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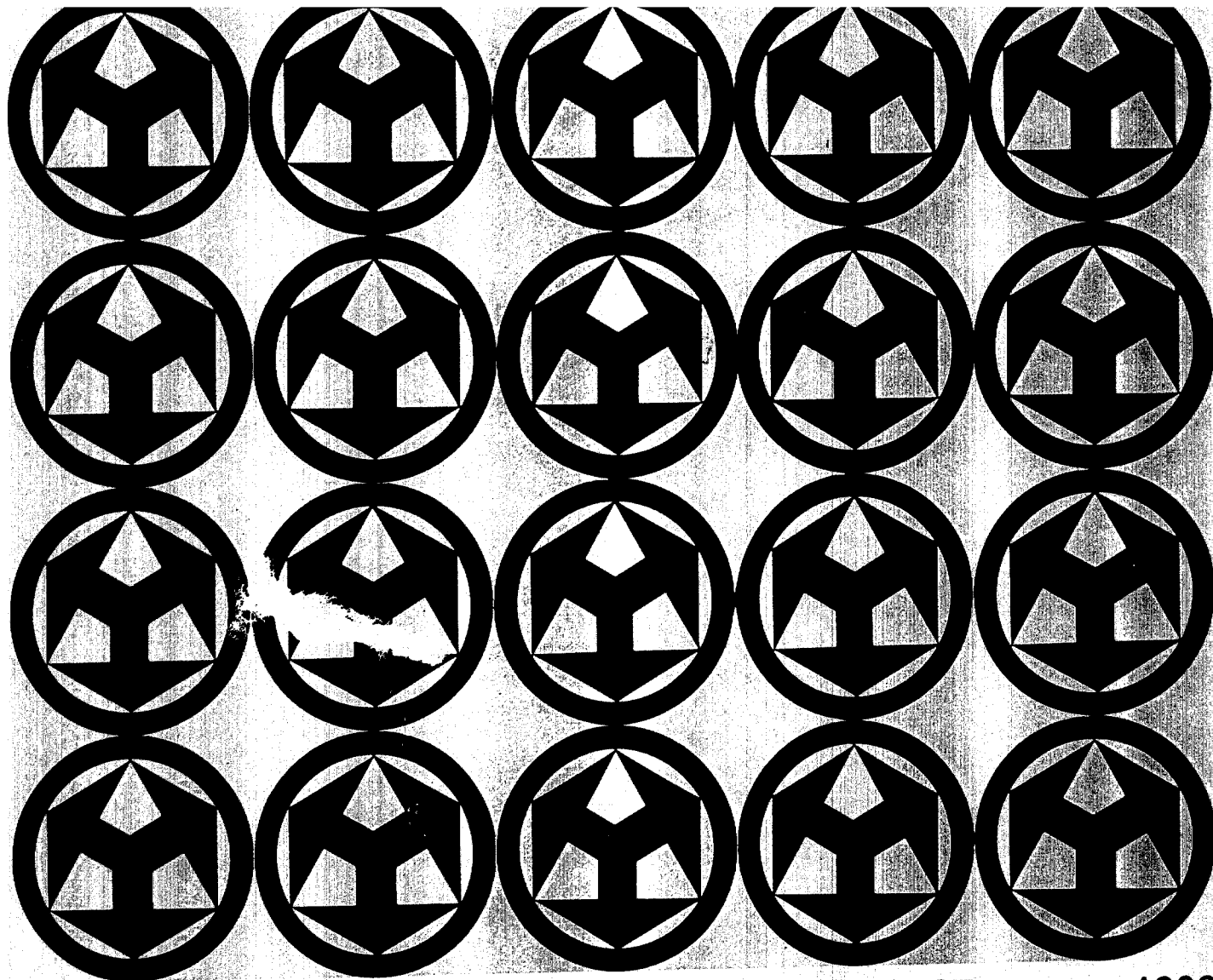
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COLORADO STUDENT HEALTH PROJECT summer 1968

COLORADO STUDENT HEALTH PROJECT SUMMER 1968

Sponsored by
STUDENT HEALTH ORGANIZATION OF COLORADO
in conjunction with
THE UNIVERSITY OF COLORADO MEDICAL CENTER

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This report is dedicated to our fond memories of Suzanne Campbell.



Preface

ACTION AND REACTION

As students in health professional schools we find large gaps among ourselves, our patients, our institutions, and the allied health professions. Our curricula emphasize the basic sciences and their clinical correlations—rarely are we introduced to community health. Our learning material is the medically indigent patient. We are taught the skills of viewing him as a pathological specimen, seldom as a human being. Health care delivery is often seen as medical crisis solving rather than an obligation to deal with a total life style inseparable from environmental and socioeconomic conditions. To the ghetto dweller health care is considered a low priority. These health care consumers are often alienated from a health care system in which they lack franchise. Hospitals are too often viewed as institutions where one comes prepared to die, deteriorate, or, at best, wait for hours to be seen. A manifestation of this health care crisis is the lack of representation of minority groups in our own schools.

The Student Health Organization has evolved in reaction to these situations. Its history has been well documented.¹⁻⁴ It has now witnessed four national assemblies and 3 years of Student Health Projects. Its numbers are now estimated at over 2,000. This involvement arose from a small but committed nucleus of medical students at the University of Southern California. The first formal activity of this group was to sponsor a student forum on controversial health and social issues deleted from the classical medical curriculum. This led to the publication of a journal, *Borborygmi*, and eventually to the formation of the Student Medical Confer-

ence: the country's first interdisciplinary group of health science students. This group initiated several action oriented community projects which ranged from a concentration on the health problems in the San Joaquin Valley of California to work with the Medical Committee for Human Rights in Mississippi.

In Autumn of 1965 these students felt the need to share their experiences on a national level. Sixty-five students from 25 health professional schools met at the University of Chicago for the First Assembly of the Student Health Organizations (SHO). The decision to establish a summer fellowship in community health for 1966 grew out of these meetings. Funding was approved by OEO and this first Student Health Project (SHP) was formally sponsored by the University of Southern California School of Medicine and the Student Medical Conference of Los Angeles. Ninety fellowships were secured for students from 40 health schools across the country. The students formed interdisciplinary teams aided by preceptors familiar with community health problems, community workers and local agencies. The objectives of the program were to aid in the procurement of health services, a role which later became known as "patient advocacy," to catalyze community action around health-related issues, and to educate the students concerning the problems of health care delivery to ghetto areas.

The movement has since grown. In the summer of 1967 three health projects based on the model of the previous year were launched in New York, Chicago, and California. These involved 260 students of medicine, medical technology, dentistry, dental technology, osteopathy, nursing, social work, and law. The new projects added ghetto-area high school students, "high school interns," to the teams in an attempt to interest them in medical and paramedical careers.

¹ McGarvey, et. al., A Study in Medical Action—The Student Health Organizations. *NEJM*, 279:74-80, 1968.

² Gordon, L. J., Ed., *Chicago Student Health Project, Summer 1967*, Chicago, Ill., 1968, Chicago Student Health Project.

³ Brod, T. M., Ed., *1967 California Student Health Project*, Los Angeles, California, 1968, California Student Health Project.

⁴ Fisch, S., Williams, J., Ed., *The Student Health Project of the South Bronx*, New York, N.Y., 1968, South Bronx Student Health Project.

These projects again stimulated more student involvement during the academic year and have led to concern not only in the area of ghetto health, but also in school curriculum reform, student involvement in planning school policy, programs demanding the incorporation of more minority students into our health schools, and a concentration on internal changes within our own institutions.

The 1968 Colorado Student Health Project derives from our own student participation in these former activities. It reflects the same joint student-faculty-community sponsorship, and shares many common goals with past programs. As stated in the grant proposal, our particular objectives encompassed the areas of community service, self-education and biomedical careers.⁵ The community service aspect involved defining community health needs as perceived by the residents and ourselves, sensitizing the existing health care institutions to these needs; promoting the full utilization of existing facilities and the evolution of new health services; and attempting to make active participants out of largely passive health care recipients. We attempted to augment our own education by living and working in the environment of our "patients"; learning to understand the inequalities of the health care system for the poor, and in turn to plan health programs as they relate to community needs; experimenting with an interdisciplinary approach to health problems; and considering ways which these types of experiences might be incorporated into our university curricula. The objectives of the high school "intern" program included augmenting our effectiveness in their communities and stimulating these students in the directions of increased community involvement and biomedical careers.

The project sites included five rural and two urban settings.⁶ This variety of placements afforded the students the opportunities for contrasting health care facilities and delivery among a number of unique groups: the migrant worker who qualifies for few health care and welfare benefits because of his transience, and

for whom continuity of care is often an insurmountable obstacle; the seasonal worker who is often unaware of existing programs and, many times, lives in areas where no such programs have been instituted; and the urban and rural ghetto dweller who is becoming progressively more alienated from a health care system in which he has no voice and is used as a "teaching case."

The summer was one of education, some concrete achievements and numerous frustrations. An initial frustration was the delay in funding which made it impossible to plan programs in advance with community agencies. This lack of structure has been criticized by many of the fellows, interns, community groups, and the sociology students in their evaluation of the project. The philosophy of unstructured objectives has been an integral part of many former SHP's. In this type of situation the student learns to base his priorities on the needs of the community rather than his preconceived notions. This has been described by McGarvey et al:¹

... the student was given a large degree of autonomy, and was supported by extensive consultative resources. With minimum structure, the student was forced to identify problems and discover solutions, drawing upon his own resourcefulness. Pressed to begin defining his identity as a member of the health professions, the student began a process of self-discovery and re-direction of professional commitment.

The argument for more structure is that it leads to more achievement. Yet the following pages document many successes of the students. Why, then, did they feel that the project was only moderately successful with regard to its service aspect? As a group concerned with contributing to alterations in the present methods of health care delivery, we cannot be satisfied with therapy analogous to treating the dying patient with aspirin. To organize projects of greater import would necessitate intense, long-range involvement. The question, then, may not be one of structure versus nonstructure but rather deep commitment as opposed to a sum-

⁵ Grant Proposal, Colorado Student Health Project, Summer 1968.

⁶ See Chapters 1, 2 and 5.

¹ See footnote 1, P. 2.

mer of exposure. If this 10 week period has led to the realization of such commitments, we have fulfilled the prerequisite toward a more germane level of function.

What have we learned? We have seen many of the problems and barriers to the delivery of health care to the "medically indigent." We have begun to develop realistic methods of dealing with these problems. These insights have stimulated the growth of new ideas and perspectives. As one student noted: "We have been observing the end stage of a disease process—we have been working in communities where you see the results of the present health care system . . . We have been patching up this end, but ignoring the process itself." The implications are that

future projects should be organized on a more sustained basis; and should involve a closer look at our own communities, the institutions in which we work, and the schools which we attend.⁷

The ultimate success of this project can only be determined when we become the health care system rather than its observers. It is hoped that the following report will reflect on our prognosis.

MICHAEL REIFF,
Student Coordinator,
Colorado Student Health Project.

⁷ A discussion of these new perspectives is included in Chapter 4.

THE PROJECT SPONSORS' PREFACE

The two faculty sponsors chosen by the Organizing Committee of Colorado students faced the SHO Colorado summer project with a good deal of optimism and only a few concerns. Our optimism related to the firm feeling that we were being asked to advise a group of idealistic young health professionals who wanted to get involved in the rural and urban health needs of our State and in the knowledge that out of their experience would come models for us as teachers, for research and services, relevant to the education of health professionals both at the student and faculty level. Our concern related to the fact that the students represented a great spectrum of motivations and attitudes. Some were likely to expect a good learning experience with the firm expectation that they would initiate some meaningful change which could be carried on by others when they return to their respective schools. Some students were emotionally deeply involved in the immediate concerns over the war in Vietnam, the political election, the shortcoming of their current educational experiences, et cetera. Among the latter, we expected to find and did find a few who saw no hope in gradual change in the medical care delivery system, in attitudes of physicians currently in practice and in government programs designed for the improvement of health care for all.

We faced a difficult task in assigning students to projects where they could make a contribution and at the same time not cause such an enormous upheaval in the local community and in our relationship to local physicians and to governmental programs as to leave behind a medical care situation worse than when they came. For this reason we justified our involvement in placement by pointing out that this summer project would not leave behind a single viable health care system and that, therefore, all efforts had to go towards improving existing

facilities and resources. The following reports fail to show, as clearly as we would have liked, the kind of admiration that developed for some of the rural physicians in private practice among many of our students, almost all of whom on arrival saw private physicians in a stereotyped and hostile way. The material describes well, on the other hand, the red tape handicapping many programs designed to help the poor to achieve health care.

During the welcoming session, we insisted that the University of Colorado Medical Center sponsorship brought with it the acceptance of certain arbitrary rules set by the University. We were concerned that a number of students would leave the project when we insisted that during working hours no buttons, whether for political candidates or for the cause of peace, could be worn. We were told that in other projects many students would have walked out right then but nobody did.

The relationship between the coordinating committee and the faculty sponsors remained cordial. We learned a good deal from each other. Because we managed to stay in the background, such rebellious attitudes which developed from time to time were directed at the student leaders rather than against ourselves.

We believe that the ultimate assessment of a project such as this requires some time. Aside from the effect on health care in the immediate project area which will be influenced by local and Federal support in the years to come, the effect on the participating students is not easily foreseen. Not all students who express interest in health care of the poor will end up delivering such care when their time comes. Some have found the poor to be unmotivated, unattractive, and unrewarding to a degree that they will be unwilling to limit their professional life to the most needy.

We think, in any case, that this may be too

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much to ask and that a single system of medical involvement of all professionals with all levels of population would be greater justice to patients and health professionals alike.

We feel admiration and affection for the students who came to Colorado in the summer of 1968 and are grateful for the opportunity to have been chosen as faculty sponsors.

C. HENRY KEMPE, M.D.,
*Professor and Chairman,
Department of Pediatrics,
University of Colorado Medical
Center.*

HOWARD HIGMAN,
*Professor of Sociology,
University of Colorado.*



Chapter 1

The Sites

The summer projects were based in three major areas of the State. The rural placements were situated in the Grand Valley on the western slope and the San Luis Valley in south-central Colorado. The urban aspects of the program centered around two areas in Denver itself. The areas are discussed separately in this chapter. Each section contains a description of the individual projects as well as a summary of the students' impressions of the health care system in their respective locations.

THE GRAND VALLEY

A. The Project

The Grand Valley was chosen as one of the two project sites which would serve as a model for the rural aspect of health care in the United States. Grand Junction was made the coordinating center for the three other areas on the western slope of the Rocky Mountains due to its strategic central location with respect to the other placements: Palisade, Fruita, and Delta, Colo. Although Grand Junction is surrounded by agriculture on three sides, the town itself is one of small businesses and prides itself for its selection as an All-American City in 1962. It abounds with civic and social activities, such as the local TACT chapter, which is striving to maintain the All-American status. Its heterogeneous population of 25,000 consists of 85-90 percent Anglo-Saxon, 10-15 percent Mexican-American and less than 1 percent black, but during the harvest and hoeing seasons, the city comes alive with an influx of representatives of many different Indian tribes and southern Negroes.

Three students were placed in each of the four areas. Their charge was to grapple with the objectives of the summer project reviewed in the preface. To achieve these goals, 12 hearty students embarked upon the task with great vigor. Their entrance into the Grand Valley was unobtrusive, but contacts with local physicians and officials were made immediately, and avenues of exploration were mapped off. Regional headquarters were established and the project was set to march forward.

But, where to march? In Grand Junction, the first order of business was to become acquainted

with our local high school student, who would give us an introduction to the community from her point of view. After this, further contacts were made with local physicians and officials, and we were told that there were few, if any, problems present in the area of health care in Grand Junction. Consequently, we drew back and through the process of elimination decided that if anyone knew the problems of the region, the local Vista volunteers would. They were quite eager to give us an overall picture of the area, and from this, three realms of inquiry were launched.

One consisted of looking into the local teenage problem, and what to do about it during the summer. One member of our team tackled this problem and over a 1 month period found that there were two main activities in which the teenager of the area participated—local dances at "The Barn," and nightly excursions through the local shopping center parking lot. Although it was recognized that neither of these activities led to self-improvement, little support could be gained for such things as opening the high school or college gymnasiums or starting a teen center. Consequently, this aspect of the problem was dropped and a new area explored; that of the mental health needs of the community. Through association with, and assistance from sympathetic members of the Grand Junction area, a program was started for patients recently released from the State mental institution to help in their readjustments back into the community. This proved to be quite gratifying from all points of view, and the result was the establishment of a precedent for following programs designed to allow the stigmatized ex-mental patient a fair chance to come back to a community and embark upon another attack on reality.

The two other students pursued the goals of the summer project in a different vein. They decided to look into the overall health care resources available to those in the Grand Junction area. To accomplish this, numerous meetings and conferences were attended to determine just how the health care system in the area operated. It was found, to the surprise of no one, that those with money had little difficulty in attaining what health care they needed, a

situation not uncommon throughout the United States. But what about those without enough money to buy health? To our amazement, it was found that even those without money had almost the same services available to them with regard to health. All they had to do was to take advantage of them, and if they needed other health services that were not available, all they had to do was ask for them and they could be set up. Thus, we wondered if any health care problems really did exist in these rural areas. We then went to those people unable to pay and asked them if they had any needs for health care that were not met. Some said no, but from our point of view, many had clearly visible health problems such as poor nutrition and sanitation facilities. Very few utilized any of the existing preventive care programs. Why didn't they take advantage of these free services? The answers to this question were phrased in many ways, but they boiled down to two basic obstacles over and above that of not having enough money. One problem was the lack of knowledge as to what "health" consisted of, and what services were available to them to help attain "health." Another problem, was what could be called an alienation from the existing sources of potential benefits. Although those in the financial and ethnic minorities may have known of the programs and services, they felt that they were not intended to be included in them, and therefore, participated infrequently. These two problems apparently were not recognized or were overlooked by those who provided the possible services, and consequently, the remaining two students embarked on a project to try and make services which were ostensibly available, actually available. Three major minority groups were found to be in a similar situation in the Grand Junction area: Most of the Spanish or Mexican-American population in the city itself, a group of 100 to 300 Indians working in various mines in the mountains to the southwest of Grand Junction and the Indians and Mexican workers who came to work in the fields of the outlying areas.

It took 1 month to come to the above conclusions, which left little time to develop solutions to many of the problems, but it was decided to see what types of approaches would

make the problems potentially amenable to solutions. The three students in Palisade and another three in Fruita worked more in the area of approaches to meeting the health needs of the migrant population. Both of these groups aided the students in Grand Junction with the problems concerning the resident Mexican-American minority, and the Indians working in the uranium mines.

The first step for all areas was to see just what kinds of respective health services were needed by the three groups. This was inefficiently done by talking with people in the various areas, but some feeling for the needs was obtained. Next, the services offered were made clear, and then the approaches to the two basic problems were outlined.

The Food Stamp Program was emphasized for the migrant workers and information regarding available health services was outlined and distributed. The means to use these services were provided by the students. Transportation was arranged, and preventive screening measures such as throat cultures were performed. This screening provided highly revealing information about the previously ignored pool of streptococcal infections. Also, the idea of a centralized mobile migrant clinic sponsored by the local hospital and staffed by local volunteer physicians was discussed with some hope that it will materialize in the harvest season to come.

The Indians working in the uranium mines were living in indescribable squalor with no sewage systems and runoff drinking water, without purification. Although they earned union wages, the area was so isolated that they were unable to do much on their own to improve conditions. When the knowledge of this group was brought to their attention, the local health authorities began to act and the problem was finally approached on a level where results could be accomplished. Through our visits to the mining camp, we were able to introduce the miners and their families to the available health services, and the Public Health Department became aware of how it could expand its services in meaningful ways. Such minor expansions as immunizations and health counselling were provided by the students, but the impact was mainly

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an enlargement of the scope of ideas and understanding about how to approach the two basic problems mentioned earlier.

In the Grand Junction area itself, the students served to expand the programs and outreach of the established agencies, and to make the agencies aware that there were other approaches to the existing problems.

This was done by such concrete methods as bringing 50 to 60 children to the immunization clinics. Classes that could be formally called health education were expanded and where previously four to 15 children had attended, 30 to 50 children were now able to be exposed to various aspects of health. In addition to allowing the established institutions to see various applications of their programs, the people who should have been able to use their programs were able to have some positive exposure to them, and hopefully, they will begin to utilize the services more in the future. The students in Delta manned similar programs and in addition aided in a study of school dropouts which is proving most valuable to the school system of that area.

At the end of 2 months, the SHP students in the Grand Valley did not have much in the way of concrete edifices to show their accomplishments or failings, but the experiences during the summer served to point out some of the sources of the basic problems preventing the provision of health care on a level compatible with the resources available. The small accomplishments were quite gratifying but the overall immensity of the basic problem often was overwhelming and made the summer a frustrating one for all involved. However, it was seen that the basic problems regarding health in the rural settings are qualitatively the same as those in the urban areas, but that the quantitative aspect is quite different. The impetus to attack and resolve the problems is sometimes in striking contrast between the two settings. In spite of this, through understanding of racial, ethnic, cultural and financial minorities, and the reasons for the current predicaments, obtained through programs such as the SHP, the providers of health for the future will be able

to expedite the process of allowing greater fulfillment for all individuals of this Nation.

SKIP BRY,
*Area Coordinator,
Grand Valley Project.*

B. The Health Care System

1. *The Present System of Health Care for the Poor*

The town of Delta has one "semi-active" and three active doctors, and a county-supported hospital with a capacity of 30 to 40. Palisade has two doctors; and Cedaredge, Hotchkiss, and Peoria, towns of 1,000, have one doctor each. According to one student, "the poor may receive identical medical treatment to the middle class . . . provided they take the initiative to come to the doctor."

In Delta, the physicians make allowances for the poor's medical expenses. They will "charge less, distribute advertising samples, prescribe generically according to their understanding of the families' financial situation." Others allow patients to pay what they feel they can afford. The hospital and one doctor bill patients without expecting payment. The physicians do not go out after the patients but expect them to come to them.

Two organizations, the Colorado Migrant Council and Holly Sugar Corp. are set up to provide health care for eligibles: Migrants in the former, and employees in the latter. The Colorado State Health Department provides free medical care and drugs to migrants, but it is not a very well known program. Public health nurses seem to be doing an adequate task of getting children of school age proper medical and dental care, but these programs are understaffed.

The Welfare Department can provide adequate medical assistance for its eligibles, while the Mesa County Health Department in Grand Junction offers a mental health clinic, a TB clinic that includes X-rays and medicine, and a handicapped children's program, including a diagnostic epilepsy clinic. The Health Department also provides a complete orthopedic clinic paying for almost everything and a plastic

clinic which pays for hospitalization, surgery, orthodontia, speech therapy, and hearing aids for those who are ineligible. "Most of the medical clinics, however, offered by the Health Department are on a referral basis by a doctor or osteopath . . . , and if an individual cannot afford to make it to a primary physician initially, he has no chance of getting into any of these clinics except mental, dental, and immunization clinics, which need no referral."

Indians are cared for by governmental agencies on their reservations, or by the Bureau of Indian Affairs if outside hospitalization is necessary.

In Palisade, health care is adequate. Public health nurses follow up cases when and where possible. They are limited by the rather mobile life many of the migrants live. Lack of preventive measures, such as vaccination, is seen to be a problem here. Two doctors in this area extend their office hours during the peach harvest to care for the additional burdens more people add.

2. *The Most Pressing Health Care Needs for the Poor*

A. A more effective outreach program. This would have to involve an increase of public health nurses to reach more of the population more often, and salary increases to make the area competitive.

B. A better transportation system to St. Mary's Hospital, which is often inaccessible for persons without a car. Since the hospital is centrally located in Grand Junction, more people could utilize its facilities if they could get there.

C. Health stations in some of the outlying districts could be useful, as they would be more personal and more accessible. For example, a clinic at Fruita would be easily reached by people from Loma, Mack, and New Liberty, and could include checkups and immunization. The problem could be solved also by a mobile clinic serving all of Mesa County and feeding into St. Mary's Hospital.

D. The "invisible poor," people who are just missed by welfare and assistance programs because their income is above the maximum poverty income, but not enough for them to afford adequate care, would benefit nicely from a low cost, comprehensive medical insurance plan.

E. Dental facilities are needed for the Fruita, Loma, Mack, and New Liberty areas, which now rely on the "terribly overcrowded" dental clinic in Grand Junction.

3. *Bureaucratic Problems Which Hinder the Usefulness of the Present Facilities to the Poor*

A. ". . . Lack of coordination among community service agencies, due to personality clashes and segmentation of aims." Better communication and cooperation could increase the effectiveness of local agencies, all of whom are striving for similar goals through different means.

1. Public health payment for migrant health care is not being made now to doctors and migrants.

2. The public health nurse can only visit families to whom she has been referred by a local agency and, therefore, misses persons who have not come into contact with any agency.

3. People on welfare, old age pensions, and social security hesitate to seek needed medical help because they are not sure they can afford it and do not know whether their assistance programs will cover it. Finding out what the agency will pay involves bureaucratic channels which a poor person finds overwhelming.

4. The public health nurse in Fruita for 1 hour per week cannot prescribe medication or make diagnoses. This causes a reluctance on the part of the people to come and see her.

B. The 9 to 5 hours of the welfare agency are often impractical, especially to people who need assistance at an hour when the agency is not open. Also, the whole idea of "appointments" is often foreign to a person who needs help "now" and not in 2 weeks.

C. The notion of filling out forms and applications is another latent bureaucratic dysfunction that limits the welfare and other agencies' success.

4. *Concrete Proposals for Better Health Care Programs*

A. Assistance for the poor in getting to the doctor, rather than a health clinic for the poor, which would accentuate the fact that they are poor and should, therefore, be segregated.

B. A low cost medical insurance plan for low income families, which would include financial assistance for buying drugs.

C. Clinics and doctors' hours which could be at night for persons who work all day and are only able to attend in the evening.

D. Increase the amount and use of information on family planning, health care, et cetera, so that more people could take advantage of these things.

E. Development of vocational training programs, like nurse's aid training program or a laboratory technician program, so the people could learn to be independent and help themselves.

F. Need for more public health nurses, at least four or five, to take the burden off those who are there now and increase the quality and quantity of the care available.

G. Some sort of training in the Spanish-American culture and language for the "professionals" working with these people. This would open communication lines and assist the professionals in helping the people help themselves. Understanding should be a task of the professionals as well as the poor.

5. *Culture Problems of the Poor as Problems for Medical Care*

A. The transitory life of a migrant compounds his other health problems. Their way of life leads to a lack of medical records on them and no personal relation with any one doctor. Also, each time they arrive in a new area, they must begin all over again finding out what is available for them, where to go, who to see, how much it will cost, etc., and even if they have been in the area before this is still a problem due to the changes in what *was* there and what *is* now there.

B. Mistrust of "Anglo medicine" seems to be a problem too, and reliance on folk practitioners is not uncommon. The "system" seems to perpetuate and encourage this mistrust with its red tape and uncooperativeness.

C. A value for preventive medicine should be encouraged, not just seeing the doctor or worrying about an illness when it becomes severe.

D. Alcoholism, and all the social ramifications thereof, is a serious problem for the poor

who often use it as the only way to exist in the world.

THE SAN LUIS VALLEY

A. The Project

San Luis is the capital of Costilla County located in South Central Colorado. The county is a valley bounded by the Sangre de Cristo mountains. Agriculture is the main source of income and all farming is done under irrigation. There are no industries in the county; 62.8 percent of the people have incomes under \$3,000. Spanish-Americans comprise 72.6 percent of the population. Many of these are descendants of the original Spanish settlers.

This area was the smallest project site as well as the most unique in that the students and the SHO project doctors were actually in charge of health care delivery. One of the primary goals in setting up the project in San Luis was to allow the students to work in a public health education-community development role. This concept remained a theory as the students consumed most of their short summer stay aiding in this delivery of medical care and of greater import re-establishing the community's knowledge that the Sangre de Cristo Clinic, the major public health facility in San Luis, did have a full time doctor with plans for year round medical service.

The support from the local medical society through the direct sponsorship of Dr. Dale Thomas of La Jara, Colo., was greatly appreciated. The students learned a great deal about the private practice of medicine by spending 1 day a week with Dr. Thomas, as well as the problems encountered in delivering health care in this community. In addition, the health science students and the high school interns had many learning opportunities under the supervision of the two SHO project doctors.

In assessing the program orientation and planning, two aspects should be discussed. The first aspect is the short length of time the project had in San Luis. If one has never lived in a rural area, there are the problems in understanding the power structure, the problems of an agricultural economy, the social behavior of the local residents, and finally the local Spanish-

American culture. Given the array of unfamiliar factors, the students were somewhat confused as to what they could do to aid the community in dealing with its health requirements. The "Con la familia" or living with a local family on arriving in the community was considered an excellent introduction. However, this was a brief 3 day stay and what the students really needed was someone who could guide them in learning about the community's problems for the length of the project. In future projects in the San Luis Valley a past SHP member could render valuable guidance as an area-coordinator. With this method of leadership the students could widen their learning experiences about the rural area.

With every evaluation, the question is raised regarding the success of the project. There are many persons who can give opinions; however, the most important person is the student who actually worked and invested his summer in the project. In my opinion, some of the successful features of the project were:

1. A constructive interchange of ideas between persons who would not otherwise have direct lines of communication—examples, high school students and medical students, RMP administrators and project members.

2. A number of tasks or services that benefited someone which otherwise would have gone undone—examples, getting a boy into school, getting a man a job.

RANDALL H. LORTSCHER,
Associate Student Coordinator,
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B. The Health Care System

1. *The Present System of Health Care for the Poor*

There are five different types of health care systems for the poor near the town of San Luis. First, the Presbyterian Medical Service Clinic; second, a State public health nurse; third, financial aid from the Community Action Program agency and welfare office; fourth, a public school health nurse; and fifth, the Alamosa and LaJara Hospitals.

First, the Presbyterian Medical Service operated the Sangre de Cristo Medical Unit, or Clinic, just outside of San Luis. This unit is quite a comprehensive outpatient clinic, which has facilities for dental and medical care as well as emergency child birth and minor surgery. Due to the students' presence and their procurement of a full time physician, the present medical staff of the clinic includes: one full-time physician, one LPN, two part-time SHORN's and two part-time medical students. In addition to the full-time physician mentioned, doctors from Alamosa and LaJara come to the clinic Tuesday through Thursday for one-half day.

The State public health nurse for Costilla County operates several different clinic sessions throughout the year which provide free medical care to county residents. On a monthly basis, the nurse with the aid of volunteer doctors, conducts a "well baby" clinic and a school age clinic at the Sangre de Cristo Medical Unit. On a yearly basis, she offers clinics for Head Start children, orthopedic problems, epileptic, and cleft lip and palate cases. In addition to these and her normal duties, she is involved in follow-up work on cases referred to her from C.G.H. and Colorado State Hospital.

The CAP agency in San Luis has an "emergency medical aid grant" from OEO which enables them to pay for any medical treatment rendered at the clinic to a "poverty family." The welfare department also pays for medical care to various eligible groups; specifically, old age pensioners, and Aid to Dependent Children, Needy and Disabled and general assistance.

