in those cases that will bring publicity to the organization. If there are other legal services available, I am unaware of them. (which doesn't mean that they don't exist or that they haven't had much impact on the community).

As far as community attitudes about the quality of the legal care that they receive go, they are resigned. They have come not to expect it, so they don't miss it. They are unaware of the role of the lawyer and exactly what he can do for them. (In this respect, I don't think Harlem's attitudes differ from those of the lower economic groups across the country.)

The concrete legal services that the project rendered were limited by several factors: only two law students; lack of experience on the part of the law students; the very nature of law insofar as it takes a long period of time to

andle a case. In terms of people reached and ases handled, I would say that they come to bout a dozen. That, as far as I am concerned, disgraceful. It was so because the project as entirely unstructured for law students. I hink that it was an error to hire us without ny real idea of what we were going to be oing or of whether there was any real need or us in a project like this. The other big mis-ake was the assumption that law students vould, on their own, know what to do. Law chool has almost no relation to social prob-ems. They don't teach us about these things. (We knew that we didn't know, but the project lirectors didn't know that we didn't know.)

If it is within the goals of the SHP (and I'm not saying it should be), law students should be assigned to work with a lawyer in the community itself. Most of the good work is being done by private, non-funded lawyers. These guys are really doing some exciting things, but they are shorthanded. It would be to the benefit of the community to assign a law student with a lawyer like this. I don't know whether this would fit into the conception of SHP that its leaders have, but it would be more effective. —F.V., *Law Student, Harlem.*

AGENCIES

Harlem

It seems as though someone has finally begun to understand what is meant by community participation. The phrase used to mean that you'd have a black Ph.D. from Scarsdale on your planning board to approve of ideas from the "community" point of view. Well, yes, he was black.

But the Riverside Health Clinic in Manhattan is something different. The Department of Health, backed by St. Luke's Hospital, has set up this comprehensive health facility, working closely with a Community Health Council which actually is made up of people living in the neighborhood, people who will be the consumers of the health care.

Since the Clinic was to be funded by O.E.O., some sort of community participation was required in the planning of the facility. Often, though, community people involved in such programs are not truly representative, and therefore do not speak directly for the needs of the people. In setting up the Riverside Community Health Council, existing community action groups were contacted and each was asked to send a representative. This group then became the Health Council.

While this system of selection may not be perfect in that only those people already involved in community programs were eligible for the Council, use was being made of the people who would be using the facility. According to O.E.O. policy, the Community Council is not salaried. This is to insure against the position becoming one of status rather than of concern. (Funds were provided, however, for transportation, babysitting, or for time lost from the job while Council meetings were taking place.)

The Council meets on a biweekly basis. Its functions are concerned with the hiring of people to staff the health facility—making sure that people hired are from the community and representative of it. The Council also determines that people hired have the proper attitudes needed to work with the community.—J.A., *Medical Student, Harlem.*

Brooklyn

One of the main accomplishments of Project RESCU (a program set up by the City Housing and Development Agency to facilitate speedy repairs following complaints) has been to prove to the white power structure that the blacks can do much for themselves.

For example, the head of Bedford-Stuyvesant's RESCU is a black man who was raised in the area. He has much knowledge about the needs of his fellow blacks and can communicate with them. He is very responsive to the complaints that are filed with the agency. He is hindered by a lack of funds and by the lack of good investigators, especially black ones. There are, according to this man, not enough black inspectors. The connotation of the housing inspector is still one of disgust and mistrust in the community. When the people see a black man coming to inspect their homes and help them, they are more responsive and also filled with a sense of pride.—D.Y., *Medical Student, Brooklyn.*

I came to the conclusion that the basic problem with Youth In Action was lack of money. It seems that the Government has managed to give just enough for the middle-class Negroes to set up a bureaucracy; these funds, however, have not been sufficient to permit the bureaucracy to function.

The funding is on a year-to-year basis, thus causing a great deal of insecurity and a high turnover rate in the administration; and since the administration is constantly changing, good relationships with the regular staff never have a chance to materialize. Furthermore, a great number of the administrators and supervisors are members of the middle class, professionals who, for the most part, are more interested in using the programs to further their own personal careers than to eliminate poverty.

If the Federal Government would supply sufficient funds on a long-term basis, many of YIA's problems would cease to exist. It would seem that the Federal Government really isn't serious about eliminating poverty but is perpetrating an immense fraud.—R.J., *Medical Student, Brooklyn.*

I was struck by the immense bureaucracy that is Youth In Action, and by the apparently large gap between administrators and working staff. The workers, who are community people, make up for a lack of formal education with a great deal of understanding and ingenuity, and are on the whole impressive.—J.T., *Medical Student, Brooklyn.*

Some of the problems with the community antipoverty agencies is that they are in a sense competitive with each other for Federal funds. Year to year funding, common in many Federal programs, is a hindrance to good rapport between different local agencies. Agencies don't communicate to each other about programs they are conducting or applying for since they don't want to chance losing anything to the other agencies. An example of this in Brooklyn was seen when the Brownsville Community Council was, with our help, writing up a proposal for a narcotics center in Brownsville through the Model Cities Program. They wouldn't let a copy of the proposal out of sight for fear that Bedford-Stuyvesant might steal the idea.

Some degree of protective self-interest is reasonable, but it would seem that if each area had a certain amount of funds allocated for renewal, health care, new construction, etc., each year (or 5 years), there would be less competition, more sharing of ideas and perhaps even less Federal and local red tape. Each community would be assigned funds depending on their needs and local conditions. On the Federal level, fewer agencies with overlapping functions would be needed. Perhaps the existing Model Cities areas could be used as a start. Each local Model Cities office would know how much money was available to its area. The expenditure of these funds could be decided by a joint action of Model Cities and other existing community agencies in the particular area.

The Model Cities program has so far ignored existing community agencies in the area, and therefore any planning proposals drawn up were probably staff-oriented and not community-oriented, as decreed by the philosophy of the program. This could probably be remedied by hiring community people to staff the committees, thus eliminating meetings which end with "we'll have to find out more about that"; and it would give the community a real, not just apparent, say in the planning.

Much resentment exists because local antipoverty agencies feel that their funds will be cut due to the creation of this superagency, Model Cities. They also feel, and rightfully so, that all their work and planning is being ignored since this new agency's committees duplicate and have preference over their own committees (which seem to have more community experience). It seems that for any action to be taken these days much preliminary planning, studying and investigation is necessary. Many of the local agencies have been doing this for the last few years and now a new agency comes to do more planning, ignoring any previous studies of the area. It appears to many people that this is a way to make poverty programs ineffective: keep them financed as long as they are just studying the situation,

but once they start to do something about the status quo, give the funds to someone else so they can plan some more.—W.S., *Student Coordinator, Brooklyn.*

Newark

Our office was located in Area Board No. 2 of the United Community Corporation in Newark. Our relationship with the UCC proved to be detrimental to our services—patient advocacy and community organization and participation. Many community residents were skeptical, even bitter, about any organization that dealt with UCC, as it is known throughout the community that UCC is part of the degenerate political power structure that has a stranglehold on the Newark community. Any attempt of theirs to service the people would be viewed as a move to subjugate the community into the power structure. UCC has also been involved in a few scandals. When Newark had its riots and fires, UCC was designated as a distribution point for food, clothes, and furniture. Before anything was distributed, the staff of each area board took what they wanted. Working in Area Board No. 2 handicapped SHP because community people were reluctant to come to our office for services or organizational meetings.—D.B., *Community Worker, Newark.*

Bronx

During the summer, I worked with two community organizations in the Bronx: the Tremont Community Council and the St. Joseph's School Head Start program. The former organization is a summer, O.E.O.-funded group; the latter, a parochial school affiliated with the large and powerful Roman Catholic parish of St. Joseph's on Bathgate Avenue.

After attending one meeting of the Tremont Community Council early in the summer, and having become acquainted with several of its permanent members, I could only conclude that it was thoroughly infiltrated by nuns, priests, and policemen, and that its lay members were neither representatives of, nor interested in, basic efforts to confront and combat the causes of poverty, sickness, and crime in the neighborhood. The major preoccupations of the Tremont Community Council during this past summer appeared to center around the maintenance of a good self-image in the neighborhood. Attempts to achieve this included numerous block parties, parades, recreational outings, cleanup campaigns, visits by political and church leaders (including the Archbishop), and organization buttons.

The summer recreation program was run by a Vietnam war veteran who was biding his time until he could apply for a job in a Manhattan business. After some fruitless attempts to question the basic goals and motives of the Tremont Community Council, I decided to adopt a position of peaceful coexistence. The Council did, after all, provide four students, two community workers and three NYCs with office space, phone, and clerical facilities. The Tremont Community Council had been bought out by O.E.O. and the church; SHP members, in turn, were bought out by the Tremont Community Council. It was a cozy arrangement: a priest offering his buddy the cop a salami sandwich, while a Vietnam veteran shooed the pesty natives out of the storefront. SHP workers maintained, in true style, a conspiracy of silence.—J.G., *Medical Student, Bronx.*

Part 3: ROLES IN CONFLICT

INTRODUCTION

For a multitude of reasons, highlighted in the categories comprising this section of the report, the summer experience for most of the SHP participants was memorable more for its frustrating role conflicts (both real and imagined) rather than for any specific task accomplishment that may have occurred. There was little disagreement as to what needed to be done during the summer ("improve health care delivery") but agreement as to how best to achieve this highly desirable objective was never reached on any level of the project organization. Furthermore, approaches to a given problem suitable for one area or area subproject often turned out, because of basic differences in the communities and health care delivery systems involved, to be inappropriate or ineffective for other areas or area subprojects. Particularly where strong project leadership and firm preceptor arrangements did not exist, the necessity for modification of many of the original task proposals and the development of new subprojects throughout the summer required that SHP workers constantly re-evaluate and redefine their roles in the project.

The diversity of views in the excerpts that follow illustrate the resulting confusion and frustration experienced by project participants as they faced the realization of their limitations, lack of power, or failure to deal with the summer's various problems most effectively, ranging from broad questions of SHP/SHO philosophy versus SHP/SHO practices, to dealings with community groups, institutions, and agencies, to relations within the SHP "family" itself.

STUDENTS AS A FORCE FOR CHANGE

Why do many in SHO feel frustrated after summer projects? Why does our bickering seem endless and unproductive? We have not decided whom we should support, the medical schools or the community; we have tried to be all things to all men.

We have failed to respond to the real problems in health—the need for change in schools and health institutions. This summer, we did much that was stop-gap. We helped, as advocates and organizers, but these roles provided few innovations; they merely reformed bad situations in a hospital system which the community detests. We should have devoted our entire efforts to helping the community gain control of its hospitals and to helping community organizers challenge the inequities of the existing health establishment. But we were still trying to protect the health establishment, project our middle-class values, and preserve our image as a "liberal" organization.

We have chosen to "sensitize" ourselves, to educate health students. But we are still acting as "good" whites in the poor community. The problem, however, is not being educated at the expense of the community. This SHP was doomed from the beginning since it chose to be educational. It chose to cooperate with the health establishment, but failed to listen to the needs of the community. The community wanted people who would help it help itself to organize area health councils and who would give the community organizers ways they could challenge the long waits and poor care of the second-class hospitals. They wanted picket lines of sincere white students and the black community around these hospitals, if that would help the struggle. Eventually, SHO would have to realize that it must work for first-class health for all, not just for the rich. To do this, health students would have to take a position favoring community control. In failing to do this, we only served to further erode the pride and self-esteem of the poor.

What is SHP? SHP itself does not know. Our project lacked participatory democracy; we never met as a whole to decide upon anything. Prior to the project, we failed to build proper ties to the community, especially in the Bronx. Thus, in many instances, we did not have well-planned projects; they just fell together. I think SHO's leadership let a sinking boat flounder by not constantly re-evaluating the project and by not providing for direct participation, or even revolt in the ranks. In essence, we did not learn from the failures of previous SHPs and we were doomed to repeat them.

The thing which haunted me most during the summer was an expression from the French student revolt this May: "The walls have ears and your ears have walls." I wanted to help the Bronx community I worked in, but I also wanted to listen to them. But people wanted action and results. They were tired of more white faces. In the inquisitorial darkness of their eyes, I could sense the deep resentment my skin had aroused. The community was not a wall. It did respond to sincerity, but it wanted its own leaders. Advocacy, or doing things for the community, would solve nothing; helping the community's leadership would. I laid some groundwork for a community health council, but much of my work organizing tenants to protest a garbage pile in their courtyard, and poor housing conditions, did little for the whole community.

I think the experience did much for me. I have a clearer idea of what the blacks want and what I need to do to help re-educate whites; white students must become more militant in their own communities.

Student power is desperately needed in the health schools. We must begin to build a base within our own society to attack what it has been doing to the black and white communities, in hospitals and in teaching institutions. Students should begin to fight for: (1) A student veto in all areas of student life and studies; (2) student-faculty control of school decisions; (3) more social orientation of courses; (4) more responsibility of schools and hospitals to the community; and (5) a militant SHO, dedicated to community control, which would bring needed information about health institutions and their politics to community groups interested in health care, and which would actively fight for sweeping changes in health schools. Health professionals of the future must begin to face the realities of our society now, and should begin to force changes by militant resolute actions.—R.C., *Medical Student, Bronx.*

Before one can relate to a "task" it is necessary to develop an idea of what the "task" is. The SHP leadership has not clearly defined the SHP "task." At the beginning of the summer there was talk about sensitization, and in the outline for the final report they ask "how the people in your community feel" or "evaluate the concrete service you provided." It is too bad they were not able to develop their leadership beyond scurrying about trying to get people to do their individual tasks. It is even a greater pity that they were not able to think beyond a "task" to be performed or a contract to fulfill to the point where they quickly lost the moral leadership of SHP and never gained the conceptual leadership which they had the potential to attain.

What are the conceptual goals which should guide one's efforts? Perhaps they should be to educate doctors and students to the medical, social and political aspects of health problems—why they exist and what can be done to correct them on a long term, fundamental basis. The question is not, how many will return, but, how can the health system from the national to the city level be changed for all people so that communities are not dependent on a few white doctors who are kind enough to return to work in patchwork, pilot project clinics.

The orientation to the type of education is key—it should be intensely political. Change in health system, and the people who rule them, will only be achieved through political action. The A.M.A. has effectively known this for years. Task-oriented service projects or paying the salary of NYCs to "sensitize" white medical students to black people gives a minimal political orientation. The overall tone of the New York SHP has been intensely a political.

It is difficult to decide what makes medical

people political. The present approach of government funds for service projects and sensitization is not the answer. That a national SHO convention is afraid to come out strongly (or at all) against the war in Vietnam or that the SHP is organized around fulfilling Government contracts retards meaningful political activity. Students must obtain a degree of autonomy from their medical school faculties before they can even begin. One approach which the Columbia SHO is planning to take is to build a hard core of politically active students and doctors to start with, and to attempt to slowly build from this. We hope to extend our base to other medical professions and perhaps to form some communication with the hospital unions eventually. This will be attempted through the continuation of the Liberation School "Politics of Health" classes at Columbia's College of Physicians and Surgeons, meetings of the coalition of community doctors, house staff, and medical students at Harlem Hospital, and through the involvement of these people in political actions on health issues at all levels. This blend of education and political action is something which can be pursued on a year-round basis without costing money.

If medical people are asked to work on a volunteer basis, they will begin to develop ways of handling the medical responsibilities of being politically active doctors; once they are professionals, they can then fall back on these approaches with confidence. Because this approach does not involve money, instead of wasting nine months of effort gaining grant money and then three months of "activity", leaders could spend the whole year actively working politically.—K.C., *Medical Student, Harlem.*

A question with which we all have to wrestle: do I serve each suffering individual on a person-to-person basis and reach only a few of the many needing assistance, or do I direct my energies at solving broader problems which could benefit the greatest number of persons? To my view, where medical politics are concerned, there just isn't time to split one's attention and energies between medical practice (for example, service projects) and medical politics, and still be effective in both areas, at least, not this early in the game when our competence in either of these areas is so limited. We can no longer afford to keep winning the small skirmishes (for example, patient advocacy) while losing the war (for example, little or no change in the health care delivery institutions with which we worked this summer). —W.S. *Medical Student, Harlem.*

Because I have not succeeded in making many grievances known to the people who *control* the health care delivery system, I feel the project should be organized to put pressure where it is needed. Perhaps SHP should not be funded if it is not going to provide a systematic means of working within the system to exert pressure. Stop-gap measures will not suffice to appease the frustrations of the patients attended to by the student, and SHP will lose all meaning to the community if it accepts in practice the wrongs of the present health delivery system.—R.F., *Medical Student, Bronx.*

The lack of sophistication of some of the leadership and most of the fellows—I include myself—in the SHP is a principal issue. I suspect all of us learned this summer, but I question whether, other than sensitizing ourselves to community health needs so we might be more effective in the distant future, we accomplished very much. For that I do not think the structure of people of SHP, or the communities with which we worked, are at fault. We are not capable of implementing vast changes in health care in poverty areas. People suffer from poor health not only because the city hospital system does not meet their needs; not only because the average physician is self-seeking; not only because the average medical school is more concerned about research than people; they suffer because their children eat lead paint off the walls; because their apartments are inadequately heated in winter and too warm in the summer, and overcrowded in winter and summer. SHP might cause a landlord to repair an apartment, but in one summer SHP is not going to begin to attack the causes of poor health in poverty areas. We are unsophisticated and we are not revolutionaries; we work within an establishment. We

may serve to improve that establishment with what we have learned this summer. With the structure of SHP as it now is, we probably will not contribute to revolution, but only to evolution.

How can we become revolutionary in our actions as well as in our words? We would have to begin accepting more sophisticated people into SHPs. People who were not idealistic the way we were. People not afraid to offend the health establishment. People unwilling to fit into existing community organizations, if those organizations might have goals with which we disagree. People willing to accept a subsistence wage for the summer, to live in the community with the people, to work with them day and night. Most people accepted into the SHP were not like this. For the most part, they were socially concious but not dedicated, concerned but not committed.—J.W., *Medical Student, Lower East Side.*

There was little threat to the Establishment made this summer. This, of course, brings up the question that SHO has been struggling with for as long as I've been associated with it, and from what I can tell from the literature, from its inception. It is the same question that caused two New York SHO leaders to resign before the summer began. Is the SHP to concern itself with political issues, or is it a service and educationally-oriented organization? I believe that any local SHP is doomed to failure unless the students and community people are in agreement on this question. One of our major problems was that even the students could not agree among themselves as to purpose. Those of us who had been working and preparing for the project during the year had difficulty understanding and were angered by the lack of commitment displayed by some of the people who came in June. They, in turn, were angered by our attitude, which at times must have seemed more dogmatic than rational. It was never really stated, either in the application or at orientation, that the SHP wasn't "just a job," and that people who weren't really willing to commit themselves were not wanted. For that reason, it was wrong of some of us to expect (and often to demand) commitment. I never understood the rationale that gave lowest priority in the selection of students for this year to people who had previous SHP experience. If students are willing to come back after one summer's experience, they must be committed.—J.P., *Medical Student, Lower East Side.*

I was confused about the role of SHP in general. It was not clear to me whether it was supposed to be a service project or a political project for better health care. As a result, I did not know which way to go. There was a lack of communication in the local Newark project as to which direction everyone was headed; everyone seemed to be doing his own thing. So it turned out that I acted mainly in the service role because it is too difficult to make any attack on organization without cooperative support. When any movements on the administration of the hospital were planned, I think medical students became fearful of being thrown out of medical school.—L.D., *Nursing Student, Newark.*

Turning to the cold, hard facts, how do we assist in providing good medical care for the most people? This, I feel, is almost an impossibility for students. We do not have the knowledge or power to provoke the radical changes that are drastically needed. The whole philosophy of doctors and nurses, must be analyzed and evaluated, and this is a task that must be accomplished individually by every person who enters these professions and is responsible for the quality of care they give. In one's mind, there must be no distinction between race, creed, or nationality, but each must be treated as an important person, "my patient," and I must do my best to assist "my patient" with his every need—physical, psychological, socio-economic, etc. Our job is not finished when we have handled the priorities, such as medications, yet patients are damn lucky if they get even their immediate utmost needs attended to. I think we can talk and talk about how an individual may assist in providing better care, but we had better ask just what everyone else is doing—including the people in influential positions—to change health care delivery systems.—P.B., *Nursing Student, Bronx.*

I see the role for next summer's SHP as * * * working directly to change institutions. The latter, I know from last summer's experience, is extremely difficult to do. I think it is a necessary step for SHO to take if it wants to provide any other service than bandaging a festering wound. Changing an institution is a slow process, and student fellows should realize this, but not let this realization discourage them. To illustrate how difficult change is one just has to ask the chiefs of each service. If the chief has been on a service for any length of time, and if he has just a little sensitivity, he will tell you exactly what is wrong with his service. Ignorance isn't the reason. This doesn't mean that fresh eyes and uncluttered minds will not bring about new ideas for change.

Changing the institution is directly involved with what the community asks of us. The community feels that if we have no power to change, then why are we offering to help. This statement was made during Orientation. Alone it is hard for the community to change a system, but united with the forces of people who will someday be a part of the system, it should be possible to start changes.

I think the project should strongly emphasize being of service to the community. Unfortunately, medical schools have a bad reputation of taking from the community without giving anything in return. Medical and nursing students study the ghetto so they can better treat poor people. What do they do to change the conditions that cause ghettos? What good is it to know that poor housing adversely influences health if no effort is going to be made to change these conditions? The same applies to the realization that city hospitals give poor care. This has been known for a long time, but the situation still remains. I believe that with education comes the responsibility to make use of new ideas and information. If the responsibility was taken there would be no conflict on the issue of who was benefiting from SHP, because both the student and the community would benefit.

I think that, as health professionals to-be, we should be concerned with prevention. Cleansing a cut and bandaging it promotes healing, but it doesn't remove the glass from the streets to prevent further cuts.—V.V., *Nursing Student, Bronx.*

I don't know anything about heart, stroke, or cancer, and I don't know anything about the enabling legislation behind regional medical planning, but if we're interested in future funding we might look at SHO under two lights; first, enviormental health; second, community participation.

If the people in the Division of Regional Medical Programs are serious about good health, they've also got to be serious about environmental health. They've got to care about good housing, safe streets, good transportation, and decent incomes. At this stage, they're probably not committed enough to stake anything on those goals; but they may be willing to keep us tootling along for a few summers. At the very least, we can keep reminding them that they can't set up routines for testing and treating people without knowing how their patients live. We could feed them ideas on how to make their programs accessible, acceptable; we could point out things they should study, such as the particular stresses of poverty and their relation to heart disease. Somebody has got to remind them that good ambulance service and good telephone service is as important to the proper care of patients as a good surgical suite. I think SHO can act as a source of new ideas in environmental health; and act as a small force fighting for good housing and decent living standards.

Community participation can tie RMP to SHO. Project fellows—students and particularly community people—are better able to identify the people and groups that RMP should be in contact with to set up local committees.

As far as I can tell, RMP has no access to the community. SHO can't honestly function as that entree, but it can steer RMP towards the right people. And SHO can keep lines of communication going both ways by telling RMP who to contact and by telling the community that RMP is moving in.—K.B., *Medical Student, Bronx.*

Outside of the community, SHP can play a very important role. One of their major tasks should be to work within the medical and other professional schools to change the curriculum and to get more ghetto youth admitted to these schools. Since the students are part of these schools, they can have a strong voice and exert pressure for change.—K.D., *Medical Student, Lower East Side.*

The white medical student must go back to his own area and make vital changes come about. He must work to get more blacks involved in the health sciences and in community health. One way to do this would be to get medical schools to admit more black students and to start programs to get black students interested in going to medical school. Medical schools are going to have to make a special effort to seek out qualified blacks and encourage them to enter the health sciences.—D.Y., *Medical Student, Brooklyn.*

INTERVIEW

Q: What direction do you think SHP should take. Should it continue to try to educate the medical student to the needs of the community or try to help the community? Or should students focus on working through their schools?

A: It was a good sensitization experience for me, but there's a limit on how much you need. You could supplement this experience by having medical students work through the medical schools trying to get them to change their orientation. We're going to continue SHO into the year, working through our Community Medicine department. We tried this summer to revolutionize from the inside, and really didn't do it. This is the question to consider: whether we can do more from within the white middle-class structure as concerned medical students. I think continuing SHPs would be good here, but they would have to be restructured; there have to be different guidelines. Something has to keep going during the summer, whether through SHPs or the medical school. It's going to be the same people anyway. But if it does come through the medical school, right now is the wrong time because medical schools are too reactionary to be objective. * * *

REPORT

I proposed an elaborate freshmen orientation scheme with a flyer, talks at orientation about the SHO project and community medicine, a siminar program with many of the parties involved during the summer, and a continued advocacy program. Through a variety of intimidating tactics, my efforts (and those of a number of others) were squashed. Our first flyer, dangerously honest and filled with what the administration considered half-truths, was not approved. We revamped the flyer and sent it to the incoming frosh, along with a bibliography of books about the community they will enter. The administration has refused to give us time at orientation because they doubt our credibility and demand a sponsor and acceptance by the medical school's student council. This is hardly feasible because the council won't be meeting for another month or so, and the administration thinks we have been "put off." Hardly! The community medicine department likes our ideas and will integrate a tour of Newark for entering freshmen into the biostatistics curriculum. It now depends on our organizing the means for this program. The seminars must be planned and the structure for an advocacy program developed. What we have proposed is student-family advocacy, some emergency room advocacy, and community doctor-student interaction. Much of this will depend on the support of incoming freshmen.—P.D., *Medical Student, Newark.*

To go out and try to be a revolutionary group cannot be done through an organization like SHP. These people who are going to try to take over the Health Department, who are going to go down there and force change, that's okay, but that's a different group of people, not us. If we did that we'd antagonize people and it would be detrimental to our using certain facilities.

If someone were to tell me that we shouldn't have an office on Springfield Avenue in Newark, and maybe we should work in the hospital, I'd really want to know why. I understand in a basic way the concept of black power, where a group of people has to get to a certain level of power to meet the white money estab-

lishment on equal economic and psychological grounds. I don't think the SHPs are keeping anyone down; I think we are helping the NYCs and some of the little kids around here, talking to them, also assisting the people through the advocacy program. Anyone who says that we shouldn't come in is hung up in his own thing which doesn't seem to be relevant to what we're doing. We're not putting ourselves in a position of power, we're putting ourselves in a position of asking the community, "What do you want us to do?"—D.T, *Student Coordinator, Newark.*

The community-oriented projects were more successful in educating student fellows, but they weren't as successful in getting things done. A lot of the time we got wrapped up in the bureaucracy of these different agencies, and that shortens your summer greatly. * * *

If the students were more radical * * * you would get a lot less done. You would make a lot more noise and you would get a lot more of the hospitals and medical schools angry with you. * * * I think in our situation the best thing is to get something done by working with these people. In a place like Newark where they get nowhere with the administration, you can't work within the existing structure because they won't hear you, so maybe there you have to become more radical. It probably depends on each situation.

I think the health system as it is today has to be changed, but when people talk about revolution, about scrapping the system and making a new system, I don't know. There has to be a radical change and maybe a revolutionary change, but it has to come through what exists. —W.S., *Student Coordinator, Brooklyn.*

I perfectly agree with attempting to reorganize the entrenched, oppressing superstructures in America that are the source of so much agony. However, I think it is a mistake to ignore the immediate stopgap measures, especially if one is involved in the delivery of health services. I think that the above two are not mutually exclusive and it would be wrong to focus on one to the exclusion of the other.—B.F., *Medical Student, Brooklyn.*

After the initial phase of orientation to Martland Medical Center, I limited myself to working with individuals of the Newark community who had some specific health problem, attempting to procure good medical care for them and, through this, to effect some changes for better health care in general. This led to constructive criticism of and suggestions for the facilities I came in contact with such as clinics, social service and welfare. I found my suggestions usually received with much hostility and also a sense of hopelessness. But I found most health and social service professionals agreed that the city of Newark must improve existing health and social services, as well as create better facilities. Unfortunately, by the time this relationship of trust and mutual concern for the community was developed, it was time for me to write this report and leave. In actuality, nothing was accomplished. —K.S., *Nursing Student, Newark.*

* * * I go to Columbia Liberation School to the seminar on hospitals to hear the "radicals" hold forth. I describe the suit (against the city hospitals) and ask for assistance on a future suit against Harlem Hospital to obtain better health care for the community. I am stunned by the apparent indifference and even hostility of the group, and come away very troubled.—R.H., *Law Student, Brooklyn.*

Too many times during the course of this summer I have seen highly idealistic and well-motivated SHP workers try to attack too large a problem (example, the poor health care given by City Hospital). Frustrated in their attempts to accomplish anything tangible, their energy becomes channeled into hypercriticism. Eventually, this criticism leads to antagonism and ill will, and the SHP worker gets discouraged, throws up his hands and quits.—B.W., *Medical Student, Newark.*

Unfortunately, I and many other student fellows came to the project with the psychological orientation that something could be done about the political problems through our service activities. As the summer progressed, it became obvious that a different focus is required. Getting out of my psychological "set"

and into another bag proved to be difficult and frustrating, since little can really be accomplished by individuals in the area of political activism, especially twenty or so students, without any power base, attempting political activism directed at intransigent health establishment professionals.—W.S., *Medical Student, Harlem.*

THE STUDENT HEALTH PROJECT AND THE COMMUNITY

INTERVIEW

In terms of basic directions for SHP in the future, and one of the limitations of this summer's project, it seemed to some of us residents in the community who're struggling with the basic problems of inadequate care, could be giving more attention to developing substantive positions on how better care could be developed. We feel that even while students are involved with problems of personal practices and intergroup relations * * * for example how they can relate to other groups such as the Neighborhood Youth Corps—they still have a basic responsibility to think about the problems of institutional change, taking resolutions and making their positions known, thinking through these things.

* * * Different communities are at different stages of evolution. On the Lower East Side, where there's already some substantial community control, you have a different situation than in a totally unorganized community, where the basic leadership which is there has to be discovered and put together in a coalition. I was surprised to find that (some of the community people at the final conference) did not know anything about hospital affiliations programs and who's controlling the development of care in their own areas, because all summer long there has been no discussion of this. I think that if the students, who really do have substantive knowledge or can get it in a hurry, don't make this knowledge available to community residents, they're losing a very great opportunity to do the very things they say they believe in.

One of the problems in an organized community is the danger of subverting the community leaders who are already in operation. We had one subcommittee which perhaps would have functioned better if there wasn't such a temptation to let the students do the work. They were very helpful, but I think that the community resident who was the chairman of the committee would have felt more of a responsibility to draw together Puerto Rican and Negro neighbors on that committee, if those four students hadn't been there functioning as a good substitute. In a less organized community, if there's a vacuum, then you can put together your leadership—whether it's chairmen of social clubs or ministers of churchs; put together a coalition and talk to them. This argument that "we don't know who the community is, so we can't talk to anybody," doesn't go, because you could put together a coalition of who it is.

* * * The basic maturity level of students varies. Some of them are very happy to play a neighborly role, to help someone do something. There are others whose need for a role is so great that they have to go in and do it for them. It might be that communities ought to develop screening processes and use certain kinds of students in certain projects. Some students might be more ready than others for a highly confidential or difficult community strategic problem. You wouldn't want to talk about those things to students who are toddling when it comes to being able to relate in a comfortable way to community people. Maybe we could develop programs for students which are basically immersement programs. In other words, maybe there could be a subcommittee of some community organization concerned with just taking students around, showing them what misery is, and how people are struggling. That way they could get a first-hand understanding of why things need to be changed.

I think there's a line between commitment and accomplishment; it's something we haven't given enough thought to. Just because a student is committed and deeply concerned about giving better health care doesn't mean he's going to be able to use his time in a way that's going to accomplish that. Then there's the question of how to hook that concern up to an awareness of the constrictions of the medical systems: the medical power structure, the

questions of State policy and city policy, and the planning mechanisms, and how these things to which we had very little access as a community were impinging upon us. In what way were the students addressing themselves to this? In order to understand that, the students, perhaps, would have to go from an immersement experience in the community into a seminar, the kind that Robb Burlage runs. Frankly, the students have a lot of power, within the medical institutions and on a policy level, if they want to put their energy in that direction.

* * * Perhaps if their contributions in communities were judged programmatically necessary, then let those students be funded, but let's not just pay them to come in and sit down and decide what they want to do. I think if you're really trying to develop deep contact between community people and middle-class people, you don't do it by putting a glob of people down in a storefront and letting them be there from nine-to-five. You do it by placing individuals carefully into situations where they get involved in family life and become aware, in a visceral way, of what life is, as in the Peace Corps and American Friends Service programs. * * *

We have to be humble about trying new models. We ought to experiment and if one thing doesn't work let's try another. I think you have a beautiful element here among these students who are dedicated, and they ought to have an opportunity to do something basic, whether or not they can bring the rest of their structure along with them. Two or three are going to live in the community now. Of course, the Lower East Side is a neat place to live, and I think a lot of people come because of that, but as they become community residents they may play a completely different role.—S.D., *Community Worker, Lower East Side.*

I believe that there is no place for an SHP on the Lower East Side next summer unless the students maintain a continuing relationship with the community. This means that the projects started must not be dropped during the rest of the year. The community is justifiably cynical about "outsiders" who come in and experiment on them and then leave when their interest flags. I don't even think it is our decision as to whether we have succeeded or failed. If we leave while they are still willing to accept, or tolerate, our presence we are being destructive by once again reinforcing their cynicism about outsiders. From what I've seen, the community people are honest rather than polite, and will tell us to get the hell out when they want us to go.—J.P., *Medical Student, Lower East Side.*

Though we did accomplish some things in the Harlem area, I hope that there is a more efficient way to spend the fifteen to twenty thousand dollars that went into just the salaries for the project personnel. I am not at all sure that we were justified in, first, going into their community as we did, without an invitation, and then in leaving after doing our 10-week thing. True, we have left some permanent accomplishments, but they are really the results of the work of a very few people who had been working independently of SHP before the summer and who will continue to do so after the summer. There were just too many people getting too much money to accomplish what, for the most part, amounted to little more than a temporary and insignificant service for the community and a sensitizing experience for themselves.—S.G., *Medical Student, Harlem.*

We are surprised to find kindness and concern for us among these people in Harlem who seemingly do not care about anything. On the other hand, there is no way for the members of the project to become acquainted with the community as a whole, and so the work that can be accomplished is small. We remain outsiders who come and go, like the summer.—A.G., *Nursing Student, Harlem.*

One main complaint I have is that our project should have been more involved with community groups or institutions. In that way, our presence would have become known to the people of Harlem and there would have been less of an aura of "here's a bunch of college kids coming in for the summer." I don't know if the community was aware enough of our existence

to have felt this way, but individuals in the group were self-conscious lest this be the appearance we present.—M.I., *Psychology Student, Harlem.*

When I began work in this project, I knew nothing about SHP. I knew that I was supposed to be a liaison between the project students and the community. I became more. I did everything from house-calling on unwed mothers to cleaning and removing garbage at the project office in the South Bronx.

In the beginning, I merely performed my duties—appointed and volunteered—without much thought to the reasons for being of this project. Then I began to think. I questioned; I was answered; I was disgusted.

According to the project fellows and SHO literature, the main goal was "sensitization" of white, middle-class, medical students. A perfectly rational idea—from the white medical student's viewpoint. But from the moral point of view, this is an horrendous injustice to the community! How can SHP invade a ghetto (to "help," of course) with an army of white medical students, and for ten weeks perform acts of charity and fellowship, but simultaneously have the anguish of the ghetto as a secondary reason for justifying the existence of SHP?

The makeup and foundation of SHP must be changed. In fact, it had better be changed, or it will get kicked from one ghetto to another until there are no ghettos left. (And then its only alternative will be Scarsdale and similar communities.)

SHO must have total commitment to the community, but not a paternal commitment. It must help train black, Puetro Rican and all minority groups to help their brothers and sisters in a meaningful manner. By meaningful, I mean meaningful from the community point of view, not the interpretation of the community point of view by the white medical students.—C.R., *Community Worker, Bronx.*

The health care in my community is very poor. It's the worst possible care anyone could get. This is why people stay away from the hospital until the last minute. Having students come in the summer is not helping. The number of people reached by SHPs this summer does not cover a third of the people who are in need of help. It's a waste of time for everyone. You have students who think they have done a great job, but it's because they filled their own need to "help poor people."—M.H., *Community Worker, Bronx.*

The main goal of the Student Health Project is to help the people of the community. At first, people were reluctant to accept any outside assistance, but gradually they began to realize that sooner or later they would need someone to help them, and they began to assimilate with the so-called "foreigners." Now, at the end of the summer, when things are really getting on their feet, everyone is packing his bag and saying "goodbye." Once again, the community is hit with the hard truth—no one really cares.—C.B., *NYC, Bronx.*

Ideally, I think a project such as this one should strive to make itself obsolete; the goal should be to help the people become more interested and show them how to gain more power to solve those problems which continually afflict their daily lives.—I.B., *Medical Student, Bronx.*

It is just that you have to decide what SHO is out to do. If it is to educate students, then the community is a good place, but if it is to help the community then maybe there are better places than out with community groups.—W.S., *Student Coordinator, Brooklyn.*

WHITE STUDENTS IN BLACK COMMUNITIES

SHAWANGA WORKSHOP: THE ROLE OF THE WHITE STUDENT IN THE BLACK COMMUNITY.

Position Papers Presented By Willard Finderson, Leslie Clarke, Mrs. Altanese Maxwell, and Peter Dorsen (Moderator).

I believe that there is a place for white students in a non-white community to a certain extent, but just because you're in the medical profession does not mean that you don't need NYCs to serve as your contact to the community. If you were to go out into the community and try to run your program by yourselves, you'd be rejected. Someone was saying yester-

day that he would like to run the show himself, but for too long we've been dependent on the whites to tell us about ourselves. For instance, whites run the school system for us, and this means that our children learn about themselves through whites, and that shouldn't be. We should have our own school systems, our own television and radio stations, things like that. This way we can express ourselves, we can tell our children about themselves without the help of whites who distort history.

As far as having a lot of white students come into nonwhite communities, they do no help. They should go to their own communities and express to their own people how we feel. It's easier for you to talk to your own people. Of course, you have to come here to find out what it's like for yourself, but it's very difficult for you to tell me how I should live. The nonwhite community needs help from just about everybody. I'm just trying to say you can't come into this community and say you're going to do it on your own, because you can't. If you want to help, you can go back to your own community and express how we feel and what we need. We should let you know what we need, and this way you can try to open the eyes of your brothers and sisters, and maybe we can get along together in this world.—W.F., *NYC, Brooklyn.*

At the beginning of the summer, I raised a big stink about why a white student would want to come into a black community. I said if they want to help the black cause so much they ought to give their own communities the word. Now it is the end of the summer, and I'm going to reverse my previous position.

This has come about by much experience, much thought, and a little bit of ink on paper. The place of the white student, if he is sincere, is in the black community doing what he knows best. There is no way of knowing if a student is sincere, that is up to him. In my experience this summer, the black man did nothing but b.s. Once they got a title and $20,000 a year, the black bourgeoise in all the top positions forgot their roots. Give a black man that title and his money and you don't see him anymore. The white students I worked with seemed a bit more dedicated to what they were doing. I don't care if you call me Uncle Tom or traitor or any other such names, my first concern is with the welfare of my people. What I want is black sincerity, and whether you be black or white you can have that. I saw dedicated black students this summer and I also saw the other ones. I'm not saying there are not white students who b.s. I just didn't come across any this summer. For this reason I don't care who comes into the community, any color, as long as he is sincere—black sincere. I noticed that all some of the militants did was call for "Black Power;" they didn't do anything.—L.C., *Nursing Student, Brooklyn.*

The bias of this report is that of a white, middle class medical student. Perhaps as a representative of this group, I derived a lot more from Newark's Central Ward than I could contribute. My skills were certainly limited, and my credibility often questioned. I definitely could be of better service as a physician, as a lawyer, as a nurse, for example, once my training was completed, if I were assigned to a specific task. And particularly, I think, if the period of time in which I was involved in the community was longer. But again, I think this period of sensitization, and perhaps even the small amount I did accomplish, was important for what I might be able to give later to medicine and to the community. Perhaps also our impatience, because we were only working for ten weeks, was quite important because we were more demanding of change and cutting red tape.

On the one hand, the student already has elementary knowledge of his profession and his skills, so that he can be a liaison for those less informed about what quality of health care they should be getting—what is adequate, and what their rights are in terms of health care. I think the white medical student could get the ball rolling, as we did in many cases this summer. But I think it's up to community health councils staffed with community personnel to replace him. This suggests, I think, a definitely political approach.

