

Student-Run Health Clinics: Developing a Vision for the Future

by

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"The very least you can do with your life is to figure out what to hope for.

And the most you can do is to live inside that hope.

Not admire it from a distance but live right in it, under its roof."

---Barbara Kingsolver (1990), Animal Dreams

I'd like to dedicate this thesis to the many clients of the Suitcase Clinic who remind me of what's important in my life, and to all those who "live inside the hope" of a just world.

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Preface

This thesis represents advocacy research more than traditional research. No claims of dispassionate objectivity will be made. I have been a subject as much as a researcher, and I've been profoundly influenced by my experiences with the student-run health clinics discussed in this thesis.

Although unaware of it at the time, my thesis process began when I stumbled across literature by the community organizer Saul Alinsky. I had been involved with university-based "community service" and "service learning" as an undergraduate student at UCLA. After years of working in this environment, I became more skeptical about the impact that "service" alone could have on communities. Fortunately, I had time away from the responsibilities of school and work to read and reflect upon my undergraduate community service experiences. I stumbled across literature on community organizing. I had never heard the phrase before and became interested in learning about the distinction between "organizing" and "service." One of the first books I read during this period was "Rules for Radicals" by Saul Alinsky. The title caught my eye and my fanciful dreams of someday becoming a radical. Alinsky's boldness, confidence, straight-forward approach, and self-described ability to "change things" rekindled my idealism. His writings introduced me to the term "community organizing" and a new perspective on working for social change. As I read about community organizing, I found references to community-oriented primary care and popular education. I continued reading from one reference to the next wondering why I had never heard of this literature as an undergraduate involved with community service. Paulo Freire's name kept appearing in the literature, so I decided to read his movement-generating work entitled "Pedagogy of the Oppressed." Freire's distinction between passive "banking" education and a "liberating," action-oriented education resonated with my growing frustrations with decontextualized, lecture-based learning. The spiral of listening-dialogue-action-reflection became my idealized *modus operandi*. I wanted to make such a process a part of my life, but I rarely found the time or

energy to do so. In some respects, this thesis reflects my personal attempts at a Freirian spiral. I'm writing this thesis for myself, to put down on paper my experiences, thoughts, perspectives, and visions for student-run clinics. Perhaps more importantly, I'm writing this thesis to introduce others involved with student-run clinics to new ways of viewing their work and programs.

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Service User Involvement
COPC Epidemiology
Cultural Competence
Coalition Building
Exposure to Theory
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Part V: Conclusion

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Part I: Introduction

Within the past decade, a growing movement has been taking place in health professions schools around the United States. As students before them during the late 1960s and early 1970s, health professions students today are starting and operating a variety of different community health programs. Among these programs are volunteer-run free health clinics for underserved populations. These clinics typically provide services to "visible" segments of health-care "underserved" populations such as homeless people, recent immigrants, or particular ethnic groups. The clinics also serve as learning environments for health professions students. Academic medical centers lend support to these clinics for educational, financial, and political reasons. Modern student-run health clinics evolved out of a long American tradition of medical care provision to poor individuals. The movement to establish community health centers during the 1960s coincided with a movement to create free clinics, including student-run clinics. Although students today find themselves in a health care environment radically different from that of their predecessors from the 1960s, many of the challenges to health and well-being faced by underserved communities remain the same.

The need for volunteer-run free health clinics for underserved populations reflects a continuing and growing gap in access to health services. In the state of California it is estimated that 20% of the population lacks health insurance and nationally approximately 15% have no coverage (Pew Health Professions Commission, 1995). Choices for the uninsured remain limited; the majority of the uninsured are poor. Those without insurance have a limited number of sites from which they can receive care. These sites include: 1) government-funded clinics, hospitals, and programs including Community Health Centers (CHCs), Migrant Health Programs (MHPs), Health Care for the Homeless Programs (HCHP), Indian Health Service Programs (IHSPs), and public health department clinics; 2) a dwindling number of non-profit and private hospitals providing charity care; and 3) free, community-based clinics, including student-run clinics. The poor and uninsured are

less likely to seek medical care and are more likely to use expensive emergency room care when compared to insured populations (Ratner, 1991). Poor and uninsured individuals are also more likely to have undiagnosed and untreated conditions that lead to premature morbidity and mortality (Ratner, 1991). Uninsured individuals have significant barriers that prevent them from accessing medical care as well as other social forces that have a tremendous impact on their health.