Costilla County provides a public health nurse for the schools in San Luis, who seems to be primarily concerned with the general health of the children.

Two hospitals in LaJara and Alamosa provide an extensive amount of care to the people of the Valley. Both have adequate operating, delivery, and emergency rooms, plus facilities to deal with most surgical and medical cases.

2. *The Most Pressing Health Care Needs of the Poor*

First, there is a lack of qualified professional people to staff the medical unit. What staff has

been available seem to be there only on a temporary basis. A full-time physician, a dentist and assistant, a lab and X-ray technician, and two nurses are needed to enable the clinic to function adequately. Next, the people need to be informed of the clinic's facilities and their eligibility to utilize them.

A second quite pressing need is an effective ambulance service. At least a station wagon, and preferably a 4-wheel drive vehicle for the out-of-way places, is needed. Many persons fail to use the clinic because of their lack of transportation to and from it; and patients and accident victims often require movement to the more comprehensive hospitals in LaJara and Alamosa.

Alcoholism seems to be a pressing problem of the area, which requires an effective treatment and education program. Psychiatric and social type counseling, in addition to a followup on patients who have been on the alcohol ward at the State Hospital, is also necessary.

A final need is for a more adequately supplied drug store. Many prescriptions cannot be filled because of an insufficient amount of drugs, and often these people are forced to go to Alamosa, when they can afford it, for their prescriptions.

3. *Bureaucratic Problems Which Hinder the Usefulness of the Present Facilities to the Poor*

Like many poverty areas, the age-old difficulties with the welfare department and the CAP agency seem to exist here. Specifically, the welfare department is often "slow" in dispensing information as to who is available for what. They are often resentful of "outsiders" meddling in their business.

The CAP agency often seems reluctant to make available information on what programs are available and to whom. The reluctance to disclose information on emergency food stamps, medical care assistance, and the medical unit has been noted.

A full time clinic director, whose interest is in the effective operation of clinic and the maximum distribution of services to the poor, would be most desirable.

4. *Concrete Proposals for Better Health Care Programs*

A. A comprehensive outreach program that would involve a "total cure," rather than "band-aid" approach to the population.

B. Health re-education of the people for such things as dental hygiene and nutrition. A latent function of this program would be to increase and improve the communication between the community and the agencies.

C. The need for full time clinic physicians. The implementation of a new grant for hiring permanent staff members will be beneficial to this goal.

D. Creation of an adequate drug store, that can fill the doctor's prescriptions.

E. An effective, full-time ambulance service.

5. *Cultural Problems of the Poor as Problems for Medical Care*

The pride and self-reliance of the Spanish-American is seen as a problem when it limits their effective participation in the clinic.

A. Many will not come to the clinic because they cannot afford it.

B. They are often resentful of government "give away" programs. They do not want someone giving them money, but want jobs where they can earn the money.

C. There is little or no conception of the notion of preventive medicine, and most people wait until they are quite ill before they will come to the clinic. This is especially true of the fathers of the households.

D. The notion of "the clinic" is still new to many of the people. Technical innovations are less readily accepted in their society than in most, and many are not ready to accept the clinic yet.

E. The use of folk medicine in place of scientific medicine is seen as a problem due to the often improper care it provides. The psychological effect is to cause the people to feel that a doctor is unnecessary.

C. *A Study of Folk Medicine in the San Luis Valley*

Introduction:

This study is concerned with the use of medical practices, other than "scientific" medicine,

as used by a sample of people in and around the San Luis Valley medical clinic. According to Saunders, "Folk Medicine," like scientific medicine, undoubtedly derives much of its prestige and authority from the fact that the majority of sick persons get well regardless of what is done.¹ Although most persons in society practice folk medicine to some extent, there is a wealth of evidence indicating that it is a very important part of the Spanish-American culture.²

Saunders lists some 25 different illnesses for which the "village folk" had remedies.³ One of the goals of this study was to take some of the more common illnesses he mentioned and discover what forms of cure were utilized. This is in no way an empirical test of his theory, but rather a study designed to discover some trends in the medical practices of the Spanish-Americans in an attempt to implement changes toward modern medical practices.

Methodology:

The SHO students in the Valley had the unique position of close medical type contact with a fairly large number of Spanish-American people. They treated the people in the clinic for various ailments, as well as making home visits for followup and additional care. These students reported several different instances of healing practices which appeared rather odd to them. For example, Miss Campbell noticed that a woman had placed a necklace of a string and dime around her child's neck to enable the child's teeth to grow straight. She also reported several instances of strips of sheet that were dipped in potato juices being wrapped around a person's head to help cure headaches. She became curious about the extent and prevalence of these practices as well as the use of other ones. We decided that one of the best ways to accomplish this was the construction of a questionnaire to be administered to certain patients of the clinic and in their homes.

¹ Saunders, Lyle, "Healing ways in the Spanish Southwest," in E. Gartly Jaco, *Patients, Physicians and Illness*, The Free Press, 1958, p. 191.

² See George Foster, "Relationship between Spanish and Spanish-American Folk Medicine," *Journal of American Folklore*, vol. 66, July-September, 1953, p. 201-217; and Lyle Saunders and Gordon Hewes, "Folk Medicine and Medical Practice," *Journal of Medical Education*, vol. 28, September, 1933, p. 43-46.

³ Saunders, op. cit., p. 196.

We constructed a questionnaire which consisted of 10 of the more common illnesses based on the 25 illnesses Saunders mentioned. The commonness of the illness was decided upon by the four SHO students on the basis of their experiences in the clinic with illnesses.⁴ We wanted to know what the person would do if he contracted any of these, and if this would change any when the illness became more severe. We asked what he would do if he contracted the illness, rather than what he had done when he had it, to eliminate anyone from saying "nothing" since he had never had it. This, it was hoped would add to a greater completion ratio of the schedules, even though the illnesses were common enough so that it was unlikely that one had never contracted them. At least one would probably know someone who had one of these illnesses so, at the very least, would know what would be done.

The severity factor to discover change was included to help better define phases of the illness and to see during what phase of each particular illness the folk remedy was used, and when the doctor was used, and whether or not these were dependent on severity. We also were interested in certain demographic facts as partialling factors with severity and folk practices, but the small size of the sample restricted their use.

A word must be included here about the nature of the sample. The sample was collected on an interview basis over a 6-week period by the four SHO students and one health intern in conjunction with the rest of their duties. Interviewing was conducted as a supplementary task to their normal duties, and the interviewing was done when they had time and with persons who were cooperative. I believe the main limitation of this was the size of the sample we were able to get and not a serious form of sample bias. However, it should be noted that the sample did consist of persons who were medically oriented by nature of their participation in the clinic. We could assume that these persons are less folk medicine oriented than those who do not come to the clinic, but on the other hand, it might be fallacious to assume that

⁴ A copy of the questionnaire is to be found at the end of this study.

those who do not come to the clinic are necessarily more folk medicine oriented. It could be that those who do not come to the clinic are just less medicine oriented than those who do come, and the clinic users would, therefore, be more concerned with folk as well as scientific medicine. This is perhaps an academic point, but one which should not be overlooked. With these things in mind, we can now consider the findings:

Findings:

Table I.—Sample Description

A. Demographic:			
1. Size:	23		
2. Where person interviewed:			
		<i>N</i>	<i>Percent</i>
a. Clinic.....	12	12	52.2
b. Home.....	9	9	39.1
c. Total.....	21	21	91.4
3. Age:			
a. Range:	16 through 92		
b. Mean:	32.1		
4. Sex: All females			
B. Folk medical practices:			
1. Total number of incidences of folk medical practices:	97		
2. Total number of incidences of nonfolk medical practices:	384		
3. Percent of the total number of practices that are folk:	21.5 percent		

Discussion:

One of the more interesting findings of table I was that the entire sample was female. This is empirical support for the student's report on the Medical Survey Questionnaire that for the most part, men do not attend the clinics,

and are more reluctant to admit to being ill than women. Women not only admit being ill more, but are more ready to talk about it, too. When men do come to the clinic, however, they are usually in a "hurry" and do not have as much time to spend there as women.

Table II is a depiction of incidents of folk medical practices for each specific ailment. These practices are utilized most often for toothaches, and stomach aches and least often for colds and constipation. This could indicate that the former two ailments are the ones that the people least trust medical science to help, and the ones which they feel best able to deal with. Their remedies are probably most successful here and most accepted and trusted by the people.

To accept this notion, it is assumed that all ailments have an equal chance of occurring and would, therefore, have an equal probability of being treated by folk medicine. In the course of treatment, some remedies lose esteem as they fail repeatedly in their effects. This causes a loss of faith in the old remedies and a willingness to try new ones. The repeated success of the new over the old will eventually cause the old to be abandoned for the new. Reluctance to try the new is due to the efficacy of old as well as the availability of the old and new and the faith in each. It is much easier to maintain faith in an old belief, even with numerous failures, than it is to develop faith in something new, even with numerous successes; and this is especially true of the more tradition oriented societies.

Table II.—Incidents of Folk Medicine for Each Specific Ailment

Ailment	Number of times folk medicine used	Number of times nonfolk medical practices used	Total number of times a medical practice used	Percent of total medical practices that are folk medicine
General or specific aches and pains.....	9	56	65	13.8
Skin conditions.....	3	15	18	16.6
Colds.....	1	58	59	1.7
Headache.....	8	58	66	12.1
Earache.....	16	42	58	27.6
Sore throat.....	5	32	37	12.2
Toothache.....	18	22	40	45.0
Stomach ache.....	22	33	55	40.0
Diarrhea.....	12	37	49	24.5
Constipation.....	3	53	56	5.4

Table III.—Trends of Folk Medicine Practice Usage from Mild to Severe Cases of Ailments

Ailment	MILD				SEVERE			
	Folk medicine	Nonfolk medicine	Total	Percent folk medicine	Folk medicine	Nonfolk medicine	Total	Percent folk medicine
General aches and pains	3	19	22	13.6	2	19	21	9.5
Cold	1	31	32	3.1	0	27	27	-----
Headache	4	22	26	15.4	2	18	20	10.0
Earache	6	16	22	20.7	4	16	20	20.0
Sore throat	3	18	21	14.3	2	18	20	10.0
Toothache	11	9	20	61.2	7	12	19	36.8
Stomach ache	7	11	18	38.9	6	10	16	37.5
Diarrhea	6	11	17	35.3	3	15	18	16.7
Constipation	1	17	18	5.6	1	19	20	5.0

Table IV.—Trends in the Use of Doctors and/or Clinics from Mild to Severe Cases of Ailments

Ailment	Doctors ¹	Other ²	Total ³	Percent doctors ⁴	Doctor	Other	Total	Percent doctor
General aches and pains	1	21	22	4.5	9	15	24	37.5
Cold	2	30	32	6.2	10	17	27	37.0
Headache	1	25	26	3.8	8	12	20	40.0
Earache	3	19	22	13.6	9	11	20	45.0
Sore throat	2	19	21	9.5	11	9	20	55.0
Toothache	1	19	20	5.0	8	11	19	42.1
Stomach ache	2	16	18	11.1	7	9	15	43.7
Diarrhea	1	16	17	5.9	8	10	18	44.5
Constipation	2	16	18	11.1	7	13	20	34.9

¹ Doctor indicates the number of times the doctor and/or clinic was used for the specific ailment.
² Other indicates the number of times a source other than a doctor and/or clinic was used for a specific ailment.

³ Total includes the number of times the doctor and/or clinic and all other sources were used.
⁴ Percent doctor; is the percent of the total that used the doctor and/or the clinic for the ailment.

Table III shows that, without exception, whenever an ailment becomes more severe, the people have a tendency to rely less often on the folk medical practice. When an ailment is mild and the cost of a mistake is low, folk practices are utilized, but as the risk increases so does the belief that folk medicine might not be the answer for cure. This finding led directly to table IV, which concerns the trends toward scientific medicine as the severity of the disease increases. We find, again without exception, that as the severity of the ailment increases people go to the doctor and/or the medical clinic more. As the threat of danger from the ailment gets greater, the belief in the efficacy of folk cures go down, and the reliance on scientific medical practices increases.

Stanley H. King has shown that there are two important variables which determine which system of medical beliefs will be used, seriousness and ambiguity. Their contention is that

when seriousness and/or ambiguity of the disease becomes high, the person will turn to the dominant belief system of his culture for cure. From this our study would indicate that the dominant belief system of the Spanish-Americans in and around the San Luis clinic is not folk medicine but scientific medicine.

While this might seem surprising at first, a little reflection will show it to be quite plausible. First of all, due to the nature of the study, we are unable to make a statement about the relative power of influence of each of these beliefs. We know from observation that folk medical practices are common and fairly extensive in this culture, and that there is a fear of anglo medical doctors. However, these Spanish-Americans are quite exposed to modern medical practices via the clinics, public health nurses and friends and children, and have, therefore, experienced many of the "wonders" of medical science. Secondly, the average age of

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the sample, 32.1 years, is relatively young. Younger groups show a tendency to be more aware of change and more ready to accept it than older groups. Third, the sample was all women and, as the students have shown, women tend to go to the doctor more often than men, and seem less reluctant to accept modern medicine. The inference of this study is that modern medicine is replacing folk medicine as the prime medical value although the former is still very significant for the Spanish-American. We are also suggesting that the degree of severity and ambiguity of an ailment, the sex of the sample and the age of the sample are very important factors in determining what type of medical practice will be used. It seems further that if a greater and a more rapid change toward modern medicine is desired, the young women are the group to work with. Time and space prevent an adequate explanation of this last hypothesis; however, let it suffice to say that young women do seem to be the carriers of modern medicine and probably exert enough familial influence to assist in implementing the change.

In retrospect, I regret that many of the findings must remain undiscussed. As in any research, many questions have been raised that must go unanswered and until a more comprehensive study can be designed and a larger and more complete sample taken, many of the interesting cross-tabulations will remain undone. The goal of this study has been to discover trends of medical care with respect to certain specific illnesses for which it was claimed folk practices were used. The manifest practical use of this is better medical care, the latent uses of this are still open to speculation and discussion, and will continue to be.

JOHN C. QUICKER,
ALFRED J. CLAASSEN.

D. Folk Medicine Questionnaire

A. Where was the person interviewed:

1. Home _____ Clinic _____
2. Age _____
3. Sex _____
4. Education _____

B. Discussion about present illness:

- C. What would you do if you had: (Their interpretation)
- | | |
|--|---|
| <ol style="list-style-type: none"> 1. Aches and pains <ol style="list-style-type: none"> a. mild _____ b. moderate _____ c. severe _____ 2. Skin condition _____ 3. Cold <ol style="list-style-type: none"> a. mild _____ b. severe _____ 4. Diarrhea <ol style="list-style-type: none"> a. 1 day _____ b. 2 to 3 days _____ c. 4 days _____ 5. Earache <ol style="list-style-type: none"> a. mild _____ b. moderate _____ c. severe _____ 6. Headache <ol style="list-style-type: none"> a. mild _____ b. moderate _____ c. severe _____ | <ol style="list-style-type: none"> 7. Sore throat <ol style="list-style-type: none"> a. hurts _____ b. cannot swallow without difficulty _____ 8. Stomach ache <ol style="list-style-type: none"> a. mild _____ b. moderate _____ c. severe _____ 9. Constipation <ol style="list-style-type: none"> a. 2 days _____ b. 3 to 4 days _____ c. over 4 days _____ 10. Toothache <ol style="list-style-type: none"> a. mild _____ b. severe _____ 11. Fever <ol style="list-style-type: none"> a. warm _____ b. hot _____ |
|--|---|

DENVER

A. The Project

The Denver Project gave me a unique opportunity to view the city in which I had grown up—its people and its policies. It was also a revealing experience to view the hospitals from the outside, as a helpless, confused patient, rather than from the inside (as a helpless, confused student). This contributed to the professional experience and perspective of all the SHP's.

The summer was a period of adjustment for the medical school, the students, the community leaders, and the people of the neighborhood. Rapport had to be established between each, and for the students, was met with immediate failure. The first day, eager to spread their altruism, many were discriminated against for probably the first time in their life by finding no place to settle. Suddenly, all the "To Rent" vacancies had been filled in the Mexican-American neighborhoods. Unfortunately, more of this was to follow—those who were most idealistic at first were hit the hardest, defeated by the system, bolted over by the immense need that every day became more apparent, and continually aware that time was all too short. The end of the summer was greeted with despair—we had changed, but the areas remained largely the same. The feeling that remains beyond all

this, and is the basis for all SHO projects, is the quiet (or not so) determination that "I will return when I am more able to help."

Despite the individual frustration, as a group an invaluable amount was accomplished in terms of laying the groundwork for further projects, for SHO, RMP, and C. U. Medical School.

For SHO it was an experiment—a stop, look, and listen to what's happening in Denver. It confirmed our question about certain inadequacies of the health care program and strengthened our desire to become involved in its change.

For RMP there are countless projects to become involved in, but the basic approach must be altered in any case. Plans cannot be drawn up within the confines of a medical school and be expected to coincide with the life of a poverty neighborhood. The glowing example this summer was a medical organization with much money and good intentions, that decided to prove these intentions by carrying out a project for the good of the "low income" community. However, implementation according to the life style of the doctors made it not only impossible but a mockery of those whose plan it was.

For the medical school it will hopefully open the eyes of the faculty that the present curriculum offers *nothing* to acquaint the student with the relationship between disease and environment, between disease and the bearer of the disease. A medical school must teach more than the study of diseased organs in the controlled conditions of the hospital; it must prepare its students to meet the request of society for care that is compassionate, continuous, and complete. To accomplish comprehensive health care in all areas, more black and Mexican-American doctors are needed.

The Denver Project used students as scouts; each was placed with a community organization as a stepping stone into the community as well as an observer of the organization, to learn the role of the particular organization in its community and the response of the community to it. We worked in two of the major poverty areas in Denver, an area in East Denver, predominantly black, and an area in West Denver, predominantly Mexican-American.

1. *East Side*

A. *East Side Neighborhood Center*. As progressive and open as this was set up to be, the three students placed here felt that their ideas were often suppressed by a staff hesitant about our involvement. Our preceptor, a staff pediatrician, was filled with good ideas and enthusiasm, but implementation was close to impossible without upsetting people or getting involved in red tape.

The center is well looked upon by the community; patients are treated in a friendly manner and with respect in the course of getting truly comprehensive care. One drawback is the long wait, a complaint so often launched at Denver General and one of the reasons for the existence of the center. The medical students and high school interns followed patients in their course through the center and discovered that a 2 hour wait at the pharmacy was customary. Often patients would leave, never to pick up their medication and thus negating all the work and lab studies that had been done. When the students presented this to the preceptor, he responded with "yes," it was already known, but would have to be proven and written up in red tape before anything could be done.

Next year's project could use two students here if at least one has worked in the center during the school year and established the necessary knowledge of the people and the setup.

B. *East Side Action Center* is indeed a site of action; programs there encompass everything from guitar lessons to shopping trips for welfare mothers. It was so well organized, in fact, that the students did not need to be creative in starting programs, but were content to do "band-aid work," the day-to-day helping of established programs. Nevertheless, this turned out to be a valuable experience for all students. The community uses the center, which seems readily accessible to the neighborhood. Attitudes vary; some do not like the element of Black Power within the center, but it is Black Power in constructive sense—self-pride, group pride, and the idea of black helping black to get ahead. The idea of white health science students going in to help should be seriously considered before next year's placement. Black

students could serve as more of an identity figure for the teenagers.

C. *Curtis Park Community Center*—placements here were hampered by the vacations of the preceptors. Footing was never truly established, and the students worked on independent projects. It is a questionable site for next year.

2. *West Side*

A. *Auraria Community Center* is a beautiful new building that looks as if it were built by accident in a low income neighborhood. It is very clean inside, but also very empty. The big recreation room is idle all day, and the entire building closes at 5 p.m. These factors made it seem as though the center was not well received by the community and the students soon became involved in more creative projects elsewhere. Placement next year will depend on the current programs and staff.

B. *Mariposa Health Station*. Though only a few blocks from Denver General, it seems to be much preferred by the neighborhood. It is an active, friendly place; neighborhood aides from day one were willing to take students with them on home visits and to help them get involved and meet people of the neighborhood, which led to numerous smaller but very rewarding projects with individual families. The aides are from the immediate neighborhood and have a good grasp of what is happening and will be a good source of information as well as help for RMP and SHO in the future. The students were actively involved throughout the summer and should definitely return next summer if not before.

C. *West Side Action Center* was the site of the SHO office, though no students worked exclusively with the center. Just how it relates to the community is difficult to evaluate; opinions were highly variable.

D. *Inner-City Parish* is run by the very energetic Reverend Beech with much volunteer help. It is a remarkably well-organized program for the neighborhood; perhaps too structured to force the students to develop their own creative approaches. But, as elsewhere, many hands are needed to help. This is a good source of in-

formation and a good model of community involvement.

E. *Denver General Hospital* was not one of the original placements, but was a focus of interest for the students. It is not unlike similar general hospitals in other major cities. Trying to blunder one's way through red tape to the source of the problem resulted in little feedback and less change. However, one of the preceptors, who had his office in the hospital, proved to be a wealth of information and the needed encouragement during the summer. He will be an invaluable source of information and ideas for next year's project or anyone interested in the West Side.

Of all the placements, the most successful seemed to be the least structured, where the students were forced to make their own appraisal of the situation and their own plan of action. "Band-aid work" designed by someone else does not justify a summer project. Many other projects were explored, too many in fact. The J.F.K. Recreation Center, American Cancer Society Pap Smear Program, and the Denver branch of the "Hielga Delano" did not receive adequate response from SHP, which was already spreading itself too thin. Nonetheless, the overall goal for the summer, that of gaining understanding of a previously foreign area of Denver and acquainting the communities with whites who were genuinely interested in becoming involved, was a success. For the individual, specific memories will fade, but each has grasped a more meaningful perspective towards the field of medicine, that disease is a symptom of the environment and the life-style of the patient.

LISA WILSON,
Area Coordinator,
Denver Project.

B. The Health Care System—East Denver

1. *The Present System of Health Care for the Poor*

There are two primary facilities of health care for the 40,000 persons in the east side area; the East Side Neighborhood Health Center and Denver General Hospital.

The Health Center can care for the "physical, mental and dental needs of the patients." Like everything else, there are likes and dislikes about this center. On the positive side, one student commented that, "This facility makes a gallant effort to give excellent medical care on a rather personal basis." The criticisms are concerned mainly with the amount of time a person must take to be seen and to have his medical prescriptions filled.

Transportation to the center is arranged through the use of buses. There is one group of buses that costs 60 cents for a round trip and another group that is free of charge. However, one student felt that not enough people knew about the free ones to take proper advantage of them, while another felt they were doing an "excellent job," as all one had to do was to call them and they would pick the person up.

Denver General Hospital was not looked upon in as favorable a light as the center and was used mostly for emergencies or when the center could not handle a specific illness. Besides the long waiting lines there, the staff, particularly the administrators, was very "impersonal and cold" to the patients whose preexisting fears of hospitals were already great. Denver General Hospital is also rather difficult to get to when one is without a car. This adds to its unpopularity with the poor in this area.

One student felt that in spite of the goals and attempts by the center to create a favorable image, it is being seen by many people as a "little DGH." If this negative trend continues, it, too, will become a place to which one comes only in emergencies.

Folk medical practices have been mentioned by several students as being a part of health care for the poor, but they are used mainly in unambiguous and nonserious cases. Because of this, they are not seen as a threat to helping the poor when they are sick, as they do seek a doctor when the illness becomes threatening. In fact, the practices could be a good thing if they keep those patients who are less ill from lengthening the waiting lines at the clinic and hospital. This is not praising ignorance, but rather looking at the useful implications of the latent functions of folk medicine given the crowded hospital situation.

2. *The Most Pressing Health Care Needs of the Poor*

A. The problem of "personalized care" deals with the unfriendly nature of urban areas compared to friendly rural areas. Since most people are from rural areas or at least extended family situations where relationships are much more informal, it might benefit these people if the hospitals were less formal.

B. A better communication system should be established. This would involve things as (1) informing more people about what is available at the center and Denver General Hospital; (2) community residents becoming more educated in the functioning of the medical facilities; (3) making information on birth control and venereal disease more available; (4) educating persons in the health professions to understand better the culture of the people they are working with; (5) orienting poverty people to the importance of keeping appointments; (6) establishing community boards to take part in decisions which effect their relationship to the health facilities.

C. "The circumstances which have gone into producing the negative attitude toward Denver General Hospital must be corrected." "Attempts should be made to make Denver General Hospital more adequate to the community." This would involve such things as the community board mentioned above.

3. *Bureaucratic Problems Which Hinder the Usefulness of the Present Facilities to the Poor*

A major problem here identified by four of the six students is the "lack of communication" among agencies. In connection with this the overlapping functions of agencies and the often confusing picture of who can do what and for whom is the picture often presented to the poor. Agencies seem to constantly refer community residents to other agencies, giving them the proverbial "run around" or as one student put it, "Nobody takes a stand or wants to make a commitment of any kind."

The lack of agency communication and their overlapping and referral oriented natures have not only confused the poor but made them skeptical of coming to any agencies at all. In addi-

tion, agencies often are involved in a competition for "cases" and "work at cross purposes" to one another. The latter is due perhaps to a lack of clearly defined agency goals, and the desire to "do well" so that the agency can be recognized as a good thing.

One student suggested that bureaucracies are too interested in maintaining the status quo, and for them to feel that change should occur would be an admission on their part that something was amiss. . . . "Innovation involves stepping on toes because someone is not doing his job well," and this is demonstrated by the need for change.

A problem connected to the above involves the large number of people who come to the homes of the poor trying to "help them." Just think, a family that has a neighborhood representative from the action center, a social worker from welfare, a social worker from the health center, a teacher or parent program aide from Head Start (or both), and a child welfare social worker coming to its home can get mighty confused if all these independent agencies start trying to solve the same problems.

4. Concrete Proposals for Better Health Care Programs

A. More "personalized" health care for the poor.

1. At the health center, the following are suggested:

a. Patients should see the same doctor whenever he comes to the clinic. Like private practice, the doctor should know the patient's name and something of the nature and history of the patient's complaints.

b. Personnel in contact with patients should be out of uniform and wear "regular, common civies" with name tags.

2. A definite need exists at Denver General Hospital to treat the poor like *people* and eliminate those long waiting lines.

3. There should be some doctors or other qualified personnel who can make house visits.

4. A home delivery system for prescriptions might be instituted to help eliminate long wait-

ing lines and/or the hiring of more people to fill prescriptions.

5. Waiting rooms should be made more attractive.

6. The health education programs should be increased.

7. A geriatrics clinic "where doctors have more time to listen to old people" was seen as an overt need.

8. At least one other health center is needed to serve the poor as the one available is not large enough to handle the volume of people.

9. Community residents should become more involved in decisionmaking capacities.

B. Alteration of the neighborhood representative program. Two suggestions were offered:

1. The program should be expanded so that there will be more "reps" who can reach more people.

2. One "multipurpose neighborhood representative" should be used who knows the people and who could refer them to the various agencies in an attempt to eliminate all the other persons from all the agencies bothering the poor.

5. Cultural Problems of the Poor as Problems for Medical Care

A. All six students mention that folk medical practices are a cultural problem for proper medical care. One student felt it played a "minor role, if any" while another said, "The use of folk medicine plays an important part in health care. It is often used rather than actual medical treatment!"

B. A distrust of white physicians, and a distrust and fear of Denver General Hospital.

C. Most persons are not oriented to preventive health care, and many will wait until they are quite ill before seeing a doctor. While this is in part a function of their value for health care and their definitions of what is illness, it is also linked to their distrust of physicians and hospitals mentioned in B above.

D. One student felt that "a major problem for medical care is that of broken homes and mothers for whom children are mostly biological events."

B. The Health Care System—West Denver

1. *The Present System of Health Care for the Poor*

There are three main facilities serving the west side of Denver. One is Denver General Hospital which has been discussed under the section on the east side. The two others are Mariposa and West Side Health Centers. These centers are concerned with "checkups, minor illnesses and injuries, chronic manageable diseases, immunizations, dental work, lab studies, and drugs and nutritional guidance." Another student stated, "the West Side Health Center provides comprehensive care, including prenatal, maternal and infant, adult, dental, social service, et cetera. . . . The Mariposa Health Station is a smaller facility providing prenatal, maternal and infant care, routine lab work, but no pharmacy."

Family health counselors, who are usually residents of the neighborhood, makes "rounds" to peoples' homes encouraging use of the health station and center, and try to mediate problems in keeping appointments, getting prescriptions filled, et cetera. In addition, there is the Denver Visiting Nurse Service which has nurses making home visits as well as helping to staff the health centers.

These agencies are free, except for small minimal payments from those who can afford it. And, "Medications are provided free of charge to the patients at the clinic at the conclusion of a visit with the doctor."

A point which several students felt was important was the emphasis by the clinics on the keeping of appointments. Over 50 percent of the people do not keep their appointments but there are always enough people around the clinics to keep the doctors very well occupied.

2. *The Most Pressing Health Care Needs of the Poor*

A. There is a great need for informing the people about the clinics and when to use them. The orientation to health should be more preventively oriented, and residents should be made aware of clinic's availability.

B. Need for transportation to the clinic and babysitters while parents go to the clinics.

C. The need to improve image of Denver General Hospital. "Thru fear and rumor, it is looked upon by some people as a slaughterhouse."

D. Need for more health facilities—i.e., more clinics, doctors and nurses.

E. Community residents must learn to keep appointments and come in before they are seriously ill. And when they do keep their appointments, they should not be forced to wait so long to see the doctors.

F. A better understanding of the poor by Denver General Hospital staff should know about the values and attitudes of people they serve and should be tolerant and empathetic. Again community residents should be more involved in decisionmaking roles and there is a need for staff conferences on "social rather than purely medical issues."

G. Need for more neighborhood family health counselors. These people should be trained to deal with the total problems of the family as sort of a multipurpose worker. These counselors could be useful in getting more people to use the clinics, through a trust and understanding which they could elicit from the people.

3. *Bureaucratic Problems Which Hinder the Usefulness of the Present Facilities to the Poor*

A. Denver General Hospital administration has not responded to the needs of the poor. It seems to be a structure that fears change.

B. The inconvenience of "forms." Often the fear of having to fill out many forms is enough to keep the poor away.

C. Lack of organizational cooperation in sending many different people into homes for followup. Called by one student a "fragmentation of services."

D. The problem of long waits to be seen at the hospital and rudeness of the clerks and some nurses help intensify the difficulties here.

4. *Concrete Proposals for Better Health Care Programs*

A. The employment of neighborhood people to act as health representatives in their own neighborhood. These people could "provide information about the neighborhood's health fa-

cilities and programs to the people of the neighborhood" who in turn could relate to the representative how things were working for them. In connection with this could be an opportunity program for qualified people from poverty areas to receive training and education for participation in the health fields, i.e., technicians, nurses, and doctors. Vertical programs must be established in health training schools.

B. An adequate transportation system from homes to the clinics and hospitals must be introduced. Also an emergency system would be most beneficial.