I also think it's awfully important that the "volunteers" continue into the winter if they

only time my kids will get a chance to get something better is if a group of white people get together and say, okay, we're going to do this for you.

Are you suggesting that we do not have a place, that we're making a mistake by coming in?

Right, you do not have a place! Besides, and this has been getting me angry all summer you've been getting involved in personal, deep problems, and all you can really do is go to Welfare with them, or take them to the hospital, and then you've got a file of everybody's personal sex life and everything like that, and then you leave. I don't believe that your mind is so together that you're not going to discuss these things that you're not going to have an idea of "this is how they live" kind of thing. I really believe that this plays in your mind after you leave. There were very few white students this summer who didn't have that typical attitude—maybe they can't help it. But you don't understand how the system has made us this way—you just say, well, this follows up with things I have been taught all my life, and this makes you feel superior. * * *

Can I put it to you and ask, why are you here with us now if you don't believe in it. * * *

I'm angry at myself the whole summer, because someone told me, I think you'll like this job because you're outgoing and you sincerely have a feeling for people, and you might really enjoy doing this kind of work. When I went to orientation I got an impression that a lot of things were going to be done for my people. I resented the idea that white people would have to be there to keep doing it, damn it; but all right, I thought there was still going to be something done. And then all of the things you said you weren't going to do, such as, you weren't coming in with microscopes, and you weren't going to write books, and stuff like that. You came in and started doing the same damn things you said you weren't going to do. And that made me disgusted * * * that made me a part of your sneaky, underhanded way of getting what you want. I think the only ones who got anything out of this were the students who maybe will get a credit in school, or the "education" of working in the community. I'm very ashamed of myself, and very disgusted with myself, and I would never, ever get into anything like this again * * *

Whenever anybody from SHP took somebody to the hospital, they got better care that day, but the day that you couldn't be there to take them, they got the run-around, they got the same old thing. SHP isn't going to be here all the time, I don't think. What's going to happen after SHP is gone?

If SHP was able to get a few people in, was able to get services for them, I think that when SHP moves out, these people will get so angry, they will get together and try to organize in the way in which SHP tried to get them service. So SHP, I feel, did something, even if * * * only to get them angry. They're going to be angry if they can't get it any more, so I think we did something.

I think it's ridiculous to assume that every white man that comes into the black community is there just to take advantage of the people, is there not to give anthing, just to be do-gooders. I think many students that went into the black communities this summer really were interested and wanted to change the situation of the people. We have our hangups in the white community, but I think the blacks have too—the fact that some black people distrust all white people, this is something that's wrong with our society. We're heading towards an all-black and an all-white society. This is terrible. If we're going to stay out of the black community, all you're going to head for is two separate communities. The fact that white people give a damn about what's going on in the black community is a very good thing, and I do think we have something to offer; I think some people really care about what goes on and can go into a black community and ask people, "how would you like us to help?" and then do for these people exactly what they want us to do. I think this is performing a service, and I think the white person does have such a place in the black community. And you say it would be better if we had black students going into the community, but we don't have them now. What are we going to do, wait around for 10 to 20 years until they come?

are accepted in the community. I'm thinking in terms of the structure of the welfare rights program where there are outsiders present, but community people must administer and pursue claims themselves.

I think it really should depend on the local climate of the particular area, as to just how much a student does become involved. On the one hand, he can live, work, and sleep in the area as VISTA workers do, or he can merely work out of a storefront and return to his white middle-class neighborhood for reasons of safety or convenience. He can also choose to work in an emergency room or agency and never enter certain parts of the community.

Certainly, the community is cynical about 10-week do-gooders. It is cynical about questionnaire makers and posters. It is cynical about photographers and bookwriters who many times catch the people's misery on their films or in their books, which only supports the distortion whites already may have. I think the question is: Is this worth the time, effort, and money involved?—P.D., *Medical Student, Newark.*

The students working with the community during the summer in the Harlem project were very helpful and they really worked very hard in our community to help our children and to serve their health needs. They seemed so dedicated. If there was any question we workers wanted answered, or whatever systems and medical terms needed explaining they did it. I think their being here was great as long as they provide a service to help the community to do what was needed. And if they didn't reach but ten children and did a very good thing for those children, then they belong. And that goes for all white students. I think more of this work should be done, but not on the basis of color, or what the community is, or whether you belong. You belong wherever there is a need for dedicated people.—A.M., *Community Worker, Harlem.*

Open Discussion

I was just wondering if WF's argument could be a counterattack, because you feel the NYCs have been attacked so far. I worked in Harlem, and I worked for a few weeks with another white student. We didn't have any NYC's with us and we were accepted in Harlem. We got a few wisecracks, sure, but that was minor. We had health services to give to these people and we went out and gave it to them. Just because we were white they didn't refuse help; they wanted it.

Do you think if there had been just black students, do you think they'd have been more effective?

I don't know, it just worked out in Harlem. I don't know the situation in Brooklyn.

I think as a community person, you can identify more with a black student than a white student. Of course, if you have some services to offer, the people would be stupid if they didn't take advantage of it. I'm just saying they're more inclined to accept a black person than a white. They'll still accept the services, but in different degrees.

I worked in the South Bronx area, and I got a chance to talk to a lot of the people. In my community, you always see white people picking up our kids; you see white people taking our kids to camp; you see white people teaching them during the winter months. Why can't we have black people being taught to do these kind of things?

A person who needs help isn't going to say, "I'm not going to accept it because he's white"; a person won't do that. But we get the feeling that we always have to be led by whites, whites have to take us to the hospital, etc. I really reject this thing of patient advocacy. All right, it's one thing for me as a black person (although I feel kind of uncomfortable) taking a 60-or 70-year-old woman to the hospital just like she's a baby but for a white person to do it makes them feel a continual dependence on whites. I've even met some black people who would rather a white student would do something for them than a black student. You know why? Because white society has taught them, "don't trust your own kind of people"; it's a sick thing that they would prefer to be taken by a white student. * * * You're not letting them grow, you're keeping them down by constantly coming in and leading them.

I don't want you coming in to take my kids to the park, or on hikes. It would seem that the

The thing about black self-esteem, and taking something away from a black person by being white and having to do something for them, that's really beautifully expressed in Carmichael and Hamilton's book, *Black Power and the Politics of Liberation.* It's really a very good document on this. To get to the things you were talking about, how would you restructure SHO, so that it would do what is the most important thing, to train community people to do what medical students think they can do. I think SHO at Yale in New Haven has done the best thing along this line, which is, they have as many community workers as students. * * * Maybe SHO should just be a sort of enabling force, so that we can enable community people to do things for themselves.

I think what we should have been doing was giving our expertise, what we know about the hospitals, to community organizations, and this is the pattern we can take for next summer. We should go in and work with these community groups during the year, so that we would have some plan of going in next summer. Then we could say, OK, you know we've learned how the welfare system works, and we know how a hospital system works, and now we're going to work with a group of five or six people from your community organization; we're going to tell them all we know about health and welfare systems. * * * I think that's where we can work, and eventually we'll work ourselves out; that's what we should work for. * * *

I think black people are all trying to reach a level of pride, esteem in themselves and things like that, so that, when they reach this level, they can communicate with the white people, with the white power structure. So they're all going towards this one aim, to communicate. What you're doing down on the bottom is irrelevant. We need help, in all kinds of forms.

The whole concept of white students going into a black community to offer what they have to offer—some mysterious type of expertise which I have yet to see—is totally bogus, because what took place in Newark this summer * * * I could have gotten twenty-five high school kids to do the exact same thing.

I think you're being very naive, very condescending, very racist, and everything else that's sick about our society, in supposing that community people don't know what good health care is, or how to get it. These people have learned over the course of many years what bad health care is. And if you go up to any one of these people in the clinics, they will tell you why their treatment is bad. They might say, my discomfort is aggravated by going to the hospital, rather than being eased. Rather than having their problems alleviated, their situation has become chronic through bad health care.

What you need is outspoken, militant people who gather people around them and make themselves more assertive to demand certain things. If you are a powerless body, and you demand from a powerful body, you're not going to get anything, which is the case in Newark. The Newark City Hospital is a very powerful body, very bureaucratic, very much in the system. They know they're very powerful, and they don't have to "sit down" to realize their power. But the community people, often, have only one recourse open to them: they have to Bogart, they may have to close down a hospital, they may have to burn it down. And there are plenty of people in Newark right now who would rather die in the streets than use that Newark City Hospital * * *

What you need for white students, first of all, is to get away from this thing of coming in to learn about us. Whites always want to be one jump ahead of not only what we're thinking, but of how we're going to go about doing it. More than that, they want to be able to give their suggestions and exercise control over how and what we're going to do. There are plenty of black people in Newark, and in other black communities around the Greater New York area, who have plenty of ideas about how they're going to change things. The whites are very curious about this; they can't stand to sit back and work in their own communities. Some of the really liberal whites realize how decadent their own society is, so they reject working in their own society; they want to come down and leech off the black society. And they can do it with the Student Health Organization, the same way they've done it with all

these anti-poverty programs, across the board.

You've got to get away from this thing of not rehiring even the few whites who perform well in the project during the course of the summer, who get beyond this learning experience, who finally realize what they can offer, and who can then come in and differ with it. The second summer, these kids aren't even hired by SHO; SHO's intention is to bring in more leeches, to suck and learn off the black community. This is what these kids do, and when they go back to their own medical schools, they can't do a damn thing. They aren't going to Bogart their way into those buildings, they aren't going to do the very things they're demanding of black people. I'm not saying we want to make a parallel health system, I don't think that a lot of blacks today want to see a parallel of the white society. We don't want to have black folks doing to their own folks, what white folks have been doing to us for so long. What you have to have is creative people who will help develop totally new methods in health delivery systems. If whites are going to come into a black neighborhood, the black people in that neighborhood should determine who the whites are who will return. The white students who worked in the Newark community should submit themselves to evaluation if they want to work the next summer. The black people they worked with should say which ones of them should come back.

I think that white students could definitely serve a role in a black community. Maybe not make up a black community health council, but they can certainly educate their own folks as to what's going on by working from out here. We can get more done that way. We have three or four kids who go to the New Jersey College of Medicine. They have been more effective by associating themselves with community people, with the high school kids, and with the non-hospital people, rather than doing it the other way around. If they did it the other way around, they'd get co-opted, they'd get softened. A lot of the health science students have seen how really desperate the situation is. Two or three of them have been threatened with being kicked out of school, just because the administration didn't want SHO people to inform freshmen about how there should be more involvement with community people as part of their medical school education—something as simple as that. Some of this experience is vital if white people expect to practice in black areas.

As far as providing an immediate service for people in a community like Newark, that is vital, because these people really don't want to be bothered with you if you can't do something definite for them. And white kids can do this. They can come with a clear mind as to exactly where they stand. A lot of them are just too mixed up, because in a place like Newark there's always talk about violence, and when such talk hits the fan, where are you going to be? I remember that at all the meetings, just before the project got under way, they kept talking about what are you going to do in case of violence. And I just sat there and said, man, you people should know what you're going to do. If you've arrived at a certain point, either you get the hell out or you know which side of a gun you're going to stand on. It seems stupid that they would worry about it since they would have been working at the hospital all summer. The first thing you would do is go the the hospital, because people are going to be coming in there, all banged-up and shot-up, or whatever, so you could be the most help there. That's the way they can be the most help now, when there are no riots, in the city hospital.

Patient advocacy is a beautiful and meaningful thing. We didn't drop it, we got hustled out of the hospital. The hospital is scared of the community, and some of the medical students are even scared of the community, though I think quite a few of them got over that. But the immediate service, the advocacy, is extremely important. Even if this project was all black, if they did not offer an immediate service to people, it would be useless and stupid; they wouldn't be able to help anybody.

There could be a place for SHP next summer in Newark. Apart from antagonizing people in Martland Hospital, student fellows only antagonized each other this summer. I would drop the policy that former student fellows not be hired the following year. This should be based

mer in the ghetto.—L.C., *Nursing Student, Newark.*

There is a certain core of adults in Newark who have really had it. They don't believe anybody, or anybody in a position of power, or the city government. They are also struggling for their own living, and because we're college graduates, they aren't going to believe us. We're too clean and too "Establishment." We're not living and sharing their experiences with them. You can be white and share the experiences and get accepted by doing the same thing, by being a day laborer. I really think you have to break that economic barrier and do the same type of work to reach them.

I've had one negative experience; it was sort of funny. One of the student fellows who didn't have his name tag on was talking to a guy from the African place across the street. Then I came in with my name tag on and broke in on the conversation; the guy took one look at me and said, "Are you a medical student from the medical school?" When I said, "Yes", he just got up and walked out. He didn't say anything, he just got up and walked out of an elaborate conversation.—D.T., *Student Coordinator, Newark.*

Those non-black people who are selected should be more carefully screened for attitudes and grasp of the problem. An upper middle-class student who honestly sees nothing wrong with taking photographs of human suffering with his Nikon–F is a mistake. His presence and his blundering are too expensive. Let him learn elsewhere. Asking to be shown through someone's home for the purpose of seeing just how bad it is is too much. Is he going to fix it? —A.M., *Nursing Student, Newark.*

I was assigned to be a patient advocate out of a poverty program storefront, the League of Autonomous Bronx Organizations for Renewal (LABOR). The office was located in the middle of an old tenement area with both black and Puerto Rican residents. The assignment at first seemed to be a challenging approach to the advocacy work because LABOR's primary concern is organizing tenants around housing code violations. I was to work with a community worker on Gouveneour Place, a short block which offered ample opportunity for being organized around housing, sanitation, and health issues.

The first three weeks were spent planning and executing a block cleanup and block party —the accepted way of getting the residents "fired up" for tenant council meetings set up by the LABOR staff. While discussing code violations with tenants, I was able to uncover very few medical problems, but heard a barrage of complaints against the sanitation department and the police who have failed to come through with a play street for three summers. The block swarms with kids, from toddlers to teenagers, and no one hears the angry parents' protests against speeders and the dirty streets. I decided, therefore, to explore the possibility of closing off the street to through traffic. While the cleanup and block party were successful as stopgap measures, neither provided the expected inducement to organize tenant councils. Nor were the petitions signed by all residents or meetings with police successful in getting through city bureaucracy and around uncooperative tenants to get the street closed.

I had questioned the merit of such measures as a means of getting to the people and helping them work together. It was explained to me that this mostly black-inhabited block had not responded to past organization efforts despite the vast need for the attention from city agencies which group effort initiates. I felt that this community was apathetic because all outside agencies had failed to use the manpower potential already there. Even LABOR operated by importing black organizers from other areas.

Were the people unresponsive because I appeared to have initiated efforts to get the street closed off? I think it naive to settle on such a simple answer, but I did begin to realize how these people feel about whites coming into their homes, exposing their dilemma of apathy and an unresponsive system controlling their lives. Appearing to know more about the system and how to apply pressure, the whites are expected to do for them what they have been unable to do. I was told by many of the outspo-

on performance and compatability with the non-white community. Community people should not be "used" to train liberal white leeches, or even to help them become more well informed. Only those who know what they can offer and how they can offer it should be hired.

SHO could possibly split its forces for the summer project into two forces. Those who will work in non-white, for example, black communities, and those who will talk to their own folks.—R.P., *Community Worker, Newark.*

INTERVIEW

Q: Do you think the health students related to the Newark community well?

A: Yes, they fitted in very nicely, they weren't too anxious, they were understanding, very pleasant—they weren't formal. The people around here don't like people to be formal. They like down-to-earth people. The students fitted in all right. If they hadn't, they wouldn't be here this long.

* * * A number of things would have happened if we'd cut into the hospital the way we wanted to. There probably would have been a riot, I know that. SHP really wanted to protest against the hospital for the people there. The hospital people don't treat the patients right. * * * If we had really pushed complaints as hard as we wanted to, and had had the people protesting, it would have been a huge mess. In a round-about way it was best to do as much as we could, but not to do it too strongly. * * *

You see, community people never really stop to think about how they're used to being treated. The people know they're being treated mean, they know they're not being treated fair, but they never stopped to realize what they could do about this until the health students came here. That's when they stopped to think, why should we be treated this way? Before they had said, "Oh well, we're going to be treated like dogs, let's get used to it," and they never tried to do anything about it. If the health students would have come in and started protesting, then the people would have remembered how the riots worked; how our people were killed and their families weren't even notified till a couple of days later; how people who were in a coma were operated on without permission from the family. * * * It would have brought back a lot of bad memories and would have really been a mess.—L.J., *NYC, Newark.*

I agree that getting "sensitized" is a good idea, but I don't think three months are needed if it is to be done in the manner we tried. My philosophy is all-or-nothing; we should move in completely or we should have a "detached" attitude, as many of us had. We returned to our white middle-class suburbs like clockwork. I think it important for white middle-class students to re-evaluate the ghetto. They'll find that the residents are some of the finest and most decent of people and that there are reasons why they act in the manner they have or feel as repressed as they do as denizens of an involuntary ghetto. But it is curious that many of us are victims of a white involuntary ghetto imposed on us by bigots and opportunists in our own families and communities, in many cases of the worst kind, the silent bigots who are the hardest to weed out and the most dangerous to our society. Being sensitized—which I admit to be of some value—we must re-enter our own communities and shatter the fears of integration and the myths of black ignorance and irrationality that are perpetuated in the white communities as they are now. We must also remember in the future, when we are doctors and nurses and lawyers, to be nonsubscribers to the hypocrisy of our milieu.—P.D., *Medical Student, Newark.*

I think that inducting a lot of white kids to come and work in a black ghetto for the summer without some type of screening or interviewing is simply a newer and better means of legalized exploitation. For years we've been pushed around and used and now when whites start feeling guilty, they want to rush right into the ghetto with their righteous attitudes and change the world. And when the summer is over, they can go back to their family and friends with news of how they've redeemed themselves through the great community service they rendered the "poor folks" this sum-

ken residents that seeing the white students in this role only aggravates the wounds they have suffered. They wondered why more isn't being done to train the community people to do my work. They argued that if I do know the system better, I should be demanding reform and working within to change it. If I as a health student am committed to helping these people get the services they deserve, in their eyes my place is not in their community, but in the clinics and hospitals.—R.F., *Medical Student, Bronx.*

The subject of health is very touchy. Most people won't discuss it openly. I feel that you must have the quality of being able to talk to a person in a way that will make him or her feel at ease. You can't expect to knock on a person's door and have them tell you, in detail, what is wrong with them physically, especially, if you're a white person.

I am black and I know when a white person comes to my door I'm a bit skeptical. I know if a white person comes to a black person's door to ask about health, the black person will think he's crazy or tell him to get the hell out of there. Despite the fact that many white students have stated that people in the community didn't receive them that way, I know for a fact that nowadays that's what you'll get.—H.H., *Nursing Student, Bronx.*

The question has often been asked, "What are white medical students doing in a black and Puerto Rican community?" Naturally, this question arouses fear and guilt feelings in some of the community. As a black person, I feel that no one black person can safely say what the community feelings are about this matter. Luckily, the SHP has not had to face this problem because when people are in need or want help they don't care about the color of the person who is giving them this help. If one were to look at the question of black vs. white, they would realistically see that there are more white medical students than black. Therefore, Student Health Projects cannot consist of all black medical students.—M.J., *Nursing Student, Bronx.*

From my experiences this summer, I have found that medical students are, on the whole, inconsiderate and self-centered. With the exception of three, I found that they are interested only in what they can gain and how far it can get them. The attitude of most medical students is one of condescension. They act as though the community should be on its knees praising them. Most of them seem to be saying, "Look, you should be glad that I'm giving up my precious time to work in your poverty-stricken ghetto area." This feeling is not voiced, but felt instinctively by the community. It is often said that a person acts the way he feels.

To being with, it's bad enough that people have to live in conditions such as these (rats and roaches crawling all over the place), but you don't have to remind them and make them feel bad about it. After all, they don't like it any more than you do. If someone were to come to my door with that kind of attitude and tell me that they wanted to help me, I'd tell them where to go and how to get there fast.—C.B., *NYC, Bronx.*

This comment is an attempt to respond to the position supported by most militant black organizations (for example, the Black Caucus of the Chicago SHP) that the "very presence (of white middle class health students) is destructive and you cannot make yourself relevant to us at all." Two crucial issues are raised here: what kind of "presence" is destructive, and what is "relevant" involvement for SHP members? I propose the concept of the "relevant absence" of white SHP members in the black community. How is this "relevant absence" to be implemented. By (*a*) tutoring and job advocacy of community teenagers and adults for entry into the health professions; (*b*) support for organizations for control of local health facilities; and (*c*) supporting constructive union demands for professional advancement and higher salaries among hospital slave labor groups.

All of this implies that Whitey must withdraw from the destructive summer colonial outposts called storefronts and confront the injustices of his own mother country (medical schools, hospitals, clinics). If he does not make

his confrontation peacefully, his black SHP colleagues will have to do it violently. As in the present systematic oppression, the future insurrection against inadequate health care will unfortunately leave its deepest scars on the poverty-stricken patient.—J.G., *Medical Student, Bronx.*

I think that in most cases of a black person and a white person working together, the white person doesn't really expect too much from the non-white, and the non-white knows this and therefore doesn't do any more than is expected of him.

What I mean is, you only get what you expect out of most people. If you expect very little, that is just what you get—very little. So if you intend to have a project next summer, don't fool yourselves, as one student said, that you are all things to all people, because you certainly are not fooling the people in the ghettos or the community people you are working with.

The people that I worked with this summer I believe were sincere and in most cases hard-working, honest people. Some of them I liked and worked well with, but others I felt were just curious to see what life in a nonwhite community was like, not because they really cared, but just because it was an opportunity to satisfy their curiosity and get pretty good pay, too.

Another thing I feel about this project is that the white students are feeling guilty about the wrongs that have been done to black people for so long and are trying to make amends, so they say to us, "What can we do for you, what can we give you to makeup and let you know we are sorry now?" Well, this may be great, but I don't want you to give me anything, not as a gift, not as charity. If white people want to help black people, don't give handouts; don't treat grown men and women as children that have to be taken care of. First ask and find out if your help is wanted, then give the help that is asked for, don't try to shove your way of life down our throats. I really think that the biggest help you can give us is in teaching and showing us how to help ourselves; show our young people how to get into colleges, what to do to get grades that are college level. Let us older people meet and work on equal levels.—N.W., *Community Coordinator, Brooklyn.*

I believe that being black is becoming daily more and more of a criterion for working in the black community. However, it should be noted that all it does is get one into the community; it does not make the job in the community any easier after you are there.

The fact of my having worked in Youth In Action since February was more of an asset than was the color of my skin.—E.C., *Medical Student, Brooklyn.*

The white student, if he comes in the area with the right attitude (that of being willing to work for the wishes of the community, not to dictate to the community what must be done), can do much good for his brothers—black and white. He can give his black brothers the tools needed to carry on the fight for better health care. He can help them organize and give them information about the white power structure that can be used to change it. He can align himself with the members of the black community in demanding reforms and revolution. He can show the medical world that whites must work together with blacks in order to make a better society for all.—D.Y., *Medical Student, Brooklyn.*

The project director and I talked about the appropriateness of medical and nursing students working in these communities this summer. Just where do we fit into the scheme of things already going on. I feel very strongly that our role should be support, not leadership. Black people should be doing their own organizing, not only because it is likely to be more effective, but because of the need for a black identity and solidarity. We're really just another group of absentee philanthropists who come in for ten weeks and do our thing and then leave. The only things that will have lasting significance are projects that speak directly to the needs of the community and which have the interest and support of the people for whom they're intended. To that end, we can try to enlist support for a project, but the real leadership must come from the people who are interested in it, not the health students.

Also, in the words of Malcolm X, we might fruitfully spend our energies "organizing our own people" and trying to make them cognizant of and responsive to the expressed needs of the community. This refers mainly to the hospitals we'll be dealing with, but also to our medical schools and some of the city agencies we deal with. We can perform a unique function in that we are health science students and can talk to doctors and nurses in a somewhat knowledgeable way. I think we should look for ways in which we can serve as intermediaries between the community and the health providers and use our position not to be apologists for the health providers but as advocates for the unrepresented. Hopefully, as decentralization and community control becomes a reality, the need for this function will wither away also. The name of the game is participatory democracy and we should try to facilitate that. These remarks apply more to the white health science students than to the blacks, but it's unfortunately true that some blacks are only slightly more effective than whites.—R.C., *Student Coordinator, Harlem.*

It's late Tuesday night, and I've had a full 24 hours to go over the black history talk. I had really looked forward to the Monday night black history class: first, because I thought it would be interesting and, second, because I had heard the speaker praised. I was disappointed on both counts.

The topic for the class was something about the transition from African to slave. The speaker began with a glowing exhaltation of the "rich" African culture and religion, and moved on to talk about the life of the plantation slave. I don't know much about the African heritage, but I found this discussion of it neither enlightening nor pertinent. It was pitifully one-sided, filled with half-truths, totally lacking in historical perspective and, at times, a complete perversion of the past to suit the speaker's own present needs. In the course of my own studies on the Civil War and Antebellum South, I had read the same authors to which he made reference (and a great many others as well), and I honestly believe he judiciously edited everything he read and presented only that which he found expedient. He criticized other Negroes (excuse me, I mean black) historians and branded them "Toms" because they had the intellectual honesty to tell history as they saw it, even if a different telling would be a better demagogic tool. I was really incensed. I came to work on this project because I am tired of white lies and hypocrisy, and I will not now accept black lies. After rejecting "Establishment" propaganda, I won't fall prey to radical black propaganda.

I have spent too long at academic institutions and will not willingly cast off respect for intellectual honesty and truth, even though it's currently in vogue to do so. It has become fashionable to class these terms under the column headed "bourgeois educational system" and reject them, and that is a great pity. At any rate, as history I found the talk a failure. It was, however, useful in that much of his approach to history exemplifies what we're seeing today in the new trends the Negro movement is taking—namely, over-reaction.

When I began working here ten weeks ago, the words "Black Power" really frightened me. They conjured up images of burning buildings, shattered storefronts, and gun-point confrontations of black and white. It wasn't the immediacy of riots that was frightening, but rather the future prospects of the black movement—where is it all leading? The idea of black control of the schools and hospitals had been mentioned at various meetings and discussions, and I refused to accept it because I inseparably linked it to a total rejection of the white community by the black. I could see recurrences of the Ocean Hill-Brownsville school incident in all the situations where blacks were suddenly given control of the local institutions. I could see the firing of white people, not on the basis of their competence, but on their whiteness alone. What was particularly disturbing is that it appears to be a rather unsatisfying culmination of black discontent both for the white community and the black as well. Whites control the money and power structure of the country, and it seemed like the black man was hurting his own struggle by permanently rejecting Whitey. These considerations led me

to write off the Black Power movement as irresponsible and immature.

I interpreted the Afro cult as the natural complement to the Black Power movement. The stress upon things Afro is easily seen and felt around here—all along Lenox and Seventh Avenues boutiques have sprung up where Afro clothes are sold and the "natural" hairstyle becomes more popular daily. I didn't like the Afro rennaissance for a number of reasons. It has all the earmarkings of a fad, and like other fads it flourishes on conformity and is steeped in hypocrisy. The artificiality of the whole thing was particularly disturbing. While the American Negro obviously does have an African heritage, the Afro rebirth, as it appears now, seemed to have little meaning for him in 20th-century Harlem. It all appeared so inane. I had no difficulty calling it "just a lot of people swept up by ethnic mongers." Of course, the black man should be conscious of his black heritage; it would be a crime to disavow it—he can no more deny it than he can deny his blackness. But the whole thing seemed so unreal—a retreat. What I came to realize slowly was that the need which forces him to seek out this African cult is very real. There is a void as to the identity of this black man—just who is he? The question is not how he appears to the world but rather how he appears to himself.

On my way to and from our office I walk past the southwest corner of Eighth Avenue and 137th Street—past the crap game *in perpetua,* and the old men sitting on the stoops and standing at the corner; past the tired faces with eyes still bloodshot from the last night's cheap whiskey; past the panhandling junkies, coming down and looking for their next shot; past purple pants and old yellow Cadillacs. The sidewalks themselves are speckled with the trodden remains of chewing gum, tar, spittle, and urine. On hot afternoons, the south side of 137th Street is in the shade—and it teems with nameless black life.

Harlem is a nightmare, and it is against that background of the all too real ugliness that I must come to terms with Black Power and the Afro cult. The question of identity looms up again, can the black man help but build up a defense against the wretchedness that surrounds him? Can he help but try to close out the ugliness? Consider the incidence of hard-drug addiction in Harlem—the needle offers relief: escape. The same for the bottle—it too promises escape. How can the black man answer the question: who am I? Is he the staggering drunkard, the unwed mother, the bastard son, or the local whore? The reality of the nightmare is too much to bear—a new identity must be found. The Negro tried to adopt white middle-class values and was doomed to failure, because he can never be white and is not now middle-class. Afro was seized upon because at least it is compatible with being black. Unfortunately, that is the only relevance I could find for the cult, and it is for this reason that I saw it too as a blind alley, a fad, a foster ethos. Yes, the black man once was African, but 250 years of slavery followed by another 100 years of mock freedom and urban poverty living have far removed him from the 16th-century African. Whatever African he had in him has long since died and cannot now, in the 20th-century America, be brought back to life. The Afro cult seemed to me a backward-looking sham. It appeared that the Negro had taken up the cult for no other reason than his denial of white middle-class America—a denial born out of 350 years of frustration and hate.

From the mid-fifties to the early sixties, Civil Rights looked as if it were going somewhere: Supreme Court decisions and picketing appeared to be gaining ground. But the process was much too slow and after the first century of "almost-freedom," every year was harder to take. The Negro of that period appears to have fallen into the trap of thinking that because he could now ride in the front of the bus his blackness would pass unnoticed. But as the slow years rolled on he soon realized that no matter how close he gets he's never going to be white. Out of the old and new frustrations came the proposition that "Black is Beautiful." The political adjunct to this is that Black can run things without Whitey, and if we don't give him the chance, he'll seize it for himself. The Negro,

unable to become white middle class, makes the psychological defense of rejecting it.

I've spent a whole summer listening to black leaders, at times working with them, and each day walking around Harlem, always trying to put Black Power and the Afro movement in the proper perspective. If you listen to black leaders you get the impression that this is the end—the final step in the evolution of the Civil Rights movement. They seem to say now all that's left is for the black community to get fully behind it, and the final assumption of power is imminent. This is what always threw me off about Black Power—the proposition that it is the matured product of black unrest.

It would be unfair to Black Power and the Afro cult were I to leave the impression that they are useless socio-psychological defenses, because, for all their superficiality and immaturity, they serve an absolutely vital function: they make being black something acceptable, not to the white man, but rather, to the black man himself. The trouble I have had with Black Power is that it disguises itself as the end, when in reality it is the means—the vehicle by which the black man can regain his self-respect and pride. I seemed to fear Black Power because of its finality—the black community is given control of its schools and responds by firing all of its white teachers. The crime in that is that by disregarding competence, the black community can destroy what institutions it has. I do believe it should determine policy and make decisions, but not on the basis of black and white.

If the black leaders were given control now, as they demand, white heads would roll, and if the matter were left at that, Black Power would be an insidious creation. But I don't believe it can be left at that. In the beginning there will be abuses of power which will arise for two reasons: (1) The immediate psychological need of the black man (the very need which prompted the birth of Black Power) will demand that for once black be on top; and (2) the black community itself will have to learn the responsibility of power (a lesson it cannot learn until it is given the exercise of power). These things will happen—they must happen —for before the black man can tackle the staggering job of revitalizing his institutions, he must come to terms with himself. When his personality development is complete he can then look to his sociological ills, and therein the Black Power phase will have to end or at least sufficiently alter itself to allow acceptance of white support and aid. The white sector has too much of the broader political power, too much of the money, and too much of the professional personnel for the Negro to ignore it—the black man would be a fool if he did.

I've asked myself where the white man fits in now, and the only answer I can come up with is that he doesn't. He can support the movement to give the black communities the power they demand, but that is all. It is the black man himself who must struggle with that power. Until he's ready to ask for, and accept, the white man's help, all Whitey can do is watch * * *—B.G., *Medical Student, Harlem.*

COMMUNITY EDUCATION AND TRAINING PROGRAMS

This summer I think the community asked to be able to do for itself what is now necessary for outsiders to do. The community wants to know how to obtain the knowledge necessary to meet its own needs. This was clearly stated during orientation, but I've seen little evidence of any action. I think it would be extremely advisable for the health science students in the future to act as tutors. There is no question as to who would benefit from the service. Part of our work this summer with the NYCs was to provide educational programs. I saw very little evidence of this taking place. A few poorly organized classes were given but no ongoing program seemed to exist.

Our knowledge could be applied by having community workers and health students teach the community how to do advocacy. If one health science student spent his time teaching patient advocacy to a group of community people, he then could work himself out of a job. Health advocates from the community should be taught as much as possible about the hospital and other health facilities. I see the role of the health science student as that of setting up relationships making it possible for the community advocates to function. A thorough in-

troduction to the hospital is necessary. I found that in my dealings with Morrisania Hospital very few of the hospital staff had been informed about SHP and patient advocacy. At the beginning of the summer, we were introduced to some of the staff, but apparently this was not effective.

One drawback I can see to having community advocates is that of status. The reason that student patient advocates are effective is because they represent a group which puts them on a higher level than the patients. If patient advocates were people who used the clinics themselves, the institutions may not feel they have to pay any attention to them.

Therefore it would be very important for a thorough saturation of the institution on patient advocacy.—V.V., *Nursing Student, Bronx.*

Instead of literally taking people by the hand to welfare, department of buildings, and hospitals, SHP should direct its goals more toward showing the people of the community how to help themselves. By this, I mean forming welfare rights groups, showing people how to put in complaints which deal with housing, sanitation, and health, directing them toward job training programs, SEEK (college discovery), and tutoring junior and senior high school students to prepare them for college or health careers.—M.J. *Nursing Student, Bronx.*

If there was nothing we could do in the hospital in the existing milieu, there was a more positive path open: the community might have been spared the indignities of that facility if the people's knowledge of health matters had been more sophisticated. There should and could be much more profit from an emphasis on prevention. This could be accomplished via lectures, demonstrations and discussions about maternity, first aid, dietary patterns, contraception, abortions, etc. The personnel for this endeavor could come from at least two sources: SHP members (out of all the education we have among us it struck me as ironic how little we were able to utilize); and the health professionals already in the community. There are local physicians, nurses, and nursing students who are possessed of varying amounts and types of knowledge. They should be contacted and asked to contribute. Why wait for the disease to happen and then fret about the cure. Get ahead of the problem.—A.M., *Nursing Student, Newark.*

Health care in Newark would be greatly improved if medical people could be sensitized to respect and have compassion for the people they are being paid to serve. I feel strongly that many people are too hardened by now, and the answer, I think, is to be found in the immediate training of community people in medical fields so that they can replace bad personnel. This should occur at all levels. People who refuse to be responsive to the desires of the community should be removed from their jobs.—R.P., *Community Worker, Newark.*

I find that in Newark, at least, a major reason for poor medical care is that people do not know what they are entitled to, or even what adequate health care is. Therefore, since New Jersey College of Medicine and Dentistry is new in the Newark community, we must first act in an observational capacity, conjoined with much communication with the residents of the community, in order to create a plan for actions that we can take. We should also act in an educational capacity, relaying our information and suggestions to the community.

I believe that this is our most important function in the community, for if we stand only as a small group of students against a large political organization, we can expect to make little or no impression. From my experience this summer, I can see that the large machines which we are fighting against, like Martland Hospital, are deathly afraid of the community and its wrath and would bow to the demands of a coherent community group much more readily than they would to us.

The majority of the people in the Newark community are unaware of their rights and the injustices imposed on them, and are not organized into any protest organization. Therefore, we must educate the community through agencies, schools, PTAs, meetings, advocacy, and door-to-door soliciting, and whatever other methods become necessary.—K.O., *Nursing Student, Newark.*

It was realized that new and totally different

methods of health care delivery were needed in light of the doctor shortage and population rise witnessed in America. Functions that classically have been the sole domain of the physicians would necessarily be taken away from him and given to persons lower down on the health professional scale, thus freeing him to see more patients. As a result, such functions as history-taking, blood pressures, pulse, immunizations, and vaccination were considered possible areas whereby a dent could be made in the solid but perhaps rusting armor of the physician, without too much fuss being made. Included in the role of "physician-assistant" were other functions, such as dissemination of nutritional, health, and safety information to visitors to the clinic.

Now, many months after the conception of the above idea, what we finally have is very different from the original seed. During this time, we molded and remolded our concepts so that a meaningful and realistic position would be established. No longer are the various functions mentioned above a part of the physician-assistant's role. The history-taking is now the primary function of the physician-assistant.

* * * The questionnaire (history-taking) was considered a total success by health science students, NYCs, and especially by the doctors of the clinic who found the screening history an invaluable aid. But a question arose as to what to do with the social pathology that was detected by the history. The answer to that, we all agreed, had to be part of the physician-assistant's role, for example, it would be his function, and a major one, to do followup work on the patients he thought required such attention. With this in mind, we set out enthusiastically to do home visits. After a number of weeks of a split regimen—clinic hours and home visits—we groped with the problem of the extent of followup care to be indulged in by the physician-assistants, in light of the fact that 95 percent of the patients seen needed followup, and it would be impossible, physically and realistically, to do so. We decided that the social worker role of the physician-assistant would be limited to getting in touch with the proper agencies and notifying the Social Service Department of the clinic, who would be responsible for gathering feedback information and informing the physician-assistant as to what has been done and what the physician-assistant should do next. This worked with great success.

Patients that we have seen (over 300) expressed pleasure with the fact that someone at last was concerned with their total health situation and not just with the episodic treatment of whatever condition their children were brought in for.

Kings County Hospital Pediatric Clinic, which was already held in high regard by the patients (for they honestly receive excellent care there) received an extra boost by this concern on the clinic's part. Patients, upon revisits to the clinic, looked for the physician-assistant and relayed to him any problems that arose since they last saw each other. The use of physician-assistants not only gave 100 percent better medical care because they concerned themselves with the total health problem of the patient, but also served to minimize the tedium of the long waiting period.

Now, what about continuation of the project? The Pediatrics Clinic is funded by a government grant under rigid stipulations as to hiring of employees. With this straightjacket I am in the process of negotiating five new positions for physician-assistants under the social service department, beginning next July 1st. Why next July 1st? After careful consideration, it was concluded that it would be much wiser, and more realistic and meaningful to have a 40-week training program that not only includes on-the-job training, but gives accredited courses in English, math, science, sociology, etc. The benefit of such a program is that someone with a minimal education (6th grade and up) can acquire skills that will enable him to have some upward mobility, rather than to place him in a position that he has no hope of ever rising above or moving from.—B.F., *Medical Student, Brooklyn.*

My experience * * * is proving to be quite interesting. * * * I learned the art of taking case histories, and the task of learning all of the names of the diseases was easier than I

expected. The doctors working with us proved to be very patient. * * * The medical students in our group are very friendly and always try to help us in any way that is possible. They have patience with us and are always around to assist if we need their help.