Public clinics and hospitals overrun with patients continue to have their operating budgets slashed; demand is outpacing supply. Long waits in crowded waiting rooms, difficulty getting appointments, and lengthy, intimidating processing requirements discourage people from seeking care. An increasingly diverse uninsured population may not seek care because of language or cultural barriers. Uninsured individuals may avoid seeking care due to fear of being asked to pay for services or medications which they cannot afford. Health care may be low on the priority list of individuals struggling to pay for food, housing, and other more essential items. Factors such as illiteracy, lack of transportation, unfamiliarity with the health care service system, and others may contribute to reduced access among the uninsured. Student-run health clinics serve as a safety net for uninsured individuals who do not access the health care system for whatever reason.

In general, these clinics espouse two main goals of providing needed services and creating opportunities for students to develop their knowledge, skills, and attitudes in a community health care setting. Service provision takes place on two levels, that of medical services for individuals and targeted public health services oriented to population groups. Students involved with such clinics are often said to be participants in a "service-learning" experience in which they learn through action and reflection. Students that participate in "service-learning" clinics learn in a variety of areas. They put their classroom knowledge into practice, and begin to see the connections between theory and action. Through their involvement, students develop specific skills and attitudes related to health care provision. By working with underserved populations, students gain exposure

to issues affecting the lives of people that may have different backgrounds from their own. Some students benefit from working with a diverse group of health professionals with different styles of practice; by observing different styles students begin to develop their own. Some clinics strive to introduce students to new models of health care provision such as community-oriented primary care (COPC) and multidisciplinary health teams.

The dual functions of these clinics as community service programs and learning environments results in a dynamic tension that raises several questions. What purposes should these clinics serve and are these purposes being realized? Do student-run clinics perpetuate a system of substandard care for the poor and the use of poor individuals as "training tools"? How are these clinics contributing to or detracted from social change? How and what should students learn from their experiences in these clinics? Should such clinics exist at all?

In this thesis, the author takes the position that student-run clinics can and have played an important role in the health promotion of underserved communities. However, without clearly-stated, strongly-held, collective values and a vision of purpose, student-run clinics may contribute to the perpetuation of a "sick," two-tiered medical and public health care system. One system that provides regular, ongoing care for the insured, and the other that provides a spotty array of services for the uninsured who often find themselves used as tools for student learning. Student-run clinics may contribute to the continued oppression of poor and marginalized groups by their methods of operation and by offering oppressed groups just enough services to prevent massive organizing and revolt around health care issues. This thesis proposes an experimental vision for student-run clinics that provides services AND works for broader social change. This vision includes a commitment to health care coverage for all citizens rather than a system of charity-based care for the uninsured. It involves a broad conceptualization of health promotion that goes beyond the simple provision of biomedical health services. The vision also entails a belief in the value of collective, democratic action for achieving social justice

and equity. This vision is a "praxis", rather than a preformed "model." It is hoped that this praxis will prove useful for existing clinics and those individuals considering the possibility of establishing a student-run clinic.

The first part of this thesis contains a review of the history, scope and practice of student-run clinics. It also includes a compilation of goals from student-run clinics around the United States. In the second part of the thesis, literature on community oriented primary care, community organizing, and popular education are used to develop a praxis for student-run clinics. This praxis addresses some of the questions, criticisms, and challenges faced by student-run clinics. The third part of the thesis reviews experiments with the praxis within the confines of a student-run clinic in Berkeley, California known as the Suitcase Clinic. The thesis concludes with an assessment of the usefulness of the praxis developed in part two and some thoughts on how it could be used in the future.