C. A preregistration program at the clinic for all poverty area people is recommended. This would replace registering only after one becomes ill and is in no position to find out if he is eligible or not. A preventive type program could be worked into this scheme by providing annual or semiannual examination for all registered people. Since the people realize the need for medical care when ill, perhaps a value for prevention could be begun by such a preregistration program for all people irrespective of their present physical condition.

D. An accurate appointment system should be introduced by Denver General Hospital instead of telling all people to be there at either 9 a.m. or 1 p.m. and then forcing them to wait. A corollary to this would be a system of appointment reminders for the people, especially just prior to the date of a long term appointment.

E. There is a great need for educational programs for medical staff people in the culture of poverty.

F. Health education programs for poverty residents in such areas as health care values, birth control, first aid, glue sniffing, alcoholism, drug problems, TB, tetanus, et cetera, must be increased.

G. A committee of area residents should be implemented to work with the clinics and help

in making all decisions which will effect the services provided by the clinic.

H. A reduction of the number of people who visit area homes seems necessary. This could be accomplished through more agency cooperation and organization of activities.

I. Health clinics should be kept open evenings so that working people may find them more available.

J. An "emergency" food bank created by food chain donations would alleviate many acute crises. This is a difficult situation because people must be taught to budget, but it is almost impossible to provide adequate food, clothing, and shelter on a welfare check.

5. *Cultural Problems of the Poor as Problems for Medical Care*

A. The non-time orientation of the poor was again seen as a problem. The absence of the value for being at a certain place at a certain hour causes difficulty in appointment making and keeping.

B. The value of preventive medicine is not strongly established among the poor for they seem to use the clinic only when quite ill. This is especially true of the males.

C. Many community residents have the belief that "if it's free (the medical care) it is no good, it's second rate." This helps propagate a double standard of health care.

D. The low socioeconomic status of the poor presents problems itself, regarding nutrition, sanitation, clothing, et cetera.

E. Some people have the attitude toward illness that you just bear with it. "For example one lady suffered from severe joint pain, thinks she has arthritis, but won't go to the doctor, and she happens to be one of the few people who like Denver General Hospital."

F. There seems to be a fear on the part of the poor of uniforms and professionalism—language, mannerisms, et cetera.



Chapter 2
The Student
Reports

SOME ASPECTS OF COMMUNITY ORGANIZATION

The papers in this chapter convey a spectrum of individual experiences and philosophies relevant to the involvement of SHO, DRMP, or any predominantly white group in ghetto communities. They express a deep sense of urgency and frustration. This cannot be taken lightly in view of the social disorganization witnessed firsthand by these students, and the realization of our own impotence in confronting even the smallest of problems in a 10 week period.

A recurrent theme here, as in other parts of the report, is that we can justify our existence in ghetto areas only by demonstrating concrete changes produced as a direct result of our presence. This may be a shortsighted point-of-view. Ultimate justification for these projects may lie in future changes in the health care system based on the insights, personal growth and firm commitments established now as health professional students. These are presented below. . . .

Ida Jean Newton is a Junior at Women's Medical College of Philadelphia who worked with the Mariposa Health Station on Denver's west side. The paper deals with problems relevant to community organization: defining a "community"; identifying its problems from both community residents and community service centers; and assembling community people to discuss these problems. A basic axiom in our attempts at community organization is alluded to in the last paragraph: That meaningful change must be initiated and carried out by the people whom it affects. The question of whether SHO should even be involved with community organizing projects is dealt with at length in chapter 4.

Ida Jean mentions the methods used by SHP in an attempt to improve conditions of a neighborhood pool. The situation was described more fully by Steven Berman:

A very real medical problem was recognized by the high school interns who complained about the state of the neighborhood swimming pool. Some of the problems included abundant quantities of glass and trash in and around the pool, no soap in the showers, and a faulty chlorine system. The Mariposa clinic sponsored a community meeting during health week on the pool problem and invited the director of Parks and Recreation to attend. The important feature of the pool controversy was the insight certain members of the community, especially the high school interns, acquired in the importance of documenting a problem and confronting the establishment through political and direct channels in order to get action.

Webster defines community as a "body of people having common organization or interests or living in the same place under the same laws and regulations." On the west side of Denver the latter part of this definition is most applicable as the area is notable for its lack of organization. The residents of the area are just beginning to get together to discuss the problems of common interest, an activity which will lead to a more structured community. At the present there is, on the whole, little communication between neighbors about matters of concern to the entire community. The basic unit is that of the family rather than that of a block or neighborhood.

It is difficult to introduce the concept of organization for the purpose of bringing about desired reforms because this has never been done here, and people must be convinced that they have the power to change things.

The problems which an outsider with ideas of community organization dancing in his head faces when he begins work on the west side are many. How does one actually identify the problems of the community rather than starting work on a project which one feels needs doing but in which the neighborhood is not especially interested. It takes quite a bit of talking, both to the members of the community and to the power structure which purports to be working in the interests of the community. This method is very slow and unless one has already established a rapport with the people, one runs the risk of being very politely yes'd to death on all actions proposed. Organizing the people around one's own goals may be more fruitful if one has been able to ascertain who the leaders are who are both closest to the members of the community and respected by them. This requires time spent around agencies listening and watching who is listened to. The summer worker can then do the leg work for projects for which the busier agency members do not have time.

The people of the community, of course, play the most vital role in identifying which problems are the most acute and in organizing to solve them. How does one meet the members of

the community? For the purposes of community organization, it is probably best to be affiliated with one of the local agencies which is well liked rather than, say, meeting people in the park. For instance, being able to say one is from the Mariposa Clinic opens many doors.

After one has both informed and been informed by the community about problems and actions being taken to solve them, there is the difficulty of actually getting people together to discuss possible solutions. They are not accustomed to and probably do not like to attend meetings, and have a tendency not to show up when one is arranged. This may be solved by several reminders and providing transportation even to those who live very near. Also, what form is the meeting to take? Should it be large and advertised by posters which may or may not be read or should it be composed of a small group of friends and relatives who will, hopefully, later spread the message around?

Both methods of getting members of the community together have been used to discuss two of our summer projects: (1) The problem of uncleaned swimming pools in the ghetto area; (2) setting up a cooperative store. The necessity of improvement in both these areas was discovered by talking to members of the community and the power structure. People in positions of authority with knowledge and influence in these areas were found and meetings were scheduled. In the case of the pool, official notification was posted at the various agencies; people went door to door to inform the community. Rides were offered and people were reminded again the same evening. This brought the desired result of having people from the neighborhood attend a meeting with city officials. An earlier attempt, in which transportation was not offered, failed.

A meeting for the co-op store was planned on a smaller scale with a nucleus of friends and family of people in the neighborhood and some interested officials. The store had earlier been discussed in smaller groups in people's homes. The second attempt, when rides were offered, proved a success.

If these projects succeed in attaining their goals, and others of vital interest to the com-

munity are planned, the people themselves will begin to initiate positive action.

IDA JEAN NEWTON.

Jim Pacht, a second year law student at Berkeley, was placed with the West Side Action Center in Denver. As in the last paper, these excerpts again deal with the frustrations of defining and relating to given "communities." The role of SHO in bringing people from these areas together with local agencies is mentioned. This has been a most productive and effective aspect of many of the projects this summer—particularly regarding health care facilities and health care "consumers." Much concern has been expressed in our discussions as to whether "agencies," as suggested here, should be in our base of operations. This is dealt with in other parts of this report.

HOW CAN I DO SOMETHING?

If you are going to work for a summer in a "poverty area," you will ask this question often. Hopefully, my comments, based on 10 weeks in the west side in Denver, will be of assistance.

To work on the west side you must know the people. The blood is a mixture of Spanish, Mexican, American Indian, and Anglo. They are a people unique to New Mexico and Colorado who are searching for an identity—Spanish, Mexican, or something different. "Spanish" is the safest name, but some prefer "Mexican." Better yet, don't use labels. These people are much like anybody else. They are *individuals*—many are intelligent, some aren't; some are fine fathers, others beat their wives and children; some are hard-working, some are lazy. And all are different from each other.

Words are all important in college, but they don't mean much in west Denver. Many agencies, "militants," and others have made promises and broken most of them. Few will seriously listen to anyone with an idea. "Why waste time" is their idea. It is said that people on the west side and in other "poverty areas" are apathetic. This is inaccurate. The young people with steady jobs—the potential leaders, leave the west side because there are better places to raise families. Many people in the west side have too many personal worries—large families, intermittent employment, debts, et

cetera. Many don't feel that anything can be done or don't know how to do it.

Knowing the people (wherever you are) won't change anything—it's merely a prerequisite to do anything. Before you can do anything, you must learn what is going on, who is capable and who isn't, and what are the genuine problems and issues. Do this at the beginning of the summer so that you have time to accomplish something. Don't jump to conclusions about individuals and issues; you will make a fool of yourself. Remember that the interests of any community are divided—single teenagers do not have the same problems as parents of large families.

You should work with people in the agencies and in the community who are capable of helping the community. You can't do much without them and someone must carry on when you leave. You may find capable persons who know the community but don't know the system, and persons in agencies who know the system, but not the community. Get these persons together; they will be much more effective. You can teach a little about the working of the system, but you don't know much yourself. Be wary of feuding factions in the agencies and in the community.

I have found that the "good people" in the agencies and in the community don't have much time. The agency people are swamped with day-to-day work, and the potential community leaders hold jobs and care for their families. Maybe these persons have some "pet" projects which they don't have time to begin. Maybe you have an idea that people like, but don't have time to initiate. Health science students could lay the groundwork, get the information, do the legwork, and leave something for somebody else to continue.

JAMES PACHL.

Jerry Yucht, a sophomore medical student at Wayne State University in Detroit, poses questions which might serve as an introduction to the discussion of our role in "ghetto" communities presented in chapter 4. He suggests here that the "needs" for the project were largely our own, in terms of self-education. "It is a near certainty that no one on the west side would have perished

in the absence of the Student Health Project." He examines our roles as "patient advocates" and community organizers, and concludes that in some instances we were useful in these capacities.

A QUESTION OF NEED

A few weeks ago I was asked by a doctor who has considerable interest in the activities of the Student Health Project if I thought there was a need for such a project here in Denver. He put some emphasis on the word need in the phrasing of his question, which meant that I would have to do some deeper thinking than was usually required in answering questions about the project.

Does Denver need the Student Health Project? The issue of need is one which is related to the stated purposes of the project, these being: (1) service to the community, and (2) educating ourselves about the problems in the communities in which we work. But it is not a word used often, if at all, in justifying our presence in Denver for the summer of 1968. My first impression on arriving in Denver was that the system of health care delivery is remarkably advanced and well organized, compared to Detroit where I came from. I had brought with me some vague ideas about working on development of facilities along the lines of neighborhood clinics. But the prior existence of the Neighborhood Health Centers and Stations indicated that the city had already made the commitment to such facilities. The need in this particular area, then, no longer existed and it became necessary to identify some other problems for which the project was needed.

After a short time on the west side, which is composed mainly of Spanish-Americans, it was seen that one kind of need was that of personal concern for individuals, families, or small groups. It is a near certainty that no one on the west side would have perished in the absence of the Student Health Project. What is less certain is that the several individuals and families who were directly assisted by project members would have managed to get through some difficult situations as quickly or efficiently. People were helped in getting medical assistance, helped in moving, taken shopping, and helped with legal problems in many

cases by project members. But was this sort of need justification enough for our presence? Is this evidence of community need great enough to bring 30 students, most of them new to Denver, into minority or disadvantaged areas of the city? I think not, since many of the problems dealt with by project members could probably be handled by community people trained in these areas or by existing agencies in the community, if they had adequate staff and the desire. It is possible that this kind of personal service could be provided by others on a long term, continuing basis; in this capacity we have served to fill a gap between what could be done and what is being done. But in filling the gap we have gained insights which could not have been otherwise acquired.

In addition to services rendered to individuals or groups, we helped in the initiation of projects which were designed to involve people of the community on a continuing basis after our departure. The two swimming pool projects are examples of this kind of action. The problem itself, in this case inferior swimming pools in project areas, was not necessarily of earth-shaking importance. What was important was the involvement of community residents in the solution of the problem, demonstrating that city agencies will respond to demands made by groups of the poor if they organize. But again the question of need. Did the west side of Denver need the Student Health Project to initiate these kinds of actions, or were the vehicles already present in the community? It seems that in this area of the city there are agencies, such as the Action Center, which could provide the impetus, but for reasons of lack of staff, or initiative, or cooperation the community remains unorganized. Again, we tried to supply some manpower and ideas to fill a gap. Unfortunately, it became painfully apparent that 10 weeks was not enough time for implementation of the grandiose schemes some of us brought to Denver to solve problems real or imagined.

We might have been more effective in community organizing if we had defined our goals more specifically and at an earlier date; this might have resulted in our interns having a

better idea of what we were doing in their communities, as well. The problems we have been exposed to may be even more trying than that of convincing government and medical profession to make the commitment to comprehensive community health care. I was educated about the problems residents face in dealing with welfare, food stamps, prescriptions, transportation and a myriad of problems relating directly or indirectly to the use of health care in Denver. To better deal with these kinds of issues we might use this summer's experience to call on only those agencies which we have found truly responsive to community needs in the future.

The real need, it seems to me, was actually ours, not the community's. We needed educating, and I think that all of us got an education. It is a very real possibility that what we have learned this summer can be passed on to our successors in Denver, as well as put to use in our own cities. This benefit can be multiplied if we follow the persistent advice of our black associates, that is, "go home and spread the word!" With the knowledge that 10 weeks time is not enough to accomplish much of any great import in the community, we can work for local Student Health Organizations along with existing community agencies and organizations, and be more effective. The summer projects could then be continuations of year-round efforts, concentrating manpower and energy on problem solving, as well as using the project as an in-the-field classroom in community organizing.

The most pressing needs of the summer were ours, since we were the ones to whom the problems were alien. Hopefully, the education received this summer will make us better equipped to deal with needs as they exist, and not as we perceive them. It was necessary for us to be here this year in order to deal with the needs of the community next year.

JERRY YUCHT.

Joe Bergquist is a junior medical student at the University of Colorado who spent his summer in west Denver. He again examines the "need" for summer projects, but here on a more intrapersonal level. He concludes, "I don't need the false satisfaction of doing something for a person which he could and should do for himself."

"WHAT CAN I DO FOR YOU?"

I spent the summer of 1968 working with the Student Health Organization in Denver. Ostensibly, we were to work in the poverty areas of Denver trying (1) to understand health problems of the area; (2) to recognize the communications problems between the poverty people and the power structure; and (3) to stimulate these same poverty people to organize themselves into a community body which would, itself, gain desired health services for its area.

Most of the first month was spent trying to understand the existing conditions of the area, which, in my case, was predominantly a Spanish-American area served by Mariposa Health Station. It should be noted that to truly understand the problems, one should probably live or at least work in the area he is studying for several months, which for me was impossible. It did not take long for the bad side of the establishment to raise its ugly, deaf, blind, and ignorant head. One would have to be almost totally impervious to external stimuli to fail to recognize the desire by the establishment to attempt to maintain its role as the father or perhaps benefactor of the poor. The attitude I ran into time and again was what I can do for you. This attitude is one of the very concepts which guarantees that the people in the ghettos will remain in the ghettos. A further extension of this attitude is the objection to "letting ignorant people run their own lives and handle their own problems."

Frustration became the rule, not an occasional happening. Projects are not set up in a month. Friends are not made quickly among people who have been shot down for so many years by the so-called liberals. In fact, some people will not accept friendship, no matter what. Some people may say friendship is not important. It is. Believe me. To me one major aspect of friendship is the necessity for letting my friends do for themselves. I don't believe a friend is one who will not allow a person to develop self pride through personal achievement. I don't need the false satisfaction of doing something

for a person which he could and should do for himself.

JOE BERGQUIST.

Nancy Adams is in Social Service at the University of Colorado Medical Center. She spent the summer in Grand Junction and Fruita setting up an "Aftercare Program" for patients recently discharged from psychiatric hospitals. This is described in some detail below. She mentions, ". . . the fine line between motivating people to act for an ostensibly good cause, and pushing people into something you are convinced is good." This became an issue of frustration to many of the students and should be of great concern to any group planning "community based projects." It might be construed as an argument for expending a great deal of initial effort toward just talking to community residents and in this way becoming attuned to *their* problems. However, she states that the first 3 weeks in Grand Junction were spent ". . . like dogs chasing their tails—madly circling and finding no direction. . . . inexcusable." Still, in the period of 10 weeks Nancy developed a well-constructed program which will continue in her absence. This question of structured versus unstructured situations was a subject of much debate in the planning stages of the project. A logistic issue finally settled the matter; although the grant proposal had been in Washington since February, final funding came on the first day of orientation. To offer our presence and then not be able to follow through would be another case in the communities' files of *promises not kept*. In addition to this, it was felt that much of the time in the first year of these projects must necessarily be spent in "learning the communities." A major point here is that the communications which we have established this summer must be continually built upon during the year. This would provide at least a sense of direction for future projects. This point was discussed in our final evaluation session:

The only point that I am trying to bring out is that I think you have to decide once you are in the community, not before, what its real needs are. I don't think you can go in and say we have a project in mind where we could analyze the user of the neighborhood health centers as compared to the nonusers, and we are going to devote all our energies to that. I think we have to go in and find out from the community what the problems are and what the community thinks.

AN IMPRESSION

The first 3 weeks in Grand Junction were mainly ones of frustrated confusion. Skip, Jeff and I were like dogs chasing their tails—madly circling and finding no direction. We began to

follow each other around—a real trailing syndrome which produced three people anxiously peering in corners for places and ways to get involved. Thus, the most important criticism I can make of this project is its lack of organization before bringing people into the community. I realize time was limited in being able to prepare for this project, but in the short amount of time we had to spend in the areas, to waste a good third of that was inexcusable. Sure, the idea for us to come into the community to learn, to create our own jobs, sounds good in theory, but may lead nowhere, depending upon the community and/or the individual. Project people must realize that lack of structure so as to allow room to move, to tap all that potential creativity, is not and should not be mutually exclusive with having definite, structured plans for action. It took us 3 weeks of relative inactivity to discover that Grand Junction is a very conservative, “don’t rock the boat” type of community. But, is it necessary to take 3 weeks to learn a lesson as basic to a small rural community as that? So the alternative is simple. Rather than getting vague promises from kindly people, such as a welfare director, which quickly evaporated into, “We’re *very* busy this summer with the budget,” et cetera, get specific things which each student can be involved with. The student could spend as much time with that as he likes and still have ample time remaining to exercise his own creativity in other areas. Now, as I’ve said, my first 3 weeks were frustrating, boring, purposeless. Basically, I felt unessential, and that wounds one’s ego, but perhaps a necessary lesson.

Then, I stumbled quite by accident on to the Mental Health Association. These people, the executive director of the Mesa County Mental Health Association, and the psychiatric social worker who is the liaison person between Pueblo State Hospital and the western slope, were in marked contrast to most others I had spoken to in Grand Junction. Their attitudes were the reverse of keeping the status quo. They were eager to change and improve and have new ideas. How could I pass up an opportunity to work with them? . . . especially when Skip’s, Jeff’s, and my jobs tended to overlap when we worked with the same people through

the same neighborhood center. So, by a simple rationalization, I decided I could be more effective working alone and with mental health. Besides, it is the field I intend to enter and it’s health related.

The after-care program here was terribly inadequate for ex-mental patients. The only half-hearted attempt made at rehabilitation was to herd them in weekly for a crafts class and “ladies from the community” would serve refreshments before they were herded back home. Lovely! Most of them had retained the institutional style of life, which is basically antilife, and continued to be completely withdrawn. Many lived in foster homes whose operators encouraged this due to their own psychological needs. The result was a zombi-ish atmosphere that was just too tempting for many of those who wished to withdraw from the living, real world, which may not be such a bad idea with America in its present condition.

But not working under that assumption, I set out to see if aftercare could be changed. And here came my first real lesson—there is a very fine line between encouraging and motivating people to act for an ostensibly good cause, and in pushing people into something you are convinced is good. In wishing to convince others of this, you stand the chance of alienating them. It takes a sort of sixth sense to know when to approach a person and how to approach him on his own, individual level, and make him accept your way of thinking. It takes time and I’m still learning, but this seems to be the essence of getting things changed. It was essential that I not alienate the foster home runners for they were the ones responsible for getting their people out and involved. My initial hostility against one foster mother who babied her people and encouraged them to be totally dependent upon her, had to be hidden, for I needed her help. (I never did get it, to the extent that I had envisioned.) The second lesson I learned was that maintaining high ideals while being involved is unlikely and may be more detrimental than helpful.

Setting up programs was a unique experience for me. Major support came from the Mental Health Association and from a zealous, reforming type of woman who had been a mental

patient herself. She and I spent time contacting the ex-mental patients in Grand Junction and Fruita and I started weekly meetings in both places. The goal of this type of group is to provide a place for companionship and social interaction and to motivate them to take increased amounts of responsibility for themselves. The group was theirs. They decided what they wanted to do (it was mostly recreational) and I tried to be as nondirective as possible, though I offered suggestions when I felt they were needed. The Fruita group went so well that I opened a biweekly canteen program in the recreation center donated by a priest.

These groups and canteen programs will be continued after I'm gone. Plans are being made to get directors and volunteers. Mesa College provides great potential for volunteers which has not been tapped. In working with a similar group in Boulder, we found college youth could add a good deal of warmth and enthusiasm to a group such as this. I met with several people from the faculty and they were eager to begin recruiting in their classes for volunteers. The canteen program will hopefully be the precursor of a day-care program when the Mental Health Center is built in Grand Junction. They hope to have the funding approved next year.

It has been gratifying that I began something which will be continued. The aftercare program would have been revamped anyway, but the opportunity to develop something myself provided a good learning experience. And what I did learn was mostly about myself.

NANCY ADAMS.

Charles Holt's placement was with Denver's West Side Action Center. The paper examines the success of the project with respect to (1) education of ourselves and the middle class community, (2) community organization, (3) improvement of health care for the poor, (4) individual crisis solving, and (5) the development of the high school intern program. As in the last paper, he mentions the frustrations of a relatively unstructured situation. The discussions of the project's encounters with the American Cancer Society and the conclusion that "perhaps our job is, as our black friends have repeatedly told us, in spreading the word to the white middle class community" will be a major consideration in planning next year's project. The aspect of the project concerning crisis solving is criticised here as

being "more like holding actions than definite solutions." This is in contrast to the next paper where the idea that such activities are important parts of our function is developed. Charles is a junior medical student at the University of Colorado.

SHP—A CRITICAL EXAMINATION

The purpose of this evaluation, presumably, is to examine the values of the 1968 Colorado Student Health Project. In order to term it a success or failure, it is necessary to look at the original goals of the project and to determine whether or not they were reached by the end of the summer. This task is made doubly difficult by the fact that these original goals were, at least abstract or unclear ones and, at most, nonexistent ones. All was not lost, however, for in the course of the summer certain goals were at least approached, if not attained. Others were recognized which had little hope of attainment. The latter were more numerous.

In discussing each of these goals and the success that each enjoyed, I must confine my evaluation to my own experience and not that of the project as a whole. I see five goals worthy of discussion. The first of these was the education of both myself and the middle class community. The former has been rather successful and the latter I think rather unsuccessful. My own education has been not so much in the reality of poverty (although, what I already knew of poverty has been indeed brutally exemplified this summer) but more in the culture of the Spanish-American people, a culture which I feel is analagous to that of the American Negro 20 years ago. That is, a culture characterized by subordination, passivity, and apathy. A culture not lacking in heritage, but in pride of that heritage. This is changing with the Negro, and presumably will change with the Spanish-American, given time.

The education of the middle class community has not gone so well. A notable example is that of the American Cancer Society. The American Cancer Society came into the Chicano and black communities of Denver this summer with a program of education about cervical cancer, followed by free clinics to give Pap smears. We offered the advice that they should enlist paid neighborhood people to distribute the educa-

tional information throughout the community—an idea about which they originally showed much enthusiasm, even to the point of vague commitment. They later claimed that they had no funds for this purpose and were therefore unable to meet this commitment. *However*, they would be able to enlist the aid of middle class housewives to canvass the poverty areas to try to convince the local black and Chicano women to have a yearly Pap smear. This copout unfortunately (but predictably) alienated most of the community workers with whom they already had contact, including this one. It is places like this where I think we can do the most good. The cancer people can't learn from the poor community because not only are they on a different wave-length, but they aren't even in the same ball park. And while we, hopefully, aren't on the cancer people's wavelength, we are from their side of the tracks and regrettably speak the same language. So, perhaps our job is, as our black friends have repeatedly told us, in spreading the word to the white middle class community.

The second goal was that of community organization. We have been moderately successful in this effort. I say moderately successful because several early attempts at having community meetings to discuss this or that problem failed dismally, while the last attempt was pretty successful. This last meeting was to discuss the health problems at a neighborhood swimming pool. Many neighborhood people presented grievances about the pool facilities and management, which were loyally, but not justifiably, defended by a director of the Department of Parks and Recreation. A committee of interested citizens was formed to carry the problem further. They did so, and the city cooperated by granting many of their requests. This to me was one of the high points of the summer.

The third goal, and presumably that at which this entire project was aimed, was the improvement of health care for the poor. It is paradoxical that this is the goal that we are probably least able to achieve. This is true because as mere medical students we have no authority to meaningfully participate in the health care of the people we are here to serve. What we can do is to either suggest to the existing health per-

sonnel improvements that should be made, or to suggest to the people receiving this health care that they demand these improvements. Which of these courses to follow obviously depends upon the circumstances of the particular situation; after considering the circumstances surrounding the pool, we chose the latter method. So in this case, at least, the goal of health care improvement is contingent upon attaining the previous goal of community organization. This latter goal was successful and I think the former will be too.

A fourth goal was the solution of individual crises. The instances in which I was able to help were successful, but they seemed to be more like holding actions than definitive solutions. As a result, I felt less effective in this capacity and spent more time working on collective projects than individual ones.

The fifth goal was to stimulate our high school interns to continue in school and perhaps into health careers. This goal has, in my estimation, been the most successful one of the summer. Several of the interns have been "stimulated" I think, and are anxious to go on to college. We are presently in the process of trying to obtain scholarship funds for them. But beyond this, and perhaps even more important to me, is the rapport we have established with these kids. One of the most valuable relationships that I personally established this summer was with the intern that I worked most closely with. Most importantly, I feel that these young people are really the only hope of the poor community.

CHARLES HOLT.

Steven Berman is a sophomore at Temple University Medical School. In his paper he discusses the community service and self-educational aspect of the project. He points out the importance of becoming analytical of the directions we are taking and suggests methods for this analysis with regard to his own placement, the Mariposa Health Station on Denver's west side. He finds the role of individual crisis solving quite relevant; it is seen as the first step toward developing "individual power" which can then be mobilized into community action. This role can also take responsibility from the very competent community aides whom he found, and allow them to devote more time to organizing which is certainly more their legitimate function than ours. Al-

though the Mariposa Health Station was found to be an ideal placement, he advocates using caution in working with the community agencies before learning the community's perceptions of them.

A QUESTION OF RELEVANCE

I worked at the Mariposa Neighborhood Health Station on Denver's west side, which is predominantly Mexican-American. This station enjoys a very good relationship with the community. Larry Sena, a high school intern, and Vi Madrano and Rose Uruste, family health counselors, helped me greatly by patiently explaining how the neighborhood people perceive their problems. They allowed me to make home visits with them and introduced me to many people in the community. I was thus able to distinguish between problems created by my intellectualizing and the real problems of importance to people on the west side.

As a first year medical student I realized that my "service" to the community would not involve direct treatment. If my contribution were to be medical it would have to involve other areas of comprehensive medicine, prevention and rehabilitation. It is important to recognize that the patient has a passive role in the treatment phase, but an active role in both prevention and rehabilitation. The active role can only be assumed when the individual develops the power necessary to control his environment to some extent. Many low income individuals are forced into a "passive" existence as most decisions which concern their lives are made in the end by others such as welfare workers, creditors, nurses, et cetera. Their passive, crisis-to-crisis style of living must be broken in some manner and the individual must gradually make some of the decisions which affect his life. In this way he can gain power in his environment and learn to budget his money, provide adequate nourishment for his family and develop work habits.

Prevention does not concern only the individual but the entire community, and therefore, the community must become an active organization rather than a group of fragmented, passive recipients. SHO should strive to help "passive" individuals break their crisis-to-crisis life style, to assume active roles and also

help create or revitalize community organizations, which expand the power of the individual.

The Neighborhood Health Station and the Mexican-American family health counselors provide a good avenue for stimulating change in an individual's life style. Bonds of trust are built between patient, family health counselor, and doctor through which the patient can be taught to cope with all of his problems better—not just "medical ones." I worked with family health counselors and developed a good relationship with two families. I also tried to obtain a realistic overall view of the role interaction between the clinic (especially the health counselor) and the community.

There is an important role the student can play which many during the summer rejected as "band-aid solutions." It falls in the area of comprehensive medicine which I call "holding action." It concerns people who are totally helpless and realistically unable to develop the power to function adequately in society. Since these individuals can never assume an active role, one is actually involved in providing institutional type care. Such families consume a great deal of the family health counselor's time and energy. The health science student can substitute for the counselor with these families during the summer and free the counselor to devote more time to those who have the ability to change their life styles. Indirectly, SHO can provide a great service to the community in this manner.

The Student Health Project can also be the most important educational experience of any health science school career. It can provide the student with the opportunity of dealing with the most crucial problem American medicine faces today—how to deliver good health care to inhabitants of low income areas. In order to approach the problem, the student must develop the means to observe accurately as well as participate in the normal life style of the poor. But how can a student in 2 months understand a basically foreign life style and community? The most important thing is to live in the community. One can then walk to work to obtain a feeling for the physical layout and natural boundaries of the community and most important become known to the residents. One should

shop in the area and become acquainted with local merchants and their attitudes. Learn how the different local agencies are perceived by people not affiliated with a given agency. It is important to be certain of the image of an agency in the community before one associates himself in any way with that agency.

There are many questions relevant to health care delivery which can only be answered when the life style of the people served by the clinic is understood. How many meals are eaten a day? What are the common measuring devices used in the home? i.e., a teaspoon of medicine may mean a tablespoon. What emotions do uniforms and white coats generate in the people of the community? What are the barriers which exist between the health professional and patient which prevent meaningful communication? How important is it to always have the same doctor—"your doctor?"

A good example of how a phenomenon common to the poverty area has practical medical importance is the relationship between "Mother's Day" and medical appointments. This phenomenon recognized by the family health counselors relates a high rate of missed appointments to the days surrounding the arrival of ADC checks. Just prior to the day the check arrives (Mother's Day) the men return home to try to obtain part of the check. The women being very lonely for companionship in many cases accept the man's presence and appointments become unimportant or forgotten. I observed this same phenomenon when I discovered that the local dancing club always had its biggest day the weekend closely following the ADC check and the men were obviously trying to hustle money from the women.