The best time is when we are given the opportunity to go out in the waiting room and call our own patients. Even though I was quite nervous at first, I greeted the people with friendly smiles and all of the fright went away from me. The parents are more than willing to come and talk with us because we not only took an interest in the patient, but also in the rest of the family and in the conditions in which they live. We figure that we are showing the parents that we too are concerned about the welfare of their children and also about the conditions in which they are living. This makes the parents feel that the health organization has a strong concern for the welfare of their child, and for the people living in the community. Speaking with these people about their children's health, and the rest of the family, gets the feeling of fright out of their system because they feel that they are talking to community people, being us, who are faced with the same problems.—L.J., *NYC, Brooklyn.*

I don't think there was that much resistance from the doctors to the idea of physician-assistants, because when it got started the doctors' main complaint was that the questionnaire didn't have this in it, or it didn't have that, and they wanted more on it, which was a good sign. * * * The St. Mary's group has had one person working for a month or so, and just recently they've got another person that we hired, and they're scheduled to have two more people hired by the time we leave in September. Thus, four community people will be working in St. Mary's after we leave.—W.S., *Student Coordinator, Brooklyn.*

I saw the SHP workers in Harlem this summer as a liaison between the community people and Harlem Hospital and the various other agencies involved. We served to help people take the best advantage of services rendered by the Harlem Hospital clinics, other clinics, and public school health programs. The atmosphere at the beginning was one of beholdeness —people did not know their rights. Many thought that because they were Medicaid recipients they were obligated to the various treatment facilities. Others felt that they could only go to a clinic and not on a private physician. Our job was to educate the community to think differently.—J.H., *Medical Student, Harlem.*

Halfway through the summer referrals from Public School 175 were running out and I requested some from Public School 100. Along with the referrals we acquired the opportunity to train 10 "parent assistants" from the school. These community mothers were in training for 6 weeks in various aspects of education, and two of us met with them for 3 weeks to explain the departments and procedures of health facilities, and to give them experience in field work on referrals. We used Public School 100 referrals and covered nearly all of them. Feedback from the parent assistants and the school administration was favorable.—C.W., *Medical Student, Harlem.*

* * * I started the project thinking that all my job would entail would be getting people started and somewhat oriented to Harlem and the goals of our project. After that, I hoped to be able to get into some projects of my own and simply be around to give suggestions and help other people by being a resource. It has turned out that there was a lot more supervision involved and I had to dream up things for people to do simply to keep them from sitting around the office doing nothing. I needn't belabor this but I have found it the biggest disappointment in the project for me personally. The reason I mention this is that the Public School 100 part of our project is an example of the way I hoped things could work; the two guys who went over to Public School 100 to see about referrals found out about the training program there for community mothers and then worked out an arrangement whereby they could be useful as advisors. This had the double advantage of supporting an already existing program and working in a role as advisor, not an organizer of a new project. There are

enough projects going in Harlem, already; we don't need to go organize any more, especially ten-week ones. (Incidentally, lots of people in Harlem have told us this, too) At any rate, I think these two workers did exactly what we should be doing and the point is that they found the job on their own initiative in the process of working on referrals.—R.C., *Student Coordinator, Harlem.*

Another means of attacking the problems of health care delivery, however, may not involve working in poverty areas but rather in the upper levels of American society. Perhaps education of middleclass America is more important than working in poverty areas in the long run. This task is much harder to undertake and, as of yet, the mechanisms of such an operation are out of sight. The task is to get the unconcerned, unknowing, and uncommitted people concerned with the problems the country faces. This, perhaps, is what SHP's in the future should direct their energies to.—W.S., *Student Coordinator, Brooklyn.*

COMMUNITY ORGANIZING

Newark

It's so difficult to have any kind of political gathering in a community such as Newark. The Leroi Jones approach is probably going to be the most productive, because it is going to let these people speak for themselves. Just organizing and bringing a group in to sit in the hospital is not going to work the way you might want it to. Ultimately, though, I think it's the best thing, because when you surround an administrator with five or six big black cats and scare him personally to death, then have some little guy come in and mediate, talk calmly to him, and make him see that he doesn't have to be afraid, then something will be done that both sides will like. The basic objectives of the administration of all hospitals, really, is to serve the community: they just want to do it their own way.

We got a group of people together and they're working on a community health council on their own. It is going to be black and Puerto Rican; they're going to try to advocate, to let people know what is available. They decided on this themselves. It is going to be year-round, and they're going to try and get funded. There seems to be a consensus that this is the kind of thing that SHP's should focus on, but there can only be so many health councils.—D.T., *Student Coordinator, Newark.*

When we first arrived at Martland Hospital in Newark, either the staff was unaware of our function or they pretended to be. During the first weeks, we were given a lot of "busy work" to keep us out of the way. During this time, however, we compiled a list of criticisms and recommendations which we offered to help carry out. Eventually, this list was presented to the hospital administrators, who did nothing. After repeated attempts to get some sort of action, followed by repeated failures, we resorted to other means in the form of trying to develop a community health council. This council, if it becomes functional, will be the biggest achievement of the summer because it should make the hospital receptive and sensitive to the requests of the black community. We, as health science students, can meet with administrators for the next ten years and get absolutely nothing accomplished, because they feel that we'll only be there for a certain length of time and then they'll be rid of us. However, the hospital will be forced to listen to organized community people because they aren't going anywhere and mean business. This council, composed of community and professional people, will be able to make demands of the hospital with no excuses accepted.—A.C., *Nursing Student, Newark.*

I believe that if the community health council fails, one of the proposed major accomplishments of this summer fails. It must be said that the grass roots in the Newark community took no interest whatsoever in our efforts, and perhaps such a council must evolve some other way. I honestly feel that community involvement in the medical school development could help create the type of environment for instruction and health care delivery that would be in the forefront of medical accomplishment. —P.D., *Medical Student, Newark.*

Our most important project is to organize

the community, and to get them to work for themselves and realize that they can do something if they're organized.

We tried to do this in the beginning. We arranged to have a meeting with the community and sent the health science students around to different churches. I think about three or four students were interested enough to go; three-quarters of them didn't even bother; this assignment wasn't important enough for them. It would be naive to suppose that white people can organize a black community.

There's much to be said for focusing on one objective. It makes a lot of sense, but the important thing is that it's not a silly objective, that it's an objective which is at the basis of a council made up of community people. I couldn't see focusing the manpower on getting everybody to health examinations: they get a health examination, so what; they still live in those shitty houses; so now they know they're sick; they still don't have enough health clinics to take care of them and when they do go to the clinics they get treated badly anyway. * * *—R.P., *Community Worker, Newark.*

Bronx

I have begun to help the tenants of one building with a rent strike; I happened to be the only one in the office when a tenant came in and asked for help. LABOR is understaffed and gave me pretty much a free hand to do what I thought best. I have reservations about my role for several reasons: (1) Should I, as an outsider, be organizing? (2) Will my handling this rent strike put a strain on my relations with LABOR? (3) Can I actually cope with the problem?

I've worked out some partial answers:

(1) No, I shouldn't be organizing. Luckily the tenants organized themselves very quickly, and I can carry out their specific wishes—write letters for them with their demands to the landlord, get a lawyer to answer their questions, get a survey of the building done. And I have a worthwhile goal in helping LABOR be a good resource for them, tapping them for personnel, for example.

(2) My personal relations with LABOR do have strains in them. Mostly I try to work them out by clearing with them what I want to do, and talking things over as much as possible. It's amazing how effective just talking is in working things out.

(3) I've made some bad mistakes, especially missing followups, but luckily the real strength is in the tenants. The most important thing I can do is keep an effective relationship going between the tenants, LABOR, and the rent-strike lawyer. But if I try to make it *my* rent strike, and judge success and failure in those terms, then inevitably I'm manipulating the tenants and inevitably I'm doomed to failure since they're the only ones who can pull it off.—K.B., *Medical Student, Bronx.*

Brooklyn

One of the major goals of this summer was to help get a narcotics center established in Brooklyn. Since it is too amorphous to expect that mass community meetings would somehow end in an actual center, we worked with a few interested community people who were motivated toward action and interested in getting results. After these people formed a concrete plan and structure for their narcotics center, the community was asked if it wanted such a center by circulating a petition.

Initially we had hoped to get people in Brooklyn mad about the problem of drug addiction, to get massive community concern and action. We soon learned that it is next to impossible to get community people to a meeting or to get them active. This is not too surprising when you realize that most people work, are struggling to feed and support their family, are asked to attend scores of meetings that never accomplish anything.

* * * How is any progress made within the community? Usually there are a few community leaders who are motivated and are very effective. It is these people who make most of the positive changes. Unfortunately, what

some people call the "community"—the person who works, comes home and doesn't give a ——is not going to accomplish anything. The few community people who are effective must represent the whole community; they can't know what every person in the community wants, but they are the only people who are taking the responsibility and must make the decisions. —E.B., *Medical Student, Brooklyn.*

STUDENT HEALTH ORGANIZATION SERVICE PROJECTS

Bronx

The original purpose of the South Bronx project unwed mothers clinic was to provide quality comprehensive professional services to young unmarried mothers in the South Bronx Bathgate Avenue area. This goal was to be accomplished through individual counseling sessions, group and family counseling sessions, classes in mother and baby care, grooming, personal hygiene, family planning and family living. Home visits where indicated were to be an integral part.

Our objectives for the Mothers Clinic were:

(1) To improve prenatal care of young mothers;
(2) To promote quality health of mothers and their children;
(3) To reduce fear of the birth process through education;
(4) To help pregnant teenagers gain an understanding of themselves;
(5) To facilitate the appropriate use of community resources;
(6) To help bring about community awareness of the needs of pregnant teenagers;
(7) To assist in the rehabilitation of pregnant teenagers;
(8) To provide an accredited continued education program for pregnant teenagers.

Those persons involved in the mothers clinic consisted of three student nurses who had completed a course in the nursing care of mothers and children, and a physical therapy student who was to serve as a translator since many of our clients were expected to be Spanish-speaking. My job was purported to be faculty advisor to this group of students.

To prepare the group for participation in the mothers clinic, a bibliography of required reading was prepared and group discussions were held, in order to help the students identify their feeling about unmarried mothers and their associated problems.

In addition, group participants located and visited some of the various agencies, such as adoption centers, shelters for unmarried mothers, etc., in order to find out how these services may be utilized in procuring assistance for our anticipated clients.

The group was aware that even though as many as one in three pregnancies in the South Bronx area is out-of-wedlock, obtaining clients for our clinic would be a difficult task. In order to reach these people, we sought assistance from the various community organizations and neighborhood groups. Key persons in prenatal clinics and public health agencies were contacted. As a result, we were permitted to interview patients during clinic visits to encourage their participation in the mothers clinic.

One of the big problems was that community groups did not offer much encouragement since they felt that there were far too many temporary agencies in their community already. Because of this attitude, a file of at least 80 candidates for the mothers' clinic, which we had been told was available, became unavailable due to "confidentiality."

Flyers were distributed, signs posted, letters written, telephone calls made, schools visited, and door-to-door canvassing was carried out as additional efforts for procurement of clients for the mothers clinic. (Even so, project directors said that this was not enough.) These efforts yielded a very few young mothers who may benefit from the quality counseling and teaching available at the mothers clinic.

As a result, we became involved in housing and welfare problems. Because of this involvement, we became acutely aware of the critical need for educational facilities for pregnant teenagers, especially in the South Bronx area. We learned from the people of the community that pregnant teenagers are dismissed from school as soon as the school officials discover that they are pregnant. Secondly, if they are

able to return to school following the birth of the baby, they are rarely permitted to return to the same school. Thus, a minimum of 18 months may be lost prior to the continuation of their education.

This problem seemed to take priority and the group then set out to discover how we could possibly help the community to meet this need. We were aware that there was a very small educational facility for pregnant teenagers in the South Bronx. Key persons in this program, as well as the few other programs of this sort in New York, were contacted. Visits were made to each of these agencies. Our purposes for these meetings were manifold, though mainly we hoped to obtain some helpful information about setting up such an educational facility.

The group was informed that the best way to proceed was to locate a suitable facility and obtain a commitment for medical services. These tasks were accomplished. We were then faced with two additional problems: first, the formal writing of a grant proposal, and secondly, finding a sponsoring agency.

Recognizing that these were problems that we could not handle alone, the group sought help from those persons who were supposed to be able to help us. Yes, there is someone who can help you with the writing of a grant proposal; where are they? Surely, you can get money from the children's bureau; how, under what circumstances? This suggestion was made just as one might tell a child that he can shake all of the money that he may need for candy from his piggy bank. Yes, there is money available from the children's bureau, but not the way it was suggested to us.

We were also told that a mere phone call was all that was needed to gain the cooperation of the Board of Education in our pursuit for educational facilities for pregnant teenagers. Isn't it interesting that the whole summer passed and this phone call was never made?

Despite the lack of cooperation by SHP advisory personnel, the group persisted in its effort to setup this much-needed program. As a result, a Committeee on Education for Pregnant Teenagers in the South Bronx area was established so that these efforts may be continued. Persons from various cooperating health agencies and community participants comprise the committee.

The storefront office has remained open through funds made available by one of the participating committee groups. What shall ultimately become of this project remains to be seen, but, thanks to our interested cooperating groups, the mothers' clinic has acquired a most vital aspect, time.

I feel that this project could have made greater strides had the group's request for coverage by the newspapers been supported. We were made to feel that this could be accomplished simply by a telephone call, but for some reason this call was not made either.

Based on my observations and participation in this summer's SHP, I do not feel that I could in good conscience encourage future participation by student nurses in this project.—F.L.M., *Program Advisor, Bronx.*

Some of our project members were working on a clinic which was supposedly for unwed mothers. Because they could find no patients and had trouble finding a place in which to hold classes, they expanded their program to any mother desiring birth control information, and any pregnant woman, married or not, living with her husband or not.

It was my understanding at the orientation that we were to work with existing facilities in the community, offering constructive criticism where necessary. This would hopefully bring medical inadequacies to the attention of the powers-that-be and changes would be implemented accordingly. Should a community need exist which was not being met, an attempt would be made to create an agency to meet said need.

With this in mind, I could see no purpose for the formation of this clinic. One of my advocacy patients, while at the Fulton Street Health Station, mentioned that she would like to obtain birth control pills. The prenatal clinic at the health station gave me a referral slip for the new family planning clinic in the area which had just opened the month before,

the research and illustration end of the book, which will be distributed through Martland Hospital and our newly formed Community Health Council.—K.O., *Nursing Student, Newark.*

Brooklyn

I think we did meet favorable reaction. Of course, a lot of what we were doing was service-oriented, like in the hospitals. * * * The people felt someone was taking an interest in them, because someone was sitting down and talking to them for 15 minutes, while usually they would be sitting there and waiting for half an hour, 2 hours, whatever, ignored. This was a positive sign. A lot of these people invited us to their homes to inspect housing violations, and on some we got results, so there again we met with favor. I don't think we tried to do too much in which we might have failed and thus angered people. We weren't promising much that we couldn't deliver.

In Brooklyn we had a group working with Youth-In-Action. At first, we had hoped to work on family counseling, birth control, homework study (which is like a Head Start program), etc., but it degenerated just to homework study and we had three people acting as teachers or tutors. I personally didn't feel that this was the best way for a health student to spend his summer. But they thought they were doing something that's their bag. You can't tell them it's not—W.S., *Student Coordinator, Brooklyn.*

Lower East Side

From the very beginning our Community Coordinator objected to the sex education program on the basis that a Puerto Rican community would not accept it, especially for the younger people. We were advised that it might be possible to work out a program for mothers, but that a program aimed at the younger people was doomed to failure. At first we did not heed the advice and we attempted to educate the two Puerto Rican girls (NYC's) working with us. We tried to have them partially take over some presentations to other groups of Neighborhood Youth Corps; however, they were not able to do so.

Our Community Coordinator was not surprised and advised us again to direct our attention to parents' groups. With the help of the supervisor for the district of the Head Start programs, we did organize a series of presentations for the mothers of the young children involved in the Head Start programs. We had one meeting with about ten mothers, most of whom were Puerto Rican, who were the family representatives for the different public schools that were having Head Start programs. Their response to the idea of available information about family planning and sex education was very enthusiastic. Some of them also felt that a program directed at their children was a very good thing. They did admit that the subjects were ones that Puerto Rican parents did not discuss with their children; however, they felt that their children should be aware of these things so that they would not face the same problems that their parents had to face. In other words, these mothers were expressing the desire for more information concerning a very important aspect of health care that was at present impossible for them to give their children and which the public health care institutions did not provide.

When we gave these presentations to parents' groups, we felt that the people were really not terribly interested; yet we were invited back to give more information. The fact was that the women were very interested but they were inhibited about discussing such material in front of strangers. We were told that after we had left they had a very open talk about a subject that had not been discussed before. We had acted as a catalyst for these mothers.

Another idea that we tried to work on was an educational program for community workers from local action groups. Some of the groups were polite and refused openly, while others said that they were interested and then the women didn't show up for the appointments with us or they claimed that they were too busy that day. We wanted to leave something of more permanent value. We wanted to give the women the tools to help other women, but the groups we visited rejected the idea.

and arrangements were made for Mrs. M. to visit it. I found the facilities at the Fulton Street Health Station adequate and the staff cooperative, and they encouraged us to bring in any problems we encountered in the course of our work.

In all fairness to the community, I do not see the point of setting up a clinic which probably will not endure past the summer. There was trouble getting the rent approved for the building, and since most of the workers are students, I wonder at the likelihood of its survival.

What I am trying to say here is that I feel the SHP clinic is duplicating existing agencies with no assurances that it will survive after the summer. Therefore, I feel a personal lack of support for it in terms of the interest of the community.—C.B., *Nursing Student, Bronx.*

The following description of the Bronx SHP Head Start health program was used as part of a grant proposal for the continuation of this program:

During the summer, the Bronx SHP operated, in cooperation with St. Joseph's Summer Head Start program and Fordham Hospital, a complete physical exam and screening program for sixty children, ages four to six. Under the leadership of a medical student, one dental student, two nursing students, two community workers, and three NYC's implemented the following: (*a*) English-Spanish letters were sent to all Head Start parents explaining the program at Fordham Hospital, with a choice of participating either through Fordham or private doctors. (*b*) From July 23 to August 16, five children per day were taken with their parents to Fordham Hospital. At the hospital they were registered, given complete physical exams, urinalyses, blood tests, and Tine T.B. tests. Health students and community workers were responsible for seeing to it that followups were made for any abnormal findings in the tests. During the week of August 19 to August 23, home visits to all Head Start families were made for five purposes: (1) Explaining the results of the examinations and tests; (2) administering a two-page questionnaire containing a family health survey and a survey on attitudes pertaining to local health care delivery; (3) making referrals where indicated; (4) providing information on existing local health facilities; (5) establishing a working file on each family for subsequent use by medical students.

* * * Results: Of 60 children enrolled in the Head Start program, 56 children were seen at Fordham, and four children were seen by private doctors. Twenty-one children had physical examinations and accompanying test results that were entirely within normal limits. The following abnormalities were diagnosed and acted upon: three underweights; two uppersites; two functional heart murmurs; two minor umbilical hernias; one inguinal hernia; one kidney infection; one urinary infection; one vaginal infection; one sickle-cell trait; three subclinical anemias; eight eosinophilia results; 12 albuminuria results; one ectopic eczema; one asthma; two positive Tine tests (X-rays negative).

The results of the questionnaires (40 returns out of 56) have not yet been analyzed in detail, but quick sampling indicated clearly a deep-seated dissatisfaction with existing health facilities, and a willingness to organize around the issues of Fordham Hospital and a neighborhood health clinic.—J.G., *Medical Student, Bronx.*

Newark

* * * My other activities at Martland included drawing pictures for the pediatrics emergency room, and helping to alphabetize the files for the medical and surgical clinic. I also observed the functioning of several other hospitals and city clinics to see how Martland's could be improved. As you can see, most of these tasks were just little service projects that did not change too many lives or make any radical improvements in health care. These experiences were rewarding but not really satisfying. This does not spell failure, but I suggest that SHO must make a more concrete stand on what its place and service to the community should and will be.

I think that the most positive and beneficial thing that I did this summer was to work on a health rights handbook which we will soon have published and distributed. I worked on

We are going to try to continue with this program in the fall though I am not sure exactly what we will do. We certainly could continue to provide the limited service of giving presentations to various parents' groups in the schools. We also may try to work with some younger people through local community groups. I am more interested, however, in working out some way of involving community women in providing the education. One idea that we have is to look into the possibility of creating jobs for women through the services in Bellevue Hospital. These women could work in the hospital and in the community providing much needed information about family planning and sex education.—P.S., *Medical Student, Lower East Side.*

In order to educate ourselves in the field of birth control, sex education, and venereal disease, we visited a number of organizations such as Planned Parenthood, SEICUS and various drug companies. Most people tried to be helpful and encouraging but those of actual value to us were the workers at planned parenthood who put us in touch with the only person on the Lower East Side who is actually working directly with the community teaching birth control. This convinced us that since there is not an excess of people on the Lower East Side dispensing such information, our services were definitely needed.

We decided that our best approach was to read as much as possible on our own and hold discussions among ourselves so as to acquaint the NYC's with human anatomy, the mechanics of reproduction, etc. We found that even if the girls we are working with are not poised and confident enough to give lectures and hold discussions on their own during the winter, they are still interested and willing to work along with us.

We have had several speaking engagements and have felt that these have been successful, depending on our ability to sense the needs of the group we were talking with.

On the whole, I feel a sense of accomplishment so far, and see the rest of the summer spent in increasing community contact and trying to see if continuing work through the winter isn't possible. (The above from an undated by weekly report; the following from a Final Report.)

When our job began this summer, I felt that there would be a tremendous amount of direction needed on my part in order to find out exactly what contribution I could make.

I feel that if more work had been done beforehand to decide exactly where we were needed, our projects might have been more fruitful. We didn't realize that the community in general was not ready to accept information about sex education and contraception. There are no community organizations presently involved in sex education, and any organizations that were approached to see if they would be interested in having us hold discussions were polite to us, but inevitably, when the time came for the talk or discussion, dates were cancelled or groups didn't show up—or, if they did, they politely listened to what we had to say but showed no enthusiasm in joining into discussions with us.

I feel that we did make one positive contribution by arranging for discussions to be held and a film to be shown throughout the public schools.

One of the most helpful people on the project, I found, was our community coordinator. I felt that if we had heeded her warnings about the subject with which we were dealing, we wouldn't have run into as many difficulties as we did this summer.—S.R., *Medical Student, Lower East Side.*

Harlem

The basic structure of our project revolved around the school health referrals. We intended to work at two schools, Public Schools 175 and 133 in Harlem and then branch out from there to more referrals at Harlem Hospital. This was viable in the case of Public School 175 only because we had previously done a health study there and already had over 250 referrals to work on. At Public School 133 we got virtually no co-operation from the school health people, mostly because the director of school health for the city of New York refused to release any but a few nonessential referral

cases. She claimed that we had enough to work on from our previous summer.

Other institutions we worked with were equally frustrating; the Department of Health at all but the highest levels is staffed by defensive, uncooperative people who seemed more intent on giving us the runaround or refusing to give information than anything else. Other groups we worked with rather successfully were Ministerial Interfaith Association (M.I.A.), a very cooperative private group health facility, Harlem Teams For Self-Help, which arranged for a job in the Harlem Hospital playroom for outpatients' children, Harlem Consumer Education Board, a member of which came to a lunch meeting at our office which was very interesting, Public School 100, where we helped in a training program for school assistants, Knickerbocker Hospital, where we tried to organize a health council around a proposed community health clinic, and the Puerto Rican Guidance Center, where we helped with research on the Washington Heights community mental health center and ran an education program for a group of N.Y.C's. In general, our relationship with community organizations was successful and we tried to put ourselves at their disposal.

We provided specific referral help for about 150 of the Public School 175 cases from a year ago. We also worked on about 25 referrals from two clinics at Harlem Hospital, and another 25 from Public School 100. We got a nucleus of six persons interested in the pediatrics clinic at Knickerbocker Hospital and worked on several cases from the department of social services there. Other assorted services included providing black childrens' books for doctors' offices and clinics.—R.C., *Student Coordinator, Harlem.*

PATIENT ADVOCACY

Last summer the concept of patient advocacy evolved. The student fellow functioned as a liaison between the patient and the health facility. As our awareness of health problems broadened, our concept of the role of the patient advocate grew to include dealings with many institutions. We saw patient advocacy as valuable for both the student fellow and the patient. The student learned about the different agencies that the poor must confront. This practical knowledge, which enables the health professional to give comprehensive care, cannot be learned any way other than by direct experience. Most medical and nursing schools do not provide these experiences in their curriculum. The patient was able to confront bureaucratic institutions, whereas before he had been confused and discouraged.

My feelings toward the benefits of patient advocacy after last summer and at the beginning of this summer were very favorable. Now, at the conclusion of my second summer, I have quite different feelings. At this point, I am not sure where either party benefits. To substantiate this feeling I will present incidents from my experiences with three families.

My first example is Rebecca, a 64-year-old Negro lady. My first introduction to Rebecca was through a dental student working on the project. Rebecca's toothless smile had caught his attention. After a brief conversation with her, the dental student discovered that she had not seen a doctor in several years. With this information, in addition to the fact that Rebecca is elderly and quite heavy, it seemed very probably that she might have medical problems warranting treatment. He suggested that she be taken for a checkup. I decided that since she did not have Medicaid or financial means to pay for treatment, our only recourse was Morrisania Hospital. Not knowing which of the clinics to go to first, we went to the screening clinic. From there went to the medical clinic twice, the eye clinic twice. Also, Rebecca had blood work done twice, an X-ray, and an E.K.G. The results up to this time reveal hypertension, diabetes, degeneration of the retina, a positive V.D.R.L., and longstanding leftsided heart disease.

At first glance, and without much thought, an initial reaction to the discoveries is that it was a good thing that Rebecca went to the clinic. After studying the situation, I am not sure this is so. Rebecca does not follow through with her medical treatment; she cannot remember to take her pills even after constant reminders; she refuses to go on a diet.

There are several other reasons why I think patient advocacy for Rebecca may have been a mistake. First of all, there is a problem about getting to the clinic: Rebecca does not seem capable of taking two buses to get to the clinic; I have always accompanied her so I do not actually know how well she would manage on her own. I have always gone with Rebecca because at first it was necessary for me to make sure that she found her way too the different clinics, and that she had all the tests that were medically indicated; later it was necessary that I go with her to follow up on the results. I had thought of the possibilities of an NYC taking my place, but decided against this because I did not have accessibility to the NYC's and also my medical knowledge was needed. (For example, I was able to clarify questions concerning Rebecca's high blood pressure and poor vision which an NYC probably would not have been able to do.) My going with Rebecca to every clinic appointment did not enable her to develop her ability to be independent.

This case points up a crucial factor of patient advocacy, which is time. It took me 45 minutes to come to the Bronx from Manhattan, which means that if we planned to go by bus I had to leave my apartment at 6:45 a.m. to pick Rebecca up for a 9:00 a.m. appointment. By the time we finished in the afternoon sometimes it was 2 o'clock.

The logical solution to this predicament was to find someone who can assist Rebecca to the clinic. She is living with her granddaughter who seems to be the likely person to assume this responsibility, but they do not get along. The granddaughter has tried repeatedly in the past to get her grandmother to go to the doctor; she very clearly told me that she had tried and was fed up with Rebecca, and that if I wanted to take her to the clinic that was fine.

Rebecca was also economically dependent on my services. She does not have the resources for cab fare as she only receives a small amount from Social Security. I started paying the cab fares because the first time she told me she had no money to get there. I paid for all transportation since, which was probably a mistake because she will have to assume the responsibility herself when I am gone.

There is still another form of dependency that Rebecca has developed in the clinic setting. She feels that she will be taken care of, so pays no attention to the proceedings and sits back and takes cat naps. I tried to overcome this by always telling her where we were going and what was going to take place. On our last visit I deliberately left her at the pharmacy to fill her prescription. All she had to do was wait for her number to flash, and then walk up to the desk and hand the pharmacist her prescription. When I returned, she was sitting in a chair staring off into space and her number had gone by. My attempt at making her participate had failed. Also, the clinic environment is not conducive towards promoting independence in people like Rebecca. It is geared for expediency, and slow people like Rebecca just bog the system down, so it is much easier for the staff to direct all comments concerning Rebecca's care to me, which just reinforces her dependency on me.

Is medical care without followup better than no medical care at all? Would this woman have been just as happy having never seen a doctor? Looking back, I feel that Rebecca's real priority need was attention. She was lonely, and by going to the clinic with her I increased her personal interactions. Would it have been better for her if I had spent my time just visiting her and fulfilling her need for companionship rather than dragging her from one clinic to the next? Even if I acted only as a companion, there would still have been a dependency on my company. Maybe the best thing for Rebecca would have been to have found her a friend.

Gladys is an 18-year-old girl who has a 3-year-old son, and is expecting another child at any time. At the time I met her, she had not followed up with her prenatal care. She saw doctor once early in pregnancy, but after moving had not gone back. I made arrangements for Gladys to register at Morrisania clinic and accompanied her there. But after straightening things out for her at the clinic, I no longer

went with her for her appointments. She managed fine by herself.

Gladys' dependency needs became apparent through our dealings with the welfare department. The rapport between Gladys' family and the investigator was very poor; the investigator was extremely nasty, making all dealings with welfare difficult for the family. Being aware of this poor relationship, I went with Gladys to welfare to help her obtain a check for a layette. Because of my presence, the investigator gave Gladys the check immediately. But what will happen after I leave? The relationship between Gladys and the investigator will still be poor. With Gladys I had more resources available to me, so hopefully my services will not just act as a temporary bandage. Welfare Rights works with people to help them deal with the welfare department, and hopefully this group will take over my role as an advocate. Also I referred Gladys to the Social Service department which will follow her case.

The most important point I have made concerning patient advocacy in relationship to both Gladys and Rebecca is that the individual's resources must be utilized to the fullest extent. To be able to develop the patient's independence a critical analysis of the situation is needed, and with that information the patient advocate should carefully define his role. For example, I decided that my role with Gladys was to see that she received good medical care, but what was not my function, I decided, was shopping with her for baby clothes and looking for an apartment. I carefully reviewed with Gladys what she needed for the baby, but told her that she was perfectly capable of shopping without me. She would have liked me to help her with the shopping, but this was not necessary and there would be no one to help her shop in the future. The same was true of finding her an apartment. I am sure that with my higher level of motivation I would have been able to make greater progress than Gladys, but this would not have helped Gladys to become an independent adult.

The last patient I would like to discuss is Mildred. The important concept in my dealings with Mildred was my role as patient advocate and my limitations. Just as in Gladys' case I had decided that my role was not a shopping assistant or a real estate agent, with Mildred I decided I was not a social worker.

Mildred is a 14-year-old pregnant girl who ran away from home 8 months ago and is now living with a 29-year-old man. She is 5 months pregnant and came to us to find out where she could receive prenatal care. We decided that because of her age and social problems the prenatal clinic at Morrisania health station would be the best for her. We also have contacts with the Social Service department from which we can be sure that she will receive good followup care.

At the clinic during the interview with the social worker, several problems became immediately obvious. The man she was living with had been admitted the night before to the psychiatric ward of Bellevue Hospital. Also, he is married. His being in the hospital left Mildred in a desperate situation; he did not leave any provisions or money, and Mildred has none. Her mother is on welfare and receives an allotment for Mildred, but Mildred has not seen her mother for 8 months. Considering that both the girl and her mother are in the Bronx, it appears that the mother hasn't tried very hard to find her daughter. Mildred did not express concern about her situation. I asked her if she had food to eat in the apartment, and she said that she had two porkchops, a pound of hamburger, and some cabbage. When I asked her what she was going to do when the food ran out, she giggled, rolled her eyes at the ceiling, and said that she didn't know. She made these same responses to other questions concerning her welfare. From her behavior she appears to be a very immature 14-year-old. The problem that the social worker and I faced was what immediate arrangements would be made for the girl. Being a minor, she could not go to her boy friend's apartment because she would have been picked up by the police. (Mildred had written her mother a letter which her mother had just received, and she had notified the police.) It was too late in the day to make arrangements with welfare concerning a foster

home or a maternity shelter, so the only solution appeared to be to take Mildred to her mother's apartment. The social worker asked if I would take her there myself, but I said that I would like someone to come with me. Looking back, this was a wise decision; what I was to encounter in the home would have been a lot for me to cope with. When we arrived we were met by a very upset mother who did not speak English. The confrontation between the mother and the daughter was very tense. After the initial confrontation, we had difficulty getting any other direct communication between the mother and daughter. Mildred said that she had only come to see her mother and that she was not going to stay, and the mother certainly did not want her to stay. The mother finally accepted the fact that Mildred was her responsibility, whether she remained at home or not. Mildred also accepted the fact that she could not return to her boy friend's apartment, and decided to stay. After both parties finally made a decision, the social worker and I left. The social worker returned the next morning to make more permanent arrangements.

This whole incident made me very aware of my limitations. Not being a social worker, I had not come across such complicated situations that demanded immediate decisions. I might have, in a moment of confusion and indecision, decided to take the girl home with me. This obviously would not have been the way to have handled the situation. (I think that patient advocates should always remember that in situations where a dependable agency is involved, we should have enough common sense to let the agency handle the problem.) I know of situations where patient advocates have gotten themselves into a bind because they have tried to make decisions they did not have the background or knowledge to make, or the resources to carry through.

To summarize, I believe that the patient advocate needs to thoroughly analyze situations, and before making any decision he should assess his capabilities. Included in his analysis a realistic appraisal of manpower and time should be considered. With this information, the advocate should use his skills to help the patient become as independent as possible.

Also, a critical analysis of the purpose of patient advocacy is needed, and a decision should be made as to whether it should be a part of the SHP services. If the decision is made that patient advocacy is valuable, then how much time should be spent in this area. In my opinion, patient advocacy is a stop-gap service. The real problem lies with the system that causes the need for an advocate. I would like to see SHP's energy directed at the institutions.—V.V., *Nursing Student, Bronx.*

Aside from supervising a restricted play area with the help of four NYC's, the remainder of my time was spent taking patients to the nearby Fulton Avenue (Morrisania) Health Center, and disseminating information about the available health services. It was in this regard that I felt most qualified to work in the community.

I was involved with two families I had met while discussing housing problems. One 21-year-old mother of three was desperately in need of medical help and will require the support of the advocate program in the coming months. This woman had neglected her own health and did not expect to get relief from her chest pains and dizzy spells by going to any city clinic. At first, I was more optimistic, but soon became frustrated upon finding how difficult it is to get good care even when one know how to maneuver through the administrative labyrinth. This woman has now been to the medicine, opthalmology, and neurology clinics without getting a satisfactory history taken. The fragmention of her condition into unrelated problems, as seen by each clinic physician and generally a new face each time she visits each clinic, works against any hope that she might have of getting better. Despite her difficulty in getting a diagnosis and therapy, however, there have been positive aspect to her trips to Fulton Avenue: she is more aware of her own needs and realizes that her children's welfare depends on her health; the Fulton Avenue clinic staff knows her and are more attentive because of my intervention; she has been given medication for insomnia and a prescrip-

tion for eye glasses which she knew were needed.

Because of this one experience, I feel patient advocacy is a meaningful experience, both for the recipient and for the health student. There are objections to the present modus operandi which should, however, be raised. Successful advocacy often depends upon the student asserting himself on the patient's behalf and demanding services which might not be continued after the student returns to school. Someone must be available to see these families after the students leave. One may ask if advocacy works only because the student represents the system. It would be much more beneficial to the community if students were working with community people who would continue the advocacy work in their neighborhood after the students leave. There is no question in my mind that the student advocate gains a special perspective by seeing health problems in a social setting which places little value on good health; but the student would gain additional perspective by working with community people and thereby give more responsibility to the community itself. Being realistic, however, I realize that such a program would require year-round supervision. If our efforts are to have further significance, we must provide an ongoing program geared to involving more than just the student as advocate. Perhaps a training program could be arranged through agencies such as the NMCD (Neighborhood Medical Care Demonstration), which depends for its success in large measure upon community health workers.

The needs for more organized pressure on the health-care delivery system and the orientation of LABOR offices to housing problems both lead me to argue in favor of having students work out of the clinics and maintaining contact with LABOR only as a means of relating health issues to LABOR's ongoing activities. The dichotomy of roles was definitely a hindrance, in my opinion, as concentration on housing problems did not allow enough time for learning about different health facilities.

I found it most worthwhile to take some of the Youth Corps workers with me when visiting clinics with patients. These teenagers, however, were assigned to LABOR by the city and were given housing assignments most of the time. They would have done well as advocates and certainly expressed enthusiasm over the prospect of such a job in the future.—R.F., *Medical Student, Bronx.*

Patient advocacy over a short term has outlived its usefulness as a concept. True advocacy implies a continuing personal/professional relationship, which students (especially those from out-of-town) are not able to build during a 2-month period. The central hypocrisy of patient advocacy is revealed by the conscious avoidance by students of further responsibilities for their patients at the precise time when they are promising these same patients guidance on referrals, and encouraging militancy with respect to hospital malpractices. Furthermore, without careful preparation, the presence of health science students in overly crowded urban health clinics usually only serves to reinforce health care fragmentation.

Advocacy has served the useful role of educating a critical number of health science students about the injustices and kinks in hospital and private medical care. Now it is time to discard this tool and develop one with a better cutting edge.—J.G., *Medical Student, Bronx.*

The hospital and welfare * * * will still be the same after SHP has gone. They will still give bad service to the people. The only thing we did was get a little better service by saying who we were. Now the people don't have us to speak for them any more. All I've seen SHP do is get involved in people's lives and then leave. —M.H., *Community Worker, Bronx.*

After spending a week earlier in the project distributing information on the Lower East Side about the new sliding scale for fees at city hospitals, I was again faced with the problem of a person who fails to seek medical help because he has no money. Our group spent a day knocking on doors to find out what medical facilities were used by the community. When I knocked at Mrs. V's door she first refused to speak with me because she was cleaning her apartment and her small grandchild needed

care. I assured her I just wanted to ask a few questions and she agreed to speak with me. I discovered that Mrs. V, who had ceased menstruating for several years, was once again bleeding, but felt that she couldn't go to the hospital because she couldn't pay the eleven dollars the hospital always charged. I became very concerned when I heard of her problem and urged her to see a physician. I offered to escort her to the hospital along with my companion, a Spanish-speaking NYC who expressed a wish to care for her little grandchild. I called Bellevue to find out the hours of the gynecology clinic; I was told to come early that the clinic was open until noon. That was all I was told.

We arrived at 10:10 a.m. the next day and were told by the clerk at the information booth that we would have to come another day because registration ended at 10:00 a.m. Feeling exceedingly foolish and responsible for bringing Mrs. V. to the hospital, I went to the clinic to speak with the head nurse. She told of the necessity of the registration period so that sufficient time was allowed to send for the patient's chart. This was reasonable. She also said, however, that the doctors (three were sitting in the room where we were, obviously amused by my appeals to the nurse) were leaving soon. Why, I asked, were the doctors leaving if it was only 10:10 a.m., when the clinic hours were until 12 noon, and there were still patients to be seen? Surely there was enough time to send to the record room for the chart, and besides, Mrs. V's problem seemed rather immediate. I was told that "rules are rules," and the head nurse asked me to leave her office. One of the doctors followed me out and suggested I take Mrs. V to the emergency room as long as we were at the hospital. As a result of her visit to the emergency room on that day, Mrs. V entered Bellevue the next week to have a hysterectomy.

Our group has discussed extensively the value of patient advocacy. What is accomplished qualitatively by helping a few individuals? What happens to the thousands of others? I don't know the answers but I do wonder what would have happened to Mrs. V if I hadn't knocked on her door.—J.M., *Nursing Student, Bronx.*

One of the things which disturbed me deeply was that many of the people who complained about bad experience in the hospital took it all very passively instead of fighting for better care. I found two women who were told to go home from hospitals because they spoke no English. I find it alarming, of course, that this should have happened, but what was equally alarming was that they left. These people must be taught to stand up and fight for their health rights; no one is going to give it to them and I don't believe anyone should. If SHP really wants to be effective, educating community workers to educate the people will be much more worthwhile in the long run than all the patient advocacy in the world.—J.W., *Nursing Student, Bronx.*

Throughout the summer we visited the homes of families we met at the pediatric clinic or in the community, and very often became personally involved with the family and were always welcome in their homes. In the case of Mrs. B. and her one and a half year old daughter, who had suspected milk and egg allergy and asthma, we were with her at all pediatric appointments, assisted her in obtaining additional welfare allowance for her daughter's special diet, and visited her at home on a number of occasions.

Although such successful advocacy was limited to a small number of families, it nevertheless provided us with better insight into community life and gave us the opportunity to contribute concrete services to individuals in the community.

I feel that patient advocacy work could be a rewarding experience for medical students during their first year of medical education. Providing an early exposure to physician-patient relationship, patient advocacy would afford the student the opportunity to view the side of a patient that is often overlooked, that of his home and community life. Too often, a patient is thought of just as he is in the hospital setting, and the knowledge of his life as a functioning individual is lacking. The student

health organizations in the various medical schools should try to have some form of patient advocacy incorporated into the curriculum for the first year or first 2 years of medical study.—E.C., *Medical Student, Lower East Side.*

I found the emergency room to be a good place for patient advocacy work, for the people were a captive audience while they waited for treatment or as I dressed their wounds. I told them of our SHP office, of our Community Health Council, and of the Family Health Clinic (just opened by New Jersey College of Medicine and Dentistry students) which provides health care for entire families, including physical examinations for all every 6 months, and medical treatment when necessary, in an attempt to give more personal health care to families who can't afford a private doctor. I was able to refer quite a few people who came into the emergency room to places where they could get help with their problems.—K.O. *Nursing Student, Newark.*

How much responsibility can or should SHP workers have in order to get health care for their clients? A community worker took it upon herself to take a young boy with a leg injury to a private physician, since his mother believes in herbs and roots and is quite ignorant of health matters. A few days later I saw this same young boy playing with his friends; his leg was starting to swell again and he did not have a dressing on as the doctor had ordered. When I questioned him about this, he told me that his mother always hits him on his infected knee when she gets angry.

Another time, I had occasion to take his mother to Bronx-Lebanon Hospital. She had had breakthrough vaginal bleeding for 2½ years with the passing of clots. She was examined by a gynecologist who gave her medication to stop the bleeding and told her to come back in three weeks for a more complete examination. The next day I saw this same woman on the street. She told me that she was tired of taking her medication because it made her sick and caused pain (she had only taken one pill). I tried to impress upon her the importance of her medication and follow-up care, but my instructions fell upon deaf ears.—M.J., *Nursing Student, Bronx.*

A Mrs. J. had called our office in Newark, having heard a radio announcement telling listeners to contact us if they had any health problems or complaints. In handling the case I learned that Mrs. J.'s niece, a 22 year-old mother of two, was suffering from cancer of the cervix. Mrs. J. was making a valiant attempt to comfort her niece at home, but B.'s pain was constant and her cries kept the household awake night and day. B. needed prompt medical attention. Conversations with our faculty advisor at Newark City Hospital and with B.'s doctors finally resulted in her readmittance to the hospital.

While B. remained in the hospital, I visited her daily. We became friends and I became familiar with the workings of City Hospital, its facilities and staff. Although the wards were crowded and impersonal and equipment outmoded, more striking was the deplorable attitudes held by several of the attending physicians and nurses. In a short time after I began to visit B., the staff began to accept me as one of them—perhaps because I was a medical student— and they soon "opened up." I heard stories of the poor care and abuse they gave to the patients. I could feel an attitude of "second-class citizenship" permeate the welfare wards. It is not uncommon for a patient's cries for attention to be answered with "shut up woman, you're lucky to be getting as much as you are," or, "for somebody who's not even paying you sure do expect a lot." More commonly, their pleas went unanswered.

In B.'s case, that of terminal cancer, the nurses were particularly hard on her because of her low tolerance for pain; her incessant groans and cries kept the staff and fellow patients on edge. Her attending physician had no idea of B.'s background or personality, and neither did she care. Practically at the moment of readmission, B's doctor had said that she would keep B. in the hospital only if we would

in the meantime make arrangements to put her in a nursing home.

Now to B.'s nursing home problem. City Hospital's social service department sends its requests to the local community welfare office for placement of patients who need posthospital care in nursing homes. The placement procedure does not begin until the doctor actually discharges the patient, so there is often a long delay between discharge and placement. In the interim, the doctor is unaware of the cause of the delay and therefore cannot understand why "these —patients stick around the hospital wasting valuable space—just a bunch of good-for-nothing freeloaders." City Hospital's social service department has no idea of the quality of nursing care given by the institutions to which the patients are sent. Occasionally a patient will return to City Hospital with bed sores, dehydration, or malnourishment, but there is no direct information as to what goes on in these nursing homes.

When B. was finally placed, I visited her nursing home and found it dirty, crowded, and utterly depressing. Maybe if B.'s doctor had been aware of this she might have been a little more sympathetic with her patient.

As I followed B.'s progress, I kept in touch with her aunt. Mrs. J. had given up her job for the last few months in order to care for her niece. Being 61 years old and with a heart condition, Mrs. J. was physically and mentally fatigued from the entire episode. She responded to the assistance I gave her with praise and affection which I was at times embarrassed to receive. In my visits to her home I got to know Mrs. J., to see her style of life, to discover some of her attitudes, and to meet her friends.

Thus, beginning with the specific problem of helping Mrs. J. get medical attention for her niece, it soon developed into a complex network of exposure for me—all of which helped me better understand the health care problems of Newark. This knowledge was beneficial for others who would call us for help, for in handling this one case I had succeeded in making a lot of useful connections which would be valuable in helping other clients of Newark's SHP. —B.W., *Medical Student, Newark.*

STUDENT HEALTH PROJECT ROLE IN AGENCIES AND HOSPITALS

Newark

Our situation in Newark is quite unique from all of the other areas in what changes we realistically expect to effect this summer, for the tide is changing its direction here, and all things portend a new guard for this city. We have tried to identify with infusion of renewed life, the momentary depressions from lack of instantaneous dissolvement of malingering evils are but split-second flickering trips through disillusioned reality. However, on the whole, a sense of project is developed and functional.

July 1, 1968, a new administration, the new, New Jersey College of Medicine and Dentistry took over Martland Hospital and promised to change much in health care delivery both at the hospital and in the city as a whole. Newark SHP feels itself in the position of helping push the college into doing what it said it would do, leading the college into areas where it has not yet gone, and developing dialogues and action experiences between the community and the health services.

At the hospital we have begun several direct actions: (*a*) specific patient advocacy in the emergency room; (*b*) admistering a questionnaire in the emergency room; (*c*) advocacy of the several clinics, especially the prenatal clinic.

Less direct but more meaningful and expectation laden actions include: (*a*) Talk with key hospital personal about specific immediate changes in procedure—trying to be part of a committee that will actually write up procedures; (*b*) talks with key hospital personnel about basic changes in staff attitudes (developed during the city's administration) and plans to develop program for training staff about "where it's at", (c) actual development of a committee of hospital, SHP, and community persons to work on these points.

At the area board we have tried to develop a health advisory and information service. However, as yet there has been a dearth of persons wanting information, less than one per day.

However, we are developing the body of knowledge necessary to help anyone.

A community committee has been organized, with exceptionally fine, able, committed local persons in charge. Their main focus is on organizing persons to be aware of what is happening on the local health scene; what is available on the local scene, and what they can do to generally improve the care given,—to see about getting decent treatment for whomever comes to clinics.—D.T., *Student Coordinator, Newark.*

I worked primarily in the prenatal clinic at Martland Medical Center in Newark. My relationship with the institution can best be explained by my relationship with the clinic's supervisor. In the beginning she was very suspicious of me and of the SHP in general, and she sought to control everything I did. When I asked about the hospital mortality statistics, she sent me to a doctor who abruptly told me not to question the nurses in the clinics.

As time went on, and the supervisor could see that I was interested in improving the clinic and willing to help rather than merely criticize, she became more open with me. She would sit down and talk with me about problems she was having in the clinic; although we did not always agree, we seemed to be able to share our feelings with each other. She took the time to listen.

She disliked patients coming to SHP with problems they were having in the clinic. She prides herself in having a good relationship with the patients and wants them to come directly to her with their problems. She is also against a community organization to help patients with health problems; she seemed to be fearful of giving the community power in the hospital.—L.D., *Nursing Student, Newark.*

When I first started working in the emergency room at Newark City Hospital I dealt with patients, talking to them, calling their families for them, helping them to contact social services, sometimes acting as an interpreter for the Spanish-speaking people. The hospital employees in the emergency room didn't know who we were. Some of them thought that we were hospital-employed NYC's, and they tried for a while to assign us to useless jobs, such as removing carbon papers from duplicate copies of patient's charts. They wanted to keep us busy so we wouldn't "spoil those useless community people" by trying to give good service.

We refused to do meaningless tasks. After about a week, we made up a list of suggestions for changes in the emergency room and clinics. The changes we suggested were not unrealistic; they were not changes which required additional funding; they were simply reasonable change. The hospital administration greeted us, smiled at us, promised us everything, but gave us nothing.

It had been my experience in the past that if you could not obtain satisfaction at one level you sometimes could achieve what you wanted by going to higher authority. I went to the administrative assistant to the president of the college which runs the hospital. He found most of our requests to be reasonable and granted them. The hospital administrators were enraged.

Nothing really happened to any of us as a result of this, and I believe it was because they were not absolutely certain about the amount of community support we had. Actually, we had very little. People in Newark generally hate Martland Hospital, but are not unified enough to do anything about it. Lack of knowledge of the community by the administration was to our advantage this time; they thought we had more power than we actually had.

I have come to believe that it is useless to play with a bad system. Nothing short of complete overthrow will bring about major changes. The black community must organize, must seize control of the city and must bring about radical change in order to survive.—K.F., *Medical Student, Newark.*

Briefly, the New Well is a community drug rehabilitation and prevention center located in the heart of Newark's Central Ward. It is a storefront operation, open at all hours to all people, and staffed voluntarily by several medical doctors and approximately 10 former addicts. No police supervision or intervention is present to scare off those who need and seek

help. Addicts pay a $10 registration fee, receive a physical examination and get a prescription for Methadone, a drug which helps them come off their heroin-induced "highs" without going through withdrawal. This procedure takes 4 days. The addict is then encouraged to attend the triweekly group therapy sessions during which everyone talks of their problems and encourages one another to stay "clean". I was impressed with the program and the caliber and dedication of the staff.

As the New Well's director told our SHP group, addicts and Newark youth who may be fooling around with drugs, often listen to him because he is himself a former addict, and a member of the black community of Newark.

A big problem at the New Well is lack of funds. Since they only began regular operations in December 1967, they have not as yet been funded, although they are now in the process of applying for a grant. In the meantime, they must rely solely on the $10 registration fee and on scanty private donations to meet the rent, repair their facilities, and keep their program running.

To help alleviate their financial difficulties, I organized a musical benefit whose proceeds will all go directly to the New Well. I was able to obtain a large hall located in the Central Ward, in which to hold the show; I got Tom McCray's African Heritage Dancers, Art Williams' Jazz Trio, Larry Young's Organ Combo, and Bill Testa's band to donate their time and talent. In addition to money coming in from the ticket sales, I sent letters to all the churches, doctors, and big industries in Newark asking for their contributions and support of our musical venture. In all, 1200 letters were sent out. The response was gratifying; about $40 poured in each day.

Not only is the money important, but so too is the publicity which will come to the New Well as a result of newspaper coverage of the event and plugs for our show on radio station WNJR. Many of the doctors and other community leaders who received our letter called to ask for more information about the New Well's program and several wanted to find out how they could be of help.

In all that I have done, I have tried to make sure that the help would be of lasting benefit. —B.W., *Medical Student, Newark.*

The attitudinal study among postnatal patients was almost wholeheartedly rejected by the students in the project as something "mickey mouse." I was more interested in it because I had helped formulate the questionnaire and realized it was one of the reasons that the dean had let us enter the community with the good blessings of the medical school. Although it did not seem to be a constructive thing to many of the students, it was one way of getting close to individual people from the community in a medical and sociological context with the possibility of followup. Actually, it proved to be a better means of meeting problems than did our storefront at the area board. Confined to bed, people were more receptive and the questionnaire, if given properly, covers a wide range of problems and is a beautiful effort at public relations to show the medical school cares.—P.D., *Medical Student, Newark.*

Bronx

The members of the community organization from which we worked were most anxious to have SHP join them, but unfortunately had not been prepared well enough in advance on what SHP could or could not do in the community; not enough thought was given as to the actual needs of the community. Perhaps if representatives from SHP would come into the community in early spring and explain SHP and give the leaders of the community a chance to go back to their people, then the short time that SHP spends could be spent in accomplishment rather than frustrations.—E.F., *Community Worker, South Bronx.*

Working out of the LABOR storefront has proved to be the greatest setback so far in terms of doing patient advocacy. This agency supposedly has its fingertips on the pulse of the community, but both students assigned there have found organization and action almost totaly lacking. The reasons for this we need not elaborate here; suffice it to say that their problems of inertia have held us back. Out of fear of usurping the staff's power, I

have gone along with their suggestions, adding my own whenever possible, always looking for any opportunity to get things going without making it look as though we, the outsiders, are actually directing.—R.F., *Medical Student, Bronx.*

Because our instructions were to work with LABOR and because we did not wish to antagonize LABOR, we ended up working for them, doing the work they wanted rather than the medically oriented service we had envisioned at the beginning of the summer. This had the advantage that LABOR can follow up what we did. But it meant that we did not function in the way we were best suited; we were doing work which people from the community should have done. We ourselves learned a great deal; we served very little.—N.A., *Medical Student, Bronx.*

Health students should consider themselves working for LABOR. They should submerge SHO independence as much as possible and try to work out within LABOR a suitable role for themselves.

I think we ran into a lot of trouble when students considered LABOR a parallel organization and demanded independence. As far as I can see, LABOR is flexible about letting people do what they want to do, if good relations and trust are established first. I think it's the students' job as outsiders to work hard to maintain good relations with the community organization.

The alternative is rather paternalistic. It involves, first, denying that LABOR represents the community and, second, presupposing that students know what the community wants or needs.

I have not been impressed with suggestions that students "run their own program within the community." Underneath those suggestions, I think, are a lot of petty professionalism and a belief that the community doesn't recognize its own needs.—K.B., *Medical Student, Bronx.*

Lower East Side

Too many times this summer, as I am sure it must have happened in years before, there have been people willing to help solve the problems of an individual or of a community in general, but the problem could not be defined to the satisfaction of both groups. Having heard so often, during orientation, that SHP workers must be sure they are working toward the betterment of the community in an area that the community deems a problem, this summer has shown the biggest difficulty to be the definition of a "problem."

On the Lower East Side, project leaders felt it would be impossible to work in the area unless a liaison had been established between the SHP and an established community group. The problem is that in a relatively small area there exists a large number of community agencies which have notoriously vied for positions of power rather than worked together. It did seem to the project leaders, though, that one organization, the Lower East Side Neighborhood Association, was representative of the desires of a majority of the community. This organization provided the Lower East Side project with its community advisors as well as serving as a base for communicating with other organizations and their activities. I felt that they tried to help as best they could but were too involved in their own ongoing activities to be of any great help. This is not a criticism, merely an observation, for lately they have been working out the myriad details involved in setting up the North East Neighborhood Association (NENA) comprehensive health service, scheduled to open in January 1969. This activity is indeed invaluable to the community. SHP's connection with NENA, however, was such that we could only request assistance if they had the time to spare. Understandably, they often didn't. I believe that any future SHP groups working in Manhattan must have a close alliance with an established group in order to be at all effective. The established group offers the greatly needed background information, actual experience and vital contacts without which a small group is lost trying to challenge the bureaucracy of New York's health care facilities.—J.M., *Nursing Student Lower East Side.*

Our contact with the Lower East Side com-

munity was exclusively through the NENA Health Council, a coordinating committee for grassroots groups in the area. It is not a grassroots group itself, and is not involved in organizational activity. I feel that white students have no business in such a neighborhood unless they are supportive in the effort of poor people to organize themselves politically. NENA is past that stage; they are now consolidating the fruits of past organization and pressure. I think it was a basic mistake to work through them. They served to insulate us from the community. The members of the council, through years of striving for a neighborhood health clinic, have become very sophisticated about health and politics. I think they still represent the community, but they are not representative of it.—J.M., *Law Student, Lower East Side.*

I worked with four other health science students in helping the North East Neighborhood Association (NENA) Intergroup Health Committee develop and write up a training program for paraprofessional personnel who would work in the health service; publicizing the clinic in the community and asking the community people for suggestions on how it should be run; and trying to find ways in which Puerto Rican nurses could be licensed by the State of New York. * * *

I found that the health science students were accepted completely by the people at NENA who seemed very happy to have us working with them. Since the health service had just been funded, there was a great deal of work to be done to get it set up and there were only two people working on the clinic when we first came. Thus we worked as a staff for the development of the clinic. The project director of the health service outlined what she thought were the important jobs to be done and then let us develop our own methods and goals; thus we worked mostly on our own.

I think the group was quite successful in fulfilling two of its three objectives. We completed the training program, our top priority task, and hopefully a grant will be obtained so that the program may soon begin; and we reached a good many people and informed them about the clinic, although, due to lack of time, we did not reach as many as we had planned. We found that there was no way Puerto Rican nurses could be licensed except by taking the New York State examination.—K.D., *Medical Student, Lower East Side.*

Those of us interested in fighting narcotics addiction decided to produce a skit using NYC residents of the Lower East Side, speaking the slang of their peers and interacting on stage in a manner to which their audiences could relate.

We realized that in order to be effective we would have to associate ourselves with ex-addicts. We began to attend daily sessions at Daytop-SPAN, and remained there until the end of the project. This association both helped and hindered us in the fulfillment of our objectives. Because of the close-knit group togetherness of Daytop-SPAN, the orientation of the organization was necessarily different from ours. This situation created a certain amount of tension, which remained between the two groups for the duration of the project. Daytop expected us to immerse ourselves completely in their therapy program while we were only there to gather information, background, and atmosphere for the play, and to insure that the portrayal maintained a certain amount of accuracy. Daytop, however, subjected our private lives to their scrutiny and jurisdiction, and refused to accept that we had come only to seek advice and not to seek "salvation." Perhaps the burden of the blame lay with us. We did not clarify our exact position and functions to Daytop-SPAN and thereby melted too far into the organization.

Once again, this emphasizes the rather serious lack of a clearcut identity on the part of the SHP. Having formulated its specific objectives, the SHP ought to have established its autonomy as an organization vis-a-vis the other community organizations with whom it worked or from whom it sought advice. The value of SHP as a link between the establishment's health and social services and the Lower East Side community is too great to allow SHP's dissipation into simply another free labor supply for various neighborhood organizations.—D.S., *Medical Student, Lower East Side.*

We had a great deal of trouble fitting into SPAN: we supposedly had a double allegiance —to SHP and to SPAN. SPAN is a very structured, rigid organization, as it has to be. As they say, "We are in the business of saving lives; we can't afford to compromise or let ourselves slip." Coming into SPAN, we originally agreed that we would do everything that everyone else did, for example, help clean up and attend all meetings, seminars, and group therapy sessions. However, in some ways we were treated with leniency, and for the NYC's this was bad because it decreased their sense of responsibility. It also caused SPAN to be upset with itself and with us, because they felt they were not living up to their own standards.

The second hangup was that no one knew what the students' role should be. We were treated as supervisors, and fell into that role too easily. The play was almost entirely conceived and laid out by the students, without it ever being explained to the NYC's. When our director finally straightened out the mess, the pendulum swung in the other direction: the students felt they had no authority at all. Once the play got underway, the NYC's were the actors and SPAN people the directors; the students floundered for a purpose. Eventually we settled on an administrative-organizing role; we set up performance places, bought props, phoned absent NYC's, etc. But through this long struggle toward a role, SPAN looked on annoyedly, not quite knowing why we were there or what their concern for us should be. Generally, SHP seemed so disorganized and inexperienced an organization that SPAN decided to try to ignore it, and to take us into their organization as individuals.

After many stops and starts, we got the play going and performed it three times, once for the people at SPAN, once each for University and Henry Street Settlement Houses; altogether we reached about 100 people. We expect that it will continue through the year. The five remaining NYC's who acted in the play are very enthusiastic about doing it in high schools throughout the year, and about coming down to SPAN and participating in groups.

It was a tremendously enriching experience to meet and get to know the people from SPAN. They are all ex-addicts, who, through their program of self-help, have become incredibly self-aware and perceptive. I found it easy to work with them; more than that, I doubt that there could have been a play, or any meaningful conception of what we were trying to do, without their help.—M.H., *Nursing Student, Lower East Side.*

Harlem

When I went out on referrals in Harlem I did not feel that I was accomplishing anything, because I was not connected with a community organization. Once associated with the hospital, however, I felt that my service was more organized and therefore more effective.—M.I., *Psychology Student, Harlem.*

Referral work formed the body of my job for the summer. Personally, I met with little resistance from the community; most families were cooperative and grateful for our services. * * * Nonetheless, a sense of friction arose in dealing with the clinics. Although we were well received and complimented by all health facilities we used in Harlem, I believe there was some resentment of our arriving so eager and fresh to do a job which the clinics alone were not doing as best they could. An example of this was the hypersensitivity of the dental clinic staff in the Central Harlem Health Center. I feel they were caught sitting on their hands and that we forced them to take on the number of patients they were actually equipped to take but had not been receiving. Goading clinics to give better service was one of our goals, however, and in certain respects we were successful.—C.W., *Medical Student, Harlem.*

I was told by many of the health establishment professionals that they felt they were doing the best they could under very trying conditions (for example, over-utilized and dilapidated facilities in Harlem hospital clinics), and they felt that we posed a definite threat of trying to "expose their inadequacies," which, although never stated, was implicit in our idealistically trying to "make things better in a hurry." Many of them, of course, aren't doing their jobs; however, it doesn't matter what we

think we're doing but rather how they interpret our motives which determines whether or not they co-operate willingly. Our handling of this "domain infringement" problem often was not very tactful (and other projects reported similar problems), so this is one area we should give more attention to in future efforts to effect change from within institutions.—W.S., *Medical Student, Harlem.*

Brooklyn

I thought the nature of our involvement in the hospital setting was extraordinarily appropriate in effecting our original aims. Personally, I do not believe that community involvement is necessarily the best way to improve health care. Recipients expect doctors to act like doctors; that is, to render healing services, and not to act as quasi-social workers or priests.—M.H., *Sociology Student, Brooklyn.*

We had hoped that the Youth-In-Action project would bloom out, because they're a gigantic organization in Bedford-Stuyvesant, and they have many programs: social affairs, family counseling, unwed mothers, sports—you name it. We thought it would be a good opportunity. As it turned out, it was horrible.

The bureaucratic problem we met is probably typical of a lot of agencies, but even worse at YIA. We made arrangements, really good arrangements, with a couple of people at YIA and then some of them left, and we were up in the air. No one else had been told about these arrangements, so we had to start from scratch. We were trying to get involved in one of their other programs (I think it was the unwed mothers or the family planning section) and we found that people over there never knew we had been working in home family counseling. —W.S., *Student Coordinator, Brooklyn.*

Most of the community groups in which the Brooklyn SHP was to operate had been contacted several months before the project began. Model Cities was a last-minute addition, and the role of the SHP in it was rather unclear. We were to work for the multiservices committees whose social service interests stretched, as our supervisor said, "from the womb to the tomb."

The Brooklyn SHP felt that the student fellows' role in model cities would be to help the multiservice committees prepare a health proposal by the September target date. We should have seen trouble ahead when, on our first meeting at model cities, the supervisor proposed that we learn Spanish for the first few weeks in order to help recruit the Puerto Rican community for the Model Cities program.

Following a week of orientation to the Model Cities concept, we reported to work in Central Brooklyn's Brownsville office and were told that our job would involve an investigation of the health facilities in the Model Cities area. We knew little of the area and started from scratch.

Investigating health facilities can involve anything from making a list to conducting a survey of patients' opinions of the various health services available. We tried to set a course somewhere in between, realizing that there was little time for in depth evaluation since the committee were being asked to submit tentative proposals by August 15th.

On July 9th, our second day in the Model Cities office following orientation, we walked across the street to check on the activities of the Ralph Community Center. We were curious to see how community action was being handled on a storefront basis. * * * The Ralph Center is small, but it did have a group of welfare mothers in a remedial reading program and we spoke to them for a few minutes to sound out their ideas concerning possible health programs such as child psychology, nutrition, the psychology of drug addiction, etc. The women were only mildly enthusiastic but we arranged to meet with a larger group for later that week. * * *

Model cities did not employ Neighborhood Youth Corps workers. Instead, some 78 college aides from the Brownsville, East New York, and Bedford Stuyvesant communities were hired. Three of these aides had attended the SHP Orientation. Since the two girls were black and the boy a native of Puerto Rico, I asked our supervisor if they could join us for the hour or so we expected the Ralph Community Center meeting to last. Much to my astonishment, I was not only told that they couldn't

join us, but I was forbidden to walk across the street! I was told that we had enough to do at Model Cities; and when I protested that we felt we had time on our hands at this point the supervisor told me not to get involved because there will be much to do.

We had not expected this type of rebuff. It had been our feeling all along that our role at Ralph Street Center would be one of coordination only, and that the women themselves would make the contacts and invite the speakers. We felt that even should the program develop on a weekly basis, it would involve only a couple of hours a week and we could not anticipate our ever being so busy as not to be able to afford 2 hours. In any case, the commitment had been made to meet the women and we contacted an assistant to the director and he arranged for us to go to the meeting with two Puerto Rican college aides in the office.

The significance of this encounter lies in its total misconception of our role in model cities that saddled and hindered us in all the weeks we worked. We felt that our task to provide health information to a planning agency designed to improve community services *in toto* was an important one. Given the scope of our research, this assignment did not demand a 40 hour week. We spent every Monday evening and one Tuesday evening trying to help the Multiservice Committee of Brownsville and East New York. The job involved a great number of phone calls, many meetings with directors of health facilities, and an equal number of reports for the Model Cities office. It did not, we felt, involve a stranglehold on our time and interests by a supervisor ill-equipped to direct us efficiently and an agency burying itself under the weight of its own memos. The net result was a gradual alienation between us and our supervisor, then the director, then ultimately the task itself.

* * * I had written a rather stinging report for the SHP. It was written at a rather low point in a day in what had been a rather low week. I will quote the final two paragraphs:

"It is our feeling that, since a proposal must be produced by September 1st, the committee will have little to do or say but rubberstamp ideas suggested by the staff. Model Cities is grossly understaffed and equally uninspiring. We have spent too much time writing reports that are never read on resources that are being listed for the umpteenth time by the umpteenth agency. Our job is to drown in bureaucracy.

Frankly, I think the job stinks. It is stupifyingly dull and nonstimulating. * * * There is no doubt that Model Cities will benefit in some way by our work; there is considerable doubt that we will benefit from four more weeks of boredom."—J.R., *Medical Student, Brooklyn.*

There were two important areas of the Kings County Hospital patient advocate program that hadn't been touched on by the 4th week of the project. One was the problem of how best to utilize the facilities of the pediatric clinic to educate the mothers that visited it, and how to make the clinic as enjoyable as possible to the other children that had to tag along. We needed to make the hospital administrators aware that much more could be done for the people who visited the clinic * * *

The National Dairy Council let us use for 2 weeks a 6 foot by 4 foot electrical cow that could "talk". Along with this cow came posters about proper nutrition; and the importance of drinking plenty of milk.

The cow served two purposes: the first thing that it did was brighten up the entire pediatric clinic for all the children. You should have seen the excitement in their eyes as the cow moved its head back and forth and mooed and wagged its tail. Many of the children had never seen a cow up close and couldn't help touching the animal. Why the — couldn't the people in the clinic, the administrators of the clinic, think of something like this? In order to get the cow free for 2 weeks, in order to get the posters and handouts for the people visiting the clinic, all I had to do was write a letter to the National Dairy Council. Can you imagine how much could be accomplished if the head of the department of pediatrics or some other person in authority tried to use his influence with various agencies in order to help improve conditions in the clinic?—D.Y., *Medical Student, Brooklyn.*

THE NEIGHBORHOOD YOUTH CORPS

A tentative program was developed in which health science students and Neighborhood Youth Corps would jointly structure a summer "experience." The objectives were : (*a*) To undertake a program which would give the NYCs a constructive and educational summer job which in some way relates to health and to medicine; (*b*) to enable health science students to become thoroughly acquainted with the health needs and health services in the community; (*c*) to develop one-to-one relationships with several adolescents, thereby hoping to have a positive influence on their further development and goal expectations.—L.K., *Medical Student, Brooklyn.*

Working with the NYC's was both rewarding and frustrating. They contributed a great deal and ran some of the projects entirely. However, some of them were too immature and didn't want to work. They didn't want to walk a few blocks when we were all going door-to-door with health information; they didn't give us suggestions when we asked them what was wrong with the summer work. They said they wanted to talk to their age-group about drug addiction, but when the opportunity came they were too embarrassed to talk.

Many times, we climbed walls in order to keep them busy. I don't think, however, that our project could have existed without them. When they were interested in something, they were creative and tremendously active.—E.B., *Medical Student, Brooklyn.*

The big problem for most of the people on the project who were working with the NYC's was that they felt they were working to make work for the NYC's; that they were constantly worried about what these kids can do, and should do, and trying not to keep them bored. A couple of the health students expressed to me that the kids are wasting their time and could be getting a better experience elsewhere. Some of the kids worked out well. In Brownsville we had two kids who were really great and they were interested. We had known one of them before this summer and we requested him, as he had indicated to us that he was interested in medicine or an allied profession. The other one I met before we hired him, and I spoke with him for a while and explained the project and he seemed interested. So both of these NYC's were screened. A lot of the other people we got were just given to us. We had requested that they have an interest in medical sciences, but in truth, when people assigned NYC's to us, I don't think they took anything like that into account. It was a real horror show for a while.

We had to get NYC's from three different areas, because we were working in Brownsville, Crown Heights, and Bedford Stuyvesant, and we had to get NYC's from different agencies within those areas. In the beginning there were hangups in all of them—the kids didn't get paid and they had to register and re-register—but after 2 or 3 weeks, Brownsville and Crown Heights straightened themselves out. Bedford-Stuyvesant Youth-In-Action has yet to straighten out. We were calling and going down there and seeing people, and we got nowhere. And last week we sent them a telegram telling them, "We've been trying to get you, and the NYC's haven't been paid for 6 weeks, and it's time something got done." Two NYC's stopped coming to the office. Last week we told them we would followup the telegram and go down there and sit there until someone did something, so we went down and we had, I'd say, about 10 or 15 people there in that little crowded office, so they saw us and we got it straightened out as well as we could have expected.—W.S., *Student Coordinator, Brooklyn.*

When the NYC's were working they did work comparable to the work which was being done by student fellows in the SHP. This is an interesting observation and may shed some light upon SHP's place in the community.

If Neighborhood Youth Corps workers are capable of doing much of the work which was done by medical students this summer, then why not set up an SHP in which the majority if not all of the student fellows are teenagers from the community. I'm sure with supervision from the Public Health Service and a few medical students such a project would work. Furthermore, if the funding is through an estab-

lished bureaucracy such as ours was, there would be no financial problems.—R.J., *Medical Student, Brooklyn.*

On the whole, I found that working with the NYC fellows to be a very worthwhile experience. Although they had much difficulty as far as receiving their pay checks went, they still continued to work with us throughout the summer. I discovered that these workers were very imaginative and as eager as we allowed them to be. That is, when we showed enthusiasm for a project, then the NYC's showed the same eagerness to get involved. If they didn't have such a problem about getting paid, then it would have been an even more productive summer for us. These youngsters know the community. They helped us get acquainted with the area, the problems that the people had, and the problems that they faced daily in their own lives in the ghetto.—D.Y., *Medical Student, Brooklyn.*

It appears that two factors contributed greatly to the somewhat frustrating situation with the NYC's. First, the unstructured nature of the work in the initial stages, the degree of abstract thinking required, and the many hours of rather uninteresting but necessary busy work. To do this busy work both effectively and with enthusiasm requires an understanding of and dedication to the ideology. By utilizing a confrontation technique with the NYC's, some success was achieved in increasing their interest and participation. Secondly, the generalized confusion of the NYC program hurt us—many youngsters were not hired until quite late and the payroll mix-ups were numerous.—L.K., *Medical Student, Brooklyn.*

In the beginning it was said that the health students and the NYC's were to be equal, but it didn't turn out that way. The NYC's were the slaves of the health students, because the NYC's didn't have the same responsibility as the health students. By this I mean the health student did everything and the NYC did the slave work, the dirty work.—R.P., *NYC, Brooklyn.*

The NYC program was nearly a total fiasco, a flop—the major failure of our project and of my efforts. Relations between me and male NYC's were cordial but superficial. I cannot remember one truly frank or constructive conversation between me and a male NYC. The boys are mostly high school students whose interests and capabilities are varied. I had more friendly, frank discussions with the girls, although these did not come until the last 2 weeks of the project. Boys were more cynical, less interested, and less vocal; they just didn't trust or like me and many other project members, and I feel they had good reason. Some stopped coming to work other than to pick up paychecks.

Here's how we let them down, as I see it. We have a kind of Cinderella complex about NYCs. That because they know their community best we presumed they have highly developed social interests and ideas. We did not tailor jobs to individuals carefully and, where necessary, we did not provide well defined tasks, thus giving NYC's a feeling of importance and belonging; it has to be nurtured and we weren't able to do this. I don't think they felt important and necessary. We did not use them as consultants. One boy failed his summer school course, and we didn't know about it until after he got the grade.

With proper direction and attention, the NYC program could be productive for them and us, but more attention must be given to it. We must learn from our past mistakes.—A.H., *Medical Student, Newark.*

Neighborhood Youth Corps teenagers were essential as a direct line into the community. They did not turn out to be secret agents at all, but were frequently direct lines to the real poor who need help the most. I did not develop as close a relation with the NYC's as I hoped to, but some of the talks I did have with a few of them were mutually beneficial. A basketball game the health science students played against them was a success, but it or a similar activity should have been held earlier in the project when enthusiasm was still high. I suggest intensive individual tutoring of the NYC's two mornings a week with as many health science students as possible participating and keeping daily records of each NYC's progress.

We never made operational a suggestion that instead of focusing our attention in the direction of what we could find for the NYC's to do, we instead charge the NYC's with the responsibility of informing us about what their neighborhood and its people were all about and bringing to us what persons they knew or knew of who needed some help. I feel a keen sense of disappointment that we didn't make our NYC's experience this summer nearly as valuable as I thought it should be. The most certain thing I can suggest to remedy this in the future is that in the first week or two when enthusiasm is still high (assuming it begins high) each NYC is made to feel important by doing something constructive and meaningful, and not just sitting around.—N.W., *Law Student, Newark.*

The problem we have is that NYC's and health science students don't relate that much. The NYC's don't have a sense of the project like the health science students do. One, the health science students don't have the same problems, with day to day living, as the NYC's, so they don't have the same objectives. We have more intellectualized, idealized objectives of a better health service. The NYC's are concerned with summer jobs, keeping busy, getting something interesting to do, and in the winter having another job, getting more money. Their interest in a way is very importantly, very basically, economic. They think of that more than we do. The most important thing we're doing is making them think—how many of these kids would otherwise be thinking about hospitals and health problems? They never would have thought about this. If they have a job and they have to think about it because it's their job, they're not going to stop thinking when the job is over. One guy is maybe going to get interested and one guy can change ten people.—D.T., *Student Coordinator, Newark.*

The most striking lack of communication was between health science students and the NYC's. It got to the point where one NYC was assigned to each health science student. I thought this absurd, but shamefully necessary in most cases, to establish this forced relationship. By the end of the first week, the role of the NYC's was set in the minds of the glory-craving, great white liberals as kids who were to be dragged along. These "kids" are a lot more mature, open, truthful, and real than most middle class health science students. The NYC's are the most powerful organ of SHP. They are the community and any student who ignores or exploits them "to know what a ghetto person is like" is ignoring and exploiting the entire community that SHP is supposedly established for. I myself underrated the potential of the NYC's initially. But fortunately, through one NYC who was "showing me the ropes", I realized their importance and worked much more effectively with them.—K.S., *Nursing Student, Newark.*

I feel the NYC's were the most important people in the project, and with most of them, especially the boys, we failed miserably. First of all, they were excluded from many of our meetings concerning hospital services, meetings which they should have attended as the main speakers on poor medical care and bad attitudes in the hospital. Secondly, many of the health science students went about their business without the NYC's. They were regarded as little kids who had to tag along after you and the biggest question seemed to be, "What are we going to do with the NYCs?" Nothing should have been done "with" the NYCs. They were all old enough to understand why we were there and what we were doing, and they should not have been treated as kids. I found the girl NYC's to be the most genuine people on the project. They were intelligent, alert young ladies, more aware of the existing conditions that they were often given credit for. Had some of the health science students stopped patting themselves on the back and befriended these boys and girls, they could have learned a lot. If the NYC's had been treated as equals they could probably have proven invaluable to the project goals.—A.C., *Nursing Student, Newark.*

This summer the Lower East Side dental educational program was performed by only NYC students. They wrote and directed their own play and have received tremendous praise

for their performances. All the Head Start schools in District 1, daycamp schools, the Poor People's Campaign, Junior High 71, the Boy's Clubs, Sloane Center, and many other agencies have all enjoyed and learned something from the plays. This group of 15 NYC's have reached about 3,500 children and young adults this summer. As well as supplying a service to their own community, they also had a great time doing it. I have personally heard that they are proud of what they are doing and hope to have an ongoing program during the school year. A few of them have come to me and expressed their personal gratitude for the summer.

I am presently submitting a proposal for funds so these NYC's can continue their activities during the course of the year. We hope to coordinate their activities with an exciting program at NYU Dental School, where they will continue to perform, to rehearse, to make costumes and scenery, and to draft new plays after school. They will perform their plays for local agencies as part of the dental school program. The NYC's will also be offered a tutorial program to aid them through high school and entrance to college. They also will attend dental educational classes where NYU faculty members will talk to them about oral diseases. From my own experiences and observations in this community for over a year and a half, and considering the recent summary of dental needs by the Public Health Department, I feel this group can provide a fantastic service to their community, a service which is desperately needed.—G.L., *Dental Student, Lower East Side.*

We, as students, had a great deal of trouble adjusting to working with the NYC's. We alternated between our ignoring their abilities and their ignoring our abilities. In the end, we, the students, moved into a cooperative, supervisory role, and it worked well. Though it was hammered into our heads that everyone was "equal," and that "no one bosses anyone," we finally realized that the NYC's were 5 to 7 years younger than us, much less experienced in the responsibilities of working, and needed guidance.—M.H., *Nursing Student, Lower East Side.*

* * * You see, one of the things about Neighborhood Youth Corps is that it's a synthetic organization developed for a particular purpose. If you have two synthetic groups relating to each other, and the core of their experience is what happens between those two groups, I think the community's going to get left off in the cold somewhere. And there's question as to what extent these NYC's are related to the community: some of them are, some of them aren't; in fact, the coordinator of the whole Youth Corps was in just as much of a hurry to move out of the community as he could be.* * * —S.D., *Community Worker, Lower East Side.*

From my point of view, the SHP could have been more organized if the students had been more thoughtful in their decisions. For the most part, I think that the SHP accomplished what was needed in the community. I think that we NYC's were very effective and very helpful to the work of the students because since we were also from the community, the people would be more attentive to what was being said.

The students I worked with were, for the most part, very nice. They made me feel mature in what I said and what I did. They sometimes disagreed on what was decided in meetings, but I think this showed that they were really interested in what they were doing.

I feel I got to know the community better because I personally went around to them, talking about the clinic. Yes, I really think that my experiences this summer may surely change my plans for the future in that now I know what I would want to consider my life's work. —N.R., *NYC, Lower East Side.*

The NYC's in our office had not been hired by SHP, but by LABOR. The ones I worked with were very good and responsible. LABOR would like to hire them part-time after school to work as block organizers. My relation to them was primarily one of a teacher—how to get complaints in a building, how to organize a tenants' council, how to do a title search. They

were expected to work independently and come to us as resources, an excellent relationship for those who were capable and mature, a hopeless responsibility for the others. I felt somehow that NYCs should be treated as our equals, but they seemed to want more direction than I expected. I think in a continuing relationship, equality would emerge. But NYC's really have to be selected for the work. Just hiring anybody off the street and giving him make-work is quite damaging.—K.B., *Medical Student, Bronx.*

This summer found me working for LABOR as a screening technician. It was not fun. First of all, I don't get kicks out of going from door to door asking for urine. We didn't help the families as far as housing and bills, etc. are concerned. I think that that is something that SHP should have considered.

As far the other NYCs I worked with were concerned, they felt the same as I did. We all thought it was a big drag and we all knew that we weren't doing it because we loved our neighbors, but because we were getting paid $40 a week for what we were doing. Being a screening technician didn't give me an opportunity to get to know my community any better because I wasn't working in my community, but I did get to meet new people.

My summer experiences didn't help me as far as the future is concerned, because I wouldn't want to do what I did in the summer for the future.—J.R., *NYC, Bronx.*

To me, this past summer has been very helpful and educational. (I know I speak for my fellow NYC's as well). For instance, I never really knew how bad the slums are until I got out there and worked in them. It was pretty depressing but that's the only way of learning about it. I was also blind to the fact that interns work hard to become doctors and when they become doctors they work just as hard to help out the sick, the ignorant and the oppressed. How do they do this? By starting community projects; or by opening public hospitals, clinics, etc. Yes, this summer was a summer I'll never forget, for I learned a little about a lot. Or a lot about a little, whichever. In short, I am grateful to the SHP for what it has taught me.—F.M., *NYC, Bronx.*

I hated every minute of it. It was the most boring and the dirtiest job at times. This project was also very unorganized, confusing, and a lot of talk as to what to do. All I really did at times this summer was fuck off in this project because sometimes that was the only thing left to do. SHP did not do much work on housing problems in the community, for what I saw. Besides, there aren't enough workers for this job anyway. Concerning the workers I worked with, well that wasn't much of a problem for me, but for the medical students, yes, it was. They should have taken the job more seriously but I don't really blame them because there was no one around to make them responsible for what they were supposed to do.