A physician should not merely be a technologist and scientist but an artist as well. These three sides of the medical profession have been identified in slightly different ways by the people of the west side. The technologist is labeled a "do-gooder," one who undertakes certain tasks without taking the time to discover their implications or if, in fact, they have any value at all. The scientist is the aloof, detached observer who has become known as a "brain picker" exploiting the poor without any concern for their lives. The community has had abun-

dant exposure to both kinds of people. Only the one who communicates his concern for other human beings is accepted on the west side. Honest communication of feelings in a manner which can be understood and respected is an art, and one who can relate to people in this way is recognized as a brother. I believe that too much emphasis in medical education is being placed on becoming "do-gooders" and "brain pickers" relative to learning to relate to others as "brothers." The realization of this inadequacy in our medical education has led me to believe there is a need for similar experiences in community medicine to be incorporated into medical school curriculum.

STEVEN BERMAN.

Steven Feig is a sophomore student at the University of Maryland School of Medicine. Through his placement with the East Side Action Center he was exposed to many aspects of the black-white communications barrier mentioned above. Excerpts from his paper amplify this problem.

"WHAT WE HAVE HERE IS FAILURE TO COMMUNICATE"

... Unfortunately, little effort in the area of direct communication is being made. In a recent incident, a Parks and Recreation Commissioner of Denver stated that he had been looking for 12 years to find qualified black lifeguards to staff an area pool. He even had announcements made over the public address system of the predominantly black high school. However, no one applied for the jobs. The students, knowing the "system," really didn't believe that they would be hired. They had heard promises before. It was not until we organized a group of poverty mothers who were concerned about the city's lack of concern in keeping the ghetto pool clean that the difficulty in finding black lifeguards was brought to the attention of area residents. Within a week, a list of qualified black lifeguards was presented to the Parks and Recreation Commissioner. In short, it was only a matter of contacting the people involved. But, the commissioner and his department never thought of it. After the meeting some of the tension was out of the air—the city

had a better feeling of the people's needs and the residents came to understand that the city, too, has problems.

Sometimes, the "establishment" does go out of its way to communicate with the Negro community. They seek out Negroes for the Bi-Racial Committees and Civil Rights Commissions. And if there is any pressing community problem involving black people, they look for a Negro with whom to speak about the situation. Thus, they make two mistakes in their efforts for a dialogue—both of which are fatal to the course at hand. The first mistake is that it is the white power structure that picks the Negro to represent "his people." In this case, the blacks haven't even received the benefit of a democracy to pick their representatives for negotiations involving themselves. Most often, the Negroes picked to represent the black community are those with ideas similar to the ideas of the "establishment." The white man picks people who tell him what he wants to hear instead of what actually exists. While the white man is patting himself on the back for his progressive, benevolent attitude in instituting these dialogues and for making great inroads in race relations, the town explodes around him, eroding some of his power. He is dumbfounded.

The other mistake, perhaps even more easily made, is the exclusion of black people from all dialogues that do not involve them directly. Black people know that they are never called upon to offer their opinion on things that concern the whole city and not specifically Negroes. They know that their opinions are not needed or wanted and consequently, they are again made to feel alienated in their own home city. This, too, contributes to the upheavals in our cities today.

It might be said that one of the most pressing needs of the American society today is an encompassing exchange of information involving all its segments so that each can better come to know and understand the needs and problems of the other. We need to communicate so that we can be acculturated enough to live with one another and so that we can be enlightened enough to see the causes of the existing poverty culture. This would then enable us to work

toward the eradication of the foundation supporting poverty.

STEVEN FEIG.

Marylou Buyse is a junior medical student at Women's Medical College of Philadelphia, who worked on the west side of Denver. Most of the projects this summer were developed as loose affiliations with community agencies. Here, Marylou presents a project model of problem rather than site orientation. She worked directly with the residents of a community, calling on numerous agencies only where they could be expedient in the problem solving. This same type of project was discussed in the final evaluation session as follows:

I think that what we are talking about is places to work with, not places to work in. I think that is one of the things that has come out, we should be working *with*, not working *in* or *under*. . . . I think we should organize around issues rather than agencies. It may take 1 or 2 weeks to identify the problems, those which may have changed or arisen during the year. After we have identified these problems, we should regroup and work around issues. If you take one issue, you might have to deal with all the agencies in the area on it. We should be coordinating the agencies; there should be some kind of link and also be a continuity.

Marylou also discusses the physical immobility of the "west side" as well as the subsequent exploitation of its residents—particularly regarding food pricing. The establishment of a cooperative grocery store seemed a reasonable solution to this problem. At the time of this writing, the West Side Action Center has set up the organizational framework for the co-op and is using students from the University of Denver as researchers of information for obtaining funds. They plan for most of the money to come from the Small Business Association and, for this reason, have to call themselves a corporation, although the co-op will be of and for the community. They expect to be able to train community people as clerks and managers so that they can obtain jobs in other stores. Presently, a credit union has been established on the west side and is proving successful.

**"WHEN IT COMES TO FOOD STORES,
THE SITUATION IS PARTICULARLY
ACUTE . . ."**

The west side of Denver is the most isolated section of the city. Enclosed by its boundaries, its people are natural targets for exploitation, deprivation, and neglect. This is evident in the noninclusion of the west side in the Model Cities Program. Its isolation is intensified by the lack of mobility of most of the residents, few cars,

little money, and large families. All of these things tend to keep west siders in their own area. With this in mind as one walks the streets and goes into various shops, most of which tend to be concentrated on or near Santa Fe, it soon becomes apparent that many of these businesses are owned and operated by Anglos, not west siders. Certainly there are some businesses run by west siders, but the fact that there aren't more indicates that something is amiss. It seems that the Anglos come over to their stores or jobs on the west side, make their money, and then take it back with them. When it comes to food stores, the situation is particularly acute. There are only a few small grocery stores in the area, no large supermarkets (Safeway moved and does not plan to return). The stores that do exist are not only mostly Anglo run (this just helps you look for exploitation), but are small and dirty, poorly run and have high prices and low quality meat and produce. When you discuss the shopping situation with the neighborhood women, you discover they are pretty much confined to their home area. They did complain about such things as shortchanging, especially when the children were sent to the store (which they very often are), and the favoritism shown by the grocers to some customers, i.e., some people get charged more than others. (This is easy to do since most items are not marked with prices.) I have been in the neighborhood stores and done comparison pricing and evaluations. The prices are quite high and can often fluctuate even on staple items. For instance, milk is 60 cents per half gallon, while elsewhere in Denver, the prices range from 43 cents at Safeway, to 49 cents in a small store. Meat is not only very high, but generally of fairly poor quality and reportedly can be just laden with fat. You can often find bad meat under a top fresh layer in a package. So, for all these reasons, some change in the shopping situation is obviously needed and wanted. When all factors are considered, i.e., the relative competition, the lack of opportunity for the people to do much shopping out of the area, the lack of a large, good supermarket and the unlikelihood that any large chain supermarket would move into the west side, the idea of establishing a consumers' cooperative seems to be a good solu-

tion to the problem. The establishment of such a cooperative store is even more attractive when it is seen as a source of jobs for men in the area, as a site for job training and a business that will keep money on the west side and return profits to the shareholders. The cooperative can also serve as a bridge to the community organization so badly needed on the west side (so they can exert enough pressure on organizations like Model Cities and not be overlooked again). If successful, the cooperative would not only serve as an additional source of income for west siders, but also would be a source of community pride, a pride in their accomplishment. We have talked to people in the community about the cooperative and have, for the most part, found them to be enthusiastic. Our meetings with them and community leaders have likewise made the cooperative a likely prospect, one that is possible but at this stage presents obstacles. To get it going, enthusiasm must be maintained and more community people must be interested in the cooperative and investing in it. A source of funds must be secured to start this endeavor. And then someone from the community must be found who is willing to organize and get the co-op going. These are admittedly formidable obstacles, our work for the summer is over, and while we have tried to lay some groundwork and spark interest in the co-op, it is now up to the west siders. The co-op is completely in their hands.

MARYLOU BUYSE.

Marcia Looney is a fourth year student at the Francis Payne Bolton School of Nursing in Cleveland. Many of her efforts this summer involved attempts to establish a "community board" to mediate complaints and become involved in the decisionmaking of a general hospital in Denver. She gives examples of the community residents' perceptions of this facility.

Many large city hospitals throughout the country have been ineffectual in responding to the needs of indigent health care consumers. These consumers often confuse the health care received with the mechanics of filling out numerous confusing forms, extremely long waits before seeing anyone, clinic systems lacking appointment systems, the disrespect shown them by certain hospital personnel, et cetera . . . On the other hand, hospital administrators often ignore the consumers' feelings about these mechanics.

COLORADO STUDENT HEALTH PROJECT

A criticism voiced of the SHP in chapter 4 is that our community orientation has directed us toward dealing with the end products of the health care system rather than stimulating basic changes in health care institutions. Marcia's activities are a first step toward this latter type of involvement.

SHO speaks of its role in terms of patient advocacy and maintaining the principles that health care is a basic human right and that all people have the right to self-determination. If we do have a role in ghetto communities, it might be in extensions of the type of project mentioned here. Setting up community boards is only one way in which we can use our leverage with our own health care institutions, still acting as patient advocates. Other areas of involvement might include insuring that paramedical employees come from the communities served, and that our schools put out more health professionals from minority groups. Only in these ways can health consumers feel that the facilities are really theirs and begin to relate to them in a positive way. The implications of these measures to better health care delivery are obvious. This whole question is dealt with in more detail in chapter 4.

PROFILE OF A GENERAL HOSPITAL

A large, red building of unimpressive architecture sits on the periphery of Denver's west side. Sometime in 1969 the area is to be blessed with a new building which should be quite beautiful. But a building, after all, is only to contain an operation. And the operation of this hospital seems to leave something to be desired.

It is one of the most hated and feared institutions in the city of Denver. Many people say they would not go there even if they were dying. Stories abound of the atrocities committed there. One may hear tales of a girl who lost an eye because of slow service in the emergency room; of a boy who lost the tip of a finger because grafting was not performed promptly; of people dying and being left in their beds all day to be finally dumped in a sack and carted out; of a woman being called a "dirty Mexican" by someone in the collections department.

One of the biggest complaints concerns waiting, especially in the clinics, emergency room, and the pharmacy. I attended the clinic one day with two patients whose appointments were for 1 p.m. The inside of this institution is painted in gloomy, hospital green. The clinics are squeezed into two hallways. There is one waiting room consisting of several rows of hard, straight-backed wooden benches. As one lady

said, "You feel poor just sitting here." One clinic has the reassuring title of "Tumor Clinic." I sat for 4 hours with the two patients I accompanied. The wait is due to the fact that everyone who is to be seen in the morning is told to come in at 8:30 a.m., and everyone to be seen in the afternoon is told to come in at 1 p.m. As we sat for the 4 hours, not one nurse approached a patient, other than to tell him that the doctor was ready to see him. When the patients were finally seen by the doctors, the physical care seemed good and thorough, however.

It seems that this hospital could greatly heighten its community image if it improved upon two things: (1) If waiting time in the emergency room, clinics, and pharmacy was shortened, and (2) if the staff, particularly the administrators, developed a more sympathetic and helpful attitude toward the people they serve.

When the new hospital is built, the clinic appointment system will be changed. Computers are being used to set up hourly appointments. However, according to a sociologist associated with the hospital, the clinic problem could be alleviated now if organization was improved. He stated that an efficiency expert drew up a report on the outpatient department and found that with organization of the staff's use of time, there would be no need for the long waits. Reportedly, the hospital's administration will not make this report public.

Reports from the community of malpractice and poor judgment by doctors is a very hard thing to prove. Professional ethics would stand in the way of any validation of those charged. It is also more probable that these feelings in the community are more a result of lack of adequate explanation to the patient of his diagnosis and treatment in terminology he can understand. The patient misunderstands what can be done for him and what is being done, and, as a result, feels he has not received adequate treatment.

It is my feeling that the staff needs education, and that regular staff conferences should be arranged, probably through the Social Services Department. This same department has arranged such conferences at Colorado General Hospital where a group of fairly verbal ADC

mothers talked to the staff. In order to try and effect some change, we decided a health committee from the community that could work with the administration would be the best solution. In this way, the community could help itself instead of us doing the work for them. We discovered that the Model Cities Program, one of the most active grass-root organizations, had such a committee already formed. The idea of working with the hospital was presented to them and they were most enthusiastic. A meeting between SHO, a representative of Model Cities, and a representative of the hospital was arranged. The hospital's chief administrator stated that he would be glad to meet with Model Cities anytime they had proposals. We informed him that Model Cities could work for the hospital, too, by doing studies of the community, such as, why people fail to keep appointments, or by imparting information to the community concerning any changes in the hospital thus improving this hospital's public image.

Therefore, it is left up to Model Cities to do what they can. I think they have the potential to develop into a strong pressure group. I feel that pressure will be necessary, since groups have previously presented proposals with lack of results. Model Cities is a new committee, and they have been mostly involved thus far in their own organization. But they are a group of intelligent, enthusiastic people, who seem to have the ability to organize the community to bring pressure to bear on this institution. Hopefully, SHO will be able to follow up on the committee's activities during the coming school year.

MARCIA LOONEY.

Bill Walker is a sophomore medical student, and Joe Sprague, a third year law student at the University of Colorado. Along with Joe's wife, Linda, they helped coordinate *Mainstream, Inc.*, "... a group of 20 boys—ages 13, 14, and 15,—who formed a corporation for the purpose of doing lawn and garden work," on Denver's east side. The paper deals with many implications of this kind of project, among them, learning the attitudes of the "white middle class" toward these youths and blacks in general, while at the same time giving the boys "... a glimpse of other life styles."

The last paper dealt with a strictly health related project. The basic question, "How is my project related to health and medical problems—" has been asked by several other groups during the summer. It was brought up in our final session:

Over the course of the summer I have come around to the idea that the SHO should be more concentrated with "health" problems, and if there are not enough health problems in these areas to keep us busy, then we shouldn't be there. This is my personal feeling. Certainly, there are lots of social problems to be dealt with, but I think there are other agencies to deal with them. SHO should look more seriously toward defining health a little more narrowly than we did this summer . . . stress the importance of health and we can do just about anything. Quite a few people at my placement told us they were glad to have us there, and they had quite a few things for us to do including cleaning up a swimming pool, developing a co-op grocery store . . . They say that next summer they are expecting us and they will have something all set for us to do when the people come in—this will take the load off them and get something done. Should we be doing this? It is better than nobody, but we should impress on the neighborhood centers and action centers that we are a health organization and we would like to work with health problems.

The counter argument is stated by Dr. Bonnie Camp in chapter 4.

THE MAINSTREAM OF SUMMER

Mainstream, Inc., is a group of 20 boys—ages 13, 14 and 15, who formed a corporation for the purpose of doing lawn and garden work. The boys all attend Cole Junior High School on Denver's east side and, therefore, use the East Side Action Center as a base of operations. Our roles with Mainstream consisted of advertising for jobs via news media—free publicity on radio, TV, and in newspapers was easy to get—handling the requests for jobs as they came in, taking the boys back and forth to their work and supervising the jobs, keeping the power lawnmowers and trucks running, handling the finances and helping the boys make up the pay-rolls every Friday.

One of the main problems in keeping the organization running was that of operating expenses. Three power lawnmowers were donated which were in a continual state of disrepair. The corporation purchased two new power mowers, and Public Service Company donated two pickup trucks on which we had to have

minor repairs done in addition to purchasing insurance. Gas and oil expenses were also considerable. Because we had no Federal or local funding for the project, these expenses were paid for out of the corporation's earnings and by selling some advertising space on the sides of our trucks to local businesses.

The boys voted to keep 60 percent of their earnings as salary, put 10 percent into savings which was to be matched by a local service club, and use 30 percent for operating expenses. However, to boys of this age, 30 percent of what they made seemed somehow less than \$3 out of every \$10 of their Friday paychecks. We had minor complaints at the beginning which built up to a crescendo by the end of the summer, but we could find no other way to pay for the expenses.

The service club did not come through on their promise to double the 10 percent savings, but we were fortunately able to do this with a small excess left over in the operating expenses fund, so that the boys ended up keeping 80 percent and spending 20 percent for expenses. Ideally, the corporation will eventually be able to cover all operating expenses with advertising money. We were unable to this summer due to delays in obtaining the trucks and the signs (which were also donated to us by Coca Cola).

Mainstream will continue in a limited way during the school year with teachers from Cole driving the trucks to jobs after school and on weekends. We hope to have Denver Opportunity fund us to hire two full-time drivers and one full-time secretary for next summer. With an early start on selling advertising, new equipment should be available by the time school is out and Mainstream should be able to expand considerably both in the number of jobs handled and the number of boys involved.

The value of this project is threefold: (1) It does the obvious thing of allowing young teenagers in need to earn money at a time when it is extremely hard for them to get jobs of any kind; (2) it gives the boys practice in handling their own business and making their own financial decisions—something which was done to a limited extent this summer and which should increase as time goes on and the boys gain more experience (they have learned at least

one lesson this summer—that you sometimes have to invest money in order to make money); (3) an important part of the project is that it allows concerned white citizens to aid the Negro community in a meaningful way—by providing jobs and buying advertising from the corporation, supplying volunteers to take the boys out, and donating equipment. We met many middle class people who were frankly surprised that “those people are willing to work.” We met others who expected the teenagers to be able to do a man's job because they were black—looking at them not as teenagers but as “poor people who need money so why don't they work for it.” Confrontations with these people may or may not have changed their viewpoints but served to make us more acutely aware of the attitudes we are fighting in this society. For what it's worth some people were very interested in the project, invited the boys in for lemonade and cookies and solicited jobs from their neighbors. From the boys' viewpoint it gave them a glimpse of other life-styles.

Mainstream is as unrelated to health and medical problems as any SHO project could be. On the other hand, it is our viewpoint that community health has to encompass many aspects of life and among these are getting jobs and earning money. The boys are also learning valuable lessons in how to deal with the community outside the ghetto, i.e., estimating jobs, asking for their money, selling advertising, etc. Whether or not Mainstream could ever be turned into any kind of activist group is questionable. Boys at this age don't have many interests beyond sports, recreation, and spending money. If they remain together as a cohesive group in the years to come, they could very well branch out into activities other than just earning money. It is hoped that we will be able to follow on into high school those boys who might have talents and interests leaning toward medical or paramedical professions and possibly get them jobs in the medical center.

BILL WALKER,
JOE SPRAGUE,
LINDA SPRAGUE.

Marion von Buettner, a sophomore medical student at the University of Colorado, worked with a number o

elderly patients through Denver's East Side Neighborhood Health Center. She suggests the need for implementing many programs, particularly topical to RMP—better nursing homes; neighborhood geriatric clinics; coordinate efforts "to bring older people together for mutual entertainment and outings, the hiring of 'quasi-social workers' from among the elderly poor. . . ."

AGING IN THE POOR COMMUNITY

Aging in the poor community is accompanied by all of the disadvantages which accompany aging anywhere—poor health, loss of physical self-reliance, financial difficulties, and loneliness. The latter two, however, are compounded in the poor community for the obvious reasons that financial difficulties beset all ages—even more so the elderly—and that the isolation and loneliness of the elderly poor are natural products of a system which forces one's neighbors and children to spend all of their waking hours scrounging for their own livings.

As cases in point, consider the following profiles of two elderly women living in the poor community:

Case 1

Age 63, never married. Ex-profession—practical nurse. Worked most of her life and had saved some money but several years of illness ate up her financial resources and put her on crutches. Now on welfare. Budgets her money well and is happy with the visits of the visiting nurse, the health aide, and the homemaker. But she is not in her grave yet and enjoys things all of us enjoy like window shopping, movies, rides in the park, church on Sundays, et cetera. There is, however, no one to take her. She normally goes out only on Christmas and on her birthday. The rest of the time she sits in her room and gets nervous.

Case 2

Married twice. Buried last husband 8 years ago and hasn't been out of the house since. Would love to go see her husband's grave at least once a year. She has three children. Daughter has been married twice and is living with a third man now, who is an alcoholic. Daughter never comes to see mother because mother threw the man out of her house when

he was drunk. She has two sons—one on east coast and one on west coast, but neither can be bothered. This lady is practically blind and has great difficulty walking because of arthritis. Because she cannot see enough to write or read or watch TV, she spends most of her time brooding, mainly over her aches and pains. When someone lends a sympathetic ear and gives some advice (even if totally unprofessional) that pain seems less and if she is taken out for a ride, the pain disappears completely. She cannot resign herself to a nursing home as long as she can still crawl, because that would mean giving up all independence.

The two alternatives for people such as these are to enter a nursing home or remain at home under the care of visiting nurses, visiting homemakers and social workers. The sorry story of many nursing homes needs not be reiterated. This is one crying need: More and better nursing homes. The other alternative—to remain home—finds the elderly with many of their daily needs taken care of by the visiting workers listed above. One helpful innovation might be a geriatrics clinic either within or without the neighborhood health center. Often the elderly are well taken care of medically, but resent what they feel is a rush-job from the doctor. What they need more than medicine is a sympathetic ear and this takes time—more time than the average GP has to offer.

The problem of loneliness and isolation requires, among other things, a more coordinated effort to bring older people together for mutual entertainment and outings. Another solution might be to hire quasi-social workers from among the elderly poor whose sole job would be to visit and socialize with other elderly poor. A monetary impetus and an "official position" may be all that is needed to urge some of the elderly to forget their own troubles and pay some attention to their neighbors in need.

MARION VON BUETTNER.

Jeff Kluger, who is a second year medical student at the Medical College of New York, examines the health care system for migrants and seasonal workers in Fruita, where he worked along with Eva Adler and Judy Lindauer. He mentions an attitude toward health care which seemed prevalent in many of the rural place-

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ments: "There were no health problems in Fruita. . . . Fruita needed union organizers and industrial development, not health students!" The approaches which the group took toward changing "the low priority on health" are described. In addition they documented the need for a mobile clinic in the area to be run in conjunction with a Grand Junction hospital and cooperative local physicians.

These students interviewed several families whom they had met in other contexts during the course of the summer. The information requested was: (1) In the event of a major illness or injury, how would the family meet the costs of treatment; (2) Are there any family members acutely ill at the present time? Under treatment?; (3) What types of chronic illness are present? Under treatment; (4) Have there been any serious injuries? Describe problem and treatment; (5) Does the family have a primary physician? Who?; (6) Is it difficult to obtain medical treatment?; (7) Does the family use the services of the Health Department? Explain; (8) What does the family do for dental care? (9) Does the family have an up-to-date immunization schedule?; (10) In the event of a medical crisis, where would this family turn for help?; (11) To what extent has illness progressed before the family sees a physician?

A sponsoring hospital and physicians have been found and funding is presently being sought. This mobile clinic should be in operation by next summer.

RURAL HEALTH

After spending 2 months in Fruita, Colo., as part of the Colorado Student Health Project, I find myself overwhelmed with the number of things I have learned about the system of health care for the poor in rural areas like Fruita and the life style of the rural poor as well as about the agencies that contend to help them.

The system of health care for the poor revolves around the concept of crisis medicine; that is, the poor person sees a doctor when he hurts badly enough so that he cannot work or cannot bear the discomfort of his illness any longer. And then it is up to the charity of the doctor as to how much of a debt the poor person has to incur because of his illness. Fortunately, many of the doctors and osteopaths in the Fruita area are understanding of the poor man's inability to pay his bill and usually allow him time to pay it off. But there are some doctors who have turned people over to the credit bureau for not paying bills as little as \$6. Even though the poor person makes it over to the doctor, he cannot pay for the drugs that the doctor prescribes because they must be paid

for in cash. One example of this that I encountered—Mrs. V who could not work because of back trouble. She went to her doctor but could not afford the money for the medicine he prescribed, and when I left Fruita, she was still laid up, over a week since she visited the doctor.

Unlike the tax-supported hospitals in the big cities like Denver, the hospitals in the Fruita area are all private and charge for every service performed, from X-rays to lab work to bed occupancy. If the poor person is not on welfare's medical assistance program, which requires 1 year of residence in the State, or if he is ineligible for disability or Aid to Dependent Children programs, he must undertake the debt of a hospital bill that is usually quite high. One neighborhood aide received a bill of \$700 from an osteopathic hospital for an appendectomy performed on her 9-year-old son. It is going to be a long time and much hardship before she pays off that bill.

Although the Health Department does offer some free medical clinics, they must be on referral from a private physician. And then they are only diagnostic, with the cost of treatment shouldered by the patient. There are no other clinics in the Fruita-Grand Junction area.

From what I saw this summer, there is no preventive medicine practiced by the poor, especially the Navajo migrant. No one goes for a checkup, because no one has the money to indulge in that sort of luxury. That goes for the poor person on Welfare's Medical Assistance Program, old people on Medicare, and just regular poor people that do not fall into any program, because in each case the individual must foot the bill himself.

The life style of the rural poor utilizes a hierarchy of importance that puts health very close to the bottom when there is no medical crisis. Brushing one's teeth is a novelty and having a checkup at the dentist's is unheard of. The children of the Navajo migrants that I have worked with had the worst teeth that the dental hygienist from the Health Department had ever seen. While the need certainly is there, and I gave two sets of toothbrushes and an adequate supply of toothpaste to one family, the children never brushed their teeth even once. I learned later that the reason was

that I gave the brushes to the mother and they never got to the children.

When we came to one of the neighborhood centers in early June as medical and nursing students, the coordinator of the center brashly told us that there were no health problems in Fruita, and that Fruita needed union organizers and industrial development, not health students. People's top priorities were jobs, money, and food and rent. Health was a luxury. Very few people practiced preventive medicine and very few bothered with immunizations, which happened to be free at a Health Department clinic. No one bothered to come to the center on Tuesday afternoons, the time when a Public Health Nurse came to answer questions on health and make necessary health referrals. It was in dealing with this low priority on health that we had our biggest and most rewarding success. By the time we left Fruita, the neighborhood center was as health conscious as job conscious, and many kids in the neighborhood knew about germs and the importance of immunizations as well as about stethoscopes, heartbeats, and good dental care.

We accomplished this in three ways. First, we held health education classes every Tuesday afternoon for the children of the poor families in Fruita, showing films of various aspects of good health and holding discussion groups. One of our best sessions consisted of showing a film on the family doctor and then letting the kids hear their hearts beat with a stethoscope, taking their blood pressure, and showing them what an otoscope and percussion hammer are used for. This particular class helped to introduce the concept of a checkup and to show them there is nothing to be afraid of when they go to see a doctor, which was the case as I observed with several of them.

Second, we started an immunization program getting over 60 kids who needed a variety of immunizations into the Health Department's immunization clinic. The success of this program as far as our concern to establish a higher priority of health, was due to the fact that it was conceived in conjunction with a Neighborhood Aide, and not solely by the SHO group. In addition, several of the parents came with us, and the large turnout told us that the par-

ents of these children were beginning to put some importance on the idea of preventive medicine and good health.

Finally, our presence itself in Fruita as health students, visiting many indigent families and inquiring about their health, working closely with the aide from the neighborhood center on health referrals, and most important, becoming known and liked by the people and children in the community helped increase the community's knowledge of preventative care. Hopefully, the new health perspective that we have helped to establish in the community will not fade in our absence.

JEFF KLUGER.

Ken McConnochie is a second year medical student at Dartmouth Medical School. He, Mary Jaegli, and Nancy Roland worked in Palisade and Clifton. The paper describes this group's impressions of the health care system in these areas, as well as their activities. The need for continuity of care for migrants is stressed. It is suggested that this might come about by increased communication between groups involved in migrant health, by providing "traveling records" and educating migrants concerning their importance. The mobile clinic mentioned in the previous paper could also help relieve the health manpower shortage in these communities, as they are all within a 10-mile radius of Grand Junction. This is presently being investigated. Ken also points out the heterogeneity of migrant groups. The implication is that no generalizations can be made and that needs must be dealt with individually.

SOME ASPECTS OF RURAL HEALTH CARE DELIVERY

Palisade

The most pressing need is some way of coordinating health care to migrants throughout the route of the migrants. This would insure continuity of care. Another possibility would be an increase in local health care staffs, enabling the Public Health Nurses to make rounds without being overburdened. With more people, a nurse could conceivably visit every migrant family. There is a need for some way of knowing where migrants are throughout the summer. This would help get information to the people who need it. Also, there is a need for better broadcasting of information to the migrant about facilities available.

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The foremost step in solving the health care problems of a mobile population would be greater cooperation among major groups involved in migrant health. One way of insuring this could involve providing records for patients to carry with them. Another is education about continuity of care and the importance of records.

Education could take place in the local recreation center which we helped to develop this year for migrants during harvest. These activities were in the form of movies, lectures, and pamphlets. We sent letters to growers to increase their knowledge of the facilities available and provided pamphlets to the migrants to inform them of these services and how they might best take advantage of them. The addition of a Public Health Nurse who would work in Palisade during harvest and Clifton the rest of the year would help get better coverage of both areas.

A plan involving the cooperation of growers in registering all migrants in a central list would help provide care to all.

Because of the diversity of the migrant population, it is difficult to place any culture or values on them. As to the winos, there is highly individualistic feeling among the group. They will not ask for help until they really need it. Most are educated Caucasians who, for some reason, have dropped out of society. They are hostile to any help "offered" and will come only on a take it or leave it basis. This means "soft sell."

The Negroes are generally from Arkansas and are teenagers. They are fairly well educated and eager to learn more. They generally seem interested in health.

The Mexican-Americans have been picking up our pamphlets. They don't seem to talk as much as previous groups. They travel in families, generally. They are concerned with the welfare of their families.

The Indians seem to be the least receptive group. They do not watch the films as do all the other groups. They bring their children with them, even to the fields. They do not ask questions and seem suspicious of health officials although they do cooperate. It may be because

they do not understand. Some speak little or no English.

Clifton

There is need for a GP in the area to care for local residents. There is need for general education for the population of Clifton, and possibly need for another Public Health Nurse in the area.

Clifton is a poverty pocket of primarily retired people. Health care is provided by the two doctors in Palisade and the Grand Junction doctors. There is one nurse for Clifton, whose work load is monstrous. There will be a community action center which intends some education eventually. To them, this is smoking and drinking lectures. There is no clinic. Health care is purely individual and there is no recruiting. These people are the invisible poor. It was not until the end of the summer that we became aware of this aspect of the community both in Clifton and Palisade. It deserves further exploration and concentration in the future.

KEN MCCONNOCHIE.

Daniel Kraus is a second year student at the University of Rochester Medical Center. He was one of the four health science students assigned to man the Sangre de Cristo Medical Unit in San Luis. Although this was the most clinically oriented of all the placements, he focuses on the welfare system rather than the more narrowly defined health needs of the community.

PROSPECTS FOR TRUE WELFARE IN COSTILLA COUNTY

From my daily log:

July 18: "Asked Evan M. (Chama Canyon) why his wife and child didn't come to Well-Baby Clinic; said his battery was dead, would I ask around town for someone to buy his homemade fence posts so he could pay \$15 for a new battery so he could drive his pickup into town and earn a living."

August 13: "Told Dave S. (LaValley) that he was ineligible for disability for his bad hand (though his alcohol-enlarged liver may be worth something), but could

get 100 percent food stamp support and free medical care. He vowed to get a job here or leave his wife and go to California to make enough money to pay his bills."