The most important thing I think I got out of this summer job is knowledge of the poor conditions the hospitals are kept in. They don't even look like hospitals to me. And also the poor housing conditions some people live in. I think there should be something done about this problem, which some people don't even consider. The one thing I really liked about my job was that I got to know some of the people in the community which I worked in.—R.F., *NYC, Bronx.*

As far as the Bronx project is concerned, I think that there was very little unity, if any at all, between the older members of the project and the NYC's. Most of the young people felt as though they weren't part of the project, but more like an old shoe that someone found and just happened to need. It is here, I felt, that the project began to fall apart. I think that the NYC's could have worked more harmoniously with the community workers, medical students, coordinators, etc, for a better understanding of the community.—C.B., *NYC, Bronx.*

COMMUNITY WORKERS

This past summer I was given a job that was supposed to be as community coordinator. The reason I got this job was, I believe, because I'm black. I made a good salary and I could use it, but I want a job not because I am black but because I can do the job.

I may be a little old-fashioned, but I take pride in doing a job well, and when I'm given a job to do I try to do it well. If I don't know how, I ask someone who does know how, and then I try to do the very best I can at it.

But this particular job no one will ever be able to say whether I can do well or not, because I really didn't have anything to do. The NYC's could have done most of what I did, and this was not the fault of the people I worked with so much as the way the program was set up. It was a sort of gentlemen's agreement thing—"We must have these people in our program or we'll look bad, so keep them happy and we'll do the real work."—M.W., *Community Coordinator, Brooklyn.*

As one of the community workers, I found working with other community workers very agreeable. In most instances, we were in common agreement as to how something was to be carried out. This is not to say that our behaviour was stereotyped, but that a somewhat common outlook on the aims of the project led to closely aligned methods of implementation. Much of our camaradarie came about through a defense of the community and its legitimacy, a defense provoked by the subtle attacks made by some white members of our staff.—R.P., *Community Coordinator, Newark.*

Our community colleagues were indispensible in a project composed largely of white, upper middle-class students who have very little idea of what is happening in the ghetto, what it's like to live there, and what it's like to be black. Individuals and personalities and the abilities and commitment of the community people have a great effect on the success of any community-wide efforts, but not necessarily individual projects.—N.W., *Law Student, Newark.*

Our two community workers were quite different people, and the way they came across was remarkably different. I believe that they may not have completely understood their relationship (power-wise) to project decisions. This understandably difficult position to evaluate may have contributed to a mutual distrust in SHO community-worker relationships.—J.C., *Medical Student, Lower East Side.*

We found, unfortunately, that although one of our community workers prefaced many of her statements with "the community wants * * *" we were actually hearing what she wanted. We found that she often had as much difficulty in communicating with the Puerto Rican and black community people as the health science students themselves had. We were told by another community advisor (who also is a member of the Health Council) that often, since the other community worker sounded so knowledgeable on such topics as city and state politics, the Health Council accepted her word on faith. And we behaved no differently at first. Her self-assurance and seeming political knowledge convinced us that even though we felt insecure about going upstate to do political organizing to get Medicaid back, we would be doing the community disservice by refusing to try. In effect, she succeeded in removing us from the community for the whole summer. I feel that I was deprived of a valuable learning experience. Hopefully, however, the primary objective of the SHP is not to parasitize off the community for our own enlightment. Considering that, the Medicaid project may contribute more of a long-range "concrete service" to the community than those projects which were more "community based."—J.P., *Medical Student, Lower East Side.*

The community workers were overall very helpful. Our community coordinator seemed less helpful than I hoped and expected. Her reluctance to give advice before it was too late caused many a mishap. Her explanation of community feelings concerning our difficulties was helpful, but I feel many mistakes could have been avoided had she interceded sooner. Our other community worker, though involved in much power play, constantly provided much needed advice concerning the community's needs and fears.

Mobilization For Youth provided us with one of our most valuable people, the crew chief of the NYC's. He assisted us in understanding the NYC's and them in understanding us. Without this help, our project would have col-

lapsed.—B.G., *Nursing Student, Lower East Side.*

I feel very funny working with professional people, perhaps because I think they're trying to put something over on me; I just didn't want to work with them. Then I reconsidered because of the fact that I was the only Spanish speaking coordinator in the whole project. * * * Sometimes I am asked questions by the students and I say, "I don't know how to answer you because I have not consulted the community;" Then the project members would say, "What do you mean, you can't answer me; you're part of the community."—H.K., *Community Coordinator, Lower East Side.*

There are community people who'll give you snappy answers. Some of us have lived there long and worked with each other long enough to know that on policy questions, the snappy answer is not always the best answer. Like I'm sure Mrs. K. has very definite recommendations on certain technical things, but at the same time the students wanted snap answers on things like broad-range policy to function on, to force someone into giving them an answer and then say, well so-and-so said that. Well, we don't want to be used that way.—S.D., *Community Worker, Lower East Side.*

In the Bronx we were fortunate in having two hardworking, intelligent and congenial women as community workers. One, the mother of seven, was white and active already in community affairs. She served as an excellent liaison between us and the Tremont Council. She also brought to the job strong ideas about our efforts and a willingness to do a job. She related well to the group and became an integral, interested member of the team. The other community worker was Puerto Rican. She was very congenial and, like her counterpart, became a friend as well as fellow worker. Through her we were able to understand some of the problems the community faced, as well as her serving as a link to the predominantly Spanish-speaking community. Both women were made to feel entirely equal on the team, and their opinions were respected and often taken as gospel.—V.S., *Dental Student, Bronx.*

The most reactionary and self-seeking member of the Tremont Community Council was a white, female community worker assigned to the SHP. She was a strong proponent of "community relations" (keep the niggers happy), and constantly showed preference for SHP involvements such as single-shot sex education, narcotics, and dental education programs which would reduce the envy of other community organizations for the concentration of our services in the T.C.C. This community worker was very domineering, vocal, and argumentative, and managed to control somewhat the range of action of two nursing students who worked with us on the project. In addition to being frequently late or absent from project responsibilities, she was an expert at ducking her own share. At the end of the project, when nineteen Bronx SHP students, community workers, and NYC's signed a petition to reallocate funds from the extravagant Final Conference to the continuation of the Unwed Mothers and Head Start programs, she was the only project member who refused to sign. With colleagues like this, who needs enemies? On several occasions, this woman openly slandered two black community workers assigned to the Central Bronx storefront. Her influence over one nursing student was so strong that this student threatened to resign from the project if one of these black community leaders were transferred to her part of the project.—J.G., *Medical Student, Bronx.*

We had five community mothers working with us in Harlem. We were told it was to be our duty to "train" them to work with Public Schools 175 and 133 health referrals. Three of the ladies are experienced in the home-visit type of work involved, and it was absurd for us to presume to train them to function in their own backyards, particularly when there were 20 of us where three or four would have certainly been sufficient. I, and I think many of the other student fellows, overlooked the two inexperienced ladies who could have benefitted from accompanying us on home visits, to the hospital, and on visits with local officials. We spent the last 2 weeks trying to make up for our earlier shortcomings, only partially suc-

cessful, I am afraid. The two are still unsure of themselves, partly due to our inadequacies. I felt the mothers suffered somewhat from the decision to hold the orientation and final conference far out of the city, they being reluctant to leave their families.—L.B., *Medical Student, Harlem.*

Our community workers were pretty good; they were better at making home visits than the medical and nursing students. Two of the five were working mainly to get themselves out of the kitchen for the summer and weren't ready to put out. The other three were quite resourceful and critical of things in the project or in health facilities in Harlem that needed criticizing.—R.C., *Student Coordinator, Harlem.*

FACULTY ADVISORS

Health science students coming to a new community from all over the country for a 10-week summer work experience must depend heavily on the advice and the orientation provided them by faculty advisors and preceptors who have long-term experience in the sponsoring institution and the neighborhood. The faculty member must be able to work equally successfully with citizens, representatives, and institutions in the community and with the students. The former are inclined to be suspicious of this invasion of largely middle class workers, and the latter are usually highly idealistic and very naive. The preceptors who have prepared the ground in the neighborhood must be extremely careful to suggest and advise students without in any way dominating their project or making decisions for them. There are realistic risks, of students antagonizing community people, or their being discriminated against because of class, race, or as "carpetbaggers." Even their physical safety may be involved at times. The faculty advisors should be available at all times and should be capable of facilitating the planning and the carrying out of student projects, through a close-working relationship particularly with the student directors. You must be able to relate sympathetically to the changing objectives of the students, while communicating to them whatever cautions are necessary to prevent them from proceeding at a pace which is unrelated to the sentiment in the community. Student health projects are an important two-way educational program, with communities receiving valuable augmentation of manpower and students receiving an indoctrination and a sympathetic understanding of neighborhood problems which will stand them in good stead as professionals. The faculty advisor can and should play a key role in facilitating this whole process.—J.W., *Faculty Advisor, Brooklyn.*

One of our faculty advisors was almost totally removed from any contact with our project. Her main concern was with a questionnaire which was given to postpartum women. If I had had more contact with this woman, I could say more. In summary, her role was one of irrelevance.

Our other faculty advisor served more as a hindrance to our project than as a boon. He advised our project members as how to best become co-opted into the bureaucratic b.s. of which he himself is part. He seemed highly resentful of the fact that members of our project saw fit to approach the top of the Martland Hospital administration with suggestions for change, which we saw as deserving immediate attention. These proposals were based on community sentiment.—R.P., *Community Coordinator, Newark.*

Our faculty advisor both expected and demanded that we remain docile, quiet workers in the emergency room, and not make any "waves." When he and the hospital administrator learned of our visit to higher authorities and of the community organization we were trying to form, we were screamed at accordingly, threatened, and invited to leave the hospital. This invitation, we learned, wasn't to be the last.—A.C., *Nursing Student, Newark.*

Our faculty advisors were virtually nonexistent. Unfortunately, both are extremely busy people and just couldn't put in much time at project meetings; they both came to several meetings at the start of the project, but not much later. One advisor taught the pediatrics

part of our training program for the mothers. She came to weekly meetings at our office for that. In the future, we should try to get advisors who have more time, I guess, but I'm not all that sure that we suffered from not having faculty direction. I felt from the start that this was one of the parts of the project that would have been nice but that it was really put in to satisfy Montefiore Hospital that we would be "well supervised."—R.C., *Student Coordinator, Harlem.*

Part 4: OPINIONS ON THE ORGANIZATION

INTRODUCTION

The administrative organization of the 1968 project reflected the spirit of community control that was of great importance to the project's student leaders and to many of the student participants. The result was a structure that was both decentralized and chaotic. Each of the five areas was directed by a health science student (student area coordinator) assisted by a local area resident (community coordinator) and advised by a faculty member from the local area medical school. These five student-community-faculty teams determined what projects students would work on during the summer, who would work where, and how day-to-day problems would be handled.

Above them in the organizational hierarchy were officers for the combined five-area project, two student codirectors, a student educational coordinator, and a faculty director representing the sponsoring agency, Albert Einstein College of Medicine. Their functions became defined as largely adminstrative (paychecks, mail notices, purchases of supplies, conference arrangements, etc.), a role definition which caused considerable consternation to these individuals who perhaps should have exercised a greater role in project affairs, as well as to those project members who did not consider their administrative functioning beyond criticism. Finally, policy statements of broad project significance had to be developed and approved by a policy making council consisting of the student-community-faculty representatives from each of the five areas, the three student central office staff members, the faculty director, and *ex officio,* the director of Montefiore Hospital in the Bronx and chairman of the department of community medicine at Albert Einstein College of Medicine.

Given this administrative structure, project decisions were usually made at the local-area level, with the central staff being essentially powerless and the policy making council too cumbersome for immediate decision and action.

GREATER NEW YORK STUDENT HEALTH PROJECT STRUCTURE

Bronx

I felt that SHP was five separate projects governed by a sincere but unresponsive leadership. This leadership failed to bring the project together so that we could learn from each other before the summer ended; failed to act in accordance with our wishes regarding funds for continuing programs, supplies, materials, etc. (Billions for buttons but not a penny for books seems to sum up SHP wisdom and foresight.) Our own Bronx project split into several projects, the result of weak leadership. In fact, weak, unresponsive leadership seems to be a major fault of SHP. Policy was not determined early enough to give direction to our efforts. Individuality is great, but we must realize our limitations as individuals.

Thus, in summary, SHP was in actuality five SHP's without a central policy or theme defined enough to guide. Central staff failed to bridge the gap between and within groups, and lacked both the leadership and wisdom to run the organization effectively. SHP was a ship without a captain or a compass.

SHP has no moral right to return to the community this fall, next spring, or next summer unless it undergoes a radical change into a student-staffed but community-run and responsive organization. It must be decentralized down to each local area and must have definite plans for self-perpetuating programs. Otherwise, its existence is unjustified and unacceptable.—V.S., *Dental Student, Bronx.*

Lower East Side

I feel that the student health project this summer tried to be all things to all those in-

volved; it cannot possibly be. It is foolish to think that we can be successful on all levels of involvement. In the future, student health projects should be more carefully defined beforehand so that all those involved have some feeling of direction and yet at the same time the projects should be flexible enough for innovations.

I also feel that there should be some method of screening NYC's so that those who are truly interested (if this is possible) become involved. This is not to say that students should not also be more carefully chosen

One further suggestion: in the future, more of an attempt should be made to increase the interchange of ideas not only between projects within the city, but also between those who have been involved with SHP's in the past and those who are presently working. I, for one, am sorry that more of us were not able to visit other projects, but perhaps this is unrealistic in light of the time factor.—L.C., *Nursing Student, Lower East Side.*

Newark

The whole program suffered from lack of structure. People are used to working in structured conditions so I think they would be most effective working under structured conditions. I think it's very important that the NYC's work with health science students. Somebody said to me that they don't see a place for the NYC's unless they work by themselves. There has to be structure somewhere, but not so it's going to put out the relationship between black and white students. I think the project should have some definite goals. White students and nonwhite students should not be thrown into a community and allowed to spend their summer "finding themselves." The leadership of the SHP, together with community workers, should have specific guidelines as to where student fellows will work and what they will be expected to accomplish.

I want to know what the central office does. * * * As far as our project has gone, as a meaningful thing, I don't think the central office has had a damn thing to do with it. I figured that the people who were going to run the central office were going to be the people who invented this job before and had it clear in their minds as to what we could do, what we couldn't do, and where the mistakes would fall. None of this really came out.—R.P., *Community Worker, Newark.*

I feel there was somewhat of a problem in project communication which was mostly the fault of our student area coordinator, but which could have been remedied by the Central Office. The remedy would be a calendar of all project events in advance, especially the weekly meetings. Meetings or events subject to change could be so labeled, and we could contact the area coordinator to learn of any changes. This lack of communication was partly where the participatory democracy we began with broke down.—N.W., *Law Student, Newark.*

Any future project should not try to consolidate five separate areas under one cover. Perhaps application and selection of students would be facilitated by one mailing address, but there should be complete and absolute community decentralization (community-student NYCs community people—in any order). This will greatly increase the effectiveness of the project.—S.G. *Education Director.*

SHP is leaning in the right direction but is not democratic enough (in the Grecian sense). The Policy Board is a good idea but should function as a communications center for the benefit of individual project members. This year motions were made and voted at the same meetings, therefore coordinators did not discuss their votes with NYCs and fellows. I feel that the following alternative would give members a greater sense of participation without necessitating their presence at endless meetings: (*a*) Any member can attend policy board meetings; (*b*) Any member can make a motion at a policy board meeting; (*c*) Policy board members have the option only to second or not second the motion; any one member of the policy board can accept a motion, (*d*) Motions are not to be voted on by the policy board at the same meeting that they are first made. Individual coordinators should return to the area projects and present motions to all members who

then vote. Each coordinator then reports majority vote of his project by telephone into central staff who tally and record it; (*e*) Central staff has a vote equal to a community project. —A.H., *Medical Student, Newark.*

Harlem

The "New Left" democratic process stinks as a way of running an SHP. With thousands of dollars of Government money to account for a contract to fulfill, well-defined bureaucratic structure is required, with a management hierarchy of responsible persons selected for leadership and managment capability, who can accept the responsibility for policy and planning (as well as day-to-day decisionmaking) without requiring interminable meetings where everyone has the right to speak his mind no matter how rapid or irrelevant his opinions. There is no guarantee that Grecian democratic vote is the best way to make decisions, especially in an organization whose members generally lack sufficient information, understanding, and experience in managing large sums of money or supervising people at work. Every form of government has established an executive wing to administer day-to-day matters as well as to make long-term policy decisions. Bureaucracy may have many, many faults (whether capitalistic or communistic) but AT&T runs a damned efficient telephone business and they don't take a referendum every time a decision is required. As long as some checks and balances exist (such as open-door policy making) we need not fear power placed in the hands of managers.

So, next time, let's establish definite organizational structure, with hire-and-fire power in the hands of project leadership, and a definite understanding that an employee-employer relationship exists between the project fellows and the funding agency. Sure, people are going to object to doing things the way our fathers did them, but since somebody will gripe no matter how decisions are made, or how much structure there is or isn't, why not let them gripe about the most effective and efficient method of managing an organization! (N.B. After the Revolution, the Russian army tried democracy. No generals, no officers. They now have officers.)—W.S., *Medical Student Harlem.*

The structure of the Greater New York student health project this summer started on a poor level. The project for a time seemed to be nonexistent. It had no headquarters, no rules, no election of officers, no nothing. I met an individual who said he was one thing, then I met another who said he was what the first person had said he was. In my specific project, I believe I encountered four persons each of whom at one time or another said he was in charge.

Nearing the end of the project, however, some structure seemed to have been in the making. Directive after directive began to flow into our local project. We read of the topics discussed and passed. * * * Yes, some sort of structure with a policy making body and various sanctions finally seemed to have evolved. At the end of the summer, the student health project had just been created.—E.M., *Law Student, Harlem.*

The central office staff (personalities excluded) served a dubious role. They seem to have evolved, by appointment or election (though not elected by the project staff), to a position of policy-making and surveillance. Their only visible activities seemed primarily to consist of floating from project to project, and rapping the day away. (The importance is not whether or not this is all they do, but this is the impression they give to many people on the project not otherwise informed.)

Most policymaking council decisions were reached without consulting the general project staff, and although meetings were alleged to have included representatives of the group, these meetings were sometimes announced 1 or 2 hours beforehand, when it was impossible to get these "representatives" together. Often we were not told the purpose of the meeting and could make no provisions to attend. The central office also saw fit to bless us with favors—picnics, educational programs. It might have been a better idea to consult the community they intended to serve.—J.A., *Medical Student, Harlem.*

My relationship with the central office staff

was one of frustration and anger. They tried to pass this off as some sort of a participatory organization and then they would send out another "order". It is not that what they wanted was so unreasonable, but rather the way in which they did it. For example, they asked for biweekly reports without an explanation of why they wanted or needed them. In addition, they imposed no penalty for not writing one, so those of us who did write them felt rather foolish. To make things run more smoothly, we should have been able to elect a representative with an equal vote to sit in on the policy-making meetings. The Central Staff members should not take out their anger on the student fellows because the response to something that the central staff is interested in was not shared by the project members. The black history classes are a case in point. Furthermore, the central staff's penchant for trying to combine business with pleasure is annoying at best. If and when I want my leisure time planned for me, I will send a request for such a service. If the NYC's want a vacation in upstate New York, they can have it. But to foist this upon the rest of us is just not fair. If we have not done our job, fire us, but to threaten not to pay us if we do not attend a Final Conference that everyone knows is being held at an inconvenient place for many of us because the NYC's want it, is just economic blackmail of the worst sort.—F.V., *Law Student, Harlem.*

Brooklyn

One of the faults with the structure of the SHP was the lack of communication between the different areas of the project (*i.e.*, Brooklyn, the South Bronx). What was really needed was a newsletter to inform the people in the different areas of what was happening. Perhaps the program next year could include one day in each week in which each group went to visit another group to see what other areas were doing.—D.Y., *Medical Student, Brooklyn.*

LOCAL PROJECT STRUCTURE

Lower East Side

First of all, I feel there is a future for SHO on the Lower East Side, but if it is to continue, structural changes should be made. Some of the frustration and feeling of being at "loose ends" and not knowing how to direct our energies was due to the fact that SHP was new to the Lower East Side. However, much of the frustration and wasting of time could have been avoided if the project had been more carefully organized before the summer began. It was fine to say wait and discuss community problems with people in the community such as Neighborhood Youth Corps workers and other community preceptors, but this could have been done before the summer began. It took many of us as long as three weeks, including orientation, to decide what we wanted to do, organize material, and to begin doing something. I also feel that placing us with already existing organizations or agencies provides a structure which is essential at least in the early stages. One must also consider that the Lower East Side is a highly sophisticated and well organized community in many ways, and that for SHP to become merely another separate organization is a poor idea.

Many of us were also frustrated by the lack of unity within the group. Perhaps it is unrealistic to think that twenty students plus Neighborhood Youth Corps teenagers could be expected to work together as a team. Perhaps if students were required to live in the community and to become involved in as many aspects of community life as possible, there would be more community concern over health care in the broadest sense. By this I mean that we should be concerned with all aspects relating to and influencing health care. One of the most valuable experiences I had was door-to-door work. Health care is a basic and nonthreatening subject which can serve as an "in" into the family setting. Once into a home, we could discuss other areas, such as housing or education, with individual families and try to help the family in whatever ways we could. It is more of an overall understanding of the many factors influencing health. It is for this reason that I feel that future SHP workers should at least experience, first-hand, neighborhood and family settings.—L.C., *Nursing Student Lower East Side.*

There was no feeling of an SHP structure this summer, either on a citywide or a neighborhood level. There was only the SHP name, and it interfered with our work. We were supposed to feel allegiance to an organization that barely existed as such. The whole Lower East Side SHP met together once a week, mainly to criticize each other's work. These discussions were not very constructive, because none of us knew enough about each other's work to make meaningful judgements or suggestions. The meetings became a kind of free-for-all in which one found oneself either attacking or defending. The only goals pronounced by the Lower East Side SHP were goals that each one of us, as individuals, had: to sensitize ourselves to the needs, problems, and attitudes of the community, and to produce some meaningful, immediate contribution to the community.—M.H., *Law Student, Lower East Side.*

I think the Lower East Side had several problems. First, each of the several separate projects seemed isolated from the others, except for infrequent progress reports. Second, there existed an atmosphere of tension among the student fellows. As well-expressed by one student, "I don't think we really want to get to know each other." I feel there is a place for SHP on the Lower East Side next summer, but in view of this summer's events, it should be better structured. Each student fellow should be made aware, before being accepted, that he is taking on a full-time job, not a nine-to-five responsibility. If a student has other obligations, he must either adjust them so they do not conflict with SHP activities, or not work on the project.

All SHP members should live in the community in which they will work, preferably nearby or together. This would help improve interpersonal relations—we would get to know each other better and be more cognizant of what each other was doing. There should be a store-front which not only serves as a meeting place for SHP, but which offers some service to the community.

If people in the community want information about health care, housing, etc., we should be able to offer it or direct them to the proper sources. Also, I think that there should be two student co-directors for each project area, so that they can share the responsibilities and lend greater objectivity in handling all matters. Finally, I think more concrete community job placements should be made. I think more of an effort should be directed towards working within specific community organizations; we have learned, maybe the hard way, that community structure does exist.—L.G., *Psychology Student, Lower East Side.*

Newark

Project structure was not deficient in any way that I noticed. I thought the lack of structure in our Newark project was very beneficial as it allowed people to gravitate to or seize upon that which they liked best and thought would be most beneficial. The only place where lack of structure was really detrimental was in the case of the NYC's who often sat around doing nothing until the last couple weeks of the project when, I suspect, the guys, at least, didn't show up at all.—N.W., *Law Student, Newark.*

The local project is basically a great idea. We maintained our integrity as a group and were able to coordinte our efforts in several areas. We were able to put our heads together nearly every day. We all worked out of our UCC office space. It facilitated communication and kept morale higher than it would have been if we were separated. When we met with hospital personnel we had at least 15 to 20 people there. The benefits of a cohesive group are many when operating in a resistive environment. I think people had more confidence and a large fund of ideas and opinions were available. We stimulated each other.—A.H., *Medical Student, Newark.*

The structure of the project should have been more carefully laid out and adhered to. I went to Newark expecting to work as a nurse in a clinic, in a storefront, in the emergency room, anyplace; I wound up painting signs and not at all utilizing the one sure skill I have. I recognize some degree of unpredictability is inevitable, but we were almost totally without structure in pursuing the vanishing hope of

"Improved Medical Care." Several different groups evolved, divided along racial lines, and pursued what they thought was the goal of the project. This might even have been acceptable if there had been some coordination, some feeling of unity. There was not much among the factions, just a sort of palid coexistence.—A.M., *Nursing Student, Newark.*

Bronx

In addition to problems with cohesiveness and communications, there were difficulties with job descriptions. This seemed particularly evident in the Bronx unwed mothers' program. The community workers seemed the most confused. Since this is the first summer that there have been community workers, it is understandable that there was some confusion. Another reason for confusion was poor orientation.

One of the roles which I thought needed clearer definition was that of the project coordinator. I see the project coordinator as a person who spends a lot of time visiting the various programs in the projects and setting up a rapport between institutions and community groups. Our coordinator spent most of her time in the office, and I think she would have been of better assistance if she would have spent more time in the community. She also became too much of a director instead of a consultant. She seemed afraid to delegate responsibility which inhibited our making plans and decisions on our own.—V.V., *Nursing Student, Bronx.*

Harlem

Concerning the structure of the Harlem project, one important thing was overlooked. The students who organized it wanted a loosely structured organization with abstract duties and responsibilities taken on by the individuals themselves, with no real power structure. This would have been fine if the organization had consisted only of students, but in dealing with members of the community we were made aware that they demanded much more of a structure. They wanted to know who the leaders were, what everyone's duties were, and to whom they were responsible.

As far as the leadership is concerned, I feel that a better system might have been the appointment of provisional coordinators and Central Office staff, and after the groups had become acquainted with each other, elections could have been held, giving somewhat of a democratic structure to the "governing" body. —J.A., *Medical Student, Harlem.*

Although some of the nonhealth science students didn't get properly integrated into the group right away because the whole thing was so unstructured, I think the Harlem group had the least group interaction problems of all the projects. I don't think the inter-disciplinary team question every really arose. We worked together as individuals—not "professionals" —and since the mothers were adults rather than NYCs, there was never a question of condescension between students and community people. Some of us at first (myself included) were condescending toward some of the nonhealth science students because we felt that they didn't really care enough, but after the air was cleared on that I think things worked well.

I think it was especially important that we all worked out of the same house. We were able to maintain a much better group sense than some of the other projects that were spread around in different agencies, and we were all able to keep sufficiently in touch with what everyone was doing so that we could lend a hand when necessary. Because people were always in touch, we didn't have the typical kinds of confrontation or sensitivity sessions (that some people think are essential in SHP projects) because things often got talked out in small bull sessions before matters came to a head. There was a disadvantage to this, however, in that some things concerning the philosophy of what we were doing and how we were going about it didn't surface until the end.—W.S., *Medical Student, Harlem.*

Brooklyn

I feel that there were too many small groups in the Brooklyn area, and that in the future these small groups should be incorporated into larger area priority groups which need man-

power, or have people "float" from group to group as each group needs extra help for specific projects, *e.g.*, the lead poisoning campaign. I would like to see an area such as Brooklyn develop one or two priority goals and spend the entire summer developing these ideas and then wind up with a concrete plan, proposal, mass meeting, etc., so that these ideas can be carried on by other than SHP people.—S.P., *Dental Student, Brooklyn.*

FUNDING

The structure of an organization can often make for success or lack of success of its activities; there were many elements of this summer's SHP which I felt limited one's ability to act effectively. By "structure" I mean any decision which is made regarding how the project is to be run, who will run it, etc. Thus, any lack of organization is part of the structure of the SHP.

The first bad decision made was for the students to be funded by a Government agency. This put us in the position of another group vying for funds to "help the poor people," and immediately set us apart as a group who was being paid to be in a poor community. It was at least fortunate that we did not get funds from OEO, as we might then have been taking money from other groups composed more of grassroots people. Our advantage in getting funds would have been that we were mostly middle class people with a good idea rather than community people trying to get money to increase power over their own lives.

Another problem that goes along with writing up a grant for government funds is that we become responsible to the funding agent, and are no longer answerable strictly to the community. Several instances have come up where it was necessary to consult our funding agency as to whether or not we could undertake a specific project recommended by community consultants, or whether or not we could use funds for various purposes not outlined in the grant. This limits the degree to which we may use resources given us through funding.

There is also a problem inherent in writing up a proposal for Government approval in that we begin to think in terms of a task that must be fulfilled. It is good to sit down and plan what we are going to do; but it is unrealistic for people with little knowledge of what it is possible to accomplish in one summer to sit down and write something up in order to get funded. What they write up may often have little relevance to what they actually do. They then begin to feel that they are not fulfilling their jobs and they have the tendency either to get upset or to work harder towards their original goals, without sitting down to evaluate whether or not their goals are realistic. What I am trying to say is that people with comparatively little experience should not expect themselves to accomplish very much in two months. When they write up some impressive goals they soon begin to expect themselves to accomplish these goals and are not as flexible as they otherwise might have been. I feel that students should first familiarize themselves with their community and then have tasks outlined by responsible community groups. It should be up to these groups to decide whether or not the students are performing effectively; this is hard to do if a proposal is on file with a Government agency that is paying and therefore ultimately controls the students whether they like it or not.

While we're on the subject of money, which after all is what separates rich people from poor people, I feel that all salaries were too high this summer. This prevents effective action for several reasons. First, community people tend to be suspicious of white middle-class students who are paid a very high salary to enter their community. There is very little that a student can actually do in two months and this increases hard feelings towards students who "aren't doing anything." It is bad enough when people ask, "What are those students doing, anyway?" But it is much worse when it is discovered what their salary is. I feel that it was similarly wrong to pay community co-directors and workers such a high salary. It is commonly known that one of the best ways for bright community people to get ahead is through one of the antipoverty agencies, which actively seek community people as participants, but not as administrators. I think that

this system creates resentment among the rest of the community which is "left behind," and tends to separate good leaders from their communities. I feel that all workers on the project should be paid the same subsistence salary. In this way it can be seen that the students are not in the community for the money, but because they really care. And community people will not be reluctant to work with us for fear of being resented by their fellow community members for sticking with the white people to get high pay.

It has become evident that with our present personnel and structure it is impossible to accomplish the things we had hoped to do. As long as people are here for money, and are responsible to some superstructure which rewards or punishes them for their actions with a salary, they cannot honestly tell people they are here because they care about them. It seems to me that the same setup that denies people down here many opportunities (including the opportunity for good health care) is the set up which gives us a more than equal chance to get a good education, good pay, become doctors, etc.

If we want to correct this situation as it pertains to health care, we must present ourselves as concerned individuals who recognize that our advantages are the other side of the coin of others' disadvantages. If SHO fellows continue to benefit from this system by being paid a large salary for "helping" the poor people, they are propagating the very set of inequalities they want to destroy. They therefore must decide to reject the benefits and make some sort of personal sacrifice, in order to be free to see other people's situations, and to be free to talk to them as people. I realize that my ideas are hard to explain in words, but I do feel strongly that this way of conceptualizing is appropriate, and we must learn to conceptualize. I don't want to put across a sense of "guilt"—just a recognition of our position. As members of the SHO, paid $900 by a Government agency, we are limited by being representatives of a bad structure. We are distrusted by the people we wish to reach.

A final problem in this area was that the NYC's were paid by a different organization, which added another voice, at least potentially, as to what could be done during the summer. Also, the NYC's should be paid the same salary as everyone else. Otherwise our talk about being colleagues and being equals, and the students' not being the NYCs' bosses, is nonsense. The argument is sometimes raised that the NYCs are younger and don't have the same educational and job experience. If this is valid, then students should be paid less than community workers who are twice their age. If the argument about education is valid then we are building inequality into our project, for many poor and nonwhite people are denied a chance to compete with white middle class people on the basis of not having had enough education; furthermore, they are consistently denied the chance for a good education. If we didn't learn that this summer, we may as well not come back. A project designed to overcome inequalities should put all its members on an equal basis, answerable equally to one another. All of us should be colleagues, each with something different, and something valuable, to offer for the common good. We must set one standard for all of us to live up to, so that we all finish the race at the same time, not some of us ahead and others behind.—*Student Coordinator, Lower East Side.*

One ongoing argument that we have had in the Lower East Side project has centered around the money that we have been paid this summer as a major factor in the loose, unstructured, and often unsuccessful project. In my opinion, the fact that we have been paid for our work has little to do with how well our project proceeded.

* * * The other argument made about our earning so much and the NYC's earning too little has also bothered me. The NYC's are young people, and when we were their age it was also difficult for us to earn. The fact is that we are not the equals of the NYC's in just about every way, and the concept of treating them as if they were our equals has seemed to be one of the greatest farces. It is one thing to respect someone's opinion and to give them an equal opportunity to express themselves; but it

is another to expect the same maturity and the same concentration from considerably younger people.—P.S., *Medical Student, Lower East Side.*

My suggestion is that student fellows should start at $60 per week, serve a probationary period of five weeks, and after evaluation by the staff and community workers, as well as area coordinators, be given salary raises computed to bring their total summer's earnings to the allocated $900. It is a hell of a bad situation not to be able to control the miserable rabble who decide that student health project is an easy way to make money for the summer. Before I became involved with SHO a nursing student said to me that "Student Health is a good way to earn $900 doing nothing!" Every effort must be made to eradicate this idea and uproot this attitude if the job is to be approached with the honesty and dedication it needs and deserves. There must be a method or device for firing people.—B.B., *Student Coordinator, Bronx.*

SHO should strive for joint-funding with community agencies such as LABOR and plan a project based on the twin issues of health and housing. SHP should also get funding from foundations to begin work on changing the institutions that project fellows come from, specifically continuing programs to get ghetto residents into professional schools.—K.B., *Medical School, Bronx.*

STUDENT FELLOW SELECTION

In late April 1968, twelve or so students from the five Greater New York areas met and read all of the 300 applications received. We agreed to accept as many black students as we could, and accepted all the applicants from Howard and Meharry medical schools. Ironically, as a recruitment device for black students, this did not work 100 percent. Two out of seven such students were white. We also accepted all other people who indicated that they were black or Puerto Rican. The students from the five areas were very concerned about continuity after the summer, so they were asked to draw up lists of students they wanted to "reserve". (Subsequently this proved to be a bogus play because the one area that complained the most about needing their own students developed the least potential for community projects.) Approximately half of the project participants were on the "reserve list".

Applications of out-of-city students and non-reserve New York City students were read by groups of our students and rated highly desirable, acceptable, and undesirable. The distillate of these applications (the "highly desirable" group) was read to the entire group and rated. The highest scorers were phoned and asked to come to New York. Not all of these applicants accepted so the lower scorers were called and subsequently the "acceptable" group of applications was delved into.—S.G., *Education Director.*

Interview

Someone told me the other day that the SHO doesn't rehire the same students each year, they have some policy where they want to give everyone a chance to come and see what community medicine should involve. That's stupid, because the first time the medical students are here they go through a lot of changes, a lot of hangups, annoy a lot of people, and it may take them a long time to get straightened out. But after they've reached that point, if you don't bring them back again, you're making a mistake. The new students have to start from scratch all over again. If you brought the experienced ones back, they wouldn't have all these hangups as to the black-white issue, and they would know what they could do, and start immediately doing it.

This policy indicates the student health organization's orientation to this thing. They want students to learn about black people—which would be for their benefit. And it would make them feel good that they had done a little something to help the cause, and these kids are supposed to go back and stir up other students in their medical school. But that's a pile of rubbish because there's thousands more white medical students who haven't got the least interest in coming here. And even if all of them had a chance to come here for the summer, first of all they don't have to live like the people live here. They may be able to sympathize

with these people, having seen the conditions and what people have to go through, but if you don't come back again, if you don't stay, it's a waste. All you do is understand the problems, maybe, and you can go and talk to your friends about them, verbalize the problems, but you won't be able to do anything.

I would say, based on one summer's experience, that I don't think SHO is useful in the long run. Take these white people that work here in the summer, or work here all year round, like these hospital people; they're here with this problem all the time, and they still offer bad medical service. They haven't learned a damn thing. As a matter of fact, they're the ones who're responsible for the bad service.

So you bring some white kids in here, and they're going to see a few things. But when they go back to school they're going to start studying, they're going to fall for the set-up which was already set out for them, and they're going to say, "Well, I had the experience." But they won't be able to do anything about it.

What SHO should do is see about getting programs for black people which will be black run. One of the first things I noticed when I came in here was that we need some more black people in this thing.—R.P., *Community Coordinator, Newark.*

Hiring: Not fair to ignore rejected applications when first choices decide on other employment. We hired one student about one month into the project. He was the nephew of Dr. Important. This guy did little, said nothing, and was rarely seen.

Firing: In a project such as ours every freedom should be given; an atmosphere of confidence and optimism is essential for any creative unfolding. People should never be fired for failing, only not working, for not doing anything. If complaints are made against a member, the policy council should consider the complaints and vote to drop the complaint, or warn the individual in question, or request the individual to appear and explain his position. Where or how someone is working is irrelevant —only if he is working.—A.H., *Medical Student, Newark.*

I wish to take issue with the composition of SHP. I sincerely wish to register a strong protest. Here are my feelings and recommendations: I think project composition should be as close to 100 percent black students as possible. At this point in black history in this country, black people need black leadership to give them any meaningful stimulation and incentive. In a situation where conditions are so extreme and time so short, the time spent battering down the color barrier between yourselves and that community is too dear.—A.M., *Nursing Student, Newark.*

I think SHP might work next summer if project members are selected differently. There must be more community people in the project. There should be at least one adult community worker to every health science student and NYC. In selecting applicants, students from the surrounding area should be given first priority so that SHP can be a continuing thing. Students should not be selected on the basis of an essay on "why I should be a member of the project." Every applicant should have a personal interview before final selection.

Selection of members for the project should not be so final that once you're in, you're in for good. Members who do not want to work with and for the project should be fired and replaced. It's fine and dandy if members want to do their "own thing" but they must also spend a major part of their time with the entire project on a united effort to improve health care. Doing your "own thing" may help to make small improvements and give you personal satisfaction, but no massive changes are going to occur unless the project members unite their efforts.—L.D., *Nursing Student, Newark.*

There is a definite need for some changes in policy so that SHP of 1969, if existent, can function more effectively with less wasted money and energy. There should be a hiring policy that attempts to accept only those who are sincere to the cause. Interviews would seem to be more revealing (than essays) and perhaps interviews with a member of the specific community who is working on the project would be most productive.

A firing policy should also exist to rid the

project of any phony liberals who are goofing off or just there to exploit the community for their own gains.—K.S., *Nursing Student, Newark.*

The students who were assigned to this project, with the exception of a few, should not have been included in a program of this nature. Some of them came into the community only for personal advancement; the narrowness of their motivation limited the effectiveness of their work. Two students in particular caused me great concern. They needed constant direction, not only about what to do, but how to do it, and at the end of ten weeks were just beginning to show anything that could be called initiative and creativity. A short-term project suffers when it is staffed with liabilities.

Medical people who are usually far removed from grassroots community work need to be sensitized and attuned to the problems of the urban poor areas, but not at the expense of the community they profess to serve. A 10-week program cannot sustain the inconvenience of being burdened with out-of-state students who have to be taught how to communicate before they can operate effectively. Students who come lacking skills in contact with the urban poor should come in as volunteers in order to learn, not as paid personnel in order to experiment. The experience they gain is pay in itself, for they certainly get more out of the exposure than they can possibly contribute.