Evan and Dave, residents of two of the most isolated corners of the San Luis Valley, differ in their means of subsistence. Evan hunts and sells elk in the winter, and Dave relies on full Government handouts. Nonetheless, it is plain that they have in common a hand-to-mouth existence, secure against starvation today, but necessarily lacking a view into tomorrow.

The unincorporated village of San Luis, the Costilla County Seat, is the headquarters for the regional Welfare Office and the Community Action Agency. The government pursues many programs here which, as the names imply, undertake to replace deprivation with welfare and inertia with action. Basic and advanced education; training in job skills; FHA loans; subsidy for food; and, eventually a comprehensive health care program in the valley; all these and other well intentioned projects are operant at this time.

Yet Evan and Dave and many more residents of this county are being overlooked in the allocation of Federal funds for OEO programs. These are perhaps especially important people, heads of families who might choose to remain in the county, rather than move away at the first opportunity, yet still quite alone in their long term fight for survival.

For it is unclear that under the best of conditions, the Federal funds would be acting in two general areas—one which we would term "stop gap" measures, such as the food stamp program, and the other, which is the establishment of excellent institutions, such as the Neighborhood Health Center concept.

These more lasting efforts, while potentially significant improvements of conditions regardless of the prevailing economic conditions of a region, will be seriously hampered in their usefulness unless still more fundamental steps are taken. I am primarily concerned about the economic future of Costilla County and the apparent Federal circumvention of this entire issue in its expenditures to date. Though talk may be cheap, it is not without reason that we might question the economic wisdom of the

present allocation of OEO resources. Surely, it is inconceivable to withdraw support where it already has been given. But I am struck by the ways in which the Government is acting at cross purposes. For, on the one hand, monies are being spent for institutions in this county, for the benefit of its inhabitants, while, on the other hand, little, if anything, is being considered for making Costilla County a more desirable place for youthful people to continue inhabiting. On the contrary, it is almost as if the CAP opportunities are concentrating on arming the youth for success "on the outside;" in industries and the professions, which at this point would be least likely to settle in this remote expanse of sagebrush. "Community Action" might more accurately be renamed "Action for Community Disintegration."

Was it purely instinctual revulsion that I felt when it was suggested that the only hope for improving this county would be to move those remaining citizens out of the valley? Love for one's homeland and its great natural beauty notwithstanding, abandonment is neither an unprecedented nor an inviable solution to the problem here. Lacking an economic base, a community has no reason to continue. Given greater opportunities born elsewhere of technological progress, Costilla County shows signs of becoming a mammoth ghost town, in much the same way that the old mining towns decayed and died. It requires no more than a brief inspection of this area to be convinced not only that without water, there is no life, but that without industry, there is no prosperity. In a county that lost 50 percent of its population between 1950 and 1960, it is folly to entertain hopes that private enterprise would consider investing in any plant as far from a main transportation route as this.

And yet, here my anger is backed not just by instinct, but by reason as well—the desert has been made to bloom in the past. Where entrepreneurs were unable to act, governments have been the miracle workers. If there exists today no economic base in the county, perhaps it is the responsibility of the Federal Government to create such a base. With land becoming even scarcer and distances less prohibitive, it would be something less than prophetic for the

Office of Economic Opportunity to appreciate the potential of an area such as this. Is it necessary to wait until Evan gets thrown in jail for poaching and Dave dies of cirrhosis before an attractive industry moves into the valley to employ them? If so, perhaps some thought might be given to the alternative—the evolution of an almost complete welfare community. Even if the Government were to make a bad investment, and granted its wastefulness and inefficiency, it would almost certainly represent less of a total cost than to support by common dole the population it might otherwise have employed. This is something private enterprise has not had to be concerned with. A reevaluation of the priorities of government spending might do well to consider the possibility of taking the important steps which the reversal of the current trend in Costilla County demands.

DANIEL J. KRAUS.

Joe Sprague is a third year law student at the University of Colorado, who did extensive work with Project Mainstream, welfare rights groups, and various families with legal crises on the east side of Denver.

NOTES FROM THE OVERGROUND . . . (EXCERPTS)

Forbidden Planet

The east side has a lot of big dogs. If somebody walks down an alley you can hear it all over town. Those big dogs yelling their heads off, turning around and around, and hitting the fence like a rhino (sort of).

They're funny dogs . . . not just routine big dogs. These dogs are sort of weird (dig those weird dogs). Their heads are connected in many cases to their bodies direct!

Anyway, what kind of a deal is it when somebody makes you live in a place and then cuts you off so you can't get any money so you got to steal everything you can from your neighbors and you all have to go out and find these alligator-dogs and keep them in your back yard to scare off the stealers. Oh yeah?

It's sort of like everything else around here. Ten million vicious circles. The police are nervous (maybe at best), the environment un-

certain—so a 13-year-old kid walking home from his piano lesson has a fair chance of getting arrested for vagrancy and maybe of getting his head beat on.

I know a big dog on the east side that I don't even like to look at for very long—I mean I only look at him sort of out of the corner of my eye or with my hands over my eyes. I don't think the people out in South Denver could even do that. He's awful lookin. The thing is that people in South Denver* don't have to look at that horrible giant dog enough. I mean that dog isn't very easy on the eyes.

Anyhow, the real question is whether the big dogs on the east side aren't really MONSTERS FROM THE ID. Something's up when you got these crazy awful looking alien dogs around. These dogs come from somewhere else if you know what I mean. I mean they're *really* something else. God, you oughta look at em. They're scary lookin mothers. It's pretty clear they don't come from any little doggie mummies—probably born of some unspeakable mental process. You know what I think? I think those dogs are some kind of SYMBOL!!

Just a Little Bit

I don't want it all, just a little bit.

If an enormous thing like the United States can introspect and really wonder (like 'geeze, what is going on?'), then it can find an answer. There's an answer. Uh huh, there is an answer.

The answer is that *you* have to change. The only trouble with that is that nobody in the history of the world ever changed except Mister Scrooge and he only changed into Jim Backus.

Alors Que Passa

Everybody knows that human conduct is mostly incoherent reflex, and if it has any meaning, it has to lie in a slim vein. I'd bet that personal mortality, in fact, is the only thing that counts, and given our terrible perception that adds up to not lying to ourselves.

It's *lying* that hangs up dissent in the United States. The question is whether lying to ourselves isn't a fundamental process. The question

* Denver's south side is a predominantly white upper middle class area.

is whether anybody with any interest in the process can reflect on it honestly. The nightmare is the unquestionable accuracy of the most insanelly radical voices around.

You know it's not them bad Russians—it's not those weird, hysterical Chinese—it's the *personal* devil, baby, on duty all the time and just lookin' for a home. And the time to beat that cat was day before yesterday.

JOE SPRAGUE.

Norman Chenven is a junior at the Downstate Medical Center in Brooklyn. He, along with his wife, Dinah, and Jane Patterson, spent the summer in Delta, Colo. The following events are true, only the names have been changed to protect. . . .

THE DELTA PROJECT

The three of us moved into the town of Delta without a shred of legitimacy. Luckily for Jane, Joe Lawson of the school district had a project ready to go for the summer. Jane was then a SHO member working for the Joint School District 50, preparing materials for a grant proposal that the school system hopes to put into effect in the coming year. It deals with the Spanish high school dropouts. Thus, Jane was a SHO member doing a job that would have been salaried by the school district. Fortunately, the program should be a very valuable one to the Spanish population in Delta.

Dinah, liking children, found a daily 7 a.m. to 7 p.m. job working in the Day Care Center run by the Migrant Association. They were short-handed and welcomed reliable and responsible help since those qualities were rare among others stationed in Delta. Thus, Dinah, like Jane, had also discovered a legitimate activity. Again it was in the capacity of a volunteer worker for an established organization. This job had a medical slant to it; taking care of kids, feeding them, and bringing them in for physical exams with local physicians.

That left only myself high and dry. Dr. Stark was wonderful. He invited me to the hospital to observe surgery and allowed me to tag along in his office for 10 days to observe his "rural practice." There was nothing particularly rural about it except that he was a G.P. Dr. Ronald

and Dr. Brothers then invited me to watch their surgery and tag along with them. There was nothing particularly rural about their new clinic either, with lab technicians and phone referrals to specialists in Grand Junction.

I occasionally tagged along with the Migrant Association nurse, volunteered to help her do Denver Pediatric Development testing, which never panned out. I took quite a few sick kids to the local doctors to get penicillin—and balloons.

At this point, I was beginning to get desperate. Particularly so, as my community representative (intern) was a Commanche among Navajos (traditionally bitter enemies) and also very "American." He had less ability or desire to communicate with Navajos than I, except to the female VISTA Associates with whom he established considerable rapport.

I was relieved of the burden of dragging my "Indio" around by a stroke of mutual good fortune. Adrian was accepted by HEP (High School Equivalency Program) and he left on 3 days notice, owing me wampum to the extent of \$140, (more than enough money to buy Manhattan Island). Since this Indio was an all-American spendthrift, I took the precaution of having the Great White Father in Denver send his check directly to me when it was issued, approximately 5 weeks too late. Adrian was thus subjected to the indignity of receiving \$14.50 from a \$180.00 paycheck after Uncle Sam and the Indian Agent (me) did our work. This is known as Indian giving.

In a burst of unprecedented energy (probably derived from despair), Adrian, two Navajo Vista Associates and I began to put up a basketball goal in the Holly Sugar labor camp. We finished it a week after Adrian had left and 2 days before the Holly Sugar labor camp closed for the season. To date, the only people to play ball on that court are Ritzy (Adrian's 14-year-old sister) and myself.

With the departure of the Navajo migrant workers, I redirected my inexhaustible energy and multifaceted talents toward the Spanish-American community in Delta. Marching forward under the banner of SHO, and always bearing in mind that racial discrimination, school segregation, and second class citizenship

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must be fought with every means at hand, I charged into the community as a salesman for the Food Stamp Program which is directed by the Department of Agriculture, but administered by welfare. Three Spanish Vista girls reluctantly drove me around for a few days, introducing me and then letting me give my spiel. "It is a REAL good program. . . ." I visited 25 to 30 households to find approximately five families that qualified for the stamps, and only two families willing to sign with welfare for the program.

It took me seven visits to the Montoya family to get them signed up. Also, it necessitated the chartering of the Special Food Stamp Loan Corporation of Delta which extended its first loan to Mr. Sam Montoya for \$10 on July 20, none of which will ever be seen again.

The Lopez family also made an application for a loan of \$10, even though they received a \$200 ADC check on the day that food stamps were being sold. The president and board of directors of the now tottering corporation executed a dramatic suicide of the mind by diving gracefully out of the third floor window of Renfrow's Furniture and Appliance Store on Main Street. The Delta Independent noted that this was the most newsworthy event to occur on the north side of town since the McCarthy gang held up the Farmers and Merchants Trust Corporation in 1893.

While the food stamp campaign smoldered with only sporadic bursts of activity, we decided to attempt to interest local high school dropouts (whoops! pushouts) in completing high school, joining HEP or GED programs, or getting job training. We enthusiastically approached Mario, Mary Valdez (secretary to the Migrant Association and lifetime resident of Delta), Lucy Renfrow (GED teacher and lifetime resident of a neighboring town), Sally, Nancy, and Carol (VISTAS, Spanish and 8 months in Delta). Mario said he had four friends, Mary had no friends, Lucy didn't know who her friends were, and the VISTAS hadn't known that there were any pushouts in Delta.

Consequently, we had our meeting with Mario's four friends. The joyous occasion consisted of two packs of Coors, 1 hour of mum-

bling, and the decision to go to the Migrant Association office the following day to find out about HEP. One of the kids said he sure would like to go to HEP, but he had to pay off his Mustang first (3 years to go).

On the following day, Sid Lucero showed up because Mario picked him up, which was a pleasant surprise in itself. John Montoya, who had been the most enthusiastic about going to HEP, was asleep and couldn't be roused in spite of two phone calls. Sid got a spiel from Frank Trujillo, the head teacher with the Migrant Association at the end of which he was given an application, told to fill it out, and soon stood in mortal peril of being accepted by HEP. He seemed vaguely uneasy about this prospect and so we told him that he would have a month to think it over before he'd have to go. He has since gone to Utah.

About this time, the great depression hit Delta. The area director for the Migrant Association on the western slope was already 2 weeks late in returning from his vacation in California.

In the director's absence, the acting director and educational supervisor decided that early August was a perfect time to shut down the Head Start and the Day Care Center for repairs and renovations since the only people around were migrant families; everyone else was on vacation. So one Monday morning Dinah found herself temporarily out of a job and I was tired of observing surgery at the Delta City Hospital. We went cherrypicking.

Much to our surprise, we found nearly 50 migrant families in the orchards, for some reason unknown to the Migrant Association. With the evident embarrassment of being presented with 30 to 40 young children that needed Head Start or the Day Care Center, the acting director and educational supervisor reluctantly prepared to reopen the Day Care facilities. Then lightning struck from Denver.

The Migrant Association auditor had discovered that the Head Start and Infant Education branches of the Migrant Association had exhausted its money for the year, with the largest rush of migrants not yet arrived. The two Migrant Association nurses and all of the teachers were fired with 2 days notice and with-

out being paid for hundreds of hours of overtime pay that they had earned. And so the Migrant Association Child Care Program was closed down for good, due to poor fiscal management, as well as an overabundance of migrant children.

The two nurses asked me to follow up on four kids who were in need of referrals to a pediatric diagnostic clinic. The earliest appointment possible, according to the Public Health Nurse, was in February.

During orientation week Dr. Jordan said that if we found any kids that needed pediatric care, he would make arrangements in Denver for them. So I called Dr. Jordan and was referred to Dr. Boyd who talked to me as if I were one of those enthusiastic SHO kids. From our conversation, I gather that he knew all about us. He then gave me a list of protocol procedures to follow before turning to the Denver Children's Clinic. I struck pure gold when I called the fourth name on the list—Dr. Nelson Scott from Grand Junction. He cancelled two luncheon engagements in order to see the kids, which is just what I envisioned SHO to be all about. What better way to eliminate the fat cat image of the American physician. Dr. Scott has agreed to follow the case of one of these children which may result in transferring the child to another family because of neglect. Another child will be placed in a special school for retarded children. A third child will be placed under vigilance for a bad rheumatic heart.

Other than this burst of activity, the Delta recession had lasted for 1½ weeks before Jane came to the rescue, offering salvation in the form of a census of the Spanish population for the school district. Thus, in the nadir of our despair and desperation, we charged into our new found project. All our goal-oriented, bourgeois middle class hangups welled to the surface. Here was a job that could be completed by the end of the summer and also could be put in a book.

The census turned out to be a SHO worker's dream. Meeting the community, getting to know our community, et cetera. Also, we got an occasional piece of pie and milk.

However, as we got to know our community in more depth, we were stricken with dismay and despair as we discovered that many of Delta's Spanish population were middle class in both aspiration and attainment. As we went from door to door, it became increasingly evident that revolution would never come in Delta. This is entirely in keeping with the character of the town. It gets no snow in winter, no rain in summer, and in case of nuclear holocaust, it has been projected by competent meteorologists that the whole thing will pass Delta by, including the fallout.

NORMAN CHENVEN.



Chapter 3

The Interns

The development of a "high school intern" biomedical careers program was one of the three objectives of the original grant proposal. Like similar programs in former student health projects, it consisted of hiring high school age students from the communities in which we would be working to sensitize us to problems in their areas and for us to acquaint them with the possibilities and realities of entering biomedical careers. A corollary to the biomedical careers program was encouraging these students to enter college, and finding placements and financial aid for them.

The proposal stated this rationale for the program:

People from ethnic minorities and poverty groups are grossly under-represented in the health professions. This disproportion reflects limited employment and obstructed career opportunities which aggravate the social isolation of the health professions. Health science students training and working with promising disadvantaged youth can raise aspirations, increase self confidence and provide career-relevant experience. In the light of contemporary social disorganization in the United States and the limitations of existing health manpower, this new career element becomes a crucial bridge between the health professions and the disadvantaged community.

Interested students in Denver were found through the Neighborhood Youth Corps and the Neighborhood Action Centers. Those in the rural areas were referred to us by VISTA volunteers as well as the local school systems. There were no rigid standards for selection.

The rural areas posed unique problems to the program. Followup would be difficult; and the areas provided few opportunities for showing the interns a full range of health career opportunities. For this reason interns were sought who not only showed interest in the project and their communities, but who also were oriented toward college careers. Interns in the Denver projects represented more of a cross section of their communities: They

ranged from local gang leaders to a black militant, to the head student of a predominantly black high school.

The Denver intern program turned out to be the most highly structured because of the possibilities of followup and the many opportunities to demonstrate a full spectrum of health careers. Each week the entire Denver group would tour a different type of health facility. On alternate weeks the interns would be responsible for conducting seminars on their communities, and the health science students for arranging programs on health careers, college admissions, et cetera.

The interns conducted their own meeting at the final evaluation session. They presented five major recommendations to the group.

(1) *The need for increased minority representation:* They felt that more minority people should be represented on the project—both interns and health science students. Their rationale was simple: They were at home in the communities, understood them far better than we, and would be the ones affected by any positive action and harmed by any project blunders.

(2) *The need for more "intern power":* Throughout the summer the interns felt stifled because they lacked any autonomy in the group. They had no say in the planning of the project, they were not present at the initial orientation meetings, and many of their ideas were rejected during the program even though they were selected because they knew the problems. The interns felt that this autonomy had many positive values: They could help organize next year's projects on the basis of the problems with which they had familiarized themselves during the year; they could then prepare the community for our presence and provide more continuity for existing programs during the year. They felt that to do these things they would need increased "operating expenses." With this autonomy would also go more responsibility. They felt that they, too, should fill out daily logs and write analytical reports, and have their own intern director to mediate their problems and negotiate on an equal basis with the health-science student project director.

(3) *The need for changes in the intern's role:* The interns felt that because a part of their

program was concerned with biomedical careers, they should have more time to work in health facilities with health professionals. They suggested that this was the only way for them to make their career plans more concrete. In addition they wished to work on projects in other areas than their own; exchange rural for urban placements and get out into white communities.

(4) *Selection priorities for future projects:* The interns proposed that they be given top priority next year if they desired to work again because they already knew the problems and could provide continuity throughout the year.

(5) *The project next year:* Most of the interns encouraged SHO to return to their communities. They did offer certain suggestions for changes in the program, however. They felt that it should be their job to find the problems and outline the power structures responsible for dealing with these problems before the project started. In this way they could eliminate the initial frustrations felt by all members of the SHP. They also noted that "SHO took up too many projects that couldn't be done in that period. If you are going to take up a project, it should be something that could be continued through the winter, or something that just pertains to the summer. If you take up a project, and you start it and then let people down, they are not going to trust you next year. Start with the little problems and work up to the big ones."

This report reflects a great deal of growth on the part of the interns during their summer experience. It demonstrates an externalization of problems which many of them had considered personal before. Their statements are all quite positive, their commitments to future involvement and their constructive ideas for alterations in the program. At the same time they demonstrate an intense feeling of frustration concerning the inadequacies of this year's program and the failure of SHO to put a dent into existing ghetto conditions. The points which they have stressed are concerned with the service aspects of the project. This is rightly so. As health science students, we can leave with our education. . . .

One positive outcome of the program has

been the enrollment of three interns, who had not before considered a college career, as freshmen at the University of Colorado.

At the end of the summer the interns were all asked to write evaluations of the project. These papers reflect many of the attitudes and criticisms discussed above. They are presented largely unedited. Selected papers and excerpts are included.

This summer I worked with SHO. The purpose of this employment is that the medical students I work with are not familiar with this community. Since I grew up in this district, I should know more about it than the medical students. Through the summer we attended many meetings with staff of Denver General Hospital, Parks and Recreation, Denver Housing Authority and other government posts. The results of the meeting from the staff of Denver General Hospital were, "Why were the people not using the local health stations?" Some of the answers: (1) People were not familiar with what was available, and (2) Fear of social harrassment.

The meeting with Parks and Recreation was to better a neighborhood park—the main recreational spot for children, teenagers, and adults. A problem was the swimming pool. The pool had a rough cemented bottom, it was unpainted, contained broken glass and other debris, and the shower rooms were not adequate—not like other community pools. The project in progress was improvements in the pool, a basketball court, an unused tennis court, a little league baseball team, and other recreational facilities.

A great help on this project was the Action Center, one of the stations of SHO, and Denver Housing Authority, who house most of the chronically deprived people. A local parish donated food, supplies, clothing, and help to the needy. A local health clinic, whose neighborhood health counselors would go into the homes and root out the problems, also helped. All of these residential stations are supporting this community. How well they succeed will be related to the peoples' abilities to replace fragmented organization. Data from SHO students will

probably prove that the community is organized as of this date.

LAWRENCE SENA,
West Denver.

I first learned about SHO (Student Health Organization) through some friends who were employed by this organization. Asking what their job was, they explained. From what they told me I was impressed and went to see about an opening. When talking to one of the health students, I told her what my qualifications were and they met standards. Then I was interviewed by the director and was hired. I started working right off with one of the interns. The project was to help better the Lincoln Park Swimming pool. We started by asking questions and talking to the staff of the pool. Our next step was interviewing other public swimming pools in the city. By this we found that pools in the minority area were the worst in the city, such as bottoms were not painted on the pools, not enough staff; poor facilities in the locker rooms—these are just a few of the poor examples. Our next step was letting the community know about it. Then we arranged a meeting. People in the community raised havoc to the manager of the pool, its staff, and administration of the public pools. After the meeting, everyone in the pool and park area saw much improvement.

We held a meeting about children in the west side area sniffing glue. These children ranged in age from 11 to 15. At this meeting we arranged that certain people would work with certain children. Jerry and I teamed up together and worked with the two brothers, and we went and visited their home. When we talked to their mother, we found out that they had been working with another group. The mother informed us that they worked some days and on other days went to the museum, to the park, et cetera. And she told us, if we wanted to see and talk to the two, for us to return at five in the evening. I returned myself several times. When talking with the boys alone, they were more free with their information, mainly because they knew me and probably thought I did the same things. From the talks I had with the boys, I found out they had stopped "getting

high" sniffing glue. They also were doing well with their other group.

My last and probably my best project was a report on "brown history." I was told that there was going to be a meeting on "brown history" and my supervisor wanted me to get this meeting ready. First of all, I started obtaining information about my subject from books and other printed pamphlets. I also made a trip to the "Crusade for Justice" office. Here I talked to a man about where I could obtain the best information on this subject. He gave me names of books where I could find the subject and told me where to find the books. For 2 weeks I studied the history of the "brown people." When the meeting began, I started my talk. After a short time talking, I was halted by questions. The answers to these questions I gave started a whole new talk—a very interesting one. Mainly, this was "black people" arguing against the "Mexican people," really on which is making more progress and why.

This was not all that we accomplished, but in my opinion, the most interesting. I did mention trips we took, such as a trip to Ridge State Hospital where mental and retarded children were boarded. We also went to Colorado University and toured the campus. We visited Fort Logan, another State Hospital, and we visited Craig Rehabilitation Center where they help the crippled. These places were some of the places we went to observe and see what the atmosphere was like there. We also had meetings with the Board of Denver General Hospital and had meetings every Thursday with SHO. We had one with the West Side Health Center. These are meetings we had during the time I worked for this organization and found them very interesting and educational. To my opinion in the short time I have worked, I do feel I had an interesting and successful summer.

GARY BACA,
West Denver.

This summer's job took me from my regular realm of work and exposed me to a different type of stimulus. My first day of work was July 1 at which time I first met the people I would be working with. The type of work

we would be doing was extremely cloudy to me from the beginning because I was used to working physically and not in the sense of applying myself to this job.

July 1 also marked the first meeting of our group; from that point it was decided that we would man the Sangre De Cristo Medical Unit since there were going to be no nurses for the SHO appointed doctor. From this time on we were engaged in familiarizing ourselves with the clinic and the specifics of our jobs. We then proceeded to set up a schedule by which the clinic would be manned and still provide for a team to be out in the community learning the ways of the place. It worked very well because the people of San Luis have always looked up to medical people. This has provided the group with a great degree of acceptance into the community. This has primarily been our line of work all summer.

I feel that personally I gained a great deal in the sense that this job has boosted or rather raised my hopes and wants of going into medicine. I learned a few simple basic operations like checking patients into rooms, and taking their vital signs of temperature, pulse, respiration, and blood pressure. Some days even taking care of the reception desk, taking hematocrits and giving Tine tests. The SHO gains, or rather accomplishments, in my eyes are as follows: (1) Provided medical services to people and filled the gap partially between the last doctor and the grant doctor. (2) May well have set the stage for another SHO project which I favor greatly. (3) It brought to a greater point of enlightenment for the grant a few things that may be helpful.

Another way of looking at what this SHO project accomplished is by the looking at what personal goals were visibly accomplished, again in my eyes, by each member; personal gains included: Bob liked the clinical work but made some exceptionally good followups; Dan basically made personal gains; Gail setting up or adding more encouragement to a referral system to make important patient followups; Sue's work in the survey overlaps everybody else's by quite a bit; Rocky—strong personal gain, motivation to go to college and he made it a point for the transportation of people to and from

the clinic not to be overlooked, but rather given a second look. Joann and I made personal gains.

To elaborate on my feelings about another SHO project, I said before I strongly favor such a project because with this year's project the seeds were only planted. So if you want to harvest your total results, you will have to make a place for another project. If you should decide to bring another project down next year, here are a few suggestions derived through our own experiences that may be helpful: (1) Have a group (student) leader, one who is truly recognized by all; (2) The first 2 weeks should be spent learning the power structure; (3) Answering the questionnaire to one's self may help in many ways; (4) Possibly for each person to set personal goals; (5) Continue Con La Famlia.

Here are the things that next year's project may pursue: (1) Help carry out preventive medicine and introduce it to the people, simply because this objective will not be completely reached in a few years even with a permanent doctor in the area: (2) Setting up a survey of some sort which may help people get insights into the community, its problems and ways; (3) Keeping eyes and ears open to any feedback on this year's project which would be harvesting your crop.

JOHN LA COMBE,
San Luis.

I worked for the Student Health Project for 10 weeks and now that it is over, I feel it has been an experience for me. I learned many things which will probably help me out in the future (I hope).

I was asked to write an evaluation on the project but I really don't know what to say; what I mean is, that I can't say we were successful or I can't say we were not because we were used as flunkies for someone else. When someone got an idea that wasn't from SHO, they figured if they could get SHO to pass out their little pamphlets and other material, all they would do is attend the meetings and receive credit. A lot of people thought that the SHO was a group of people to do their dirty work. This is one reason I feel so unsure of myself.

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I feel that I haven't done much for the community itself; it seems that if we started a project, people in agencies would often say this is not needed in the community. I don't know whether the people didn't want or need help, or if they wanted help and then we were afraid to get something started and be let down. And if they felt this way, I don't blame them. I, myself, would be afraid to put faith in a program that will be in action only 3 months. I feel if there was more time, the SHO would really be an active program.

JAKE PINO,
West Denver.

In working with the Student Health Organization this summer, I have felt that I, myself, didn't accomplish too much. On the whole maybe we did help out a little on the east side, but it wasn't enough to look back at and be proud of. And I am sure I speak for the rest of the high school students when I say that none of us really got the full effect of our jobs this summer. What I mean is since the first meeting we have been hearing about helping our community, but so far, we haven't done too much. The community seems just the same. The only way I can see to better it or make it a success is to stick to what they plan to do besides grabbing at something big and failing, and just giving up. I think they should work with the little things, then work up to the big ones and take it from there. If things keep going this way, I think the project is going to be a flop. But if the project can stick to one specific program, I'm sure the ball can get rolling and the project can be known throughout the different communities because I'm almost sure that there are a lot of people on the east side who don't know a thing about the project or its purpose.

VINCENT C. ROBINSON,
East Denver.

There are 23,000 people in the ghetto area in the west side in Denver, Colo. In the midst of these 23,000, there are an extra 16 willing and able people who have come to help the 23,000

people in this ghetto area. These extra 16 willing and able people are SHO.

SHO is the Student Health Organization, a group of Health Science Students from different States who have come into the ghetto area to help with the many, many community problems. Among these health science students, there are high school interns. The interns were hired from the neighborhood to identify the problems to the health science students. The problems identified were social and health problems. Their goal was to set up facilities for a health center. However, there was one here in the west side of Denver, Colo. Therefore, our goals were really "social goals," such as working with family problems and the community problems. Some of the problems were: (1) Getting a Mexican family welfare and information about the health center and moving other families and obtaining food for them; (2) Getting a youth out of a reformatory; (3) Showing the younger children (age 10 to 14 years) sex education movies because lack of communication between them and the parents; (4) Showing teenagers (age 15 to 20 years) health movies, such movies were on drugs, maternity, smoking, et cetera; (5) To better a swimming pool, trying to make a better park and recreation facility for the people in the community.

What would have been accomplished? I think the swimming pool, but we didn't have enough time to really accomplish anything in the short time here. People in the community weren't interested. There were many things SHO could have accomplished but we were short of time.

The shortcoming of the program was that it wasn't planned properly. I felt that someone in the Action Center should have known more about SHO, why it was there, et cetera. Then the health science students could have just hired the high school interns and gone to work right away. There was shortness of time. Also, the majority of the health science students should come to work on time and to the tours. And please—not so many meetings!

My impression of the program was good, but only one (or two) bad things. It was good because it helped a lot of people in the community. It helped me learn about health and education and to understand the people in the commun-

ity. It helped me look into my future as far as school and to go on to college—to be someone and help the people in the ghettos. Especially the younger group because the younger group are going to develop into future leaders in the community. I want to inspire them to do something good and worthwhile and to stay in the community and help develop it. The bad part was that we were short of time. SHO changed my feelings toward the ghetto because I felt people there didn't try, didn't have the intelligence, and they were all bad. Yet, I found out different, because I never realized that some people didn't know about their rights, how hard some have tried, and how some misuse their high intelligence. There are many intelligent, kind, and happy people in this "ghetto area." Now I realize why they remain like that.

I felt that SHO was a worthwhile project and now that the health science students are more familiar with these problems; I hope they remain, or come back. I felt there was a shortage of funds to carry on certain projects that involved actual cash. My biggest concern is *more time*, as 10 weeks is hardly adequate.

MARGARET ANN LOVATO,
West Denver.

I learned a lot about my community this summer. I found out how people of the community look on outsiders. I believe we accomplished a lot. Our first couple of days at one of Denver's health stations, the nurses and doctors gave me the impression that we weren't needed and were just wasting their and our time. I also think the organization was used as a service product, because we were used as free labor more or less to do service for the health center. I also think we should have gone into the community more. I feel the place we were needed most is the community. I also believe that we took up too many projects and found ourselves too hung up and stopping on projects to go on to others when they weren't finished.

I think in order for the project to be a success for the years to come the organization must set out a goal when the summer starts and complete it. This plan must be very con-

crete and worthwhile project that will help the community. For instance, our project of cleaning a neighborhood pool was very worthwhile, but because of our short time on it, we didn't get to finish it and complete it. If we had started at the start of the summer, I believe we could have said of ourselves that we of the SHO of the east side had helped the community help themselves.

NORMAN HARRIS,
East Denver.