Next summer if there is a project, students and community people who worked effectively this summer should be given priority when staffing begins. A project of this sort can function more effectively if the same people combine their efforts to identify the causes for failure and the reasons for success and make concrete plans to restructure the program.—B.B., *Student Coordinator, Bronx.*

From the experiences and observations of this summer, I do not feel that there should be another SHP like this summer's. Any health professional student not having a good deal of involvement in the community doesn't have any business in the community. Such students only hinder and screw up the projects and for some of them to realize what's happening goals. After all, it takes over half the summer for some of them to realize what's happening in the community. The others never know. I feel that only students having at least a full year's experiences in a community can go and work there during the summer. Students who want to become aware of community health and needs can learn initially through seminars and discussion workshops outside of the community in their schools. Those who are still more concerned can apply for part-time jobs during the summer with a community agency. They would then be under the responsibility and authority of that agency. I would never like to see another SHP go into a community area where very few of the fellows personally know what the hell to do and when to do it.—G.L., *Dental Student, Lower East Side.*

For next summer, it is important that the SHP attempt to bring back people with experience in community health in the areas they are located. A single summer on the Lower East Side is no more than an introduction to the problems of health care in this community. It is on-the-job training in community health, with an emphasis on the training, not on the job. Involving students in programs this winter, or having them return to the SHP next summer, will enable students to use what they have learned for the benefit of the community. If this is not done, the summer will have been, in the words of the black caucus, "*two* months in the sun seeing how the niggers live."—J.A., *Medical Student, Lower East Side.*

The majority of the students chosen for the SHP should be from the area in which they will work in order to insure a transition staff for year-round work. Allowances should be made where necessary to preserve the interdisciplinary approach. New students should not have to go through some of the basic orientation for half of the summer in the areas where projects have already existed. Structured discussions and seminars with experienced workers are suggested to help prepare them. It is advisable that the project be planned so as not to require needless repetition at the expense of the community.—L.K., *Medical Student, Brooklyn.*

INTERDISCIPLINARY TEAM

I found that working with students from all different fields was a very worthwhile experience. Each of the fellows had something unique to offer the project. The interdisciplinary team at Kings County Hospital worked very well together and used the combined talents of the members, with their individual contributions, to a great extent.—D.Y., *Medical Student, Brooklyn.*

The concept of an interdisciplinary team is a sound one and in practice is both stimulating and enlightening. The availability of legal advice was helpful on several occasions, and educational. In the lead poisoning project and at the hospital-based projects, nursing, dental, and social work students, with their different outlooks and approaches, complimented each other.—L.K., *Medical Student, Brooklyn.*

This aspect of the project was one of the most valuable factors for the success of the project. I felt, as a sociology student with a background in education, that I contributed much towards making my colleagues more aware of the importance of role relationships and informal organization in the hospital.—M.H., *Sociology Student, Brooklyn.*

The medical students whom I worked with were quite understanding and easy to get along with. Anything which I thought would arouse any difficulty, I directed to the students I worked with, and they'd explain it to me until I was able to comprehend and direct it back to them. They treated us as equals to them, and I grew to respect them for it.—L.J., *NYC, Brooklyn.*

The interdisciplinary team was helpful as it brought together a variety of skills and outlooks that helped in solving or at least recognizing causes of problems. An example is the highly charged atmosphere of the emergency room where people were often treated as something less than people. One student had a Master's degree in psychology and recognized that it was the tension of their work which caused many of the employees in the emergency room to occasionally treat people without dignity. He and two nursing students were familiar with the technique of group catharsis whereby persons who work together under tension can get together for an hour a week after work to discuss all their likes and dislikes about each other and their work. Properly conducted, such a session can act as a real help in reducing friction in their work.—N.W., *Law Student, Newark.*

The interdisciplinary team is a good thought, but relatively meaningless once put into operation. Personality problems can occur anywhere in the team. Having a law student on hand is worthless unless the student is already familiar with urban politics and law. In the case of the city of Newark, the "team" loses even more relevance. People on the undergraduate level could function just as well. They would spend less of their time trying to use clinical procedure; they wouldn't use the project as hustle for medical or dental school.—R.P., *Community Coordinator, Newark.*

I think the biggest problem among the health science students was lack of communication. Some of the health science students I barely saw all summer. I had vague ideas what they were doing, but did not know how, if at all, we could be of help to each other. Many times I felt there were hard feelings among the health science students and we were unable to communicate these feelings to each other. Many times a lot of people did a lot of talking and no one did any listening. I think the inability to listen on the part of many of the health science students created the big communication problem. A weekly sensitivity session might have helped this problem. By sensitivity sessions, I do not mean a meeting where people give their philosophies of life, tell about their general gripes and throw a bunch of vague nonsense at each other. By sensitivity, I mean the group should sit down together and express specific feelings about the project, individuals, their work, and problems they've encountered. This requires not only the ability to express your feelings freely, but also the ability to listen to others express their feelings.—L.D., *Nursing Student, Newark.*

My "working" relationship with our law student was not profitable. I could not seem to fit his work in with anything I was doing. I encountered a patient who had fallen downstairs in her apartment building for the second time and hurt her back because the landlord would not fix the stairs. I thought the law student might be interested in the case, but he seemed to think there was nothing he could do about it.

I think the other project members were able to use me when they came up with a problem concerning prenatal care, postpartem care, birth control, or anything else related to nursing.—L.D., *Nursing Student, Newark.*

My contact with the three medical students working on this project was constructive and very enjoyable. I picked up much of the needed medical background on lead poisoning from them. This project was, of course, particularly well suited for interdisciplinary work. My experiences with our NYCs were scanty, since they were almost totally utilized for the medical screening program. I liked what I did see of the high school students, more or less in passing. In short, relationships within the project seemed very good, and I feel that we've gotten quite a bit done with sufficient interaction but a minimum of mutual interference.—A.K., *Law Student, Bronx.*

I think that working with the various disciplines was a good experience but one handled in a haphazard way. If some organized way of displaying the "uniqueness" of each discipline in alleviating health problems and establishing total health care were available, I would have felt elated. Nevertheless, the nursing students found out what makes medical students tick, and vice versa.—J.C., *Medical Student, Lower East Side.*

I found that the students I worked with had a disturbingly little amount of initiative, enthusiasm, or devotion to accomplishment of our goal. To too many of us, the project was just a job, and that accounts for at least some of our failures to accomplish our goals in and for the community.—M.H., *Nursing Student, Lower East Side.*

It's a funny thing about the interdisciplinary team. We nurses are very touchy creatures about getting stepped on by doctors, and often, since we are very dedicated to the idea of the "*team*", get very up-in-arms about doctors' attitudes. At the beginning of the summer before we started working, before we knew one another, the situation was very tense, but once work progressed, except for the "normal" joking, we worked as one group, not as students of nursing or students of medicine. We did make one mistake; because we worked as health science students I wasn't always cognizant of the different disciplines, so when my group was having some difficulties on a legal matter, we never thought to consult the law students among us. We really didn't make the best use of our team.—J.L., *Nursing Student, Lower East Side.*

The interdisciplinary team really did not exist over the summer. None of us worked in any kind of professional capacity. Whatever I did, a nursing student or a law student could have done. It was a good experience for the various health professional students to work together, though I don't think that it was as necessary as finding competent people to work on the project.

* * * One fault of some of the people on our project has been that they have not made an effort to work well with everyone, but rather they desire and seek the advice of their close friends. It seems to me that one doesn't have to be best of friends with someone to work well with him and to respect him. Being in the SHO has always seemed like being in a kind of clique, especially at NYU. I believe that the attitudes that many of the students have developed over the summer of not caring and of feeling left out are derived from the "in" or "out" feelings that are so clear on our project. —P.S., *Medical Student, Lower East Side.*

Overall, my feeling for my colleagues was one of high respect. I have never been associated with any project in which I personally liked and admired so many of the people connected with it. They impressed me as an intelligent, dedicated group whose frustrations were not the result of any inner shortcomings

but rather due to external factors. (There were people here, however, that I felt should have been fired, not only because they were not really doing anything, but because they were a demoralizing influence on others in the project.)

The interdisciplinary team was a very good idea as far as interaction goes. I don't know what positive aid this was to the community, but I felt that I personally gained something from being involved in it. The real problem is that the work is reduced to the lowest common denominator so that everyone can do the work. Therefore, I don't feel that the project capitalized on the individual talents of the participants. In the long run, however, I think that it is difficult to overestimate the positive effect of this interdisciplinary team approach. Professionals are so impressed with and caught up in their own world that any contact with those outside that world is a benefit to all.—F.V., *Law Student, Harlem.*

Part 5: EVALUATION

INTRODUCTION

During the summer of 1967, slightly over fifty medical health science students participated in the Student Health Project of the South Bronx, a federally financed summer program designed to involve students in the health problems of a Negro and Puerto Rican poverty area in New York City. Almost every member of the 1967 project finished the summer with a smile—students, faculty, and evaluator.[1] Thus, it was not surprising that during the fall and winter of 1967 considerable effort was spent by students and faculty in securing funds for a "bigger and better" student project for the summer of 1968. These efforts were rewarded with success, as approximately $200,000 was granted by the Division of Regional Medical Programs of the U.S. Department of Health, Education, and Welfare for a 1968 summer project.

The 1968 Student Health Project of Greater New York consisted of five separate projects: the South Bronx, Harlem, the Lower East Side of Manhattan, the Bedford-Stuyvesant, Crown-Heights, and Brownsville sections of Brooklyn, and the Negro slums of Newark, New Jersey. In structure, each was modeled on the previous summer's Bronx project pattern of placing students in diverse settings and allowing them considerable flexibility to pursue (or not pursue) their interests. Thus, the students worked on such varied programs as mental retardation, narcotics addition, illegitimacy and unwed mothers, hospital services and patient advocacy, medical services for school children, and various community action programs for health care improvement. Not only did they work in traditional health settings (hospitals, clinics, doctors' offices), but they also worked out in the community, with action groups interested in health care problems. In essence, the only common ingredient in the pot pourri of student activities was health—defined broadly enough to include the social and political interests of ghetto inhabitants.

The major focus of this evaluation will be to document the primary sources of satisfaction and dissatisfaction with the project (other than administrative problems) and to offer some explanations for the change from a totally satisfactory experience in 1967 to the somewhat less satisfactory experience of 1968. Most of the following discussion is based upon self-completed questionnaires given to the 1968 project student participants immediately before the project began in late June 1968, and then again during the final conference held at the end of August. Interviews with project personnel during the summer also contributed to this evaluation report.

The Student Fellows

Table 1 below indicates the disciplines and backgrounds of the seventy-six (76) students who responded to both the June and August questionnaires.[2] Clearly, the majority of student fellows come from health science schools in the New York City area, and from white middle and upper class backgrounds. The students were not, however, without experience with poor patients before the summer program began, although wide variation existed in this respect also. Thus, thirty-nine percent (39%)

[1] See Ronald Miller, "The Project Evaluated," *The Student Health Project of the South Bronx: Summer 1967*, eds. Stan Fisch and Jody Williams, privately published under a grant from the Office of Economic Opportunity, pp. 181–97.

[2] In general, the responses of these 76 students reflected almost perfectly the responses of the 99 who responded to the first questionnaire. Appendix I contains comparisons of the respondents who answered both and those who only answered the first, and shows minor differences. Attitudinal and information comparisons (not shown) also indicated similarity of responses. Thus, it is felt that the analysis based upon these seventy-six respondents can be generalized to the total project membership.

had no experience or just a little bit, twenty-nine percent (29%) had had some experience, and thirty-one percent (31%) had had a good deal or a great deal of experience with poor patients before the summer program began.

Table 1.—Student backgrounds.

Discipline	%	*Religion*	%	*Family income*	%
Medicine	54	Protestant	17	Under $5,000 yr.	5
Nursing	24	Catholic	29	$5,000–$ 9,999	26
Dentistry	7	Jewish	42	$10,000–$14,000	29
Law	9	Other	5	$15,000–$19,999	9
Social work, Sociology	4	None	5	$20,000 and over	26
Other	3	No response	1	No response	4
Total	100	Total	100	Total	100
Race		*Sex*		*School*	
Caucasian	82	Male	100	New York City area	67
Spanish	3	Female	41	Non-New York area	33
Negro	12				
Other	3				
Total	100	Total	100	Total	100

[3] While percentages may not add to 100% because of rounding in these and subsequent tables, totals are always reported as 100 percent. All 1968 table percentages are based upon 76 respondents.

Finally, the students had different reasons for joining the 1968 project (table 2). Given this divergence in student backgrounds, experience, and expectations, a major problem of the project's student leaders was to organize the project to satisfy the desires and expectations of all student project members.

Table 2.—Reason students joined 1968 project.

Reason joined	*Percent giving reason in June 1968*
To help initiate and continue political action for social change in a poverty area	28
To help poor people get better medical care	42
To learn about the health problems of the poor	28
To learn about disease, health and medical care during the summer	1
No response	1
Total	100

The Project as an Educational Experience

The educational aspect of the summer project, the sensitization of students to the health care problems of ghetto residents, was a prime consideration in the development of the project. The project was viewed, in effect as a continuation of the student's professional education, although qualitatively different in the process of learning. In order to measure this learning experience, the potential educational content of a course in community medicine was divided into 31 subareas after discussions with both faculty and students. Student fellows were asked in late June and then again in August to indicate how much they knew (almost nothing, a little bit, some, a good deal, a great deal) about each of the items. As table 3 indicates for a selected sample of these information areas, the students learned a great deal during the summer.[4]

For example, while only fourteen percent (14%) of the students said that they knew a good deal or a great deal about the organization of health services for the poor at the beginning of the summer, seventy-two percent (72%) said they knew that much at the end of the summer. While similar results were obtained for most of the information areas, a few showed almost no improvement in knowledge. Two of them, cancer and heart disease among the poor, were the two major areas of interest to the Regional Medical Programs Division, the agency which granted the project funds.

Thus, in almost every one of these areas (with the exceptions noted) a definite increase in student knowledge was evident. Table 4

[4] The other areas which are not shown but generally also indicate increased knowledge are malnutrition, sex education among teenagers, lead poisoning, prenatal care, pediatric care, geriatric care, dental care, educational problems, family-domestic problems, folk medicine, Medicare and Medicaid, organization and problems of city hospitals, new innovations in health care, and new health careers for non-professionals.

summarizes this increase in knowledge by the students as it combines all 31 areas into an information index.[5]

Table 3.—Student learning experience during the summer.

Area of Knowledge About the Poor	*Percent saying they know a good or great deal about each area*	
	June 1968	*August 1968*
Organization of health services	14	72
Quantity of health care received	22	76
Quality of health care received	30	74
What professional practice is like for poor	12	41
Narcotics and drug problems	33	61
Birth control	29	54
Illegitimacy and unwed mothers	29	47
Welfare services	26	50
Rat bites	16	25
Housing conditions	47	80
Job problems	37	61
Community attitudes toward health problems	17	66
Community groups concerned with health problems	17	65
Mental illness	20	25
Mental retardation	10	17
Cancer	8	7
Heart Disease	9	9

[5] The information index was constructed by giving arbitrary scores of 1,2,3,4,5 to the five information response response categories noted in the text. The total score for each respondent on the 31 items was then classified as either low (scores under 80), medium (80–99), or high (scores over 100). No responses were counted as 3; if there were more than two no responses, the respondent was classified as no response.

Table 4.—Information index June and August, 1968.

Information Index Score	*June 1968*	*August 1968*
Low information	44	12
Medium information	46	51
High information	10	37
Total	100	100

Additionally, the information level of the students was directly related to their membership (or nonmembership) in the Student Health Organization (SHO), a loose amalgamation of medical and health science student organizations which are especially concerned with the health problems of the poor (as well as with political-social issues such as community control and black admissions to medical schools). SHO was largely responsible for the genesis of these student projects, and much confusion has existed for the past two summers over the relationship of the student health organization and the student health project. SHO members (see table 5) had higher information scores in June, 1968 than did non-members, and maintained this differential at the end of the summer. While nonmembers became sensitized during the summer, organization members also increased their knowledge about the health problems of the poor.

Table 5.—Information index scores and membership in the student health organization.

Information index score	*June 1968*		*August 1968*	
	Member of SHO	*Not a member*	*Member of SHO*	*Not a member*
Low information	34	59	4	25
Medium information	53	35	55	45
High information	13	7	40	31
Total	100	100	100	100
	(N = 47)	(N = 29)	(N = 29)	(N = 47)

Besides this objective data on the educational value of the summer project, the students also felt subjectively that the summer had contributed to their professional education. In August, seventy-four percent (74%) said the summer contributed a good deal or a great deal, seventeen percent (17%) said some, and eight percent (8%) said the summer contributed only little bit or something to their professional education.

Thus, educational gains should certainly have contributed to the satisfactory nature of the Student Summer Health Project of Greater New York. In 1968, however, one must ask, "Is education enough?"

A Clash of Perspectives

The educational aspect of the summer project—the sensitization of students to the various health care problems of the urban poor—was seen by the faculty members from Montefiore Hospital and the Albert Einstein College of Medicine (through which the grant was submitted and funded), and most of the faculty members concerned with the project, as the prime reason for the project. To them, educa-

tion was of greatest importance. To the "educationalists," radical political action for reform of health care services was an alien and threatening concept—and widespread improvement of current health care services was implicitly discounted as unrealistic. In fact, early in the spring of 1968 (during the project's formative stage) a direct confrontation of the education and political action perspectives resulted in the two then student leaders (both highly politically oriented) resigning their positions as they felt the faculty sponsor was restricting their actions and redirecting the focus of the project. As the faculty sponsor later noted in his reaction to a student manifesto about the political action necessary for improving health care, "With regard to the manifesto I noted that in the preamble there was no mention of education and as far as I was concerned it was an educational program."

The two new student codirectors felt compelled to "give in" and accepted the educational philosophy formally. They noted, "Student placements will be on the basis of the potential educational value of the experience to the student." However, the students also maintained their interest in the reform of health services as they noted that the dual goals of the project were the education of the students and the reform of health care services. Informally, however, the student leaders and the politically radical (and vocal) student fellows stressed over and over during the summer the need for radical political change to achieve health care reform—especially, community participation, community control, community, community, community! Witness some of their statements at the end of the summer which negated the value of the project's educational goals:

> The community should be served, not the students. The project is educational, but does this validate using ghetto residents?
>
> I don't think it should be the purpose of SHP the student health project to sensitize. I don't approve of parasitizing off the community for our enlightenment.

Thus, while educational achievement may have been an accepted goal in and of itself in 1967, it was not so accepted in 1968! Emphasis upon political action for health care reform, especially community control, made education a secondary (although still important) aspect of the project.

Community Control and Political Radicalism

The controversial issue of community control—community control of education, community control of welfare services, community control of medical services—dominated the ideological interests of the students during the summer, especially the leaders and the (vocal) politically radical student fellows. Education was not their primary goal; the improvement of health services for the poor via control by the poor was their slogan. This is not meant to imply, however, that all of the health science fellows favored community control. In fact, wide disparity existed on this issue during the summer, and was a major source of conflict and internal project debate.

Since the issue of community control was clearly important to the student leaders during the spring, several questions on community control were included in the June questionnaire. The students were asked what relationship community people should have with medical personnel in making decisions at a neighborhood medical care center; they could strongly agree, agree, disagree, or strongly disagree with each of the nine possibilities listed in table 6.

Table 6.—Student attitudes toward community control of medicine.

	Percent strongly agree, or agree with each statement	
Community people should	*June 1968*	*August 1968*
Advise medical personnel on budget decisions	76	72
Advise medical personnel on decisions about the scope and practices of the center	78	79
Advise on the hiring and firing of medical personnel	57	67
Have an *equal vote* with medical personnel on budget decisions	67	63
Have an equal vote with medical personnel on decisions about the scope and practices of the center	71	74
Have an *equal vote* on the hiring and firing of medical personnel	52	64
Have the *final controlling vote* on budget decisions	26	36

Community people should	Percent strongly agree, or agree with each statement: June 1968	August 1968
Have the *final controlling vote* on scope and practices decisions	29	45
Have the *final controlling vote* on the hiring and firing of medical personnel	20	37

While the majority of students felt in June that community people should either advise or have an equal vote with medical personnel on budget, scope-practice, and hiring-firing decisions, less than one-fifth of the students felt that community people should have the final controlling vote on these issues. Therefore, a community control index was constructed by combining answers on these three final controllining vote questions.[6] As show in table 7, fifteen percent (15%) of the students were community control radicals in June, while another nineteen percent (19%) were community control moderates.

Table 7.—Community control index.

Community Control Score	June 1968	August 1968
Community control radicals	15	36
Community control moderates	19	16
Community control conservatives	65	45
No response	1	4
Total	100	100

By the end of the summer, however, many more students had become advocates of community control, based on their experiences during the summer and the proselytizing behavior of the pre-summer community control advocates. Thus, community people were always given a larger role in hiring and firing decisions (either in terms of advising, an equal vote, or a final vote); and, community people were seen as competent to have a final vote on all decisions by an increased number of students.

This view of increased radicalism among the students as a result of the summer project is reinforced by data on political attitudes which was also incorporated into the two questionnaires. Students were asked to express their opinions on five issues of current importance to political radicals:

(1) Violence and rioting by Negroes in slum areas are justified if they result in social change;

(2) The seizure of administrative buildings by Columbia University students was justified by their cause and ideals;

(3) The burning of draft cards by opponents of the Vietnam war is morally justified;

(4) The seizure of factories by French workers and the French general strike should be emulated in the USA by poor people; and,

(5) Black militants are right in excluding white newspapermen from press conferences.

Student responses became more radical (that is, the percentage agreeing with each statement increased) from June to August. This is clearly shown in the Political Radicalism Index, (table 8) which shows the same radicalization as on the issue of community control.[7]

Table 8.—Political radicalism index.

Classification	June 1968	August 1968
Political radical	37	51
Political moderate	40	25
Political conservative	21	16
No response	3	8
Total	100	100

The debate over community control created serious problems for the project. Not only did the call for community by some students oppose the views of others:

> The community people are more important, intelligent and trustworthy than the health science students; versus.
>
> The "community" is a myth used, by those who are afraid to make real changes, to stifle action.

but, the radicals resented the project's less than total commitment to the theme of community control:

> It was set up, of, by and for students, not to really help the community. It took more than it gave.
>
> It was too tied into the medical establishment and not to the community. SHO lacked a real community philosophy and failed to be militant enough for the community or to listen to it effectively.

[6] Each respondent was scored 1, 2, 3, or 4 on each question corresponding to strongly agreed, agreed, disagreed, or strongly disagreed on the three final vote questions. Scores then classified as radical (1–6), moderate (7–8), or conservative (9 or more). No responses counted as 2.5; no response to more than one question resulted in the respondent being classified as no response.

[7] Respondents were given scores of 1–6 corresponding to very strongly agree, strongly agree, agree, disagree, strongly disagree, very strongly disagree with each item. Added scores then classified as radical (14 or less), moderate (15–19) and conservative (20 and over). No response counted as 3.5; if there was more than one no response, the respondent was cassified as no response.

> SHO . . . is a liberal, white service organization. As such, I don't think it should be in a black community at this point.

As such, the ideological involvement of some of the students in political radicalism and community control contributed to the undercurrent of tension which permeated the Student Health Project of Greater New York, and contributed to the feelings of discontent, dissatisfaction, dismay and disappointment which many project members felt at the end of the summer. .

Satisfaction: An Overall Evaluation

As noted in the introduction, almost all of the student and faculty members left the 1967 summer project with smiles on their faces. Faculty members were enthusiastic about the gains of the summer, and worked diligently with the students during the winter to prepare for the next summer's project. The same cannot be said now. In fact, thoughts of another summer project are presently far from the minds of the Einstein faculty members who supported the 1967 and 1968 projects. Student reactions to the two projects followed this pattern. As table 9 indicates, the 1968 summer was a disappointing experience for project members, when compared to the previous year's project.

Table 9.[8]—Student satisfaction with the summer projects.

Project was	*August 1967*	*August 1968*
Highly satisfactory	83	43
Slightly satisfactory	4	28
Slightly unsatisfactory	6	5
Highly unsatisfactory	4	18
No response	4	5
Total	100	100

This shift in attitudes toward the summer project from 1967 to 1968 is clearly shown, once again, in the percentage of students who would recommend that a roommate or close friend at school apply to a similar project the following summer. (Table 10). While ninety-six percent (96%) said they would recommend a roommate-friend apply after the 1967 project, only

Table 10.—Student attitudes toward recommending that a roommate or friend apply for project the following summer.

Would student recommend roommate-friend apply?	*1967*	*1968*
Definitely yes	79	33
Probably yes	17	20
Not sure	2	22
Probably no	–	9
Definitely no	–	14
No response	2	1
Total	100	100

fifty-three percent (53%) said they would do so after this summer's project.

Finally, one must assume that a satisfactory project would have resulted in more students wanting to work in poverty areas (when they become full-fledged professionals) after the summer than had wanted to work in poverty areas before the summer. However, this did not occur in the 1968 student health project; no gain in the percentage of students who wanted to practice their profession in a poverty area occurred. In fact, there was a very slight negative shift from the seventy-two (72%) who wanted to work in poverty areas in June to the sixty-eight percent (68%) with the same desire in August, 1968. In brief, the 1968 Student Health Project of Greater New York cannot be considered an unqualified success.

The reasons for this less than totally satisfactory experience have been alluded to before, but can be placed in proper perspective now. First, the positive aspects of the educational gains of the summer were minimized by the conflict over considering education as a primary project goal. Since the "education-lists," both student and faculty, were constantly assailed by the vocal politically oriented students, this tension no doubt lessened the student's satisfaction with the knowledge gains of the summer project. And, it resulted in many faculty members feeling that the educational gains just were not worth the aggravation. Second, the students were dissatisfied with the limited nature of those changes that were accomplished during the summer. While more students reported that they had achieved some change in the community in 1968 as opposed to 1967 (67 percent said they accomplished

[8] The number of cases upon which percentages are based for the 1967 project is fifty-three (53); as usual, the base for the 1968 project is seventy-six (76).

hange in 1968 compared to 58 percent in 967), almost all of these changes were either ndividualistic as they helped one patient or ne family, or they were temporary and of lit-le significance. Broad, widespread change was ıot accomplished. In 1967 this was permissible; n 1968 it was not. As several students noted, 'There should be no summer projects. They ıhould be all year or not at all."

Third, the controversy over community con-ıol (and political radicalism) and its relation-ıhip to the reorganization of medical services for the poor served to supply the tension needed to minimize the positive aspects of the summer program. The Spring confrontation of education-oriented faculty and political action-oriented student leaders foreshadowed the summer's conflict over community control, political radicalism, educational exploration of the ghetto, and "meaningless" piecemeal change "with the system."

What had been a highly successful project in 1967 had become a much less successful—even unsuccessful—project in 1968. Why? The reasons given above are part of the explanation; but, they are only part. Perhaps it was the students, the faculty, the radicals Or, perhaps it was America in 1968 as compared to America in 1967. Perhaps it was not the Student Health Project of Greater New York, at all. Perhaps it was Vietnam, Lyndon Johnson, Hubert Humphrey, Richard Nixon, and Mayor Daley.

Appendix I.[9]—Student backgrounds: Comparison of those who answered both questionnaires and those who answered the first questionnaire.

		First questionnaire	First and second questionnaire
A.	Discipline		
	Medicine	54	58
	Nursing	24	24
	Dentistry	7	6
	Law	9	8
	Sociology, social work	4	4
	Other	3	3
	Total	100	100
B.	Religion		
	Protestant	17	22
	Catholic	29	27
	Jewish	42	39
	Other	5	5
	None	5	5
	No response	1	1
	Total	100	100
C.	Family income		
	Under $5,000	5	6
	$5,000—9,999	26	25
	$10,000—14,999	29	27
	$15,000—19,999	9	10
	$20,000 and over	26	27
	No response	4	4
	Total	100	100
D.	Race		
	Caucasian	82	79
	Spanish-speaking	3	3
	Negro	12	15
	Other	3	2
	No response		1
	Total	100	100
E.	Sex		
	Male	59	61
	Female	41	39
	Total	100	100
F.	School attended		
	New York area	67	66
	Non-New York area	33	33
	No response		1
	Total	100	100

[9] The number of respondents to the first questionnaire was ninety-nine (99), while the number responding to both questionnaires was seventy-six. (76). The percentages given in this appendix are based on these numbers. The main text of the report using the data abased upon the rsponses of the 76 who responded to both questionnaires.

THE STUDENT HEALTH PROJECT AS A LEARNING EXPERIENCE

Those of us who worked to develop a 1968 Student Health Project in New York City saw the 1967 California project as a partial model and tried to incorporate as much of it as we could into the planning. A tacit assumption we all made was that students would be brought to New York City to work in "medically disadvantaged areas," for example, black and Puerto Rican ghettos. In this way the students would:

(1) Learn about these communities, their sights, sounds and smells; but more importantly, the students would realize, from first-hand experience, how the community environment determined the people's life-style and their percetion of all things, especially health. This proved to be one of the most invalid assumptions one could make. I realize now that it is grossly unfair to bring two-

month "summer trippers", most of whom do not live in the community, and view their summer as nine to five job exposures to poor people, into someone's home and expect the people to unburden themselves to the student, relate to the student in any other than a short term, *ad hoc* manner and it is most reenforcing to the student's subtle feeling that he can act in this role with poor people, but would never dare go into his own community and ask what he asks, or assume the role he answers in poor communities.

(2) Help the community get better health care. This goal was our number one goal, but attached to it is the subtle idea that it is all right for a student, to act as a "patient advocate" and take the community person to the hospital and use his own knowledge of the systems to help the community person. Students were also supposed to work with some community organizations, either through them (using their office and phones to contact people) or to become a summer apprentice to the community group and offer specialized assistance where possible—and where decided by the organization. I am happiest about the last type of task, where the student works with a community organization, because it is the least condescending to the community people, and makes the most efficient use of the student's special knowledge of the system or of uniquely medical matters (for example, dental hygiene, birth control).

(3) Work with a member of the Neighborhood Youth Corps (NYC), making it easier to come into a community, finding out about a ghetto youngster, and maybe interesting the teenager in a career in on of the biosciences, but certainly helping the youngster with high school subjects. This was the most disappointing aspect of my summer. Working with the NYC organization was impossible. I know that New York City NYC program was having its difficulties (as witnessed by the constant turmoil and investigations, but trying to deal with the confusion, inefficiency, and lack of understanding made it almost impossible to have NYC youngsters in the Bronx and Brooklyn projects. Many health students were interested in the NYC's, but could not treat the youngsters as equals on the job. Maybe it was that the students received $900 for the summer and the NYC's received $320 but probably it was that the health science students could not accept the idea that their summer problems required creativity in setting up tasks compatible with the community's needs, the NYC's capabilities, and their own abilities. The best relationships between NYC's and students were in Brooklyn where some students encouraged the NYC's to take an active role, and the NYC's accepted this involvement and functioned beautifully.

Unfortunately, much of what I have said thus far, places pivotal emphasis on the personality of the student, NYC, and community person. Our project was set up this way under the guise of "creativity" and "flexibility," but for these assumptions to hold, the parties concerned must have some knowledge of what is expected of them. One of the glaring faults of this summer's program was poor project development. The project descriptions were reassuring, but what backed them up? In Harlem and in Brooklyn, most of the problems and preceptorial contacts were valid and existed. In the other three areas (especially the Lower East Side), the students were constantly confused and frustrated by a lack of direction and a paucity of personal contact who understood the Student Health Project or what they, as preceptors, were supposed to do. I can, however, offer a theory as to why this happened. We were not sure of our funding until two weeks into May, after students had been accepted and plans for Orientation set into motion. Being unsure of the status of our venture, or if we would have an SHP at all, students probably found it diffi-

cult to make firm commitments. When the contract was finally agreed to, I'm sure that student coordinators in all the areas had to tighten up loose arrangements, but in Newark, The Bronx, and the Lower East Side the arrangements never jelled and remained amorphous for the better part of the summer. Throughout the summer new preceptorial arrangements were constantly being made. This was a drastic mistake. If the supporting structure had existed, and if the project staff from the top down had felt more secure in our roles and was clearer about direction, much of the confusion and frustration could have been avoided and more would have been accomplished.

As for the educational function I was supposed to direct, this started with Orientation, which was in two parts. From June 23–26 we met at Bader's Hotel in Spring Valley, N.Y.; the remainder of the week was to be spent orienting the five student groups (with NYCs where possible) to the five communities. In general I thought the project Orientation session was adequate and accomplished my intentions. The first full day was devoted to an overall view of the communities SHP would be in during the summer. Films, speakers, discussions, and lots of free time were used to help the students obtain an overview of community feelings and problems in the Greater New York Area. One full afternoon was spent talking about NYCs (the twenty or so NYCs who attended the Orientation spoke to the students in a wonderful two-hour open discussion). The second day brought health professionals who had some notion about community health. The students and community people asked many revealing questions and I think received a reasonable superficial exposure to some of the current thinking in Community Health (none of it was radical, however). The third morning was taken up by a great discussion of "Community Control of Health Care Facilities"; this seemed to be the logical culmination of the previous Orientation topics. However, this last discussion was all rhetoric. In fact, one of the community people spoke to me during August and said that some of the promises made at Bader's by the health professionals were simple bullshit and she was unhappy with their deception (she gave me no particulars). On the whole, Orientation had given the group a needed *esprit de corps*, and a very low-keyed introduction to the community health scene in New York City. This was not a radical Orientation, merely an easing into the summer's problems. Some people resented the site of our Orientation and Final Conference sessions (both were held at resort hotels outside of New York City). The problems inherent in finding a place to feed, provide meeting facilities for, and house participants (which is not necessary, but we felt this would be optimal) at a reasonable price in the New York Area are HUGE. This was one of the greatest stumbling blocks all summer. We were a large group and needed large facilities. Bader's Hotel was ideal (even though it was not in the community) because we were the only group in the hotel for the three days it was the hotel's off-season and the price was right.

The educational programs *per se* during the summer never really achieved my goals. I fast realized that the project participants were reluctant to travel very far to hear a speaker and were not really bristling with ideas as to the kinds of speakers that would interest them. There were two lecture series, on black and Puerto Rican history, given by Mr. S. L. and Miss C. M. Mr. L. presented the problem of a self-appointed black historian. His treatment of black history was interesting but not extremely substantive. He certainly knows quite a bit but his digressions confused matters and took the group away from the factual matters. Miss M. was excellent. She not only knew a vast amount about Puerto Rican History and Culture, but she was an eloquent example of the second generation Puerto Rican in the United States. In Newark, R. P. (the Community Coordinator) arranged a discussion group with his NYC's. These groups met twice a week and discussed *Before the Mayflower*, a black history text by Lerone Bennett Jr., and *Black Power*, by Carmichael and Hamilton. These were far from militant discussions, but merely an attempt to help the NYC's become more verbal and less afraid of expressing their ideas. These

books were chosen because they deal with the one inescapable attribute felt by all black people in America—blackness, its origins, and its consequences.

The Bronx project attempted weekly tutorial sessions. For health science students there was instruction in Spanish, and for NYC's there was instruction in science, mathematics, and music. However, many of the students did not have time for these afternoon sessions, and the NYC's could not always attend because of their responsibilities.

I am convinced that each area has to have its own educational coordinator who is in constant contact with the area people and is acutely aware of their desires. I attended area meetings once a week but received little feedback as to the type of programs the people wanted.

The Final Conference was steeped in disagreement, good intentions, and subjectivity. Many students did not care to attend the final conference (August 26–28) because they needed a rest before starting school in the fall and they wanted that week for part of their vacation; many people felt the conference should not have been held at the Sha-Wan-Ga Lodge in upstate New York; indeed, many people felt very strongly that the final conference should have been held in New York City, in one of the five communities SHP was working in. In choosing a site for the final conference we were faced with many more problems than with orientation. We felt that if people were to commute each day to the Final Conference we would be ending the sessions early and beginning late in the morning—the logistics would be much simpler if everybody was in one place for the entire three days. Sha-Wan-Ga Lodge was far from the ideal location, but it was the best we could find in terms of space, facilities, food, convenience, and price. If I seem to be harping on seemingly trivial issues, it is only because much of my time this summer was spent worrying about just such details and precious little time was spent in a nonbureaucratic bag. Much of the "central staff's" time was spent patching up situations that arose because of poorly functioning area leadership, and simple confusion caused by poor planning on our part. Coupled with a student ignorance of the ways of a bureaucratic system, and our lack of assurance as to which decisions we could make and which decisions required a policymaking council vote, this kept us in a very confusing and confused state of affairs until we were almost through with the project (maybe we never got out of it).

The Final Conference relied almost exclusively on health science students and community people to lead discussions, present working papers, and determine the focus of the Conference. Much of the discontent and frustration was vented at this Conference, as well as the crystallization of the issue that had been cropping up throughout the summer: *Reformists* vs. *Revolutionaries* in the health care field. That is, should the SHP and SHO try to reform a bad, though not unsalvagable, system or should the thrust be to work with any and all allies to totally revamp this system. This is the major decision of any activist-minded person and was coupled with a crisis in choosing allies for health students. We asked each other should students work in communities or should they only serve as advisors to community organizations (someone suggested that our name should be Community Health Organization). The fallacy of the first assumption enumerated at the beginning of this report was exposed and much introspection and soul searching followed. The Final Conference was not orderly, people complained about "to much talk," no direction, and no continuation of projects throughout the year (however, three area projects have been funded through the winter). This was not unexpected and merely reflected the clashing of ideals, none of which have absolute worth and all of which might be tried.

We ran into a problem in our project because the five areas and the participants seemed at times to be less important than the unified Student Health Project. We talked about autonomy and creativity, but were faced by poor support on the local level, many willing students but some not willing at all, much money, and a bureaucratic structure second to none behind the project (Montefiore Hospital runs a very efficient bureaucracy, and their staff was invaluable) which often did not function as responsively as we would have liked. The ten-

sion was between the five individual areas and what each thought was important, what could be allowed to permit proper functioning of the project, and what Montifiore and Washington were willing to allow. These three power groups were never at direct odds, but the communication between the three was not good and this lead to much ill will.—S.G., *Education Coordinator.*

If SHO does continue, which I hope they do, they should do some serious thinking about the summer's experiences. Unfortunately, many of the comments I have to make this summer are the same ones I made last summer.

First of all, Orientation should be more specific. For example, those working in the Bronx need to know about the Bronx. Mimeographed sheets of all community groups, health facilities and service agencies should be made available to each project member at the beginning of the summer. This summer, halfway through the project one list of medical facilities and community organizations was available in our office. This list should also include such things as clinic hours, how to register, and who the heads of each department are.

It is also important to know basic functions of the community groups. Last summer there was an excuse for not having this information available because it was the first summer for SHP. This year it was not excusable, and next year we should not attempt a project without having this information readily available. It is rather astounding to find out that a student working one block from the N.M.C.D., can go half way through the summer without knowing of its existence. Equally astounding is that a community worker in the last week of the project can admit to not knowing about Welfare minimum standards forms.

Orientation should also include a discussion of roles. For example, community workers should be told that they are to be involved with welfare and housing problems. Part of their introduction to their new role should include specific information about welfare. They need to know the lines of authority, the rights of the clients, the procedures of the different centers, etc. This summer everyone did a little of everything without benefitting from anyone's specific knowledge. By defining roles some needless overlapping can be eliminated. A clear definition of a role does not limit initiative or creativity. It should enhance it. If the community worker knows how the welfare department functions, this in no way stifles his ability to work with welfare clients.

* * * It seems that if students were given a specific orientation, a definition of their role, and started the summer by defining their focus, then the level of frustration would be lowered and the feeling of accomplishing higher.—V.V., *Nursing Student, Bronx.*

My reaction (to orientation) was negative. Most students who go to work in projects like this already have some awareness of ghetto problems. The resource people do little more than tell us in more vivid detail what we already know in general. Specific names of programs and people are lost on me, as I have no way to connect them with their environment.

The Orientation seemed to be trying to give us a feel for the ghetto in a resort hotel atmosphere. It should have concentrated on the organization of the power structure , and the poverty organizations, and left the ghetto feeling to a time when we could experience it. I want to become "sensitized," too, but not at Bader's Hotel. It was like going to France to learn German.—R.H., *Law Student, Brooklyn.*

To me the orientation was unnecessary because I now how it is to live in a ghetto and I need no one to tell me how it is. The only thing the orientation did for me was to give me a chance to know the people I would be working with. Also to find out what their personalities were like so I would know how to approach them.—W.F., *NYC, Brooklyn.*

My only criticism of the project was the pre- and postsummer meetings. They seemed to have too much of the "party atmostphere." I am certainly not one to dislike parties, quite the contrary. But I prefer my parties to be paid for by me and not out of funds allotted for the urban communities' problems.—B.W., *Medical Student, Newark.*

In improving SHP for next summer, the

most apt suggestion I can make is that the students in each specific project familiarize themselves with the community and the project before the summer so that when June comes they can start work immediately without first spending a great deal of time learning about the problems of the area. This of course would necessitate much time during the school year, something medical students may not be able to do.

I believe the orientation session at Baders was most useful and should be continued; though much of what was said there was perhaps not necessary (for example, what is a ghetto?). There were two films shown, one of SHP in California and one on the South Bronx, both of which gave us an idea of ghetto life, and, perhaps more important, explained attitudes we might face while working in these areas.—D.K., *Medical Student, Brooklyn.*

The orientation program at Bader's may have been costly to SHO and boring or useless to old SHO members but to anyone newly acquainted with the organization, it held three opportunities: to learn a bit about SHO, its goals, philosophy, etc.; to learn the exact plans and expectations of the various projects (with chances to reconsider choices!); and to get a feel of some attitudes the next ten weeks might support or struggle against.