During the summer of 1968 I worked as a student intern in SHO on the east side. I feel the group could have been better if it had had a better understanding of what it was to accomplish. The main problem was getting started. Some had great ideas but when it came to actually putting them to work, this was another story. One of our problems (I think) was how some of the people that talked to us kept comparing and telling us that we could do what they did in other cities. Maybe this was a mistake because Denver is different from other cities, and it also has many different problems.

I don't feel much can be done in 9 weeks. I think SHO should start a little earlier next year. I feel we accomplished something this summer but it wasn't very much. When we first started out, we were not accepted by the community people right away. We had to gain their trust. Many people still don't trust us and don't want us to be here. However, this was only a small portion of the people. We first tried working with the larger problems but we didn't get anywhere. We met up with an awful lot of criticism. When we found out that we couldn't really accomplish all the things we wanted to with the larger problems that would take years to do, we started on the smaller ones. This was better because we can actually put our fingers on some things we did. At least this way we didn't get the people's hopes up high and then disappoint them like has happened so many times before. I feel the SHO will be a greater help next year in Denver

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since it now has a better view of what it should be doing.

MARIE ARRINGTON,
East Denver.

I felt that the Student Health Organization was a good thing because it had a lot of good ideas for the community. People were interested in what they had shown to them. They also helped the younger kids out. For instance, one student helped a family from Mexico get help. He also helped another family move closer to the Neighborhood Health Center. All these people appreciated it, too. Because when I was younger I never had an opportunity for anyone to help me like they have helped the people here. When I was younger, I was bumming the streets looking for something to do because there was nothing to do. This is why some of the kids today get into trouble. I know, because I used to when I was younger, so I had to find out my own fun. When my friends and I would get money, we would spend it on something to "get high on." My friends influenced me to smoke, steal, and to get into trouble. I would

even fight with people just because I didn't like them. Also, when we would want to go to a dance and we didn't have a ride, we'd steal a car, but sometimes I would get caught alone driving it or with my friends. My friends taught me how to steal and drive a car. We would steal just Chevy's because they had an ignition that you could start with the turn of your wrist. One time I was drunk and stole a car and ended up wrecking it. I got away, though. I've been caught twice for stealing cars, but all because of my friends influencing me and letting me help them only because I was dumb, or should I say I wasn't smart enough to think. This is how I grew up . . . If I had another chance I'd try to show the kids that are growing up the wrong way the right way. Through SHO, I have had it lucky even that I got a job like I have now. It helped me understand people and their problems and helped them get in the right road to a better and more convenient life. So I say the SHO is a good thing for me and the community and hope they can come back next year because our part of town can ALWAYS have help.

Name withheld.



Chapter 4

Perspectives

The final evaluation session for the project was held at the University of Colorado Medical Center. In addition to health science students and interns from the project, the meetings were open to our advisors, members of the communities where we worked, members of the health care community and the press.

It included a discussion of individual placements, their assets and liabilities, successes and failures, as well as a hard retrospective and prospective analysis of Student Health Projects in general.

Peter Bonavitch, a third year law student at the University of Chicago, who has been integrally involved in both Chicago SHP's, delivered the keynote address to the conference. He spoke of the frustrations of SHO's involvement in ghetto communities and the very basic moral questionability of such involvement. He suggested that we not only reexamine our presence in these communities, but also channel the experience which we have accumulated there into more productive and effective roles. We have learned much from the communities often at their expense; we have learned that institutions are responsible to a great extent for existing problems in the ghettos. It is these institutions which are truly our constituencies, where our ability to catalyze changes in health care lies; in basic analysis of health care institutions, specifically our own health science schools, and in white middle class communities. . . .

NEW PERSPECTIVES

The final state of several SHO projects really is confusion, division, and hopelessness in many ways. I will just try to communicate that to you using Chicago as a model. I will start by telling you the story of what happened about 3 weeks into the summer project in Chicago this summer, and that which happened at Robert Taylor Homes. Robert Taylor Homes is the world's largest high rise urban renewal project for low income people, which means it is the world's largest vertical ghetto. There are about 27,000 black people who are housed in Robert Taylor Homes along about 30 blocks of Chicago. Last summer, SHO began a health clinic at

Robert Taylor Homes, or *tried* to begin a health clinic at Robert Taylor Homes, and by the end of the summer, all that we had succeeded in doing was to organize some residents into something that was called the Robert Taylor Health Committee; through the winter SHO people were working with people with this committee to try to get permission from the City Board of Health to open a health clinic there. It was going to be a very modest kind of clinic, doing mostly diagnostic work and feeding people into nearby hospitals. Finally, about half way through June, the Board of Health gave its permission to open up this clinic, and Student Health people from this summer's project were going to work to finally get the clinic set up, get equipment in and to get it opened up. About 2 weeks into the project, the clinic was about to open. It was going to open on a Monday. The Thursday before, we had a meeting in the same church where the clinic was supposed to be to discuss something entirely extraneous, and about eight young black kids from the community showed up at this meeting because they saw all these white people going into their church and they wanted to know what was going on. About half way through the meeting, they asked us what we were doing there. Some people tried to explain what SHO was and explained that we were meeting in that church because it was where the Robert Taylor Clinic was going to be. They said, "What Robert Taylor Clinic? We live in Robert Taylor Homes and we don't know about any clinic." We explained that we had a health committee which was composed of residents in the community, and they said, "What residents in the community?" We mentioned some names, and these kids didn't know any of these people—they were young black militants. They said that they would like to meet with the people who were going to be working in this clinic and find out what they were going to be doing. They asked if any black people from SHO were going to be working at the clinic. It happened that one of the girls was black and the other five were white SHO people.

They agreed on meeting the next day to discuss how the clinic was going to be run, how it was going to be staffed, et cetera. What came out of that meeting was an edict from these

black kids that they didn't want any white people running their clinic, that they had had enough; the essence of what they said is that they had enough white people coming in and telling them how to run their own community, and if they were going to have a clinic, they wanted it to be staffed by black people—they wanted black people to be deciding how big the clinic was going to be, they wanted black people to decide where the money was coming from and what the money was going for, and no white people had better show up that Monday. If they came Monday, they wouldn't leave again!

There followed a long series of negotiations back and forth. After about another week or two, the SHO people agreed that they really didn't have any legitimacy running the Robert Taylor Clinic, that they would do their best to try to find black doctors, to try to find black nurses to run the clinic, but there would be no white SHO people involved. The black militant kids agreed that they would also do their part to find black doctors and black nurses. The end of the story is that the clinic is being run and operated with a black staff. The mothers, the people who were on the Robert Taylor Health Committee, a puppet organization for SHO, have been phased out of the operation to some extent and these black militant kids are having much more of the say of what is going on.

The whole story points up something that is going to happen or already is happening more and more in Chicago. I think it is something that will happen in Denver also—at least in the black communities. In these communities there is really an upsurge of a feeling of identity which you are going to start running into. This raises some pretty basic questions about what SHO should be doing, about what the real purpose of SHO is. In Chicago, this touched off a crisis within the organization because about one-third of the people felt that these black kids were absolutely right, that we really had no legitimacy in the community and that SHO should really have never gone into the community in the first place with this kind of attitude—like we are going to give you now a health clinic—lucky you! Another faction re-

sponded by saying the health clinic is something that is needed in the community. It doesn't really matter who staffs the clinic—it is a health clinic and it is going to start healing people and that is all that counts—white, green, black, yellow, or whatever. Still, a third faction said that it is really good that this thing happened. We are really performing our function by acting as a catalyst to the community. We go into the community with our white middle-class selves and the community responds by throwing us out and organizing itself—organizing its own health clinic.

This stresses the importance of becoming analytical and starting to ask some basic questions about what SHO wants to be doing in the communities, and beyond that what SHO wants to be doing itself. I think you can set up a progression of the way that white liberals have seen their role in the black community. I think the first stage is that a white liberal tends to see himself as the savior and healer in the community. I am talking about a white, liberal, medical student. I think this was the initial idea of many people who come into Student Health Projects. They see themselves as going into the community and fixing things—going to save the ghetto in 9 weeks. It takes much less than 9 weeks to realize that we are not going to save the community, that sometimes the community doesn't want to be saved, and even if it does that we don't have the time and we don't have the resources and we really don't have the skills to do it.

The second phase is that we feel if we can't save it, we can organize it, and pretty soon we begin to realize, especially if we go into the communities which are beginning to feel their racial identities very strongly, not only that we can't organize it, but that we shouldn't be organizing it—we are white and the community is black. We can't do it effectively because of the hostilities that exist in the community. We should not be doing it—it's really not our place to do it. This is the kind of point-of-view that SHO in Chicago is coming around to.

The third stage is that SHO should be acting as a catalyst in the community, that we can go into the community and try to set up some kind of ongoing program and hope that the

community will respond by saying, "No, we want to do it ourselves." You can argue that that is a good role for SHO, more effective than either of the other roles, that is, going in and saying, "We know what is best for you, you are not really getting any place, you are not really very far advanced politically. We have thought about this a lot and decided that we were going in and try essentially to turn you off, try essentially to make you mad and get you mad enough to do it yourself." There is still a kind of condescension implicit in all this.

If you reject all the three that I mention, we can say that we have no role in black or brown communities, that those communities have to resolve their own political crises, they have to resolve their own identity crises. They have to get themselves together at their own pace and with their own leaders as they want to. Or you can say, I am available—I as a medical student, or a social work student, or a dental student, or whatever, have certain skills that I can offer to the community, certain technical skills. If the community wants to come to me and ask me, I will be happy to offer them, but I am not going to make any policy decisions, nor am I going to try and run it for them. That is where we are at the end of the project in Chicago.

Now the next question is if the Student Health Organization does not have 10 week summer projects that go into ghetto communities to perform basic services, then what is the role of SHO? In order to answer that you would have to think about what kind of an organization SHO is and you would have to think about the people that SHO gains its forces from. You would have to face up to the fact that the medical students are largely an affluent, white middle class group.* The statistics are that only 15 percent of all medical students come from families whose income is less than \$5,000, and 14 percent come from the 1 percent of families whose incomes are in excess of \$25,000 per year. So you have to start asking who is the constituency of SHO? There are two types of constituencies that you can talk about—the constituency that the medical students form from a white

upper class, middle class community. The other type of constituency you can talk about is other medical students, hospitals and health institutions, and just the institutions in our society that provide health care to people.

It is a premise of the SHO that health care is a basic human right. It is another premise of the SHO that the institutions that provide health service should be organized so that they give health service according to the needs of the people and not according to how much money there is in it for the doctors or how much money there is in it for the hospitals or the drug industry. The obvious question follows: Is the system organized to give that kind of health care? I think we would agree that the answer would have to be "no." It is organized on the basis of fee for service. It is organized on the basis of what the doctor can get out of the patient. The patient who can pay gets good medical care, some of the best medical care in the world. The patient who can't pay often gets the kind of medical care that you can get in any underdeveloped country in the world. There are all the statistics, like Woodlawn, a community in South Chicago has an infant mortality rate that is approximately the same as Nigeria's. In 1963, the nonwhite child (92 percent Negro) under 5 years of age had a death rate twice that of the white child.* In 1961, the United States ranked 15th in infant mortality statistics,** all of which is intolerable for a nation that is as industrialized and urbanized and highly developed as we are.

The welfare medical assistance system operates not to give people the best possible medical assistance, but to keep them from starving and to keep them from dying in the streets. Welfare recipients in Chicago are shuttled to Cook County Hospital which is the city run hospital and is a chaotic kind of mess of a hospital. And, I am told, that Denver General Hospital sounds very much like Cook County Hospital, and that welfare patients in Denver are also forced to go to Denver General Hospital, just like they are forced in a slightly more subtle way in Chicago to go to Cook County Hospital.

We had better start talking about the way

* Lasagna, Louis. *Life, Death and the Doctor*, Alfred A. Knopf, New York, 1968.

* Health, Education, and Welfare Indicators, p. 29, June 1965, U.S. Department of Health, Education, and Welfare.

** Epidemiology, Vital Statistics Report, WHO 19, 434, 1966.

the medical schools recruit their students. The way medical schools set up their curriculum. We have to talk about the mechanics of the medical school system. We have to talk about the reasons the medical schools discriminate against black people in admissions policies. We have to talk about the way that medical schools exploit interns and residents by paying something like \$4,000 to \$5,000 a year for doing really the bulk of the work in any teaching hospital. We have to talk about the way that hospitals operate in their admissions policies and in their staffing policies. This is the kind of analysis that SHO really should be doing. SHO should be dealing with the institutions that it knows best and those are the health care institutions. We should be researching the institutions that deliver health care and find out who controls them and find out why we have such an anachronistic system of health care delivery in the United States and find out where the health establishment's leverage is in the Federal Government, in the Department of Health, Education, and Welfare. Who are the people that really make the decisions? We have to start finding out where we can get at the power structure so that we can begin to change it and how we can change the whole orientation of the system. It really amounts to turning the whole system upside down, because what we are asking for, if we really believe that health care is a basic human right, and if we believe that the system should be oriented in that way, is to completely abolish the whole fee system philosophy. We ask that people get health care as they need it—not when they can pay for it.

If we can't analyze our own institutions and how they relate to the ghettos what possible legitimacy can we have in these communities at all? . . . None. I realize that most of what I have said has been directed at white SHO students and white professionals, but that is the bulk of medical professionals in general and this is exactly what we have to start changing.

PETER BONAIVITCH.

A reply to these remarks was offered by Dr. Bonnie Camp, a pediatrician at Denver's East Side Neighborhood Health Center, physician for the San Luis Project,

and constant source of ideas during the development of this SHP. She speaks below on the legitimacy of our involvement in ghetto communities in terms of our personal growth and ultimately of positive effects on the community . . .

COMMUNITY PRESENCE—A JUSTIFICATION

The implication in much of the discussion I have heard is that if one were really dealing with "health" problems, particularly the analysis of health care institutions, SHO would be able to accomplish more and students would spend less time in frustrating, useless activity; or the alternative argument that low-income communities don't need SHO to show or tell them anything. My remarks are addressed to the idea that there is a good deal that SHO can accomplish by continuing to go into the communities both in personal growth to the students and ultimately in returns to the community.

First of all, at least one Public Health Commission has pointed out that racism is the number one health problem in this country today. If you are not talking about a narrow definition of health, that is fine. But a narrow definition has been implied in much of the criticism that I heard yesterday, in much of what everyone has been saying today, and apparently implied by the representative from RMP in what he had to say about funding. Personally, I feel that for you to adopt a narrow definition of health is as much a flight from the real problems as has been the tradition in the past. Perhaps one of the things the health science students could do a little more effectively would be to acquaint the interns with some of the things that are involved in a broader definition of health. One could say, why is racism considered the number one health problem? Well, it is probably because of the kind of information contained in the U.S. Civil Rights Commission Report, the Kerner Report, and the Coleman Report on Education in the United States and on racial isolation in the public schools. You can call these social issues or racial issues; but if you want to bring it back down to the narrow definition of health, you can even talk about how you can make sure people keep their appointments

in a health clinic when a child needs continued followup care, about how much you can rely upon mothers to give medicine to their children, and about the delivery of health care. You just can't separate the problems of delivery of health care from these other broader problems. I think if you want to confine yourself to a narrow definition of health care, you might as well flee back to biochemistry and microbiology, anatomy and physiology. You can escape the broader problems which are the hard things to deal with and the things that will tear you apart. Emotionally, I think that is what you all have been faced with this summer. . . . the fact that it is the social, the mental, the little menial tasks that make delivery of health care in a poor community a big problem. It is the problem of taking care of a family of eight children, all of whom have a different kind of medical problem, a mother who is psychotic and a father who is in a penitentiary for having molested one of the little girls of the family. That is the kind of problem you could spend your whole time with. . . . just trying to deal with one family like that. I feel very strongly about this, that the more you cling to a narrow notion of health, the further away you get from the real advances of even having SHO. The very fact that there are medical students who are concerned with other problems than starting IV's and doing gallbladder operations is really unusual in the history of medical education. And as far as getting black people and other minority people into these kinds of schools and education programs, you may be interested to know that the Howard University School of Dentistry was unable to admit black students to its freshman class last year because of the lack of applications. So they have 70 white freshmen in the school of dentistry. One out of every 670 white people go into one of the health science fields; but only one out of every 5,000 Negroes go into a health science field. It is an enormous problem to find people who are both representative of their patients and well-trained in a health care profession. The impact of this kind of problem is not something you are likely to recognize on the basis of any 10 week personal experience. However, I think that your efforts to stimulate in health science professions is

something that should be continued. A lot of effort and energy should be directed toward this; and if nothing else, expand your intern program about five times. So if you want to talk about a program, don't worry about it not being relevant to a narrow definition of health. Make it relevant to the broader problem of delivering health care.

BONNIE CAMP, M.D.

DISCUSSION

These two points of view provided the nucleus for an evaluation of our presence in ghetto communities and the future direction of Student Health projects. Excerpts from this discussion are transcribed below. They reflect not only the frustrations of 10 weeks of an extremely intensive involvement, but also the marked personal growth, the constant reevaluation of our roles as individuals and future health professionals, and new directions to firm commitments made over the course of the summer. Few answers are provided, but perhaps the evolution of these ideas is a necessary first step.

ON DEFINING A COMMUNITY

Throughout this report people have been referring to an ostensibly straight-forward entity: "the community." SHO has classically thought of itself in the role of "community advocates." One of the greatest sources of frustration to all the SHP's has been the problem of deciding who are truly representative of these census tracts, these "communities," in which we have been involved. This dilemma arose continually over the course of the summer: In the decisions of whether or not we should work with agencies which may or may not have been representative, in attempts to establish a community board for Denver General Hospital comprised of "representatives from the community," . . .

AUDIENCE: In your talk you referred to a vague entity, "the community." What you had in mind were militants, those eight black kids who came into the meeting. They are the leaders and spokesmen of the community. I'm not

convinced that they really are "the community" or even the leaders of "the community." I am impressed with some of the things black militants have done. I am unimpressed with others. Did those eight kids ever confront the original committee that you formed?

PETER BONAVIDICH: Yes, they were eventually forced to get along with each other. There was initial friction.

AUDIENCE: Who comprised the original committee?

PETER BONAVIDICH: Eight mothers.

AUDIENCE: And which group of eight best represented the makeup of the Robert Taylor Homes?

PETER BONAVIDICH: I have to make a value judgment because I don't even know what it means to represent the community. I don't know what community legitimacy is. It takes a great deal of effort to find out . . . You have to talk to people, evaluate the kind of support these kids have in the community. We discovered that there seems to be an understructure to these kids in this particular case. And there is more sympathy for them and what they want to do than for the original mothers. There is obviously an age breakdown. All the 40-year-old mothers don't care whether they have white students or black students manning the health clinic. They want a health clinic in Robert Taylor Homes. But the militants, who are a pretty large group, want black staffing.

AUDIENCE: But ultimately SHO made the decision for Robert Taylor Homes as to whom their clinic was going to be run by.

PETER BONAVIDICH: No, what we did was to pull out. That is right, we deserted the community and we waited for the community which was running its own health clinic to decide for itself, and to ask us to give them whatever help we could.

AUDIENCE: It is a very false assumption to state that 27,000 people in Robert Taylor Homes belong to the community; this is a complement of millions. There is a community of militants, and there is a community of other people with community interests. What you did was accept the most vocal group as the community. Who was the most representative group there? The black militants wouldn't have anything to do

with those 40-year-old ladies. Who is going to use the health clinic, the 22-year-old kids or the 40-year-old ladies with six kids?

PETER BONAVIDICH: There are two commitments really. One is the commitment to the principle of community control. Another commitment is whether you agree or disagree with the proposition that clinics or institutions in black communities should be controlled by the black people or by the white medical establishment.

AUDIENCE: We are talking about an isolated small clinic, but the implications are obviously much more general. This is a problem which medical people are going to have to face now. There will always be one segment, the users—mothers and children; they are going to want medical care. There is another segment which is not looking for stop-gap therapy but for long term solutions. These long range goals necessitate that the community develop itself without white intervention. But you were in the position where you made the choice by either remaining there or withdrawing.

PETER BONAVIDICH: My personal feeling is that SHO should not put itself in a position where it has to make that kind of decision, because I feel that SHO as an organization should not be even the force that is providing resource help to the community; that it should be provided by some other health institution.

A QUESTION OF LEGITIMACY

Because of the problems of defining the communities in which we were involved and our subsequent relationship to them, it was felt by some that we should respond only to the requests of certain segments of these communities for our presence. In this way just whom we represent would be clear, as would our specific roles. Others felt that we had absolutely no legitimacy in ghetto communities because "that kind of service function provides a safety valve which releases some of the pressures which might operate otherwise to develop an effective political organization." . . .

Just because there is no local political organization, political awareness or militancy in a community does not mean that it makes it open to entry to any white liberal who wants to go

in and save the place. It really means that the community is open to exploitation. It means that the entrance of a white liberal organization into that community will retard its development, because that kind of service function provides a safety valve which releases some of the pressures which might operate otherwise to develop an effective political organization.

I think you have to go beyond what is merely educational and talk about what is morally right, morally sound. Going into ghetto communities is highly educational. The historic function of summer projects has been to pull medical students toward some kind of realization of the ills of the health care system. This is a very efficient way of accomplishing that task, but it is done at a very high cost to the community. At some point we have to take the moral stand that it is wrong to do that. It just isn't right to exploit the community for the sake of educating medical students—at least for an organization like the SHO which thinks of itself in some kind of moral terms. It is immoral because there is a kind of paternalism involved and because we are not dealing with the people as a group, we deal with them as some kind of pathological specimen, a show case.

I don't think it is true that the average medical student coming into the community would see it as a disease entity under a microscope—something removed. In fact a very large function of SHO is to have its people relate to individuals in the community as human beings and not just as clinical case presentations.

I think that your coming from a white middle class community and going into a black community and trying to organize it and set up clinical facilities and things of this nature is a well meaning project. But coming from upper middle or middle class white families, you don't know any of the problems of the ghetto and you are trying to impose those same middle class values which you hope to avoid on people who don't want them.

It is for the community to judge whether or not they want our presence, and the judgment we are asking the community to make is, "It's going to be good for medical students, and therefore, it is going to be good for us in the

long run if we ask them to come into the community to educate them to our ills." The community has a legitimate feeling that they have been studied to death. If they don't want to perform the function of educating us, they shouldn't have to.

THE QUESTION OF EXPOSURE

The grant proposal for this project stated three major objectives: service to the communities, the development of a high school inter-biomedical careers program, and self-education. In the previous discussion it was implied that our own education comes about at too high a price to the community. In this section it is argued that individual commitments toward changing the health care system in the future can be made only on the basis of this type of exposure to ghetto areas as health science students. Those sympathetic with this view argue that at some time we must find to what extent we are capable of becoming involved with patients as human beings. The counter-argument is that SHO has evolved by this type of community involvement to the point where, "people who have grown up with SHO have developed theoretical perspectives about their own lack of legitimacy in exactly the things that caused them to join the group in the first place." This faction argues that it is not necessary to repeat our past history to maintain a sense of involvement. . . .

I think there is a point that we have missed. We have been discussing SHO's presence in ghetto communities in terms of medical education. In medical school you are taught not to get emotionally involved in a patient. "Don't go overboard or you can become involved with every patient!" But at one point in your life you must become emotionally involved in a patient as a total individual. Perhaps something good will come out of a 2 month stint working with someone on a medical problem out of the clinic, going over it every day, and trying as hard as you can to accomplish whatever goals you have set. Through this you can begin to understand—as students, or as residents in a hospital, or when you are practicing—what it means *not* to get involved with a patient. You

must see how far you can allow yourself to go. If you have never become involved before in your life, then I think that when you hear people give this advice, you just have to find out where the point is for yourself. This project is a unique opportunity to come to grasp with that important question in your medical education and your lives.

If you understand the inception of SHO, these were the people involved in civil rights; they saw the conditions first hand, and that is what moved them—not reading the papers. This is why these projects are so important because reading the papers you don't get moved as much as you do working in the communities. The motivation to change the system comes from the experience we have all had.

These people who have grown up with SHO developed theoretical perspective about their own lack of legitimacy in exactly the things that caused them to join the group in the first place. I don't feel that we have to repeat all our prior history before we can develop a better perspective. I don't think that every person has to live through the whole thing. Many of the people in SHO, many of the active members, are people who have not gone through the whole student health movement. Some of the people in the project this summer really never had any contact before with that kind of sensitization, and yet they came to the project aware. They came into the project questioning its validity.

Some people like myself had to be exposed to this kind of experience. I came out of it with a certain feeling. If I hadn't done it—if I had read the paper and saw it on TV, it would be very hard for me to say I am going out and do something.

THE ROLE OF HEALTH CARE INSTITUTIONS

One possible solution of the dilemma of the urgent need for self-education and SHO's lack of legitimacy in ghetto areas as a group would be for the health care institutions to assume whatever roles the summer projects have fulfilled. This would mean an incorporation of such activities into the curriculum of health science

schools. This might be interpreted as passing of the proverbial "buck." On the other hand, our project experience has clearly demonstrated that a great many of the problems of delivering health care to ghetto areas arise from an inexcusable lack of communication between health care "providers" and "users." Perhaps such service projects, if legitimate at all, should be the function of health care institutions. . . .

The question we have asked is: Should SHO be the institution that sensitizes medical students to the problems of the ghetto in this kind of direct experimental way? I don't think it should. First, no one should enter these communities until they are asked, and then I would have the health systems of the institutions do it.

The white liberal medical student has no role by himself or as a member of SHO in the black community even as a resource person. The resource people should be supplied by other institutions, and other institutions should be facing that dilemma. SHO should not think of itself as some kind of junior hospital or as an organization that sets up junior hospitals. I think the medical school and the hospitals which are actually in the ghetto areas should be dealing with the community at all times on some kind of equal basis. The institutions themselves should be developing the relationships, with the community, and asking the community if they want medical students to come in.

Another point we mentioned was how are white liberal students to find out or to expose themselves to the ghetto? I think the answer is that our health science schools have to provide that. SHO should not be expected to do this since its goal is really to change the health care system. We should not be expected to perform this kind of service function. The medical schools themselves should expand their community medicine or preventive programs. That means that the medical schools themselves must undergo a radical change. They must begin to negotiate on an equal basis with the political powers in the community.

THE FAULT, DEAR BRUTUS . . .

If we have no legitimate role in ghetto communities, we must define new perspectives for our energies.

We are constantly being told by our black and brown associates, particularly the militants, that our role should be in spreading the word to our own communities, in our own institutions. If there is a role for SHO in black or brown communities it should be assumed by black or brown students. . . .

SHO has among its interests, not only changing the health care system, but providing a more humane education for medical students and for all health science students. There are many different interests involved. Instead of working with ghetto communities, we should enter the white communities to help the health programs that are in the black communities. Those white communities, our own communities, are responsible for propagating the double standard of health care.

I think the white community is much more nearly the constituent or the source of the people who are in the SHO. If we have any leverage, it is in the white communities. There would be much more conflict, much more hostility if we even started doing anything substantial there, because that would mean real change.

If I learned anything this summer it was the extent of prejudice among whites—even my own parents, aunts, uncles, friends. . . . For instance, we came to this old man's house, and I happened to mention that after we had scrubbed for 8 hours, and it was really dirty because he was too debilitated to clean it himself, he immediately started spitting tobacco again. My friends started saying, "There, you see? Now you know, 'these people' want equality, but are just plain dirty." I think we should take high school interns into the white community and go see those people, make them see they are individuals—no better or worse than themselves.

The essence of this conversation is that the problem is outside, not inside. I feel the same way after working with the East Side Action Center, where we sat around for a few days with our mouths open, trying to look like water fountains and stay out of the way. We then jumped into a project called Main Stream which engulfed us, and we felt like we were doing something with 20 boys; it was a productive summer for them, and for us getting to know the community at the same time, but I

don't think it warrants going back again next year. I think our job is on the outside working with the white community in general and specifically with the white institutions presently exerting control over certain aspects of ghetto dwellers lives.

There is a faction of SHO called the black caucus. This group consists of all black students. There is a feeling growing in the black caucus that their legitimate function is to begin to look for black students to work with the community organization in their communities, to organize them around the problems of health care. Again, that all rests on the proposition that black communities are the constituencies of the black students and the white students are the constituents of the white communities, which is practically all of SHO.

I think that the way things are now socially, a black person going into the black community and aiding in terms of the educational opportunities and things that you talk about would be more understood and appreciated. There wouldn't be a development of hostilities on either side, and I think that you should be able to find some black people to work in this particular project.

A QUESTION OF LEGITIMACY RECONSIDERED

Still, arguments remain for our presence in these communities based on the present lack of involvement of other institutions in assuming our roles, the overwhelming immediate needs of ghetto dwellers causing organization around health issues to assume a low priority, and the need for continuing the high school intern program, one of the three objectives of the summer program as well as one of its most successful aspects. . . .

"What has SHO tried to do? Has it gone in and tried to organize the community?"

"Yes, but we think that is a mistake."

"Well, they are not going to organize themselves. Their problems seem to revolve around just making enough money to live. Under such circumstances the existing conditions will remain the same."

If our aim is to change health science students, but at the same time begin changing the

health care system, then we might send new people in to help the communities. Let them see the problems first hand. You are not going to get new recruits to come around and work for a summer on health care analysis, because they don't understand it and they don't care!

One of the objectives of the high school intern program was to put individual problems into a community context. Before the project these kids only looked upon their own personal problems; they didn't realize that the whole community was affected by the same problems, and we should give them a chance to look at the problem as social rather than personal, and to direct their own efforts toward organizing.

Other arguments are based on certain inadequacies of community agencies and our role in influencing them. A sample of comments concerning agencies with which we had contact in all of the project areas is presented below. . . .

The agencies don't focus on health. They are interested in jobs, money, houses, roads, water: Health is the last interest. I think that a re-orientation toward health considerations is our most valuable role.

I don't think that our sanction by the _____ Center is a sanction from the community because I don't think that the people on the staff are really representative of the community.

_____ has a lot to offer but it is very defensive about letting information out to the community because it just raises their aspirations and they start making more demands on the director, and he just doesn't know what he is doing.

I can't evaluate the organizations because they are not getting anything done.

The agencies are there but they are not good. There was only one agency person in the whole community with whom we felt really comfortable, and he was a Spanish-American who understood his people's problems. He was the only person that we could talk to.

The _____ agency has a hard time getting anything done. They are more interested in rubbish rules, being on time to meetings, and parliamentary procedure, than in community action.

The agencies cooperate when we're around but then they do nothing.

Our role in assuming responsibility for these agencies and our influence on them is discussed. . . .

What we did as SHO's was to be dedicated and do the jobs for them. The Public Health Nurse should have been taking care of two children whom I brought in from _____. The _____ Council should have found out about a migrant family for whom I got public health forms for health care. _____ should have been handling food stamps, they were trained to do it. I took care of food stamps myself. I went around from family to family to try to get them in the food stamp program.

The town where I worked has an ideal setup in terms of agencies and service organizations which might encounter public health. They are willing to take anyone. There are eight Vistas, plus a supervisor, and it is a community of 3,000. It has all these resources there and the reasons they don't function is that the people in the organizations are lazy or don't really care or are not dedicated.

After our 10 week presence, the Public Health Department now realizes that they can do things that they have never done before. They now have the first rush of activity they have ever seen; they now know what public health means—more than waiting for the people to come to the building for immunizations. We showed them that 60 children would come for such a program where they had only four previously.

I think that this is the most important thing about the project. It really doesn't matter if you go some place and set up a program or set up a clinic—those are just additions to the structure already there. Our only legitimate function is going places and opening up people's eyes, making them more aware of what is happening and more aware of themselves—people in Public Health Departments and Welfare Departments. Then when we leave it doesn't matter whether we have an existing program there or not, because we have made some effect on the structure. To affect the people there and make them aware of what benefits they can have is

a concrete change—you don't have to leave a monument behind.

THE CASE FOR INSTITUTIONAL ANALYSIS

The point was made several times in our discussion that what we have done in ghetto areas amounts to "band-aid measures" rather than "preventive cures." We have been dealing with the end product of the health care system rather than with its roots. Our work is easily ignored by the medical community which largely passes us off as "those idealistic kids." Yet it is the unresponsiveness of the medical communities which has catalyzed growing student involvement in preventive measures rather than our historical concern with crisis therapy. . . .

We are posing a dilemma—we shouldn't go into the community, but the only way we can learn is to go into the community. I think if we started working within the power structure in our own institutions and if we ran into some of the dynamic people there, we might start getting turned on just as much. The medical power structure doesn't pay any attention to our work in the black communities. We are not going to be labeled for that. But, if we were to start mixing with the white medical establishment we might have a chance to create some change.

We have been observing the end stage of a disease process—we have been working in communities where you see the results of the present health care system. We have been abandoning the place where we have leverage. This is in the medical schools and the hospitals. We have been patching up this end but ignoring the process itself. In a way we have been retarding the development of the people who would like to change things in the affected communities. I think we should be analyzing the existing health care institutions and change them before they begin to affect these communities.

The problems of the black communities are extremely well documented already.

Research of health care institutions is a more worthwhile channel for our energies than going into the ghettos for 10 weeks. If you talk about

marginal change, and you know the amount of change you accomplish in a given time, it is going to be greater for this kind of study than it is for the summer projects. Our energies could be better directed. If you don't do anything else but get a few more students to come around to realizing the kind of health crisis that we are in, then we really accomplish something. The future of the health care profession is in the hands of present health students.

The idea of research really burns me because we will come up with these sophisticated analyses of just how things got the way they are, but will that make any difference in the way we are going to be able to affect things? We will come up with some real nice sophisticated, understanding medical students, but no change.

"Why can't we develop an understanding that really attempts to get at the root of the problem? If the root of the problem happens to be that a particular medical establishment is a white racist group, then that is one thing to document."

"What happens then? Where do you go from there?" "You use the media. I really see that as a kind of educational function for ourselves, the medical community and the general population. This kind of exposure must lead to positive action."

I think it is naive to assume any exposé that SHO could write of any institution or powerful city hospital could do anything but cause a defensive reaction.

Maybe we shouldn't expect anything but a defensive reaction, but I think that is the type of thing that we have to begin doing.

If SHO came up with the kind of documentation we have been talking about, and if the corruption and the kind of corporate exploitation is the kind of control that interests like the medical establishment and the drug industry exert on the health profession, and is really as great as we think it is, then that is something that needs to be said and something that people will be interested in.

We agree that, with the kind of medical care that is being made available, we want to change that system where we have the best leverage. This is in the medical schools and hospitals. If SHO has any power it is there.

BRINGING IT ALL BACK HOME

The transition between these short but intense and committing summer experiences and reunion with our health schools has been found painful. Many of the reasons have already been stated: The lack of communication between our schools and the communities with which we have been involved; the immobility of our schools toward dealing with the problems which we have seen. Some participants have dealt with this transition by dropping out of their respective school, not unlike those students described in Kenniston's book, "The Young Radicals—Notes on Committed Youth." The optimistic alternative to this course is the role of SHO in changing our institutions—living our experiences, "bringing it all back home."

Once we know something that exists, what do we do? Do we sit back and waste our time doing menial little jobs taking one family to the doctor. SHO now can have some kind of identity as a group of people who are committed based on some common feeling, but there is the feeling that something needs to be changed. It can be changed within the health schools, hopefully. We can begin to make demands on the administrations of our schools to set up some kind of quota system to admit minority students, to begin to train minority professionals. We can begin to change the whole structure of medical education which is uselessly long and brutalizing because they teach us to regard patients as specimens, something to be worked on as interesting pathology under the microscope. They bring in gangs of residents and interns, third and fourth year students to look at "this case," "examine "this patient." Another concern is the fact that hospitals provide no mobility for nurse's aides and

almost no mobility for licensed practical nurses, and they pay the hospital orderlies and the sub-professional groups almost starvation wages, not to mention the wages of the house staff.

I do think that it is a legitimate function of SHO to begin to recruit people, and I think that SHO should demand that it be a function of the medical schools to begin actively to recruit minority groups, out of high school into college, and out of college and into the medical schools. I see this as more of a pull of SHO and the medical schools rather than any kind of push within the community.

Even when you assemble numbers of minority students with the right credentials, few know how to go about the whole application process, which is a whole skill in itself. It is really only the big medical schools, the fairly prestigious ones, which are doing anything meaningful in that area. The State medical schools which train the bulk of medical students really just are admitting token "black" students.

For the bulk of minority students an attempt to increase admissions would require a supplementary education program as well as continuing financial aid. Students presently in health schools could aid in all aspects of such programs.

The question now is what to do when we get back to our schools? How do we start working with our own community right away? Ten weeks of experience stands between us and our schools. Can we direct ourselves from the very time that we get back to utilize the things which we have learned this summer and apply them to constructive projects in our institutions and even to the basic concern of relating these experiences to our classmates and influencing them? That's our bag. That's where it's at.



Chapter 5

The Evaluation

Alfred Claassen and John Quicker are sociology graduate students at the University of Colorado. During the summer they examined many aspects of the project including general changes in student attitudes, the student's specific feelings about the project, and community residents' and agencies' reactions toward the SHP. In addition, they compiled the logs of daily activities summarized below and the project participants' descriptions of the health care system in their respective areas, as well as the study of folk medicine in the San Luis Valley presented in chapter 1. The methods used are detailed in the appendix.

They worked independently of the project staff. It was felt that in this way they might come upon a more objective analysis than if they were considered a formal part of the project. As a result, the opinions expressed here are their own although most of the project staff and participants would likely be in agreement with a majority of their report and recommendations. I have taken the editorial prerogative as project coordinator to control certain points raised here in the preface of this book. . . .

THE PROJECT EVALUATION

Alfred J. Claassen and John C. Quicker, Department of Sociology, University of Colorado.

In this evaluation we begin with a discussion of the students, who they are, their backgrounds, where their interests lie, and what their attitudes are like. We then discuss the effects of the summer's experience on the students and the interns, evaluate these effects, and suggest improvements for next summer. This concluded, we summarize some of the accomplishments of the project in carrying medical and related services to the poor. Finally, we turn to some of the problems in this aspect of the project and again make recommendations.

A. The Students

1. Demographic Characteristics

Age: Twenty-five of the 30 students were between the ages of 21 and 24. The range was from 20 to 28.

Professional Background: Twenty of the students were from medical schools, all but four of these being second year students, the others, third year. There were also four nursing, one education, three social work, and two law students.

Social Action Experience: Probably the most valuable experience as a background for the Student Health Project is community development. 27 percent of the students reported previous work in this area. Public health experience is another factor which 33 percent of the students reported; 30 percent indicated participation in past action projects similar to the S.H.P.; 50 percent of the students had done some tutoring of underprivileged children. A total of 70 percent could call on experience in one of these areas.

Residence: None of the students were from towns of fewer than 2,500 people, 23 percent came from small towns, (2,500 to 25,000); 33 percent from medium size communities; 14 percent from cities of 100,000 to 500,000, and 30 percent from cities of over 500,000.

Occupational Background: The occupations of the fathers of participating students were very high in status as they have been in the other Student Health Projects. Table I indicates the breakdown. Family income is also high, the median being \$15,000, and a full third over \$20,000.

Table I.—Father's Occupation

	Percent
Medical Profession.....	23
Nonmedical Profession.....	20
Executive.....	10
White Collar.....	17
Skilled Labor.....	17
Semi-skilled Labor.....	0
Unskilled Labor.....	0
Farm.....	0
No Response.....	13

Religion: The distribution of religious preferences of the students was also not that of the general population: 40 percent Jewish, 30 percent Protestant, 3 percent Catholic, and 27 percent had no preference.

Political Party Preference: The political views of the health science students differentiated them most strongly from the typical

medical student. The former's party preferences were 43 percent Democrats, 54 percent Independents, 3 percent Peace and Freedom, and 3 percent Republicans.

Other Characteristics: All 30 of the students were of the white race; 16 of the 30 were males, and 75 percent had both parents born in the United States.

Main Concerns: When they entered the Student Health Program, 53 percent of the students looked forward to the learning aspect with greatest interest, 27 percent to being able to help the poor, and 20 percent to a gratifying experience. When asked to list their primary apprehensions about the program, 33 percent were afraid that the summer would bring no concrete accomplishments, 20 percent were worried about personal inadequacies, 17 percent questioned their ability to gain acceptance in the poor community, and 23 percent listed other concerns.

2. Attitude Scales

Identical attitude questionnaires were administered to the students as they registered for the orientation period at the beginning of the summer and again at the evaluation session at the end of the 10 weeks. The questionnaire was made up of the 10 scales to be found in the Methodological Appendix ranging from 7 to 14 items each. The first six scales have been used in the past by the California Student Health Project, the last four were constructed by us for the Colorado S.H.P.

Scale 1 measures the relative emphasis of the student on learning from the summer's work or on helping the poor. Scale 2 measures the degree of compassion, as opposed to aloofness that the student feels the physician's role should entail. Scale 3 measures attitudes concerning the idea of public health clinics. Scale 4 concerns humanitarianism, or, more specifically, the degree of respect for the poor and their characteristics. Scale 5 gets at beliefs and misconceptions about the poor and is coded for favorableness and unfavorableness. Scale 6 measures favorableness toward the members and practices of the medical profession. Scale 7 involves domestic, political liberalism vs. conservatism. Scale 8 measures the degree of

liberalism in views toward the relationship between politics and medicine. Scale 9 measures knowledge of the culture of poverty. Scale 10 aims at activism or militancy or the radicalism of the methods of the student in approaching our Nation's problems.

The first six scales were coded 4-3-2-1 and the Colorado scales 6-5-4-3-2-1; in each case the highest score was given to the most liberal answer with the exceptions of scale 1 where "helping" was scored high, scale 6 where unfavorableness was scored 4 points, and scale 9 where sociological accuracy was scored high. In the appendix, the high scoring answer is the one with the asterisk. There were 32 students in the Colorado Student Health Project and in 9 of the 10 scales the N was 29 with both before and after responses and for scale 5 it was 28.

Initial Attitudes

The most salient characteristic of the students' attitudes at the beginning of the summer was that they were extremely liberal for medical students in political views generally and in feelings about the medical profession and medical problems specifically. In order to illustrate these views, table II gives the mean scores on each of our scales.

Table II

Scale Number	Mean Score (In June)	Mean Score (In August)	Possible Score
1 Education.....	22.38	20.68	36
2 Physician involvement versus aloofness.....	45.31	45.25	56
3 Public health clinics.....	29.97	31.45	44
4 Humanitarianism.....	24.79	24.89	28
5 Beliefs about the poor.....	30.24	30.24	40
6 The medical profession.....	24.86	26.10	36
7 Liberalism-conservatism....	52.67	56.67	72
8 Politics and medicine.....	47.03	47.44	60
9 Knowledge of poverty.....	44.87	44.87	60
10 Approaches to change.....	50.97	52.62	78

In order to convey a feeling for what these raw scores represent, we will give several examples of median answers to various items. On scale 7, liberalism-conservatism, the students agreed to the statement, "With our Nation's great wealth, no form of poverty should be

tolerated." They disagreed to, "Anyone can pull himself out of poverty who has the will to do so." With regard to the medical liberalism, they agreed that "Considering the incomes of other segments of society, physicians earn more than enough already." To further differentiate themselves from the average medical student they agreed that, "If community medical services are to be expanded, the Government should play the major role in backing this expansion." Concerning activism, they slightly agreed that, "The system has a way of corrupting idealists who think they can work within it." They slightly disagreed to, "In pursuing social change breaking the law is never justified."

Attitude Change

Fortunately, social psychologists have developed a large body of findings on the mechanics of attitude change. A survey of this literature led us to predict a number of attitudinal reactions to the experience of the summer on the part of the students. For two different reasons, we anticipated a general shift in the humanitarian or liberal direction. First, the milieu of the medical school is much less liberal than that of the S.H.P. Thus, through association with a greater than usual percentage of liberals, the general trend of attitudes should be to the left. Secondly, Festinger's dissonance theory would anticipate the attitudinal paralleling of actions. Participation in the S.H.P. is a liberal action and conservative beliefs would lessen the importance of the summer's activities giving the actor less satisfaction. The more successfully the student perceived his summer's activities, the more strongly this principle would operate. Third, constant focusing on the problems of the poor with a corresponding lack of attention to competing problems such as high taxes and military obligations would be expected to increase the salience of poverty as a problem and hence bring a liberal shift.

A second prediction was that, again because of the salience factor, our eight students assigned to health clinics would change more in a liberal direction on the five scales touching medical problems than would the other students.

Table III gives the results of our first prediction concerning the shift to liberalism for

those scales covered by it. Since our prediction was that there would be change in a liberal direction, the no change subjects are added to the negative change subjects in the statistical computations. Table III shows that with reasonable significance three of the eight scales confirm our prediction. Thus, the students became less favorable toward the medical profession, more politically liberal and more activist-oriented. However, as can be seen, the changes noted in the table are all in the predicted direction and a Chi Square of the totaled items is significant at the .001 level when including them with their reversals.

Table III

Scale	Number of positive changes	Number of no changes	Number of negative changes	χ^2	Level of significance
2	15	2	12	-----	
3	17	5	5	.43	.30
4	14	6	9	-----	
5	14	3	12	-----	
6	18	4	7	1.68	.10
7	19	3	7	2.79	.05
8	14	3	12	-----	
10	20	1	8	5.53	.02

Again we will turn to changes in median responses to specific items to illustrate these general trends. To the statement, "Many physicians are in practice just for the money;" the students first tended to disagree and later tended to agree. Also, at the beginning of the summer they tended to disagree and at the end tended to agree that, "Physicians are generally not responsive to the health needs of poor people."

On domestic political liberalism, the following were the strongest shifts: (a) From slightly disagree to slightly agree that, "Police brutality was a major reason for our riots last summer." (b) from disagree to strongly disagree that, "Minority groups are trying to move too fast in seeking reforms." (c) from disagree to slightly agree that, "Conditions are so bad in our cities' ghettos that no Negro could be blamed for rioting." (d) from slightly agree to agree that "The unemployed should not be blamed for turning down low paying menial jobs."

There were also several revealing shifts on activism items: (a) From slightly agree to agree on, "Most liberals talk humanitarianism but are not willing to make the sacrifices demanded by action." (b) from disagree to only slightly disagree that, "Nothing can be gotten from 'White America' without violence forcing the issue." (c) from slightly agree to agree that, "The system has a way of corrupting idealists who think they can work within it."

Table IV summarizes the findings relevant to our second prediction concerning the strong "effect of working in clinics on medical attitudes." Scale 9 is included because most of the items concern knowledge about health practices of the poor. Here the students who had close contact with the medical problems of the poor all summer, as expected, showed change in the direction of greater accuracy of knowledge in this area. On the attitudinal scales, even though the trends are in the direction predicted, they are not strong enough to confirm matters. It is interesting that the only slight reversal comes on attitudes toward the profession. Students from clinic placements maintained their same level of esteem for physicians in their general approach to the poor, whereas the other students became more disenchanted.

Although we did not make further predictions, the theory of attitude change led us to become interested in another aspect of the questionnaire responses. This is the difference between the changes of those students in urban and rural placements.

If attitudes are viewed as functionally understandable responses which the individual makes

consciously, or more often unconsciously toward adapting to his social environment, then large environmental differences are likely to parallel important differences in attitude change. In the Colorado S.H.P. half of the students worked in the midst of turmoil and a sense of urgency pervading Denver's urban ghettos. The other half worked in rural agricultural communities primarily with Spanish-Americans who settled the Southwest three and four centuries ago with a "mañana" culture and emphasis on the extended family that served its people well in the past but in the context of American industrialism leaves them confused and in poverty.

With such contrasts we felt certain that the radically divergent experiences of urban and rural students would show up in their attitudes. Table V confirms this supposition. It will be recalled that scales 7 and 10, the political liberalism and activism measures were the ones that most strongly confirmed our first pre-

Table IV

Scale	Site	Positive change	No change or negative change	Fisher exact probability
2	Clinic	5	3	
	Nonclinic	10	11	
3	Clinic	6	2	.10
	Nonclinic	11	10	
6	Clinic	4	4	
	Nonclinic	14	7	
8	Clinic	5	3	
	Nonclinic	9	12	
9	Clinic	6	2	.01
	Nonclinic	7	14	

Table V

Scale	Site	Positive change	No change or negative change	Fisher exact probability
1	Urban	3	11	
	Rural	6	9	
2	Urban	7	7	
	Rural	8	7	
3	Urban	8	6	
	Rural	9	6	
4	Urban	7	7	
	Rural	8	7	
5	Urban	4	10	.10
	Rural	10	5	
6	Urban	9	5	
	Rural	9	6	
7	Urban	13	1	.001
	Rural	6	9	
8	Urban	8	6	
	Rural	6	9	
9	Urban	9	5	.05
	Rural	4	11	
10	Urban	14	0	.001
	Rural	6	9	

diction of a general liberal trend. However, we now learn when partialling by sites that the effect is entirely due to the urban students who almost unanimously become more liberal and radical. In fact 60 percent of the rural students remained the same or became more conservative.

Now turning our attention to Scales 5 and 9 (measuring respectively favorableness of beliefs about the poor and accuracy of beliefs about them) further light is shed on the differences. Students in the urban setting changed toward significantly more accuracy in their assessment of demographic and behavioral characteristics of the poor and, at the same time, were less inclined to accept liberal platitudes about the poor. The rural students became less objective and more favorable.

Different types of experiences must have influenced these findings. First, the great feeling of frustration, immediacy, and necessity in Denver with the constant threat of riots, incidents of police brutality, and militants predicting chaos impressed the students with the need for extensive reform at the earliest time. "Go slow" methods were not working. The poor are angry and vocal, making their discomfort extremely visible. On the other hand, the rural poor are still generally content with their life styles and in many cases are not aware of or concerned with existing poverty programs.

Secondly, as we will explain later we feel that the urban sites were generally more successful than the rural ones. Thus, again from dissonance theory, there would be a tendency on the part of some rural students to repudiate the whole philosophy of aiding the poor with the existing approaches rather than identify with what they perceived as an unsuccessful experience. Thus a conservative attitudinal reaction would be understandable.

Finally, it should be mentioned that at the beginning of the summer the students put a relatively higher emphasis on the educational experience goal of the summer program than on the concrete accomplishments that would come. This became even significantly stronger by the end of the summer. Perhaps this was due to the sobering realization of poverty's magnitude and their own limitations.

3. Careers

Included in both the pre- and post-summer questionnaires was the open-ended item, "Describe your immediate and long range career plans." Since the program was almost entirely made up of returning students, the immediate plans largely concerned finishing school. The change in long-range plans is indicated in table VI.

Table VI

	Before	After
Career type only mentioned.....	6	6
Undecided.....	9	6
Career including poverty work.....	14	17

Before and after, six students mentioned a specific career such as private practice as a pediatrician or radiologist, without mentioning a desire to become strongly involved with problems of the poor. However, 14 did mention such plans in June and 17 in August. This is not significant statistically but we feel it is a trend worth considering because, if anything, there were perceived demand characteristics in the questionnaire in June to appear committed and dedicated that were not as important at the end of the summer. Thus, if our findings erred, they would almost certainly have done so in a conservative direction. At any rate, we feel that an increase of three professional medical practitioners committed to a life of concern for the underprivileged is a noteworthy accomplishment in the program.

4. The Summer as a Learning Experience

In addition to all of the above, which is central to the question of the meaning of the summer to the students, we asked them to comment on the success or failure of the summer as a learning experience. We coded their responses on a continuum from 0 to 9 with 0 representing failure, 9 representing total success, and 4 and 5 representing moderate success. The mean rating by the students was a complimentary 6.94. Again the urban score of 7.56 was more positive

than the rural 6.36. Thus, the students averaged a rating of *very favorable* for the summer as a learning experience.

In addition to their own expressed satisfaction about previously mentioned significant shift of the group as a whole toward a more humanitarian and committed approach toward the problems of the poor, and to a greater emphasis on careers associated with poverty work, their increased knowledge of the culture of poverty is an extremely important factor. All of the students are nearing an end to professional educations that in a few years will place them in a powerful upper middle class where the impact of their experiences of living and working in poor communities cannot help but be felt.

5. *The Orientation*

The project began with a 3 day orientation for the students in a hotel in a deteriorating section of downtown Denver. The students then moved to their placement locations for 2 to 3 more days of on site orientation. Questionnaire items asking for evaluation of this summer's orientation and suggestions for future orientations were given out at the end of the summer. Again, favorability was coded from 0 to 9. The mean rating was 5.21 or slightly more favorable than unfavorable. Two suggestions were offered by the majority of the students and we are very much in agreement with both of them. First, there should be a much heavier emphasis on concrete problems which are likely to be faced and concrete options for meeting them. This would go hand in hand with a lessened emphasis on the theoretical aspects of poverty. The students enjoyed the lectures and talks of the resource people but seemed to want information about how they might proceed given their skills and limitations. The rural students were even stronger in feeling this way because of the greater relevance of most of the orientation to urban problems. We would go farther than the students did in recommending separate orientation sessions for urban and rural people after a joint introduction to the mechanics of the project. If such a separation were not set up, greater specificity would be irrelevant to one or the other of the two groups.

Secondly, they suggested that the high school interns be included in the orientation sessions. We wholeheartedly agree with this and will discuss it further with other aspects of the intern program.

6. *The Intern Program*

Eighteen high school interns from the placement areas aided the students throughout the summer on all but one of the sites. We have information on this phase of the project from interviews with local citizens familiar with the project, from the SHO students and from the interns themselves.

There were three general goals for the intern program. First, it was hoped that the interns would be helpful in planning and carrying out projects with the SHO students. Second, it was hoped that through the experience the interns gained from the summer they might have a basis for doing further poverty work in their communities. Third, through close contact with well educated, academically successful role models, it was hoped that the interns would be encouraged to expand their own career plans.

We will briefly discuss the project's success in meeting these three objectives and then offer some suggestions for next summer's project.

Concerning the first goal, half of the 12 interns who were able to come to the final debriefing session felt that "the best use" had been made of their skills in the project. Those who were disappointed almost unanimously mentioned that they had never understood SHO and its goals and thus were never quite able to figure out what they were supposed to do. Those who expressed satisfaction were generally in structured situations with clear responsibilities.

About a third of the SHO students felt that the interns had been quite helpful, another third felt that they had been of some help—particularly in instructing the students in the ways of the local areas and in serving as contacts with community people, and another third felt that their interns had been of no help.

We feel that this goal of the intern program was not successfully realized. We would not want to set an arbitrary success level but one-third to one-half of both groups expressing

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satisfaction with performance is clearly not enough. The interns were very confused about the program and anxious about their role in it. Several of them felt that because of this, much of their time was wasted. Several others felt that they were treated as inferiors and given busy work of no real importance. On the other hand, many of the health science students felt burdened by the interns. Many felt that they had their hands full being productive themselves and were unable to lead another person around. We will discuss suggestions for improving this situation after mentioning the other two goals.

The second goal, of providing experience in poverty work so that the students might continue such efforts in the future was most definitely fulfilled. The interns were in the midst of planning various projects and took part in their execution. They are now aware that things can be done to alter undesirable situations and that they are in just as good a position as anyone else to bring about changes. Whether or not they will use their skills is another question and one which we cannot answer.

The third aim, of stimulating the careers of the interns, was extremely well fulfilled. The interns were asked if their plans for the future had changed during the summer. Seven of the 12 reported change, five reported no change. Four of the five no changes had planned to go to college before the summer and still planned to do so after the summer. One intern had planned to get a job and was still planning on it. Among the changers, three had planned some technical training, but now wished to become health professionals. Two had planned to enroll in college but had no goal in mind and now were determined and confident that they would finish. Two others had planned to get jobs and now planned to go to college. At the end of the summer, SHO was able to arrange full scholarships for three of the interns to the University of Colorado who would not otherwise have been able to attend. We feel that these career changes alone are important enough to render the intern program very successful.

We would now like to mention our suggestions for an improved intern program in future projects. First, it is vitally important, as we

have said before, that they be included in the orientation session. With very little idea of what the program was all about generally and what their role in it was specifically, we feel that the interns performed quite well this summer.

Second, we feel that there should be stronger selectivity in the recruiting of the interns. A few of the interns were not sophisticated enough to fully benefit from and contribute to the project. To achieve this, as well as for reasons we will bring up below, the project should be funded for planning and organizing expenses beginning around April 1. There must be expense money to allow project and area coordinators to spend time and careful consideration in lining up interns with high potential: Graduating seniors with intelligence and energy but little direction. These individuals are often informal peer group leaders with sensitivity and knowledge of their communities. It is expensive to find them but the payoff can be immeasurable.

Third, provision should be made for weekly pay checks to the interns beginning at the end of the first week. This summer they were paid bimonthly beginning at the end of the fourth week. This is strain enough for the SHO students, most of whom had outside financial resources, but it is far too difficult an arrangement for low income high school students, and it resulted in considerable difficulty and much borrowing.

Finally, we recommend that the proportion of high school interns be increased to one for each SHO student. We feel that the project should consist of two member teams, an intern and student each. Several reasons lie behind this proposal. First, we think that this would more thoroughly cut through the status gap between interns and students, enabling the two groups to participate on a more equal basis. Second, it would greatly increase the exchange between interns and students allowing each to learn from the other to a far greater extent than was possible this summer. The intern's future would be affected more, and the student's empathy with and understanding of those in poverty would be accelerated. Third, the interns would be more apt to be confident in the ambig-

uity of an unstructured situation if he had close intellectual and moral support from a student.

B. Service to the Poor

In this section we want to look at what was accomplished during the summer as far as concrete action is concerned and then locate the weaknesses of the project pointing out ways of avoiding these difficulties in next year's project. The primary sources of our data are the daily logs, which most of the students completed most of the time; interviews with 30 people around the State who were knowledgeable about the program; the evaluations of the project completed by 31 of the 32 students at the debriefing session; the evaluations completed by the interns; and extensive conversations with the staff and students in the project.

Elsewhere in the final report the activities of the students are extensively dealt with, so here we just want to run down a list of some of the valuable services rendered by the project.

In Denver the SHP helped staff and get Project Mainstream off the ground. The students encouraged and provided technical expertise for the Welfare Rights Organization. They also procured a copy of the unavailable Welfare Department rules manual and put together a booklet of legal information for the poor. They helped organize community pressure, and lobby for safer and cleaner parks and pools where an alarming number of children had been injured by broken glass. A byproduct of this was two new organizations of neighborhood mothers. Students put a great deal of effort into helping the Fiesta on the west side. They did some outreach work for a neighborhood clinic and worked for more personalized health care at that clinic. A great deal of time was spent in various recreational efforts—many of high educational value. Two bus loads of children were given their first ride in a jet plane. A number of career, sex, and health educational classes were held. Shutins were taken shopping and to church on Sundays. A lot of work went into the planning of a cooperative supermarket that will not see final fruition for some time. A free bus was set up to take low income mothers shopping.

A run down of some of the accomplishments in the rural placements is equally impressive. In San Luis, students staffed the Sangre de Cristo Medical Unit, provided outpatient services and carried on an educational program about the facilities available to the townspeople. In Grand Junction, students helped extend current outpatient mental health programs while drawing up proposals for new ones, and contributed to educational and recreational programs for children and teenagers at the local community center. In Delta they conducted an extensive survey of community needs to provide the documentation for an energetic school board to apply for the funding of health, recreational and educational programs. They also brought the attention of agencies to many specific cases where health care was badly needed. In Palisade, three health science students opened a teen center, helped the Public Health Nurse, published a resource information booklet for the migrant laborers and worked on ways of making the food stamp program more easily available to the migrants. In Fruita students helped bring low income families into contact with the Neighborhood Center making existing programs much more effective. At one point they took a bus load of 60 children into the Grand Junction Clinic to get their immunizations. They also taught health education classes that were well attended.

Just from this sample of the activities of the summer, we rate the Student Health Project as very successful. It is our judgment that the students were dedicated, creative, and extremely sensitive interpersonally, and that this paid off for the people served and in the rewards of a good learning experience. But this does not mean that the project could not be improved next summer. The students themselves would be the first to admit this. When asked to rate the success or failure of the summer as to helping the poor, their mean coded response was 5.61 again using a scale of 0 to 9 running from failure to success. The urban mean was 6.08 and the rural means was 5.13. Thus, their own view of their activities could be described as only moderately successful.

With the knowledge that the summer was a good one, we want now to turn to the problems

that arose with an eye toward a still better experience next year. The most serious difficulty this summer arose from a general deficiency in planning. We feel that this stemmed from three factors. First, and most obvious, this was Colorado's first Student Health Project and some questions had not been confronted before by the staff. Second and of great importance is the already mentioned fact of the unavailability of planning funds to support the careful groundwork that is necessary to set up a smoothly operating program. Third, we feel that this summer's project put too much emphasis on the unstructured approach.

There were several undesirable consequences of this weakness in planning. Preceptors and sponsoring agencies were led to have false expectations as to what the summer would be like because the SHP wasn't exactly sure. In most cases, sponsors expected somewhat closer contact than the students were willing to operate under. The students themselves, who were fearful of being drafted into meaningless work, often avoided the sponsor. The result was some unnecessary antagonism. The sponsors felt let down and uninformed of the students' activities and somewhat suspicious. On the other hand, students lost the benefit of valuable support and information about the community.

Another consequence of the unstructured situations was the sheer trauma many students experienced when they found themselves alone in a poor community with crushing social problems and no idea whatsoever about where to go and what could be done. They then began to busily learn about the community, talking with as many people as possible. But shortly, perhaps after 2 weeks, they would begin feeling guilty about having wasted their time and taxpayers' money with no accomplishments. It is also very difficult to explain what you are doing to confused and suspicious townspeople. At this point many students felt compelled to jump into any activity to justify their being there. Sometimes this resulted in unduly ambitious programs which couldn't succeed, and sometimes it resulted in nearly trivial undertakings with little use. Then a few of the other students would withdraw, feeling the situation was hopeless either because of the faults of poor

people or of the bureaucracy, and wait for the end of the summer keeping busy enough not to be conspicuous. Fortunately most of the activities turned out to be quite reasonable and constructive.