Local area orientation, on the other hand, might have been a little more diligently done. In the future, such proceedings could serve as a guiding push into the summer's activities and save the student fellow from wasting precious time learning what old project members could easily pass on. Admittedly, some things will require a certain amount of time for each student to get on his own.—A.G., *Nursing Student, Harlem.*

We found that our goals were somewhat different from those of the citywide SHP. In the introductory remarks and the comments on the 1967 California SHP film the first night of orientation, it became evident that much of the purpose of the New York SHP was "sensitization." *Our* primary goal was to improve the school health program in Harlem public schools by demonstrating that a model for using community people as health workers can work. "Sensitization" of student fellows had a low priority.—R.C., *Student Coordinator, Harlem.*

I feel that we were also severely limited in designating ourselves as a project to "teach" other students about poor communities. While this is an admirable and necessary task, many of the more experienced of the students were not capable of structuring a project which could provide useful service to the community while giving uninitiated students first exposure. This is because most of the students who set up the project didn't have very much experience themselves. I don't think that in several weeks or a month or even a year a health science student can be knowledgeable enough or accepted enough by the people he is working with to take it upon himself to bring other students in to get a feel for what is going on. In my opinion, all projects which are beginning for the first time should be composed only of local students with some experience, who share some attitudes about "health care as a right," the economics of poverty, the poor educational system, etc. Their goal should be: (1) To provide themselves as consultants to the community on whatever projects are underway—they should not start their own projects; (2) to meet people in the community and become knowledgeable about the special problems and resources of that community; (3) to discuss, say at the end of the summer, with the community people they have worked with, ways in which more students and community people may work together in the fall.

I do not think that students new to an area should identify themselves as SHO or SHP or anything else; this marks them as another group with something to do. Their only task during the first summer should be to help out existing community groups. If this were the case there would not be a city-wide SHO as far as community work goes. There might be some central staff to arrange seminars, confrontations, etc., but it should not be concerned with individual projects, which at least at first would be directed strictly by the individual community. I think that the central staff this summer was very ambivalent about its role—

supervisor—director or facilitator—but this would be eliminated if they did not decide things for the individual projects.

I should state here that the idea of bringing out-of-state students to various project sites, which goes along with the idea of educating students and creating other SHOs, is overambitious and hampers activities. Aside from the difficulty of getting a group with such divergent views together to do something, it is difficult to think in terms of ongoing projects when 75 percent of the project staff leaves almost as soon as it arrives. This also rubs in the fact that students can and will leave the community, but residents are stuck there. Along these lines we might also say that students should be required to live in the communities in which they work.—S.D., *Student Coordinator, Lower East Side.*

The first few weeks on the project have been so full of different kinds of experience that it would take me many pages to relate all that has happened. . . . One moment I feel as if there is real purpose to our work and then the next hour I feel as if the entire effort is a futile one. There is very little structure to my project other than that which I make. Nothing in my educational or work experience has been this way. The past year at medical school, especially, convinced me that it was unnecessary to have to think and to be creative in one's work, but this summer has been as much the opposite of last year as possible. Every day is different and is only as meaningful as the effort which I put in. In some ways this is good, I am learning how to work in a loosely structured job and how to create something of value in the summer's work.

I wonder, however, if we are actually going somewhere as an organization of professional students who really do have talents and knowledge to offer the community. I feel as if I am going to come away from a meaningful experience with a much greater understanding of the problems of the poor and a feeling of sympathy for the people, a feeling acquired only by walking the streets, by smelling the air that people breathe, by seeing the homes in which they live, and by talking to people with whom one has never spoken. Yet I feel frustrated because I know that sympathy on my part does nothing for those people. I feel frustrated because I see that the problems are so enormous that I can do almost nothing. I also feel frustrated because many of the limited goals that we have established will not be achieved. But then I think about how I felt after the first time I sat with a group of Neighborhood Youth Corps teenagers, trying to make boys and girls confront each other about their ideas on male and female anatomy in a sex education class. I felt very good because I say that these youngsters could respond to me and that we could work together; that I could bring something new to their lives.—P.S., *Medical Student, Lower East Side.*

After 2 years of working as a student in Metropolitan Hospital I really cannot say I learned anything new about the delivery of health care. I spent the summer in another area of New York City where most of the problems were basically the same, but I did experience more about the delivery of health care and hear more of the actual feelings of the people. What I had learned before was learned, dressed in white, as part of the hospital structure; what I experienced this summer was experienced as part of a community organization (NENA) fighting health rights issues on its own grounds. I found this completely invaluable to my understanding. When a person is sick and must go to a hospital, he comes to you (the nurse, the doctor) on your grounds: you are the controlling factor in the relationship; he has no voice and does not say what he feels. When you go to him and meet him on his grounds, you are a guest in his home; he has more authority and can meet you on a one-to-one basis.—M.L., *Nursing Student, Lower East Side.*

You fight a deadline because you don't want to disappoint the community, and then they don't showup; you can understand it, but it doesn't help your feeling of that big comedown. Now you know how the people of the community must feel when they get promised things and don't get anything. I was too naive going into it; I didn't expect any hitches; we

kept our end great and this guy had promised he would get the kids for the physical exams and I took him on his promise. I now know you can't do that. If we were to do this again, we would arrange for the kids to come ourselves, and leave nothing to anyone else. That is one thing I have learned this summer; I've learned to rely on other people a lot less.—W.S., *Student Coordinator, Brooklyn.*

I have heard our SHP advisor say more than once that it is difficult and almost impossible to assess the effects of any community service. Bearing this in mind, I think that the major accomplishment of my summer's efforts has been my own education.

This education began in family counseling where I learned about welfare, housing, and mental health problems that affect some ghetto residents. I also saw how these problems are interrelated and how they affect ghetto residents' health and well-being. In the VD education program, I learned about venereal disease and also how little is known about it and its cure in the community. It also became evident that even though people had many misconceptions about VD, they were well aware of the social stigma involved with having contracted syphilis or gonorrhea.—E.C., *Medical Student, Brooklyn.*

There had been many arguments concerning the wording used in our questionnaire. For example, we wanted to know if the person was living with his or her spouse. One could simply ask: "Are you living with your husband?" We did not want to do this. These people have been picked on too often. They have been constantly questioned, often with too little compassion, about their personal lives; questioned by people who have different value systems and different concepts about what life really is like. By asking the number of children in the house and the number of relatives, etc., we would figure out by a person's response to the question about the total number of people living in the house whether she did indeed live with her husband.

One of my first lessons learned was that all this beating around the bush was quite unnecessary. It wasn't as important to concentrate on the wording of the question as it was to concentrate on the way it was asked. These mothers are not stupid. They can tell when someone is sincere and when someone really cares about the well being and safety of their children.—D.Y., *Medical Student, Brooklyn.*

The huge Brookdale medical complex was considered not worth a damn and all I knew about it was what I heard and all I heard was bad. Validity is not inherent in universality and because all of the gung-ho people from both SHP and the community had climbed aboard the "Bury Brookdale" bandwagon, I didn't believe any of it.

When the opportunity was presented to work at Brookdale with complete freedom, I secured the position. Seven weeks' of examining programs, speaking to patients, and quietly observing the procedures and handling of patients' convinced me that the blowhards I'd heard at the summer's beginning did not know firsthand what they were talking about. In fact, they had fallen prey to exactly what they so staunchly warned against: the blind acceptance of stories which, as I later found out, should have been either buried long ago or never even begun.—J.G., *Dental Student, Brooklyn.*

* * * I spent most of the time talking with the three boys, about my age, who work as guards in the office. I quickly learned that they were quite as complex as I. I was interested and surprised to learn that the reality of the ghetto, with its junk, crime, and imminent death frightens them as much as it would me if I lived there. And these boys are by no means powder-puffs—one is an ex-addict, and all are fully in the midst of the Bedford-Stuyvesant "scene." I was very discouraged by their bland acceptance of everything that occurs around them; the universal gambling, dope, and stealing from one another is a depressing reality that is acknowledged fully but left unchallenged in their thought or conversation.—J.T., *Medical Student, Brooklyn.*

For people on the outside, there is a feeling that the black community in Newark is dangerously unified and ready for complete revolu-

tion. When I walked into Newark this summer, I was afraid. My orientation had never before been that of a revolutionary; I had always been a reformer. I didn't believe in violence as a solution to any problem. I didn't like the idea of "black power" because all it meant to me was separation. I believed that everyone had to get together to solve racial problems. After about 2 weeks in Newark, I changed my opinions and my orientation.—K.F., *Medical Student, Newark.*

Although I have lived just outside of Newark for most of my life, I found myself spending the first few weeks of the SHP program getting familiar with the city—objectively and subjectively. There were streets to know, bus lines to learn, names to memorize, landmarks to note, people to meet, etc. There were also attitudes to recognize and to understand—mine, as well as those of the community in which I was to work. My previous life in the suburbs had not exposed me to the real working of Newark; initially I was in a state of overwhelming ignorance. But as I came to know more about Newark and its people, I was able to participate in the SHP task of improving the medical care offered to the people of this community.—B.W., *Medical Student, Newark.*

The problems of health care delivery change quickly revealed themselves to me to rest more with the medical establishment of the hospital and New York City health department, than in community apathy, lack of sufficient information about health services in the community, or lack of parental concern and cooperation. (I was surprised and pleased to discover how well ghetto mothers do take care of their children's health needs, within their limited means, even though not up to middle class white America's standards.)—W.S., *Medical Student, Harlem.*

I really didn't expect to receive too much "sensitization" as far as the community was concerned, since I was born in Harlem and have spent several summers there recently. However, I was surprised to find that my relationship with white people was greatly improved. It seems that every time I manage to become somewhat prejudiced against white people, I meet one I really like. From past experience, however, I try not to forget that I am black and he or she is white. The other day I was walking down 125th Street with one of my coworkers. I noticed that some people were staring at us; then it hit me: "I'm black—she's white." I had forgotten. It's much easier and more comfortable to forget. I'll have to do it more often.—C.R., *Medical Student, Harlem.*

The people who came to work in the project should have already had a meaningful attitude toward the people they would be in contact with, for example, the community, before they went into the community. And if some students didn't have these attitudes, or there was some doubt that they did, then the students should have been screened out. This is not the place to develop attitudes. This is the place to work for the community as a result of these attitudes.—C.R., *Community Worker, Bronx.*

WHAT NEXT?—SUGGESTIONS FOR THE FUTURE

I think there may be a place in ghettos for white liberal medical and nursing students next summer but it is a rather specific and conditional one. I think students should only go into a community at the request of a community group. I think the students should see their role as primarily that of support for groups already working on health, or who are trying to build an awareness of health issues in their communities.

I would personally suggest that there be no more SHPs like the ones we have had for the last 2 years in New York. It is just too expensive and too exploitative of the community (we learn more from them than we provide) to justify taking government funds. If we could fund a large number of community people, as they did in New Haven, that might be better. On the other hand, I think it would be better if SHO concentrated on what it could do year-round to raise significant issues in health in the community where the medical schools are. SHO should concentrate on providing human medical care that is responsive to the needs of the community and at the same time should

turn other medical students on to the concept of medical care as a right, not a privilege. SHO should develop the attitude of standing on the side of the consumer of care and criticizing the facilities from that point of view, not from the point of view of the professional deciding what is best for a community without consulting them.

The last thing I want to say relates to the people I have seen on the SHP this summer. These remarks fall into the "I love humanity but I can't stand people" category, I guess. I think that SHP is in a dilemma; it was started by a group of people who were much more radical (in the sense that they were willing to address themselves to "root" problems) than the people who have climbed on the summer project bandwagon. For example, we've talked about alternative structures that seem to get at the problem of community control, but most of the SHP medical students are suspicious of community control. We've talked about the "politics of health" but most of the students in the summer projects are essentially apolitical; to wit, the Detroit SHO convention declined to take a stand on the war in Vietnam. So what we have is a liberal service organization, for the most part, that tries to sound radical but that has no real sophistication or understanding of root causes.

I think that there will probably be more SHP summer projects, simply because there are a lot of liberal medical students who would like a chance to prove something by "doing their thing" in the ghetto. Dealing with realities, then, we have to decide how to make the service projects as good as possible while leaving the smaller group of more political students to deal with the issues of decentralization to neighborhood clinics, community control of health facilities, redesigning health care systems in ghettos so that they take into account the life styles of the poor, and the fact that even if the New York City hospital system were run efficiently (an impossibility in a bureaucracy wracked with union and personnel problems) it couldn't provide decent medical care because the budget allocation isn't big enough. All these issues we have to leave to the small group which may serve as the "cutting edge" to anything SHP can become.—R.C., *Student Coordinator, Harlem.*

I now believe that the best thing SHPs (or more appropriately year-round active SHO campus groups) can do is to focus all available manpower on a single significant ground-floor objective (as determined by the needs of the specific community through prior discussion with people in the community)—be it service-oriented (for example, a health rights and resources community education campaign) or activist-oriented (such as assisting some specific community group in forming a community health advisory council). Otherwise, we can do the most good working within the medical care delivery institutions of which we are a part to effect changes in practices and policies.

Medical student activities (whether SHO/SHP or not) should be directed toward two important and closely related objectives:

Communication: We can work to facilitate communication between health service establishment, professionals and community people (and vice versa), example, liaison with hospital administrators where community people couldn't get a foot in the door, or working to develop formal hospital "community relations" programs so that the "real" public (not just the news media reporters) can know what good and bad things are going on inside our ivory towers. At present, as clearly demonstrated in Harlem, rumors about the hospital are allowed to run rampant in the community and rumors about the community run rampant in the hospital.

Responsiveness: We can work to convince health professionals of the pressing need to respond to community requests for information, cooperation, suggestions for services or modifications of existing services, etc. (How long must the community keep asking for evening clinic hours before someone listens?)

We also can work to increase community awareness of the facilities and services available (community education programs) or opportunities they should not let pass (available jobs or positions on advisory committees, etc.).

Specific SHP service projects should only be

initiated at the request of some responsible element in the community which has existed long enough to have some real feeling for the community's needs and desires (PTA's, health councils, etc.).

Dropping twenty or so health science students (and some unmotivated NYC's or community workers) into as complex a situation as exists in urban areas like those in New York to tackle whatever problems can be found in ten weeks just can't go on. The idea of sensitizing health science students to the urban health care problem in this manner is too selfish an objective to justify spending several hundred thousand dollars. It's immoral to use the community for our own educational purposes without providing it with something enduring of significant benefit.

I don't see how we can continue bringing in a new group of students each summer to sensitize them, each summer attacking the same problems to no avail, repeating the previous year's mistakes, alienating the same establishment functionaries (who soon come to view us as a joke), and leaving behind the same community disillusionment with student projects. Not to mention the health professional at Harlem Hospital who commented that we should be paid no mind because we're just another bunch of mixed up kids having an identity crisis, who all are in the bottom third of our class!

In the first place, most of the students selected for SHP's are already somewhat aware or they wouldn't be here, and a summer of foul-ups and frustrations doesn't really have sensitization value for them anyway. As for the others, who do need such exposure: is a 10-week SHP the right time and place to do it? I agree with the Harlem community worker who told me that future SHP's should consist of five committed students and twenty mothers, rather than the twenty students and five mothers that we had.—W.S., *Medical Student, Harlem.*

The only SHP organization relevant to these distinctive problems is one which minimizes city-wide student and faculty political infighting and which maximizes local student involvement in the issues of community control over entry into health professions and over health care delivery.

Future SHPs, therefore, should develop autonomous organizations to attack the problems in each borough. Borough leadership should be shared equally by one militant student and one experienced community-leader. Funding should be entirely independent of either Federal Government or medical schools. The ultimate purpose of such an arrangement would be the ouster of the health science student leader and the assumption of complete control by community spokesmen. This is the strange political dialectic that white health professionals will have to learn to accept: *Success means getting kicked out.*—J.G., *Medical Student, Bronx.*

I suggest that SHO ought seriously to consider making the relation between itself and the community more explicit and formal so that the team of community worker and health student could be developed more easily. For example, SHO could try to form an alliance with LABOR for joint-funding next summer; housing and health problems go naturally together. The basic idea would be that health advocacy is a good way to build up the number of services LABOR can provide, and that LABOR is a good entree for working in the community as health advocates. The idea seems to me to have advantages over the present funding and organizational structure:

(1) SHO would be clearly allied with the community and not with the Establishment. From what I've seen this summer, the SHP funding agency and policy making committee haven't made any contribution to the project. If anything, they forced unnecessary compromises on us in the planning stages. A clear alliance with the community would give us a sound and practical basis for learning what community health will have to mean in the future, and for working out that meaning.

(2) An alliance with LABOR based on joint-funding would give project fellows a larger role in defining how they will work out of LABOR. The ambiguity of the present relationship created prob-

lems this summer; joint planning of the project and joint training of project members would give us a chance to work out conflicts on a realistic basis and strengthen our relationship with LABOR.

(3) LABOR employees could provide better continuity after the summer is over.

(4) Joint-funding with a community organization would give SHO a good opportunity to get LABOR involved in health issues and aware of the problems that must be solved. This opportunity to expose and develop our thinking shouldn't be lost. We simply cannot go on educating ourselves, believing that when *we* are the medical establishment, we'll make the needed changes. Nor can we continue to try to dream up community groups (i.e., by calling meetings) that we can then manipulate to support our positions on health care. We must begin working on a mature, realistic alliance with community groups, with sharing of power.—K.B., *Medical Student, Bronx.*

There is definitely a place for SHP in my community. However, there would have to be major changes made in many of the organization's basic ideals. First, the program must be organized well in advance. The community should give SHP certain ideas for the project, but SHP should also have its own ideas. And be ready to act on them. The leaders of the project should be able to tell the student fellows and other workers exactly what they will be doing. This was one of the main drawbacks. I spent most of the month of July looking for the things to do, then when I finally really got started August was half over. Secondly, SHP must have strong leadership. With an organization as large and spread out as the Greater New York Project, you must have leaders who are able to make a decision without taking a poll of all the workers. I would also suggest that instead of spreading the project all over the city, SHP should concentrate on one area and try to have large successes there instead of small ones all over.—J.W., *Nursing Student, Bronx.*

I'd suggest that skeleton ideas for projects be worked out long before summer, and that project fellows be asked to apply for particular projects and, as part of their application, give some idea of how they think the project might be organized and implemented. In this way, the Orientation session could get down to decisions as to how each group of eight or ten student fellows was to operate, and discussion of underlying philosophy would take place in the most useful context of real alternatives and the effects they would have. I suspect one reason why the lead poisoning project will leave concrete results, aside from the nature of the project, was that project fellows formulated goals and thought about methods before the summer work began.—A.K., *Law Student, Bronx.*

I don't think that there should be an SHP next summer, in the form it took this summer. Rather, SHP should be a kind of liaison, or coordinating body, to place health professional students and perhaps NYCs in various community organizations throughout a specific area of the city. I do not believe that SHP can accomplish anything worthwhile (in terms of immediate contributions to the community) if it tries to function as an autonomous body in the community. Students simply do not have the experience, the know-how, or the time to produce something in a 10-week period. We can become more aware of the needs and problems of poverty-stricken people, and benefit them more, by offering our manpower services to organizations which the people themselves have created out of awareness of their own needs. Perhaps that way we can also convince them that we are not flighty, well-meaning but do-nothing kids, who have come slumming for the summer.—M.H., *Law Student, Lower East Side.*

A place for SHO in our community? I look around Crown Heights and I say yes. Perhaps a coordinating employment project for biomedical careers and paramedical professions. Why not extend the patient advocate position to other hospitals and other communities. We

could establish some liaison with hospitals in the area and ask them for their opinions. * * *

As lead poisoning cases in the area continue to rise, we could make a project of checking on apartments that are serious enough to warrant immediate emergency attention by the city and try to get loose paint and plaster on the city's list of emergency conditions that must be taken care of immediately.—M.H., *Sociology Student, Brooklyn.*

Thus far the student health project functions only during the summer months. This means that every summer a new relationship has to be fostered all over again and that the new students have to learn all over again how to cope with the problems and the people of the community; while the people of the community have to learn how to trust the new students. With this type of short-term relationship, the only ones who are benefitting are the students. So far, nothing concrete has been left in the community. Why can't student health projects be run on a year-long basis so that there will be continuity of care, personnel, and trust?—M.J., *Nursing Student, Bronx.*

My most immediate suggestion in continuance of the program throughout the year. The success of this project has been in becoming aware of the health needs of an impoverished community and in becoming so involved with poor people and their unceasing problems that one's commitment to community medicine is strengthened. However, these successes do not begin to initiate the radical reforms that are urgently needed in the administration of health care to the indigent. Reforms will come only with constant pressure on the existing system of health care. This point was illustrated vividly in the Newark Project by administrators of Martland Medical Center, the established center of health care for the indigent of Newark, constantly giving evasive responses to suggestions for better health care delivery, knowing they would only have to listen to these suggestions for a limited period of time.

Another factor illustrating the limitation of a ten-week program and the need for a year-round program is community trust and support. To merit community trust and support a program cannot pull out at the end of a 10-week period. To effect changes in health care an organization must have community support. Although part of the Newark project is continuing in the form of planning a health advisory council, made up of community people, this is not enough. Although the students must return to their respective schools, communications and activities could be continued through the work of the NYC's, community workers, and faculty advisor, and possibly previous health science students who have completed their education.—K.S., *Nursing Student, Newark.*

I believe any future projects should seek to make themselves available to assist directly any already existing organizations in need of help. This would provide us with the needed background information to avoid trial and error learning which we had little time for. It also would serve as a lever to get us into the community quicker, and in an already respectable way.

It was my feeling, in the beginning of the summer, that I would be living right in the area. It was a mistake not to do so. Though a few individuals did, I think future project fellows should try living in close proximity, managing the affairs of a home and job together. All money should be pooled to go for rent and food. Any leftovers would be divided up at the end among the workers as salary. I believe this would really lead us to experience, first-hand, what it means to exist on a restricted budget. Granted, this is an idealistic view, but maybe some of the ideas can be modified and put in working order.—J.M., *Nursing Student, Lower East Side.*

* * * Perhaps one person could be specifically in charge of NYC activity for two to three weeks. This person might arrange for one or two NYCs to work alongside some person in the community whose job they are interested in learning or aspire to: surgeons, anesthetists, X-ray technicians, attorneys, police, firemen, etc. Another suggestion to ponder is whether two community workers would be bet-

ter than one because some competition might develop between them to see who could do the better job. Or at least each might, out of a sense of pride, strive to accomplish a body of acts which they can point to.—N.W., *Law Student, Newark.*

RECOMMENDATIONS

Recommendations From Community Worker Workshop

(1) Questioning of the concept in practice of the patient advocacy role: (*a*) A feeling that the outsider (usually middle class white) is further deepening the psychologically debilitating dependency position of the person being helped. Doing everything for, and failing in the teaching function which will enable people to advocate for themselves; (*b*) The concept of confidentiality is frequently violated. Isn't this a reflection of an unconscious racism?

(2) On the selection of community workers and coordinators: Selection should be done by a community screening group who reflect the highest aspirations of that community. Priority should be given to those community workers who have worked with the project before and demonstrated their value.

(3) On the question of whether students have anything significant to offer, or whether their presence is irrelevant, the group was split. For those who felt students had no place, reasons were: (1) Their presence is a perpetuation of white power; (2) they are not needed because when they leave the community is in the same bag. For those who felt they had a place, it was believed that: (1) Students could open up doors; (2) students did provide services where none previously existed. But this group still felt the issue was community control, and believed that the proportions between community staff and students must be reversed. Following further discussion, it was agreed that this question was best answered by each individual community since factors such as degree of organization and level of political sophistication had to be considered.

(4) There were some complaints that some students become impatient working with lay people and would revert back to a reliance on other professionals despite the talk of equality.

(5) It was unanimous that the project should take responsibility to send to every project staff member in advance of the program a list of what project funds can and cannot be used for.

(6) Everyone should have job descriptions before starting the work.

(7) Finally, community staff want, psychologically, to know that students cared and really are with us. "Even a student who goes back to California could send a card to say 'I was thinking about you'."

Recommendations for Community Control

At this morning's workshop on the role of the white medical student in black communities, an important question was raised but not resolved. It was mentioned that the only way the health care delivery in ghetto areas could be significantly improved would be for the community to take control of the hospitals and health facilities and run them. A medical student suggested that that was impossible—it takes ten or twelve years to become a doctor, how can community people do the things that doctors do? This completely missed the point, we think, and we would like to set out our views on what community control means, how it could be accomplished, and how SHP could relate to the movement toward community control that is taking place in so many areas these days.

The philosophical basis of community control has its roots in this country at least as far back as Thomas Jefferson. The classic liberal ideal of Jefferson, the faith in the individual and the commitment to participation in self-government, is one of the foundations of our political system. What we have seen in the United States is the rise of institutions which

were immune from the political system and were unaccountable to the people who were affected by them; hospitals in ghetto areas with boards of trustees who didn't live in the community are a good example of this, because they so often become unresponsive to the needs of the people they serve. The two chief benefits we see from community control of health facilities, then, are that they would be made responsive to the needs of the community and that by having elected health councils or boards they would be accountable to the people they serve.

We suggest the following ways to set up a community health council or board for either a neighborhood health center or a community hospital:

1. Make contact with a few active individuals in the community who are concerned about health and want to do something to improve the delivery system.
2. Set a date for a mass meeting to discuss the health situation and what can be done about it; disseminate information about the meeting as widely as possible, using radio, newspapers, leaflets, and contact with community groups. The community people could make the personal contacts and the initiating group could provide the funds and produce the leaflets.
3. At the mass meeting, suggest mechanisms for electing a board or council and let the assembled group decide which method to use. Possible mechanisms would be representatives from all community organizations in the area, a one-third community, one-third professional, one-third organization representation, an election from a slate of all people who had submitted petitions of support, etc.
4. While the board was being elected, assign a group to explore means of funding the clinic or cooperating with the hospital system.

We suggest the following powers for the community council or board; the obvious assumption is that community people do not need to be doctors to control non-medical decisions about the health facilities:

A. Control setting of priorities—the community groups should be the one to assess the needs of the community and set the priorities of care provided by the facility in orderto meet those needs. For example, if there is a serious narcotics problem in the community, the community groups should be able to put narcotics treatment high on the list of priorities; also facilities for premature babies, or screening for lead poisoning may be more important for the community than more glamorous things like open-heart surgery or sophisticated research.

B. Hiring and firing of medical and ancillary staff—the community group should be able to control the hiring of medical personnel after they have been screened for professional competence by the medical board or director and ancillary personnel on the basis of interviews. In both cases, the community groups could concern itself with such things as the attitudes of the employees toward the community from which the patients come, their sensitivity to people, and their dependability. Firing could be done on the basis of staff and patient complaints.

C. Control of the finances of the health facility —we contend that community control implies fiscal control. Administration of the finance could be in the hands of a comptroller or manager employed by the clinic or hospital, but decisions as to where the money wil be spent should be in the hands of the community group.

We feel that community control is where things are headed these days and decentralization of health facilities in neighborhood health clinics is one of the most significant trends in medicine. SHP might involve itself precisely where these two trends meet; it might set itself up as a resource to community people who want to develop health institutions that are responsive to community needs or who want to assume control of existing institutions. Students might be able to research other facilities that have been set up under control and find out if they are working; they could help with the organization of the first meeting; and they could know enough to get out when they are not needed or when they are getting in the way. Indeed, if SHP is to have any relevance to what's happening, and not be just a liberal service organization where future doctors and nurses get sensitized, then it must embrace and relate to the concept of community control.

From Workshop on the White Student in the Ghetto

1. Black people have depended on whites too long. Any program has to create a black economic structure in a "together" community. Blacks don't want to be used any longer, to be studied, or to be filmed —especially to their own disadvantage.
2. White students can do more by going to

effective means of approaching the goal (depending on project site, previous history of successes and failures, etc.)

4. Necessary sensitization should be primarily in winter programs and only secondary in the summer projects. Summer should be for doing work and accomplishing project goals.
5. A special point in the winter program should be the recruiting of black and Puerto Rican high school and college students who show inclination towards medical and paramedical professions.

Two types of project actions are recommended:

A. Working with independent agencies doing whatever they want (i.e., footwork, research, etc.)
B. Setting up projects whose aims are to be continued by a community group. The nature of the project to be decided and structured during the winter months.

Summer projects:

1. *Structured service projects.*—Summer projects that are specific in design and are staffed by highly selected students with similar ideological views. Students could work in hospitals or with community groups where significant preparations have already been made. This would avoid the period of picking out a course of action and working out of group dynamics problems which past SHP's have had to go through.

Affiliation with a community organization.—Projects which could be funded jointly with a community organization so that the health students are putting themselves at the direct disposal of the community. The project would have to be designed by students and community organizations together from the start.

3. *Funding community people.*—Projects would be made up mostly of community residents who are interested in health issues. The students would use their expertise to get a grant and would support the project by doing research on issues that the community workers raise. There should be more community people than students in such projects.
4. *SHP fund-raising and research.*—The assumption is that SHP should try to get funding from private or local sources. Students or community groups who are working on improving health services or raising political issues in health would apply for funds for their projects. SHP might work with law students or civil liberties groups to research legal implications of the projects.
5. *A Live-in Project.*—Students would live in a community, at the request of a local group and do direct community organizing around health, organizing neighborhood health councils, bringing direct action against hospitals, etc. The prototype for this is the Cleveland SHP.
6. *A Work-in Project.*—Students would get jobs in hospitals or summer research stipends (in community medicine, if possible) and would raise issues of inadequate health care. They would seek alliances with community groups that could mobilize support for improvement in health care provision. Year-round projects at schools:

We feel that any projects should aim at educating fellow students about the inadequacies of health care provision, especially in low-income areas, and should try to correct injustices that exist in their own medical centers. Projects could include courses in the "Politics of Health" or the "Crisis in Medical Care," holding workshops for community people to build an awareness of health as a right, and devising means of direct political action to bring about change in the local health facilities.

their own white communities. If they want to be involved in the black community there have to be safeguards to guarantee sincerity and loyalty to the community.

3. White students are interfering with existing community structures. People don't want whites there all the time (especially on a summer basis) doing what blacks should do for themselves.
4. SHP has initiated actions which can be pursued by the community—legal suits, advocacy, patterns of reforming the structure.
5. The pattern of action may be reformist or revolutionary. The revolutionaries among us regard advocacy as patchwork. There are health councils galore in a lot of communities, but what is needed are law suits, picketing. Medical, nursing, and law students may disseminate information, but the community should take over the hospitals.
6. Perhaps the Student Health Organization should be retitled the Community Health Organization, run for and by black students. It is suggested that black communities select the professionals who will be trusted, using a greater number of community people rather than risking getting insincere health students. It is unfair to the community to send in 'fresh troops' each year just so they can be sensitized, and then leave, returning to their schools (to a white structure) where, in fact, they will be coopted.
7. Health professionals are needed because there aren't enough black doctors, lawyers, nurses. In certain cases, organizations employ professionals they themselves respect. Health professional students know what good health care is and can point the injustices out to the community, who, in turn, can do whatever they want to do to correct them.

Recommendations from NYCs

1. Students need more experience as to community happenings, i.e., better orientation to the community before working in it.
2. Working relationships weren't established because of health student attitudes of superiority and lack of interest in the NYCs.
3. NYC's feel that if they are to be considered equal as stated at Orientation, they should be given the same wages as the students. Opposition to this means that orientation statement was idealistic and not worth a bag of beans.
4. Late wages discouraged NYC's from working.
5. Equalization of work between the NYC's and health students: Students shouldn't ask NYC's to do anything they wouldn't do, e.g., Bronx lead poisoning project where NYC's had to collect urine specimens from house-to-house; the students collected a few times but not to the extent that they made the NYC's collect.
6. Lack of constructive work initiated for either NYC's or health students discouraged NYCs.
7. Some NYC's feel that the students took advantage of them as individuals.
8. NYC's would like to have practical health education, such as first aid, artificial respiration, what to do in emergency situations like strokes, heart attacks, etc.
9. NYC's feel they would appreciate tutorial programs involving their needs and interests, done on a constructive basis.
10. NYC's would like to have representation within meetings and have something done to abolish their dislikes. They want spokesmen to make project directors aware of their gripes and take action.

Recommendations for Future Student Health Organization Projects

1. Summer SHP's must be a direct continuation of SHO activities that exist during the year.
2. The main SHO objective should not be to sensitize or educate students or community, but rather to basically change the structure of health care and delivery.
3. Attack should be whatever is the most

Appendix A: LISTING OF PARTICIPANTS

CENTRAL OFFICE STAFF

Project Director:

Marylyn Gore—Albert Einstein College of Medicine.

Student Co-directors:

Nivia Nives—Bronx Community College School of Nursing.

Peter Bryson—Downstate Medical Center.

Educational Coordinator:

Simeon Grater—Albert Einstein College of Medicine.

Faculty Sponsor:

Martin Cherkasky, M.D.—Director, Montefiore Hospital and Chairman, Department of Community Medicine—Albert Einstein College of Medicine.

SOUTH BRONX

Student Area Coordinator:

Bernice Baker—Bronx Community College School of Nursing.

Community Coordinator:

Marie Gallishaw

Faculty Advisor:

Harry Becker—Albert Einstein College of Medicine.

Medicine:

Nora J. Avins—Woman's Medical College.

Karen E. Benker—University of Southern California.

Ingrid Buhler—Albert Einstein College of Medicine.

Robert Cohen—Albert Einstein College of Medicine.

Peter Cummings—Case Western Reserve University.

Robert Ferrell—New York Medical College.

Christopher Frantz—Albert Einstein College of Medicine.

John Graves—Albert Einstein College of Medicine.

Michael Pawel—Albert Einstein College of Medicine.

Nursing:

Iris Arroyo—Bronx Community College.

Patricia Benson—Syracuse University.

Harriet Hair—Bronx Community College.

Madeline Jervis—Bronx Community College.

Anna Lopez—Bronx Community College.

Vicki Vernig—San Jose State College.

Jean Whelan—Hunter College.

Law

Arthur Kaplan—Harvard University.

Dentistry

Victor Sternberg—Tufts University.

Community Workers

Miriam Feliciano

Elizabeth Frole

Mercedes Hunter

Carmello Rodriguez

Program Advisor

Fannie May

BROOKLYN

Student Area Coordinator

Warren Sweberg—Downstate Medical Center.

Community Coordinator

Marian Williams.

Faculty Advisors

June Finer, M.D.—Columbia University.
Jeff Weiner—Downstate Medical Center.

Medicine:

William Basta—Downstate Medical Center.
Richard Berkowitz—Downstate Medical Center.
Ernest Braasch—Downstate Medical Center.
Eric Cameron—Downstate Medical Center.
Benjamin Fass—Downstate Medical Center.
Robert Johnson—Downstate Medical Center.
Daniel Koblentz—Downstate Medical Center.
Leslie Kriegman—Downstate Medical Center.
Margo Mazur—New York University.
Joseph Ryan—Downstate Medical Center.
Jules Tanenbaum—Downstate Medical Center.
Richardo Wilson—Downstate Medical Center.
Daniel Yellon—Downstate Medical Center.

Nursing

Leslie Clarke—Boston University.
Ellen Pindus—Molloy College for Women.

Law

Roger Haines—University of California at Berkeley.

Dentistry

Jan Wade Gilbert—Meharry Medical College.
Steven Parnes—Meharry Medical College.

Sociology

Marian Hyler—Tufts University.

HARLEM

Student Area Coordinator

Richard Clapp—Columbia University.

Community Coordinator:

Mary Smalls.

Faculty Advisors:

Ezra Davidson, M.D.—Harlem Hospital.
Doris Wethers, M.D.—Knickerbocker Hospital.

Medicine:

Joan Adler—University of Cincinnati.
Louis Bartoshesky—Cornell University.
Ken Cousens—Columbia University.
James Cowan—Meharry Medical College.
Stephen Gluckman—Columbia University.
Barry Goozner—Columbia University.
John Hibbert—Howard University.
John Obedzinsky—Columbia University.
Colin Romero—Howard University.
William M. Smith—Columbia University.
Carter Willsey—Columbia University.

Nursing

Angela Gaetano—Hunter College.
Patricia Jones—Bronx Community College.
Barbara McFadden—Bronx Community College.

Law

Ellsworth Martin—Howard University.
Francis Vergata—University of Chicago.

Psychology

Marla Isaacs—Columbia University.

International Affairs:

Janet Barrett—Columbia University.

Clinics	Scheduled days	Time	Ext.
*Endocrine & Obesity	Wednesday	1:00-3:00 p.m.	715, 717
*Hematology	Wednesday	9:00-11:00 a.m.	715, 717
*Neurology	1st and 3rd Mondays	9:00-11:00 a.m.	715, 717
*Pediatric Follow-up	Monday, Tuesday and Thursday	11:00-12:00 noon	715, 717
*Pediatric General	Monday through Friday	8:00-4:00 p.m.	715, 717
*Physical Handicapped	2nd Tuesday	9:00-11:00 a.m.	715, 717
*Premature	Wednesday	1:00-3:00 p.m.	715, 717
*Respiratory Follow-Up	Tuesday	9:00-11:00 a.m.	715, 717
*Seizure	Thursday	9:00-11:00 a.m.	715, 717
*Surgical Follow-Up	Wednesday	1:30-3:30 p.m.	715, 717
*Urology	Tuesday	9:00-11:00 a.m.	715, 717
Surgery:			
*Breast	Wednesday	1:30-3:00 p.m.	414
Child	Monday, Wednesday and Friday	9:00-11:00 a.m.	580
Diagnostic	Monday and Tuesday	1:00-3:00 p.m.	580
	Thursday		
Female	Thursday and Friday	9:00-11:00 a.m.	490
Followup	Thursday	1:00-3:00 p.m.	580
Hand	Wednesday	9:00-11:00 a.m.	580
Male	Monday, Tuesday, Thursday and Friday	9:00-11:00 a.m.	589
*Plastic	Monday	1:00-3:00 p.m.	580
	Thursday	9:00-11:00 a.m.	414
*Podiatry	Tuesday	9:00-11:00 a.m.	408
	Wednesday	1:00-3:00 p.m.	408
*Proctology	Monday and Friday	9:00-11:00 a.m.	580
*Thoracic	Monday and Thursday	1:00-3:00 p.m.	418
*Tumor, Head, & Neck	Wednesday	9:00-11:00 a.m.	490
*Urology-Adult	Tuesday and Thursday	9:00-11:00 a.m.	580
Infertility (Male)	Wednesday	5:00-8:00 p.m.	580
*Vascular	Tuesday and Friday	1:00-3:00 p.m.	418
Ear, Nose and Throat	Monday, Tuesday, Thursday and Friday	1:00-3:00 p.m.	490
Eye	Monday, Tuesday, Thursday, Friday	1:00-3:00 p.m.	
Oral Surgery	Monday through Friday	8:00-4:00 p.m.	657
Others:			
Blood chemistry	Monday, Tuesday and Thursday	7:00-9:00 a.m.	408
Mental Hygiene— (Adult and Child)	Monday through Friday	9:00-5:00 p.m.	567
Adult	Tuesday, Wednesday and Thursday	5:30-9:00 p.m.	567
Rehabilitation Medicine	Monday through Friday	8:00-11:30 a.m.	584
Employees Health Service	Monday through Friday	8:00-4:00 p.m.	417

*Appointment clinics

Central, Harlem Destrict Health Center
2238 Fifth Avenue (137th Street) AU 3-1900

I. Dental clinic

1. The patient must come from a public school within the health district (Public School 189, 136, 175, 133, 197, 120), but they do not have to be referred through the school—if a child attends one of the schools a parent may bring him to the clinic.

Community Workers:
Charlie Mae Jones.
Nettie Knox.
Maxine Livingston.
Altamese Maxwell.

LOWER EAST SIDE

Student Area Coordinator:
Steven Dubovsky—New York University.
Community Coordinator:
Helena King.
Faculty Advisor:
Alice Miller—New York University.
Medicine:
Jerome Aronowitz—University of Maryland.
Edward Charney—New York University.
Joseph Colletti—Howard University.
Kenneth Ducker—New York University.
Judith Pleasure—New York University.
Diana Post—New York University.
Sharon Ruskin—Marquette University.
Peter Sheckman—New York University.
David Sternberg—Tufts University.
Joseph Willner—New York University.
Nursing:
Beryl Gifford—Hunter College.
Marilyn Levine—Hunter College.
Judith Levy—Hunter College.
Joan Musaro—Hunter College.
Law:
Martha Halpin—Yale University.
Jonathan Marsh—New York University.
Bettina Plevan—Boston University.
Dentistry:
Gerald Low—New York University.
Psychology:
Linda Gunsberg—Yeshiva University.
Community Worker:
Sharon Diaz.

NEWARK

Student Area Coordinator
Daniel Tartaglia—New Jersey College of Medicine.
Community:
Reginald Peniston
Faculty Advisor
John Seebode, M.D.—New Jersey College of Medicine.
Medicine
Richard DeBlasi—New Jersey College of Medicine.
James Davis—Howard University.
Peter Dorsen—New Jersey College of Medicine.
Karen Filkins—New Jersey College of Medicine.
Andrew Hurayt—University of Rome.
Dennis Massler—New Jersey College of Medicine.
Bruce Wermuth—Stanford University.
Walter Wiechetek—University of Maryland
Nursing:
Andra Cross—St. Mary's College.
Laura Doner—O'Connor School of Nursing.
Ann Maroney—Syracuse University.
Joyce Quock—O'Connor School of Nursing.
Kathleen Sherdian—St. Joseph's College.

Law:
Neal Wiener—Loyola University of Los Angeles.
Community Workers:
James David Branch
Katherine Cunningham

NEIGHBORHOOD YOUTH CORPS

George Acosta
Myrna Alvarez
Louis Aquino
Cathie Baker
Alan Benton
Shirley Beechem
Gail Bristol
Eugene Brown
Alfred Burt
James Canty
Joanne Challenger
Pat Carswell
Roscoe Carthen
Victor Castro
Nelson Cintron
Michael Colden
Earl Collins
Kevin Collins
Gregory Dabney
Gregory Darby
Bradley Davis
Vashti Davis
Alvin Duggins
Rafael Figuera
LaVell Finerson
Willard Finerson
Walter Fletcher
Nellie Garcia
Maria Gomez
Mirella Gomez
Jeffrey Goodson
Elaine Hale
Walter Hall
Nurseal Hill
Dwight Jackson
Agnes Jacobs
Alzrina Johnson
Gloria Jones
Lilly Jones
Leonard Knox
Eric Livsey
Michael McClamb
Frank Morales
Josephine Morales
Arthur Murphy
Mason Napir
Julio Nieves
Elizabeth Norwick
Terry Ormand
Doris Ortiz
Martha Pacheco
Gladys Padilla
Gwendolyn Page
Carlos Perez
Raymond Perez
David Ravenell
Tom Reynolds
David Rhabb
Jack Rivera
Naomi Robinson
Nilda Rodriquez
Leroy Rozus
Rodney Shepard
Laverne Singleton
Cassandra Smith
Joan Smith
Leon Terry
Randolph Tomlin
Mamie Towns
Gabriel Vasquez
Julio Vasquez
John Watson
Norm Whitlow
Phyllis Whittiker
Marilyn Whittfield
Marilyn Wilder
Denise Wills
Nina Yung

Sociologist Evaluator:
Ronald Miller—New York University.
Administrative Assistant:
Jody Williams—Albert Einstein College of Medicine.
Project Secretary:
*Richard Perez.

Appendix B: HEALTH RESOURCES IN THE HARLEM AREA

HARLEM HOSPITAL OUT PATIENT DEPARTMENT

Lenox Ave. and 137th St. AU 6-3300

People in charge	Service
Dr. Wesley	Director ambulatory care
Dr. Russell	Director social services
Mr. Watkins	See for clinic problems
Mr. Giddings	Surgery clinics
Miss Mebane	TB clinic
Mrs. Johnson	Emergency room coordinator
Mrs. Place	Pediatric clinic coordinator
Dr. Kahn	Director Pediatrics
Miss Richardson	R.N. pediatric clinic
Mrs. Williams	Clerk, pediatric clinic

Clinic procedure:

I. New patient (never been to H.H. before)
   1. Start at the initial screening desk
   2. Screening area
      a. examination for the type of medical problem
      b. clinic card number is assigned
      c. medicaid application can be made
      d. blod and urine tests are ordered
      e. X-ray (required by state law)
      f. sent to a specific clinic window for the medical problem
   3. Specified clinic window
      a. medical records are completed and sent to be kept in the file room
      b. Now the patient may be:
         (1) given an appointment for the correct clinic for his problem *or*
         (2) sent directly to the correct clinic when immediate service is possible *or*
         (3) sent to the emergency room if immediate treatment is needed but the clinic for his problem is closed
   4. When a patient goes to a specific clinic for his problem
      a. drop the clinic card into the box or hand it to the clerk
      b. clerk then either fills out medicaid form or makes out a bill for the patient
      c. patient then sits and waits to be called for treatment

II. Old patient (been to H.H. for that problem before)
   1. If the clinic that the patient goes to is an appointment clinic, the patient goes straight there on the day of the appointment and drops the appointment card in the box or hands it to the clerk. The patient's records will already be there.

III. Old patient with a new problem
   1. Patient must first go to the screening desk for an examination for the type of medical problem
   2. Then the patient may
      a. go directly to his specific clinic if it is a non-appointment clinic *or*
      b. get an appointment for his specific clinic if that clinic requires appointments *or*
      c. go to the emergency room if immediate treatment is needed but the clinic for his problem is closed

IV. Obstetrical-Gynecological Clinic (Ob-Gyn)
   1. It is on the 3rd floor of the K building
   2. It requires a double registration—once on the ground floor at the clinic registration desk, and then again on the Ob-Gyn floor (3rd).

3. Ob-Gyn does its own screening and keeps its own records

V. Emergency Room
   1. Ambulance service is by police call only
   2. All patients must be registered and screened at the emergency room registration desk.

VI. Pediatric Clinics
   1. They are on the 3rd floor of the pediatric building—patient goes directly there to register
   2. These clinics see infants and children up to about 11–12 years of age.
   3. Procedure
      a. Patient goes directly to the pediatric clinic
      b. *New patients* go to the clerk to register and to fill out a medicaid application:
      Old patients go to the clerk and give her the clinic card and the medicaid card (if they get medicaid).
      c. Now sit and wait to be called for treatment
      d. *Note:* to save time—if the child has a clinic card (any child who has been to H.H. before or was born there has one) the parent can call a day ahead so then his child's hospital records will already be at the clinic and will not have to be sent for when he comes.
      e. If there is any trouble ask for Mrs. Place. She is in charge of the clinic and is there to take care of a patient's problems

VII. Oral Surgery Clinic
   1. This is the *only* place in the Harlem area that one can go to get teeth pulled (except to a private dentist).
   2. Must get there at 8:00 A.M. to have a general examination. This is required before they will give a patient the general anesthetic (gas).
   3. Parent must accompany child the first time to register him, then the child can come with anyone the next time.

VIII. Opthamology Clinic
   1. Very poor clinic at H.H. Go someplace else like to MIA.

XI. Psychiatric Clinic
   1. All of the psychiatric facilities available to the Harlem area are described on pages 14–18.

Additional Remarks about Harlem Hospital:

1. The specialty clinics have anywhere from 3 weeks to 2 months waiting list.
2. A playroom will be opened in the pediatrics clinic at the end of the summer. It will be staffed by a full time paid worker from the Domestic Peace Corps. It is there for the children who come to the clinic so that the waiting will be more bearable both for them and for the parents who bring them.
3. *Paying:*
   a. The fees at H.H. are determined on a sliding scale; this means that a person pays an amount that is based on the income of his family.
   b. Patients do not have to pay when they get the treatment; they can ask that the hospital send them a bill.
   c. The bills usually do not come for many months.
   d. If a person has medicaid, he only has to bring the bill back to the hospital along with his medicaid card. That takes care of the bill.
   e. A patient should not worry about any billing problems. Treatment must be given for all, regardless of financial status.
4. If a patient has any difficulty in one of the clinics, he should ask to see Mr. Watkins.

*Appointment clinics

Clinics	*Scheduled days*	*Time*	*Ext.*
Gynecology			
*Cytology	Monday	1:00–3:00 p.m.	630
*Dysmenorrhea	Thursday	9:00–11:00 a.m.	630

Clinics	*Scheduled days*	*Time*	*Ext.*
*Endocervicitis	Wednesday	9:00–11:00 a.m.	630
*Endocrine	Wednesday and Thursday	1:00–3:00 p.m.	630
	Wednesday	9:00–11:00 a.m.	630
*Gynecology General	Tuesday	12:30–3:00 p.m.	630
Gynecology General	Monday, Tuesday Thursday, Friday	9:00–11:00 a.m.	630
*Infertility	Wednesday, Thursday	1:00–3:00 p.m.	630
*Menopausal	Thursday	9:00–11:00 a.m.	630
*Tumor Follow Up	Monday	1:00–3:00 p.m.	630
Maternal Health	Saturday	9:00–12:00 noon	628
*I.U.D.	Tuesday and Wednesday	9:00–11:00 a.m.	628
*Oral Contraception	Wednesday and Thursday	12:30–4:00 p.m.	628
MEDICAL CLINICS:			
*Allergy	Wednesday and Friday	9:00–11:00 a.m.	408
*Cardiac	Monday, Wednesday Thursday and Friday	9:00–11:00 a.m.	639
*Chest & T.B.C.—	Monday, Wednesday,		
Adult	Thursday and Friday	9:00–11:00 a.m.	418
Children	Tuesday	9:00–11:00 a.m.	418
Dermatology	Monday through Friday	1:00–3:00 p.m.	639
*Diabetes	Tuesday and Friday	1:00–3:00 p.m.	668
Diabetic Supply and Instruction	Monday through Friday	9:00–11:30 a.m.	408
*Gastroenterology	Consultations, Wednesday	1:00–3:00 p.m.	637
Hematology	Wednesday	1:00–3:00 p.m.	580
*Medical	Monday through Friday	9:00–4:00 p.m.	637, 668
Medical Reception	Monday through Friday	9:00–4:00 p.m.	540
*Neurology	Tuesday	1:00–3:00 p.m.	580
*Thyroid	Tuesday	9:00–11:00 a.m.	639
Venereal Disease—			
Male G.C.	Monday through Friday	9:00–11:00 a.m.	639
Syphillis	Monday through Friday	1:00–3:00 p.m.	639
OBSTETRICAL			
Antepartum (new cases)	Monday through Friday	9:00–11:00 a.m.	631
*Antepartum (revisits)	Monday through Friday	1:00–3:00 p.m.	631
*Antepartum Adolescent	Friday	1:00–3:00 p.m.	631
Family Planning General	Tuesday, Wednesday and Thursday	5:30–7:30 p.m.	631
		1:00–3:00 p.m.	631
Post partum	Tuesday	1:00–3:00 p.m.	631
Orthopaedic and fracture:			
*Fracture—			
Adult	Tuesday and Friday	1:00–3:00 p.m.	414
Child	Friday	9:30–11:30 a.m.	592
*Fracture—End Results (Long term follow–up)	Thursday	1:00–3:00 p.m.	414
*Orthopaedic—Adult	Monday	1:00–3:00 p.m.	592
Child	Friday	9:30–11:30 a.m.	414
Pediateric:			
*Allergy	Wednesday and Friday	9:00–11:30 a.m.	715, 717
*Cardiac	Thursday	1:00–3:00 p.m.	721
*Dermatology	Tuesday	9:00–11:00 a.m.	715, 717
*Development	Monday	1:00–3:00 p.m.	715, 717
*Deabetes	1st Tuesday	9:00–11:00 a.m.	715, 717

*Appointment clinics

Clinics	Scheduled days	Time	Ext.
*Endocrine & Obesity	Wednesday	1:00–3:00 p.m.	715, 717
*Hematology	Wednesday	9:00–11:00 a.m.	715, 717
*Neurology	1st and 3rd Mondays	9:00–11:00 a.m.	715, 717
*Pediatric Follow-up	Monday, Tuesday and Thursday	11:00–12:00 noon	715, 717
*Pediatric General	Monday through Friday	8:00–4:00 p.m.	715, 717
*Physical Handicapped	2nd Tuesday	9:00–11:00 a.m.	715, 717
*Premature	Wednesday	1:00–3:00 p.m.	715, 717
*Respiratory Follow-Up	Tuesday	9:00–11:00 a.m.	715, 717
*Seizure	Thursday	9:00–11:00 a.m.	715, 717
*Surgical Follow-Up	Wednesday	1:30–3:30 p.m.	715, 717
*Urology	Tuesday	9:00–11:00 a.m.	715, 717
Surgery:			
*Breast	Wednesday	1:30–3:00 p.m.	414
Child	Monday, Wednesday and Friday	9:00–11:00 a.m.	580
Diagnostic	Monday and Tuesday	1:00–3:00 p.m.	580
	Thursday		
Female	Thursday and Friday	9:00–11:00 a.m.	490
Followup	Thursday	1:00–3:00 p.m.	580
Hand	Wednesday	9:00–11:00 a.m.	580
Male	Monday, Tuesday, Thursday and Friday	9:00–11:00 a.m.	589
*Plastic	Monday	1:00–3:00 p.m.	580
	Thursday	9:00–11:00 a.m.	414
*Podiatry	Tuesday	9:00–11:00 a.m.	408
	Wednesday	1:00–3:00 p.m.	408
*Proctology	Monday and Friday	9:00–11:00 a.m.	580
*Thoracic	Monday and Thursday	1:00–3:00 p.m.	418
*Tumor, Head, & Neck	Wednesday	9:00–11:00 a.m.	490
*Urology-Adult	Tuesday and Thursday	9:00–11:00 a.m.	580
Infertility (Male)	Wednesday	5:00–8:00 p.m.	580
*Vascular	Tuesday and Friday	1:00–3:00 p.m.	418
Ear, Nose and Throat	Monday, Tuesday, Thursday and Friday	1:00–3:00 p.m.	490
Eye	Monday, Tuesday, Thursday, Friday	1:00–3:00 p.m.	
Oral Surgery	Monday through Friday	8:00–4:00 p.m.	657
Others:			
Blood chemistry	Monday, Tuesday and Thursday	7:00–9:00 a.m.	408
Mental Hygiene—			
(Adult and Child)	Monday through Friday	9:00–5:00 p.m.	567
Adult	Tuesday, Wednesday and Thursday	5:30–9:00 p.m.	567
Rehabilitation Medicine	Monday through Friday	8:00–11:30 a.m.	584
Employees Health Service	Monday through Friday	8:00–4:00 p.m.	417

*Appointment clinics

Central, Harlem Destrict Health Center
2238 Fifth Avenue (137th Street) AU 3–1900

I. Dental clinic

1. The patient must come from a public school within the health district (Public School 139, 136, 175, 133, 197, 120), but they do not have to be referred through the school—if a child attends one of the schools a parent may bring him to the clinic.

2. To be eligible the child must be between the fifth grade through junior high school.
3. Parent *must* accompany child only on the first visit, when history and financial information are given and a consent form is signed. No treatment is given on the first visit; appointment will be made for a later date. Registration times are 9–11 a.m., 1–4 p.m. Monday through Friday.
   a. Treatment appointments can be for the morning or the afternoon; parent need not be with the child on these visits.
4. *Paying:* Depends upon family income. If income is too high one is not eligible for the services, if the patient is eligible the services are free.
5. The dental clinic does everything but tooth extractions (must go to Harlem Hospital oral surgery or private dentist).
6. School dental chairs
   a. A number of schools have dental chairs. These are merely extensions of the dental clinic, and therefore function similarly and provide the same services.
   b. Locations: Public School 24—22 East 128th Street LE 4–2866.
      Public School 68—127 West 127th Street MO 2–1410.
      Public School 144—134 West 132 Street MO 2–3460.
      Public School 156—2960 Eighth Avenue AU 1–4347.
      Public School 194—242 West 144 Street WA 6–0580.
      Public School 133—2121 Fifth Avenue AU 3–3056.

II. Social hygiene clinic
1. Dr. Bloom is in charge.
2. Person may receive free venereal disease examinations and treatment without appointment.
3. Hours:

Monday	9–11.
Tuesday	1–5
Wednesday	9–11.
Thursday	1–7
Friday	9–11.

III. Maternal and Child Health Station
1. Services:
   a. This facility is for well babies; One should not take a sick child here.
   b. Periodic physical examinations.
   c. Immunizations for DPT, polio, smallpox, and measles. (Monday and Friday, 9–11 a.m. come early).
   d. Parent can come ask a doctor or nurse advice, etc.
   e. When child enters school the records that are kept here will be sent to the school.
2. Children from birth to school age are eligible.
3. Walkin (with parent) will be accepted the first time, but afterwards must have an appointment.
4. Hours: Monday and Thursday AM and PM.
   Tuesday, Wednesday and Friday AM only.
5. Additional Locations:
   Morningside Health Center, 264 West 118th Street MO 3–3822.
   Upper Harlem Child Health Center, 231 West 151 Street TO 2–2640.
   Mt. Morris Park Child Health Center, 122 Street and Madison Avenue LE 4–4612.
   St. Nicholas Child Health Center, 281 West 127th Street UN 5–1300.
   Stephen Foster Child Health Center, 50 Lenox Avenue EN 9–4610.

IV. Chest clinic
1. Only location is the Morningside Health Center, 264 West 118th Street MO 3–3822.
2. At this clinic chest X-rays and other tests are given to find out if person has tuberculosis or other diseases of the chest. If disease is found, treatment is given.
3. Call for an appointment.

V. Eye Clinic
1. Persons up to 21 years of age are eligible for the eye examinations and prescriptions for glasses.
2. Patient is usually referred through a school nurse or through a child health station, but parent may call for an appointment.
3. There is an additional location at the Morningside Health Center.

VI. Health Education Services
1. Dr. Monrose is the health education officer for the district. He is located in room 212.
2. Consultation services are offered in the planning of health committee activities and health programs for church groups, PTA's and other clubs and settlement houses.
3. Films and pamphlets on a wide variety of health topics are available. A minimum of three weeks notice is essential in booking films, although by special arrangement one may pick up the films at the NYC Department of Education Film Library at 305 Fifth Avenue, room 11D, within 3–4 days of ordering.
   a. The order must be placed with the district officer. No more than 4 films may be ordered at once.
4. Speakers are also available with 4–5 weeks notice.

VII. Other Agencies in Central Harlem District Health Center building.
1. Visiting Nurse Service of New York, room 215 AU 6–7210.
2. Family and Child Welfare Student Unit, room B36.
3. Pediatric Social Service, room 211.
4. Alcohol Unit, rooms 307, 308, 311.
5. Community organization for Social Service, room 318.
6. Rehabilitation Medicine, rooms 334, 335.

Summary and Time Schedule of
SERVICE IN CENTRAL HARLEM HEALTH CENTER DISTRICT
(February 1968)

Legend: A=9–12 a.m. P=1–4 p.m. E=4–7 p.m. *=First and third Tuesday of month

	M	T	W	T	E
Central Harlem District Health Center Building, 2238 Fifth Avenue, NYC. 10037 283–1900.					
Dental	AP	AP	AP	AP	AP
Social Hygiene	AP	P	A	PE	A
Maternal and Child Health	AP	A	A	AP	A
Eye	AP			P	A
Morningside Health Center, 264 West 118 Street, NYC. 10026 MO 3–3822.					
Dental	AP	AP	AP	AP	AP
Maternal and Child Health	A	A	A	AP	A
Eye	P	A	A	A	A
Chest	AP	A*PE*	A	AP	AP
Prenathan and Family Planning	P	P			
Upper Harlem Child Health Center	A	A	A	A	
231 West 151 Street, NYC. 10039 AU 3–1970.					
Mt. Morris Park Child Health Station					
122 Street and Madison Avenue, NYC. 10035 LE 4–4612.	A	A		A P	A
Prenatal and Family Planning	A	A	A	A	A
St. Nicholas Child Health Station					
281 West 127 Street, NYC. 10027 UN 5–1300.	A	A	A	A	A
Stephen Foster Child Health Station					
50 Lenox Avenue, NYC. 10026 _N 9–4610.	A		AP		A
Alexander Hamilton Child Health Station					
2690 Eighth Avenue, NYC. 10030 862–8002.					
Dental Clinics in the Schools (See page 3)	A	A	A	A	A

MINISTERIAL INTERFAITH ASSOCIATION (MIA)

110 East 125th Street Suite 204 427–5700

Clinics:

Monday	Internal medicine	10–12 noon.
	Dermatology	1–2:30 p.m.
Tuesday	Ear, nose and throat	9 a.m.–2 m.p.
	Gynecology	2–4 p.m.
	Allergy	10 a.m.–12:30 p.m.
Wednesday	Ophthamology	10 a.m.–1 p.m.
Thursday	Pediatrics	10:30 a.m.–1:30 p.m.
Friday	Internal medicine	10 a.m.–1:30 p.m.
Saturday	Ear, nose and throat	9 a.m.–1 p.m.
	Optometrist	1:30 p.m.–4 p.m.

1. MIA is a very pleasant place—it does not look like a clinic. The staff is courteous and thorough, and the wait tends to be the shortest of any clinic in the Harlem area.
2. It is best to call and make an appointment for one of the clinics in advance.
3. Get there early—30-45 minutes before clinic starting time—for the shortest wait.
4. *Paying:* patient must pay from 8-10 dollars per visit. They accept medicaid. They will not send a bill as Harlem Hospital Clinics do.
5. For eye problems, go to the optometrist first. He will refer patients to the opthalmologist if it is necessary.
6. If there are any difficulties see Dr. Farkas, the director.

MANHATTAN EYE AND EAR HOSPITAL

210 East 64th Street TE 8–9200

Clinics:

Eye clinic—First floor.
Ear, nose, and throat clinic—Second floor.
Allergy clinic—Second floor.
Hearing and speech clinic.
Laboratories—Second floor.
Pharmacy—basement.

1. A modern, well-equipped facility.
2. Mrs. Benoit is the Outpatient Department Supervisor.
3. Mrs. Fernandez is the Registrar.
4. First visit is for registration and screening only; a parent must accompany a child.
5. Second visit is for a speciality clinic for which the patient has been given an A.M. or P.M. appointment (always on the same day of the same week as the first clinic visit).
6. For a foster child the BCW number and the case number are required.
7. Procedure for a new patient
   a. No appointment—arrive by 8:30 a.m. on any weekday.
   b. Patient gets number at the information desk and sits to wait for an interview.
   c. At interview the patient receives a clinic card and a chart number.
   d. Patient then gets in line and pays in advance for treatment (see Paying below).
   e. After paying the patient receives his chart and goes to the screening clinic where he gives the chart to the nurse and waits to be called.
   f. Doctor screens the patient and recommends either returning to the screening clinic or to a speciality clinic at a later date.
   g. Patient takes white slip to appointment window and there receives an appointment slip which he *must not lose.*
8. *Paying:*
   a. The first visit costs $5.
   b. All subsequent visits cost $4.50.

c. X-rays, laboratory work, etc. all cost extra.
d. Special fees may be reduced at the discretion of the payment desk, but patient must always pay something unless Medicaid or insurance covers fees.
e. There is *no* billing procedure—patient must pay (or present Medicaid card) on the spot.

KNICKERBOCKER HOSPITAL
70 Convent Avenue, AU 1–4100

1. Pediatric clinic only.
2. A.M. on Monday and Friday.
   P.M. on Tuesday, Wednesday, and Thursday.
3. No screening is required; appointments can be made by phone.
4. *Paying:*
   a. The first visit costs $3.
   b. All subsequent visits cost $2.
   c. Patient does not have to pay at the time of treatment; the clinic will send a bill.
   d. Medicaid is accepted in full.

ADDICT REHABILITATION CENTER
253 West 123d Street

1. A half-way house for individuals desiring to be cured of heroin addiction.
2. Persons desiring to enter must send a letter or call Mr. James Allen, the director. A personal interview follows this letter.
3. Has both inpatient and outpatient services. As of now women are only seen on an outpatient basis.
4. This is a realistically oriented facility which is run by a staff of ex-addicts.
5. Mr. Allen or one of his staff is also available to give illustrated talks on drug addiction.
6. One of their most important functions is the finding of jobs for the patients stay-at the center. One of their most important goals for a patient is the achievement of economic self-sufficiency and stability.

CHILD PSYCHIATRIC SERVICES AVAILABLE IN THE HARLEM AREA

Because of the increasing awareness of the need for child psychiatric treatment in the Harlem area and because of the difficulty in attaining such treatment, these facilities have been compiled separately.

HARLEM HOSPITAL
2238 Fifth Avenue, District: 116th. Street to 155th. Street

Inpatient service: there is no inpatient service. Outpatient service: handles approximately 500 patients a year.

A. Staff: 3 full-time psychiatrists
   3 part-time psychiatrists
   1 psychologist
B. Diagnosis: waiting period is from three days to a month; diagnosis is done in a conference with a psychiatrist, a social worker, and a psychologist.
C. Treatment: children are referred to Bellevue, social agencies, special schools, Rockland State Hosp., and the Bureau of Child Welfare for placement in special homes. Treatment at Harlem Hospital seldom exceeds one appointment a week with a psychiatrist; occasionally, children are treated by a social worker.
D. Special facilities: Harlem Hospital runs a special school for children aged 9 to 13. There are now 15 children in it and there are plans to expand it.

ST. LUKE'S HOSPITAL
421 West 113th. Street, District: 86th. Street, to 125th. Street,
Morningside to the river

Inpatient service: no inpatient service. Outpatient service: handles approximately 500 patients a year.

A. Staff: rotating staff of residents.
B. Diagnosis: waiting period is about a month; the child does see a psychiatrist after he has gone through the pediatrics clinic.
C. Treatment: waiting period is about 6 months;
all treatment is by psychiatrists—appointments are seldom more frequent than one per week per child.

PRESBYTERIAN HOSPITAL

West 168th. Street and Broadway, District: 155th. Street to 181st. Street

Inpatient service: there are 16 inpatient beds (in the New Psychiatric Hospital) which are used for teaching and research as well as treatment. Outpatient service: handles approximately 800 cases a year and accepts about 15–20 per cent for treatment.

A. Diagnosis: waiting period is one to 3 months and all children must go through the pediatrics clinic before child psychiatry.
B. Treatment: varies depending on the needs of the family—may be appointments with psychiatrist, family conuseling, or group therapy; may be as often as three times a week. Referrals are drawn from all sources.

METROPOLITAN HOSPITAL

1901 First Avenue, District: 42nd. Street

Inpatient service: there is no inpatient service. Outpatient service:
Out-patient service:

A. Staff: 7 full-time psychiatrists.
5 part-time psychiatrists.
B. Diagnosis: a child can be referred from all sources to an intake social worker for initial screening; there is a one-week to 2 month wait for diagnosis by a psychiatrist.
C. Treatment: there is a 2 month wait for treatment.

MT. SINAI HOSPITAL

144 Madison Avenue, District: unlimited

Inpatient service: there are 15 inpatient beds which are used for teaching and research as well as treatment; the service has 7 psychiatrists part-time and patients are usually not accepted for more than three months.

Outpatient service:

A. Staff: 8 psychiatrists—part-time
2 psychologists—full-time
B. Diagnosis: children are referred from al lsources and are screened in the summer; a doctor sees the child and a social worker sees the family. In September 25–30 cases are accepted for the year—no more are accepted.
C. Treatment: here again, patients are accepted who will be good teaching material; children seldom see the therapist more than once a week.
D. Special facilities: there is a NIFAST clinic (Non-intensive, Flexible, Adaptable, Short-term clinic) for "crisis intervention"; this clinic meets once a week and accepted 350 cases last year; it is staffed by 6 residents, 3 attending psychiatrists, 1 social worker, one assitant, and one community worker; it accepted all but neurological or brain-damage problems.

Other & hospitals outside the Harlem area:

Hospital for Joint Diseases—1919 Madison Avenue, Psychiatric Clinic, TR 6–7000
Belluvue Hospital—1st. Avenue and 30th. Street Mental Hygiene Clinic, OR 9–5000
Roosevelt Hospital—428 West 59th Street Psychiatric Division, 544–7000
Jewish Memorial Hospital—Broadway & 196th. Street, LO 9–4700
New York Infirmary—321 East 15th. Street Psychiatry Clinic (No district, but no emergency or inpatient facilities).
CA 8–8000
New York Medical College—106th. Street & Madison Avenue Dept. of Psychiatry.

Clinics in the Harlem area:

NORTHSIDE CENTER FOR CHILD DEVELOPMENT

31 West 110th. Street EN 6–6464

—waiting list for treatment is over a year.

—the center does not take brain-damaged or handicapped children.

A. Staff: therapists, psychiatrists, psychologists, social workers.

B. Fees: sliding scale.

JAMES WELDON JOHNSON COMMUNITY CENTER

2089 3rd, Avenue TR 6-3533 District: 96th. Street to 125th. Street from 5th. to the East River

James Weldon Johnson Community Center—2089 3rd, Ave. TR 6-3533

District: 96th. St. to 125th St. from 5th. to the East River

A. Staff: psychiatrists, psychologists, social workers.

B. Diagnosis: there is a waiting list of about six families for screening and the clinic will not accept retarded or brain-damaged children.

C. Treatment: the waiting period for treatment is about 15 families or three months; appointments can be made as often as twice a week; no fees.

KAREN HORNEY CLINIC

329 East 62nd. Street TE 8-4333

A. Staff: psychiatrists, psychiatric social workers.

B. Diagnosis: there is no waiting period for diagnosis or treatment.

C. Treatment: usually "family-oriented" with appointments once a week with a psychiatric social worker; fees are adjusted but are not Medicaid eligible.

Other clinics outside the Harlem area:

Payne Whitney Psychiatric Clinic—525 East 168th Street, TR 9-9000, District: 34th. Street to 96th. Street, east of 5th. Avenue.

Postgraduate Center for Mental Health—124 E. 28th. Street, MU 9-7700 all types of therapy; no Medicaid.

New York Clinic for Mental Health—150 5th. Avenue, CH 2-3778.

Catholic Charities Guidance Institute—122 East 22nd. Street open intake; 1 month wait, Staff: 1 psychiatrist, 1 psychologist; 4 social workers.

Alfred Adler Mental Hygiene Clinic—333 Central Park West

American Foundation of Religious & Psychiatry—3 West 29th. Street, MU-6138, Staff: ministers, priests, or rabbis in psychiatric training.

Girls & Boys Service League—138 East 19th. Street GR 3-4300.

Henry Street Settlement—265 Henry treet, OR 4-1100.

Hudson Guild Counselling—436 West 27th. Street, 255-1400.

Institute for Crippled & Disabled—400 First, Avenue, OR 9-0100. special groups for obese and neurologically damaged; no geographic limit.

MEDICAID

I. Centers:
   1. Main Center: 330 West 34th Street.
   2. Local Centers: 451 Lenox Avenue (133rd Street). Harlem Hospital (Women's Pavilion Rm 103).

   207 W. 151st Steret.

   2384 7th Avenue (139th Street).

   254 St. Nicholas Avenue, (123rd Street).

   75 Lenox Avenue (114th Street).

II. To Apply You Need to Bring:
   1. Social security number.
   2. Last eight wage stubs or earning statement from employer.
   3. Name of bank and amount of savings.
   4. Amount of stocks and bonds.
   5. Health insurance: name of company, policy number, amount of premiums.
   6. Life insurance policies.
   7. Veteran's serial number, veteran's administration claim number.
   8. Medicare card (if over 65).
   9. List of any medical expenses for current year.

III. Medicaid Complaints:
   1. Send letter to the mayor and a copy to Mr. Hamp Coley, 330 West 34th Street, New Work, N.Y.
   2. For a complaint about a drug store:
      a. Immediately call Elihu A. Gorelik, 790-3757.

b. Send letter to Mr. Alex Green, Room 367, senior pharmacist, Bureau of Health Care Service 330 West 34th Street, New York, N.Y.

—the complaint should state:

(1) the name, address and phone number of the pharmacy.

(2) the name, address and phone number of the patient.

(3) the item (prescription) in question.

IV. *List of Medicaid Drug Stores in the Harlem Area:*

America Pharmacy, 1645 Lexington ---------- 876–9981
Ascione Pharmacy, 2268 1st ---------- AT 9–0811
Asbell Pharmacy, 1600 St. Nicholas ---------- WA 1–5994
Atwater Pharmacy, 1404 Madison ---------- AT 9–0400
Beta Pharmacy, 1960 7th ---------- MO 3–5567
Bishop Pharmacy, 273 W. 125th ---------- 864–0151
Black Rexall, 1882 3rd 5 ---------- EN 9–1350
Broadmoor Pharmacy, 2675 Broadway ---------- AC 2–2914
Brown's Pharmacy, 159–06 Harlem River Dr. ---------- AU 1–7242
Callipo, J., 2146 2nd ---------- 534–9455
Cardinal Drug Store II, 2338 2nd ---------- SA 2–0805
Cardinal Drug Store I, 935 Amsterdam ---------- 666–7039
Claremont Chemists, 3181 Broadway ---------- MO 2–0220
Clunie Pharmacy, 21 Convent ---------- RI 9–6970
Cohen's Drug Store, 2101 Amsterdam ---------- LO 8–3763
Cohler's Block Drug Store, 1938 3rd ---------- EN 9–8533
Cohn, David, 1990 2nd ---------- TR 6–2451
Cohn, Nathan, 1596 Madison ---------- LE 4–0151
Columbia Chemists, 1121 Amsterdam ---------- UN 4–3773
Co-op Drug Co., 376 Manhattan ---------- AC 2–0668
D&S Farmacia Central, 2040 2nd ---------- 722–7100
Delane Pharmacy, 586 Lenox ---------- FO 8–3777
Delcina Pharmacy, 1741 Park ---------- EN 9–6540
Dorris Pharmacy, 1450 Lexington ---------- 289–8012
Drug Mart Pharmacy, 326 W. 125th ---------- RI 9–0313
Dumbar Drugs, 2802 8th ---------- 283–9055
Eighth Ave. Drugs, 2512 8th ---------- 283–9636
Eldorado Drugs, 2647 Broadway ---------- MO 2–6030
Embassy Pharmacy, 2457 7th ---------- AD 4–1800
Eureka Pharmacy, 2500 7th ---------- WA 6–5546
Farmacia San Martin, 3340 Broadway ---------- 286–5353
Famous Pharmacy, 1837 7th ---------- MO 2–2070
Fein's Ethical, 3586 Broadway ---------- 286–4344
Finklestein, L., 1863 2nd ---------- 722–9388
Forman Drugs, 2630 8th ---------- 281–1400
Friedlands Pharmacy, 574 Lenox ---------- WA 6–4703
Globe Pharmacy, 3361 Broadway ---------- WA 6–8900
George's Gothic Pharmacy, 2180 5th ---------- FO 8–0600
Ganbarg Drug, 2810 Broadway ---------- UN 4–0700
Godettes Pharmacy, 2000 Amsterdam ---------- WA 7–9571
Gubins, J., 100 E. 111th ---------- 534–9876
Harlem Cut Rate Drugs, 68 W. 116th ---------- 369–9766
Hart Pharmacy, 1661 Amsterdam ---------- FO 8–8867
Hartly Chemists, 1219 Amsterdam ---------- RI 9–8480
Heights Pharmacy, 701 St. Nicholas ---------- 234–9803
Idell Pharmacy, 302 E. 100th ---------- 348–9880
Jaystone Drug Co., 104 Lenox ---------- EN 9–3636
Jomel Pharmacy, 2069 2nd ---------- TR 6–8071
Kenwood-Peters Pharmacy, 144 W. 125th ---------- 865–1052
Kirschemer Pharmacy, 1711 3rd ---------- 831–3786
Langer Drug, 3399 Broadway ---------- AU 1–0500
Lasalle Drug, 3143 Broadway ---------- MO 2–6908

Lax Drug, 360 Lenox ..... EN 9-0365
Las Marias Pharmacy, 6138 Lexington ..... SA 2-4627
Lato Drug Co., 2243 2nd ..... AT 9-0030
Lenox Terrace Drugs, 20 W. 135th ..... AU 6-2120
Lenox Pharmacy, 145 E. 125th ..... SA 2-9305
Linchon Pharmacy, 2310 8th ..... MO 2-6915
Litvin Pharmacy, 2423 2nd ..... SA 2-2053
Majestic Pharmacy, 356 W. 145th ..... AU 6-6780
Malach Pharmacy, 2185 8th 864-8114
Mills Pharmacy, 2032 Madison ..... SA 2-3128
Mishkin, 1961 Amsterdam ..... AU 6-0444
Morningside Hts. Pharmacy, 1302 Amsterdam ..... MO 6-4337
Morton Pharmacy, 1693 Madison 722-9527
Mt. Carmel Pharmacy, 2325 1st ..... TE 1-9876
Mt. Morris, 1931 Madison ..... TR 6-4041
Pacific Pharmacy, 1821 Amsterdam ..... AU 6-0960
Palmer Theresa, 2395 Broadway ..... SC 4-4800
Pharmacraft, 3645 Broadway ..... AD 4-4528
Physicians Prescriptions Service, 2340 7th AU3-4052
Pleasant Pharmacy, 363 Pleasant ..... AT 9-5677
116 East Drug Corp., 116 E. 125th ..... TE 1-1151
Raysol Pharmacy, 1870 Lexington 348-2117
Rexall Drug Store, 1350 Madison ..... TE 1-2354
Rio Pharmacy, 3839 Broadway ..... LO 8-2880
Rico Pharmacy, 170 Manhattan 749-8317
St. Nicholas Pharmacy, 840 St. Nicholas ..... AU 1-1700
S-O Cutrate Drug Co., 1486 Lexington ..... AT 9-4120
Santos Pharmacy, 3419 Broadway 962-9298
Schaaf Pharmacy, 2149 8th ..... MO 2-6019
Schreier's Pharmacy, 1878 Lexington ..... EN 9-4760
Sharff Inc., 350 W. 125th ..... UN 4-6300
Shirnat Rexall, 3559 Broadway ..... AU 6-5790
Siegel's Drug Store, 111 E. 115th ..... EN 9-4030
60 E. 125th Drug Corp., 60 E. 125th 427-6610
Snow & Yeoman's Pharmacy, 3661 Broadway ..... AU 6-2940
Swan Pharmacy, 3645 Broadway 281-9990
Taft Pharmacy, 1080 Amsterdam ..... UN 4-8600
Terry Drugs, 3481 Broadway ..... WA 6-6910
Theresa Pharmacy, 104 Lenox 369-9850
Theresa Pharmacy, 3901 Broadway ..... WA 3-7617
Thomas, John, 2601 Broadway ..... UN 4-6600
Tosan Drug, 3419 Broadway ..... AU 3-6623
Trau Pharmacy, 2123 3rd ..... EN 9-4013
Unity Drug Co., 2621 Broadway ..... AC 2-4100
V&J Pharmacy, 2247 1st 348-2543
Vim Drug, 3817 Broadway ..... WA 7-0220
Webster Drug, 2509 Broadway ..... RI 9-3063
West Side Drugs, 3524 Broadway 926-5500
Whelan, 145th & Broadway ..... WA 6-3250
Whelan, 2802 8th ..... AU 6-3590
Whitehouse Pharmacy, Amsterdam & 122nd ..... MO 6-7989
Williams Pharmacy, 2155 7th ..... MO 2-2876

ADDITIONAL IMPORTANT RESOURCES OF THE COMMUNITY

Department of Health:

Dr. Harris—Commissioner in charge of child and maternal health.

Dr. Pitkin—Director of School Health (566-7082)

Dr. Frederickson—Director of Harlem Health Center (AU 3-1900)

Miss Ambrose—Central Harlem Director of Nursing

Harlem Consumer Education:
2325 7th Ave. (926–5300)
Harlem Self Help:
179 W. 137th St. Rm 12A
1. Qualifications: 17–21 years of age fill out application.
2. Functions: 21 weeks of basic education in math, science, and english.
HARYOU ACT:
Local Boards:
No. 1 207 West 151st Street 368–7000.
No. 2 2386 7th Avenue 862–3500.
No. 3 451 Lenox Avenue 862–1166.
No. 4 254 Saint Nicholas Avenue 666–6920.
No. 5 Lenox Avenue 666–3935.
Legal Aid Society:
It is not used very much because results depend very much on the lawyer one gets, and because they will not handle any controversial cases.
United Block Association:
68 East 131st Street (281–6000, 234–3822)
Mrs. Addie Patterson—Problem Broker
Mrs. Testamark—Schools (20 West 128th Street 281–6307)
Miss Brabham—Operator (6th floor)
Urban League:
204 West 136th Street (AU 6–8000)
Mr. Wingate—Director
Citywide Coordinating Committee For Welfare Rights:
514 West 126th Street (Amst. + Bdwy.) 3rd Floor
Local: 2325 7th Avenue (131st St.) 926–5300
2430 7th Avenue (141–2nd) 286–9399
FOR EMERGENCY PHYSICIAN IN MANHATTAN CALL 879–1000

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