Finally, the loss in many cases of the first 2 to 3 weeks of the 9 weeks in the field is a costly price to pay. Whatever the final course of action hit upon by the students, it could have been 50 percent more effective if the period of uncertainty had been eliminated.

With a combination of measures we think this could all be avoided. The first suggestion involves a structured, preplanned assignment for the student for the first 3 to 4 weeks in the community. It might begin with 6 or 7 hours a day and taper down to 3 or 4 at the end. It might focus on outpatient services or a badly needed survey or anything else agreed upon that would render valuable service in the community. A number of such positions could be agreed upon ahead of time by the preceptor and area coordinator. When the SHO students and interns arrived in June they could settle upon which of the possibilities best suited their skills and interests and the community's needs.

From this concrete starting point, students and interns could get to know each other and the community. They could also slowly be thinking about creating projects of their own for the last two-thirds or half of the summer, which might or might not be connected with the sponsoring agency. This should be open.

This, or any other approach, would require about \$1,000 or \$1,500 in planning expenses to enable each area coordinator to spend about a week in April or May at each site carefully setting up possible options for the students when they arrive in June. The sponsors must understand the desire for autonomy and creativity of most SHO students and be willing to limit their demands on them. For the first 3 or 4 weeks with the preceptor, careful plans and procedures should be set up so that serious work could begin immediately on the students' arrival.

We feel that this approach would have some very worthwhile results. With the careful spelling out of roles and expectations, the friction between sponsors and students would be cut to

a minimum. With a productive, structured initial period, the pressure would be off the students to make premature decisions about what to do with the summer. None of the students would feel coerced into doing meaningless things with the agencies. There would also be no embarrassment in explaining what they were doing with community people. They are "working with the health department's education and information program," etc.

Planning difficulties were the summer's central problem and were most acutely felt on the western slope, but the students performed well in spite of them. We now want to turn to some more specific problems. First, there were many occasions in which resource people within the SHP were needed but unavailable. Important planning decisions about which way to proceed are often difficult to make for relatively unexperienced students and interns. This summer there were only two area coordinators instead of the proposed three and this was unfortunate. There was also a tendency for the two area coordinators to become too tied down at their homesites which caused some hardships for other students. In Denver this also led the overworked full-time project coordinator to take a good deal of his time away from a heavy administrative load to be of assistance in the solving of low-level problems. We recommend that next year there be four area coordinators, one each for east and west Denver and one each for the San Luis Valley and the Western Slope, and that they be encouraged to remain free and available.

The Palisade placement on the western slope was also a problem this summer. There is very little poverty in the community during the year except for the fruit harvesting season with its large influx of migrant laborers. This usually takes place about the first week of August. At this time there is a great need for medical services of various kinds which the SHP could provide, but not before. This year the three Palisade students spent the first 6 weeks of the summer there working energetically with the Public Health Nurse in neighboring low income communities, in setting up a teen center and in making preparations for the migrants. We feel that given the structure of the SHP and

the timetable of the migrants, next summer's SHP should not include a Palisade placement. There is an acute need for the students all summer long in Grand Junction, Denver, and in many other communities in Colorado, particularly in the San Luis Valley.

A final item we wish to mention is that the two law students were as successful as any two other students in the project. They were very useful to the program and beautifully supplemented the health care and community organization work of the other students. We think that five or six could be a still greater benefit to next year's project.

C. Conclusion

In conclusion, we have found that the first Colorado Student Health Project was very successful. The students learned a great deal about poverty and problems in the delivery of health care to the poor. As a group, they also became significantly more humanitarian in their attitude toward poverty. The interns also had a valuable experience, becoming much more aware of problems in their own communities. More than half of them also raised their career aspirations during the summer. Most important, the students provided a long list of services summarized above to low income areas around the State. On the basis of all of this, we feel that the project should be funded again next year.

We have also found some problems in the summer's project. The rural students as a group did not become more humanitarian and tolerant of the poor. The interns were not as valuable as had been hoped in contributing to the project's activities. The orientation period was somewhat too theoretical. Also, the structure of the project was loose in general, particularly in the Grand Junction area, and the area coordinators were often inaccessible.

In order to benefit from the knowledge of these difficulties we have made the following recommendations for next year:

- (1) The orientation should place a heavier emphasis on the practical: specific suggestions about possible modes of action when confronting common problems.

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- (2) Except for the first day, there should be separate urban and rural sessions during the orientation.
- (3) The interns should be included in all aspects of the orientation.
- (4) The number of interns should be increased to equal the number of students.
- (5) Interns and students should be paired into working teams engaged in all activities together.
- (6) The grant should include about \$1,500 to pay planning expenses for the area coordinators in the spring.
- (7) There should be structured positions for the students for approximately the first 3 weeks with the remainder of the summer unstructured.
- (8) There should be four area coordinators.
- (9) There should be an increased number of law students in the project.



Appendix

COLORADO STUDENT HEALTH PROJECT

PARTICIPANTS

<i>Health Science Students</i>	<i>High School Interns</i>	<i>Health Science Students</i>	<i>High School Interns</i>
<i>Grand Junction</i>			
Nancy Adams University of Colorado Social Service	Glenda Romero	Daniel Kraus University of Rochester Med II	
Jeffrey Reichenthal Downstate Medical Center Med II		Gail Wilcox, R.N.	
		<i>Denver—East Side</i>	
	<i>Fruita</i>	Larry Corman University of Maryland Med II	Marie Arrington
Eva Adler University of Colorado Nursing IV	Virginia Martinez	Steven Feig University of Maryland Med II	Bert Brussard
Jeffrey Kluger Medical College of New York Med II	Vickey Martinez	Jack Lissauer University of Maryland Med II	Norman Harris
Judy Lindauer University of Colorado Nursing IV	Candy Medina	Joseph Sprague University of Colorado Law III	Vincent Robinson
		Linda Sprague	Clara White
	<i>Palisade</i>	James Swallow University of Colorado Med II	
Mary Jaeggli University of Colorado Nursing IV		Marion von Buettner University of Colorado Med II	
Kenneth McConnochie Dartmouth Medical College Med II		William Walker University of Colorado Med II	
Nancy Roland University of Denver Graduate Student, Social Work			
		<i>Denver—West Side</i>	
	<i>Delta</i>	Joseph Bergquist University of Colorado Med III	Gary Baca
Norman Chenven Downstate Medical Center Med III	Adrian Pebahsy	Steven Berman Temple University Med II	Wayne Barella
Dinah Chenven	Mario Ramos	Marylou Buyse Women's Medical College Med III	Margaret Lovato
Jane Patterson University of Colorado Graduate Student, Education		Keith Henriquez University of Denver Graduate Student, Social Work	Jake Pino
		Charles Holt University of Colorado Med III	Lawrence Sena
	<i>San Luis</i>		
Suzanne Campbell, R.N.	Jo Anne Apodaca		
Robert Frampton University of Oklahoma Med II	John LaCombe		
	Rocky Madrid		

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Health Science Students

Marcia Looney
Francis Payne Bolton
School of Nursing
Nursing III
Ida Jean Newton
Women's Medical College
Med III

High School Interns

Health Science Students

James Pachl
University of California
Law III

Jerry Yucht
Wayne State University
Med II

High School Interns

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PRECEPTORS

Grand Junction:

Robert Ross, M.D.
Medical Preceptor
Grand Junction Neighborhood Center
Preceptor: Mr. Augie Reyes
Mesa County Mental Health Association
Preceptor: Mrs. Mary Humphries
Mesa County Public Health Department
Preceptor: John V. Sessums, M.D.

Fruita:

Robert Orr, M.D.
Medical Preceptor
Fruita Neighborhood Center
Preceptors: Mrs. Del Martinez, Mr. John
Montgomery
Fruita Teen Center
Preceptor: Mr. Jack Chaney

Palisade:

Chester Bliss, M.D.
Medical Preceptor
Mesa County Migrant Council
Preceptor: Mrs. Harry Talbot

Delta:

R. J. Bennett, M.D.
Medical Preceptor
Delta County Public Schools
Preceptor: Mr. Harry Anderson

San Luis:

Sangre de Cristo Medical Unit
Mr. Charles Jackline, director
Preceptors: Dale Thomas, M.D., Lawrence
Andreini, M.D., Bonnie Camp, M.D.

Denver—East Side:

Curtis Park Community Center
929 29th St.
Preceptor: Reverend George Turner
East Side Community Action Center
2800 Glenarm Place
Preceptor: Mrs. Sarah Collier
East Side Neighborhood Health Center
529 29th St.
Preceptor: Burris Duncan, M.D.

Denver—West Side:

Inner City Parish
912 Galapego
Preceptor: Reverend Harland Beech
Mariposa Health Station
1178 Mariposa St.
Preceptor: Andre Chabot, M.D.
West Side Community Action Center
1042 Santa Fe Drive
Preceptor: Mr. Leo Rodriguez

CONFERENCE SCHEDULES

Colorado Student Health Project Orientation
1612 17th Street, Denver, Colorado

Sunday, June 23, 1968

Arrival of Health Science Students
8 p.m.—“Mixer”

Monday, June 24, 1968

7:00– 8:00 Breakfast
8:00–10:00 Registration
10:00–12:00 General objectives
Michael Reiff Randall Lortscher
Lisa Wilson Skip Bry

“Health and the Community”

Dr. C. Henry Kempe, Chairman, Department of Pediatrics, University of Colorado Medical School; Sponsor, Colorado Student Health Project

12:00– 1:00

Lunch

1:00– 3:00

“The War on Poverty”

Professor Howard Higman, Director, Action Research in Socialization Processes, Boulder, Colo.; Professor, Department of Sociology, University of Colorado

3:30– 6:00

Free

6:00– 7:00

Dinner

7:30– 8:30

Movie: “Harvest of Shame”

8:45–

Small groups: “Why are we here”?

Tuesday, June 25, 1968

7:30– 8:00

Breakfast

8:15– 1:00

Community panels

Mr. Paul Reese

Assistant Director, VISTA

Welfare Rights Mothers

Mrs. Anna Deleon

Mrs. Sonja Betts

The Ghetto Scene

High school dropouts

1:00– 1:45

Lunch

1:45– 2:45

“Some Aspects of Cultural Shock”

Dr. Sidney Margolin, Professor, Department of Psychiatry, University of Colorado Medical School

3:00– 4:00

“Black Power”

Mr. Frank Bailey and panel

4:30– 6:00

“Civil Rights and the Community”

Mr. Warren Alexander, Civil Rights Commission

6:40– 7:00

Dinner

8:00– 9:00

“The Law and the Community”

Mr. Edward Sherman, Public Defender, City and County of Denver

9:30–

Small groups: “Where are We Going”?

Wednesday, June 26, 1968

7:30– 8:00

Breakfast

8:15–12:00

“The Urban Community”

Dr. James Kent, Mr. John Hernandez, Mr. Nate Avelos

1:15– 4:00

“The Rural Community”

Mr. James Chavez, East Side Neighborhood Health Center; Mr. Tomas Atencio, Colorado Migrant Council

4:00– 4:30

“Malnutrition and Community Life Styles”

Dr. Peter Chase, Department of Pediatrics, University of Colorado Medical Center

7:00–

Sit down dinner

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Midproject Conference Dr. Kempe's Cabin

Friday, July 19, 1968

- 1:00 Arrival of students
- 3:00- 5:00 Group session—reports from individual projects
Supper
- 8:00 Group session—reports continued

Saturday, July 20, 1968

- Breakfast
- 9:00-12:00 Area meetings—individual problem solving
- 12:00- 1:00 Lunch
- 1:00- 4:00 Health science student meeting
High school intern meeting
- 4:00- 5:00 "Planning Methods for Change"
Mr. Robert Hunter
Action Research in Socialization Progresses

Sunday, July 21, 1968

- Breakfast
- 9:00-12:00 Keynote: "The American Health Care Crisis"
Dr. Quentin Young, Past Chairman, MCHR

Final Evaluation Session University of Colorado Medical Center

August 28, 1968

- 9:00- 9:30 Introductory remarks
Dr. Conger, Dr. Kempe, Prof. Higman
- 9:30-10:00 Selected health science students' reports of summer experience
- 10:30-10:45 Coffee
- 10:45-11:00 Selected high school intern reports
- 12:15- 1:15 Catered lunch
- 1:30- 3:30 Peter Bonavith: "New Perspectives"
- 4:00- 5:00 Written group evaluation

August 29, 1968

- 9:00-12:00 Individual projects—successes and failures; prospective recommendations
- 12:15- 1:15 Lunch in hospital cafeteria
- 1:30- 3:30 Open forum
- 3:30- Final remarks: Project staff

Demographic Data-Orientation Sessions

1. Birthday:
2. Father's occupation:
3. Check approximate income range of your parents:
 - \$0 to \$4,999
 - \$5,000 to \$9,999
 - \$10,000 to \$14,000
 - \$15,000 to \$19,999
 - \$20,000 to \$24,999
 - \$25,000 and over
4. Which of the following best describes where you lived at age 15?
 - Rural farm community
 - Rural nonfarm community
 - Small town (2,500 to 25,000)
 - Middle-size town (25,000 to 100,000)
 - City (100,000 to 500,000)
 - Large city (over 500,000)
5. Sex:
6. Your race:
7. Your religion:
8. Political party preference:
9. Were both your parents born in the United States? (Yes) (No)
10. Have you worked with any other action program such as the Student Health Project (SHP)? (Yes) (No) If yes, list all the programs you have worked with.
11. The one thing you are looking forward to most in SHP is:
12. What, if anything is the one thing you are most apprehensive about in SHP?
13. How important were the following items in making your decision to work in SHP? (Circle one for each item)
 - a. Working in Colorado:
 - None
 - Very little
 - Moderate
 - Considerable
 - Very high
 - b. Working with the poor:
 - None
 - Very little
 - Moderate
 - Considerable
 - Very high
 - c. Helping in a health program:
 - None
 - Very little
 - Moderate
 - Considerable
 - Very high
 - d. Salary:
 - None
 - Very little
 - Moderate
 - Considerable
 - Very high
 - e. Friends applying:
 - None
 - Very little
 - Moderate
 - Considerable
 - Very high

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- f. Opportunity to work with other health professionals:
 - None
 - Very little
 - Moderate
 - Considerable
 - Very high
 - g. Acquire better understanding of welfare problems:
 - None
 - Very little
 - Moderate
 - Considerable
 - Very high
 - h. Participation in a social experience:
 - None
 - Very little
 - Moderate
 - Considerable
 - Very high
 - i. Making a contribution to community improvement:
 - None
 - Very little
 - Moderate
 - Considerable
 - Very high
 - j. Other (specify):
14. What do you expect this summer to have in store for you? For each of the items below indicate your expectations.
- a. How many hours a day do you expect to work on your project?
 - b. How do you think your living conditions will be? (Primitive, Adequate, Ample)
 - c. How much risk of physical danger do you expect to encounter? (Great, Moderate, Slight, None) If you answered "great" or "moderate," from what source do you expect this danger?
 - d. How do you expect your working conditions to be? (Poor, Fair, Good, Excellent)
 - e. How much do you feel you will accomplish in terms of (check one for each):
 - (1) Learning about problems of the poor Very little Some A great deal
 - (2) Your professional education Very little Some A great deal
 - (3) Personal fulfillment Very little Some A great deal
 - f. How much social involvement do you expect to have with the persons you work with? (Circle one for each)
 - (1) Patients None Very little Moderate Considerable
High
 - (2) Coworkers None Very little Moderate Considerable
High
 - (3) Project staff None Very little Moderate Considerable
High
 - (4) High school interns None Very little Moderate Con-
siderable High
 - (5) Preceptors None Very little Moderate Considerable
High
 - (6) Neighbors None Very little Moderate Considerable
High
 - (7) Community participants None Very little Moderate
Considerable High
15. Why did you choose to work with the SHP this summer?
16. What are your short and long range career plans?

Student Attitude Scales—Orientation: Final Evaluation Sessions

Scale I

- | | | | | | |
|--|---|---|---|---|--------|
| 1. It is very important to achieve some goals in my summer work that will have an effect on the community. | * | A | a | d | D |
| 2. Unless we do all we can to help the people in the community this summer, it is not likely that much will get done. | * | A | a | d | D |
| 3. The chances of doing much more than getting an education for myself this summer are very limited. | | A | a | d | *
D |
| 4. While it is desirable that we help provide health service to the poor, our own personal learning comes first. | | A | a | d | *
D |
| 5. The major purpose of the work this summer is to learn about the problems of delivering health care to the poor. | | A | a | d | *
D |
| 6. Our main objective this summer is to get the best education we can about the health problems of the poor. | | A | a | d | *
D |
| 7. Even if no improvements in health care for the poor result from our summer work, the summer can still be considered successful if we learn about the health problems of the poor. | | A | a | d | *
D |
| 8. We have to try to do all we can to help the people in the community this summer and forget about any personal benefits. | * | A | a | d | D |
| 9. Unless there are concrete accomplishments in the community as a result of my efforts, the summer work cannot be considered successful. | * | A | a | d | D |

Scale II

- | | | | | | |
|--|---|---|---|---|--------|
| 1. A patient's religious beliefs should take priority in determining the nature of medical procedures. | * | A | a | d | D |
| 2. Compassion is a luxury which the busy physician cannot afford. | | A | a | d | *
D |
| 3. Patients are appreciative of sympathetic treatment on the part of the physician. | * | A | a | d | D |
| 4. The parents of an unwed pregnant girl should always be told. | | A | a | d | *
D |

- 1) Asterisks indicate response given highest score
 2) SA = Strongly agree
 A = Agree
 a = SLA = Slightly agree
 d = SLD = Slightly disagree
 D = Disagree
 SD = Strongly disagree

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|---|---|---|---|---|--------|
| 5. The wife of a patient who has just contracted syphilis and refuses treatment, should be informed. | * | A | a | d | D |
| 6. All patients that have a fatal disease should be told. | | A | a | d | *
D |
| 7. Patients from lower income groups are unable to understand the nature of their illness. | | A | a | d | *
D |
| 8. It is important for physicians working with poor patients to get to know them well so as to best serve them. | * | A | a | d | D |
| 9. The patient has a right to demand a specific treatment. | * | A | a | d | D |
| 10. A physician cannot just concern himself with things medical, but must consider all aspects of the community life. | * | A | a | d | D |
| 11. A physician must make every effort to preserve the life of a grossly abnormal baby at birth. | | A | a | d | *
D |
| 12. It is important for the attending physician to determine if a hospital patient has received visitors. | * | A | a | d | D |
| 13. The unconscious patient is entitled to, and should receive, the same consideration as the conscious patient. | * | A | a | d | D |
| 14. In dealing with patients, it is enough for the physician to advise treatment without explanations. | | A | a | d | *
D |

Scale III

- | | | | | | |
|---|---|---|---|---|--------|
| 1. Clinics sponsored by local health agencies are mainly intended to keep down the pressure for socialized medicine. | * | A | a | d | D |
| 2. Public health clinics can provide good preventive health care. | * | A | a | d | D |
| 3. Because of the way in which public clinics are organized and administered, it is just not possible for them to provide a high level of medical care. | | A | a | d | *
D |
| 4. Public health clinics can do very little for the people they are supposed to serve. | | A | a | d | *
D |
| 5. Medical personnel who work in clinics cannot provide highly individualized service to patients. | | A | a | d | *
D |
| 6. Physicians who work in public health clinics can get to know patients fairly well and provide them with good medical care. | * | A | a | d | D |
| 7. Public health clinics are not in a position to provide high quality medical service to the poor. | | A | a | d | *
D |
| 8. It is possible to provide first rate medical care in a public clinic setting. | * | A | a | d | D |

- | | | | | | |
|---|---|---|---|---|--------|
| 9. Physicians who work in public health clinics really care about poor people and their health needs. | * | A | a | d | D |
| 10. Health clinics for the poor can achieve only a very limited degree of excellence. | | A | a | d | *
D |
| 11. Medical personnel who work in public clinics just cannot give the time that is necessary to adequately handle each patient. | | A | a | d | *
D |

Scale IV

- | | | | | | |
|--|---|---|---|---|--------|
| 1. Those who accept charity lack dignity. | | A | a | d | *
D |
| 2. An unwed pregnant woman is to be respected. | * | A | a | d | D |
| 3. Any unmarried mothers who have more than two illegitimate children and are on public welfare, should be sterilized. | | A | a | d | *
D |
| 4. An individual cannot be judged from the amount of money he earns. | * | A | a | d | D |
| 5. Forceful sterilization of the mentally retarded is an act in violation of the dignity of the individual. | * | A | a | d | D |
| 6. The experimental use of potentially dangerous drugs in habitual criminals, against their will, is justifiable. | | A | a | d | *
D |
| 7. Despite all the problems involved, good health care can be provided to the poor. | * | A | a | d | D |

Scale V

- | | | | | | |
|--|---|---|---|---|--------|
| 1. The Mexican concept of manhood is based on the size of a man's family rather than the quality of his family. | | A | a | d | *
D |
| 2. Mexican-Americans want to take care of themselves; they do not want help from others. | | A | a | d | *
D |
| 3. In the Mexican-American community, the people who achieve respect are the gang leaders and big drinkers. | | A | a | d | *
D |
| 4. One of the striking things about poverty people is the need they have for individual contact and the concern of others. | * | A | a | d | D |
| 5. Poor people are content; they are generally satisfied with their lot in life. | | A | a | d | *
D |
| 6. Poor people are generally receptive to efforts at being friendly and helpful. | * | A | a | d | D |
| 7. The majority of poor people are concerned and interested in improving themselves. | * | A | a | d | D |
| 8. It is difficult to escape the conclusion that most poor people are apathetic about their situation. | | A | a | d | *
D |

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|---|---|---|---|---|---|
| 9. Poor people often take advantage of the government. | A | a | d | * | D |
| 10. Mexican-Americans live for today and can see no purpose in worrying about tomorrow. | A | a | d | * | D |

Scale VI

- | | | | | | |
|--|---|---|---|---|---|
| 1. Many physicians stand to lose a fair amount of their practices if public health clinics are put into operation. | * | A | a | d | D |
| 2. Many physicians work very hard because they are compulsive people, not because they are altruistic (or have a desire to serve). | * | A | a | d | D |
| 3. Many physicians are quite cold, aloof, and condescending in their relationships with patients. | * | A | a | d | D |
| 4. Many physicians are in practice just for the money. | * | A | a | d | D |
| 5. A physician should determine his fee in part by patients' ability to pay. | * | A | a | d | D |
| 6. Physicians are generally not responsive to the health needs of poor people. | * | A | a | d | D |
| 7. Many physicians feel that the health needs of the poor are being met by existing agencies and services. | * | A | a | d | D |
| 8. A large number of physicians feel that the reason many people are poor is because they are lazy. | * | A | a | d | D |
| 9. Physicians cannot afford to do charity work outside of the traditional organized "donations of time." | A | a | d | * | D |

Scale VII

- | | | | | | | | |
|--|----|----|-----|-----|-----|----|----|
| 1. The public education received by most of the poor is generally equivalent to that received by most of the middle class. | SA | A | SLA | SLD | D | SD | * |
| 2. Police brutality was a major reason for the riots in our cities last summer. | * | SA | A | SLA | SLD | D | SD |
| 3. With our Nation's great wealth, no form of poverty should be tolerated. | * | SA | A | SLA | SLD | D | SD |
| 4. Minority groups are trying to move too fast in seeking reforms. | SA | A | SLA | SLD | D | SD | * |
| 5. The poor feel degraded by our welfare system. | * | SA | A | SLA | SLD | D | SD |
| 6. Conditions are so bad in our cities' ghettos that no Negro could be blamed for rioting. | * | SA | A | SLA | SLD | D | SD |
| 7. Anyone can pull himself out of poverty in the United States who has the will to do so. | SA | A | SLA | SLD | D | SD | * |
| 8. Welfare should not be paid to women who continue to have illegitimate children. | SA | A | SLA | SLD | D | SD | * |

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|---|---|----|---|-----|-----|---|-----|
| 9. The unemployed should not be blamed for turning down low paying menial jobs. | * | SA | A | SLA | SLD | D | SD |
| 10. Poverty in America is the fault of society and not individual lack of motivation. | * | SA | A | SLA | SLD | D | SD |
| 11. The poverty in America is one of more discomfort than of real deprivation as other countries know it. | | SA | A | SLA | SLD | D | SD* |
| 12. Few receive welfare who do not need it. | * | SA | A | SLA | SLD | D | SD |

Scale VIII

- | | | | | | | | |
|--|---|----|---|-----|-----|---|-----|
| 1. Medical care is a right not a privilege. | * | SA | A | SLA | SLD | D | SD |
| 2. A sizeable increase in the number of practicing physicians would seriously threaten the economic well-being of the medical community. | | SA | A | SLA | SLD | D | SD* |
| 3. Good medical care is generally not available to the poor in our country. | * | SA | A | SLA | SLD | D | SD |
| 4. For all of its problems this country's system of health care is the best in the world. | | SA | A | SLA | SLD | D | SD* |
| 5. Need alone should be the criterion for the provision of medical care. | * | SA | A | SLA | SLD | D | SD |
| 6. The physicians who treat the poor are generally of a lower quality than average. | * | SA | A | SLA | SLD | D | SD |
| 7. Many of the poor are constantly in danger of losing their jobs because they cannot afford adequate medical care. | * | SA | A | SLA | SLD | D | SD |
| 8. Considering the incomes of other segments of society, physicians earn more than enough already. | * | SA | A | SLA | SLD | D | SD |
| 9. Far more physicians are needed in order to satisfy national health needs. | * | SA | A | SLA | SLD | D | SD |
| 10. If community medical services are to be expanded, the government should play the major role in backing this expansion. | * | SA | A | SLA | SLD | D | SD |

Scale IX

- | | | | | | | | |
|---|---|----|---|-----|-----|---|-----|
| 1. Many of the poor have a stable, simple life with more happiness than they would know with a well-paying job and a middle class life. | * | SA | A | SLA | SLD | D | SD |
| 2. Knowledge of family planning is generally absent among the poor. | * | SA | A | SLA | SLD | D | SD |
| 3. Drinking is more of a cause than a symptom of many of the problems of the poor. | | SA | A | SLA | SLD | D | SD* |
| 4. In general, the poor would prefer a modest immediate gratification to a larger, long-term success. | * | SA | A | SLA | SLD | D | SD |

COLORADO STUDENT HEALTH PROJECT

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|---|----|---|-----|-----|---|----|---|
| 5. Superstitions about matters of health by the poor still form a significant barrier to adequate health. | SA | A | SLA | SLD | D | SD | * |
| 6. In many lower class families the wife has a greater earning ability than does the husband. | SA | A | SLA | SLD | D | SD | * |
| 7. In most cases the poor are concerned with curing present health problems but have little concern about prevention. | SA | A | SLA | SLD | D | SD | * |
| 8. The poor generally accept death more easily than do members of the middle class. | SA | A | SLA | SLD | D | SD | * |
| 9. Minority poor have significantly more children than do poor Anglos. | SA | A | SLA | SLD | D | SD | * |
| 10. Defeats and frustrations cause fatalism on the part of the poor more often than they result from it. | SA | A | SLA | SLD | D | SD | * |

Scale X

- | | | | | | | | |
|---|----|---|-----|-----|---|----|---|
| 1. In pursuing social change breaking the law is never justified. | SA | A | SLA | SLD | D | SD | * |
| 2. Local governments and business communities would generally like to help work toward social improvement. | SA | A | SLA | SLD | D | SD | * |
| 3. As a first step toward halting lawlessness in America, agitators like Stokely Carmichael should be locked up. | SA | A | SLA | SLD | D | SD | * |
| 4. Nothing can be gotten from "white America" without violence to force the issue. | SA | A | SLA | SLD | D | SD | * |
| 5. Most agencies that are designed to help the poor hamper them as much as they help them. | SA | A | SLA | SLD | D | SD | * |
| 6. Most liberals talk humanitarianism but are not willing to make the sacrifices. | SA | A | SLA | SLD | D | SD | * |
| 7. Cooperation and process of subtle manipulation of influential citizens is generally more effective than confrontation. | SA | A | SLA | SLD | D | SD | * |
| 8. In the past decade, a good deal of progress has been made in improving the lot of the bottom one-fifth of our society. | SA | A | SLA | SLD | D | SD | * |
| 9. Most Americans would be content to tolerate the most severe injustices in their society unless prodded into action. | SA | A | SLA | SLD | D | SD | * |
| 10. The system has a way of corrupting idealists who think they can work within it. | SA | A | SLA | SLD | D | SD | * |
| 11. By solidifying the conservative opposition to social change most demonstrations and protests probably do more harm than good. | SA | A | SLA | SLD | D | SD | * |

12. Demonstrations and protests are often a convenient way of avoiding the responsibility of going out and helping those in need. SA A SLA SLD D SD *
13. Rich and impoverished segments of our society are now farther apart economically than they have ever been. * SA A SLA SLD D SD

Individual Evaluations Collected Throughout the Summer

COLORADO SHP DAILY LOG

Name _____ Date _____

Briefly fill out and turn in a log each day to your area coordinator.

- (1) What important feedback did you receive from the poor community or power structure today?
- (2) What was the most significant experience of the day?
- (3) What was the most rewarding experience of the day?
- (4) What was the most frustrating experience of the day?
- (5) Other: Include any experience, idea, problem, et cetera.

COLORADO SHP

Community Medicine Questionnaire

- (1) Name _____
- (2) Describe the present system of health care for the poor in your area.
- (3) What are the most pressing needs in the way of getting better health care for the poor in your area?
- (4) What bureaucratic difficulties hinder the usefulness of present facilities to the poor in your area?
- (5) What concrete proposals do you have for programs that might bring better health care to the poor in your area?
- (6) In what ways do the values or culture of the poor in your area present problems for adequate medical care?

Student Questionnaire—Final Evaluation Session

HEALTH SCIENCE STUDENTS

- (1) In what ways was your summer a success or failure as a learning experience?
- (2) In what ways was your summer a success or failure as far as services to the poor were concerned?
- (3) What suggestions could you make that might be implemented next summer in order to make the SHP more effective?
- (4)
 - a. In what ways was the summer successful or unsuccessful as a learning experience for the high school interns in your area?
 - b. In what ways were they successful or unsuccessful in contributing to the program in your area?
 - c. How could the intern program be set up more advantageously next summer?
- (5)
 - a. How valuable was your orientation at the Oxford Hotel?
 - b. How could it be improved?
- (6)
 - a. What agencies did you work with in the field?
 - b. What were the specific successful and unsuccessful experiences you had with each agency and why?
 - c. What other agencies were available, but not utilized, and why?
 - d. What agencies might be utilized advantageously next summer and why?
- (7) What are your short and long range career plans?

HIGH SCHOOL INTERNS

- (1) Home town _____
- (2)
 - a. Did you have any career plans before the start of this program? If so, what were they?
 - b. Has this program in any way changed your career plans? If so, in what way?
- (3)
 - a. What kind of work did you do this summer?
 - b. Do you feel that the program made the best use of your skills this summer? Why?
 - c. How could the skills of the interns be employed better next summer?
- (4)
 - a. What were the failures of the SHO program this summer?
 - b. What were its successes?
 - c. How could it be improved for next summer?

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Public Health Service