Part II: Student-Run Health Clinics

Historical Context

American medicine has been profoundly influenced by its relationship with poor and underserved communities. Modern hospitals evolved out of health and social welfare organizations for the poor (Starr, 1982). Student-run clinics today share some similarities with health care dispensaries for the poor established during the early and mid-nineteenth century. Dispensaries provided free medical services, but were known as dispensaries because they mainly *distributed* medicines. Some labeled them "medical soup kitchens." These dispensaries operated on small budgets and utilized the services of volunteer physicians. Physicians used the dispensaries to train medical students, to gain experience in diagnosis, and to advance their own careers (Starr, 1982). As the number of medical students and schools increased, so did the number of dispensaries. By 1900, there were an estimated 100 dispensaries in the country (Rosenberg, 1974).

The growth of dispensaries disturbed private practitioners and charity reformers. Private practitioners objected to the use of dispensaries by people who could afford to pay for care. Charity reformers argued that dispensaries would weaken the self-reliance of the poor and lead to their further degradation. Neither of these criticisms proved valid. Several studies indicated that only two to twelve percent of dispensary users could afford to pay for care (Starr, 1982). Studies also verified that timely medical assistance often prevented people from becoming poor rather than keeping them in poverty.

Dispensaries were characterized by long waits and the use of patients as student learning tools; these factors contributed to the reduced use of these programs by those who could afford care. Dispensaries, largely dependent on medical student labor, disappeared as free standing institutions as the number of medical schools dropped and as hospitals became the centerpieces of medical training. Many dispensaries were absorbed into hospital outpatient departments which took over some of the responsibility of providing care to the poor and uninsured.

Dispensaries are similar to modern student-run clinics in that they offered free services to the poor, relied heavily on medical students, and served as an educational experience. Dispensaries and modern student-run clinics also share similar challenges albeit within different context. These challenges include finding adequate funding and volunteer staff, balancing educational and service goals, finding a niche in the medical and public health care systems, and avoiding the "disempowerment" of the poor.

The history of modern student-run clinics dates back to the 1960s when significant change took place in national health policy. During this period, President Lyndon B. Johnson put forth his vision of a Great Society that would end poverty in America. Young health professionals and students from a variety of fields seized the opportunity to promote a new vision of health care practice. This vision entailed the creation of neighborhood health centers (NHCs) that worked with specific underserved communities, provided community-desired programs, and engaged in community development as well as health service provision. It was hoped that these health centers would provide a stimulus for initiating broader social change (Geiger, 1984).

With fiscal support from the Office of Economic Opportunity (OEO), the concept of NHCs became a reality in several locations including Boston, rural Mississippi, and Chicago. Most of the early NHCs were started by progressive health professionals and sponsored by a hospital, medical school, or county health department. As the concept gained in popularity, so did the number of NHC sites. The NHCs brought together community organizers, local citizens, health professionals, and sometimes students. Each of these groups had different rationales for supporting NHCs.

Organizers often viewed the clinic or health center as a basis for political power to initiate larger social change. Health professionals were interested in providing health care services. Local citizens often supported NHCs because of the employment opportunities they offered rather than their programs and health services. This diversity of interests created a dynamism that helped sustain NHCs, but it also reflected deeply ingrained

differences about the ultimate purposes of NHCs. A similar diversity of interests characterizes modern student-run health clinics.

The development of NHCs was made possible by a national focus on poverty, the belief in health care as a right, and the willingness of the nation to direct substantial federal funds toward solving domestic problems (Caldwell, 1986). These same forces plus a growing faith in local grassroots action contributed to a concomitant movement to establish volunteer-run, free, community-based clinics. A subset of these clinics included student-run clinics. In addition to supporting NHCs, the OEO also supported Student Health Organizations (SHOs) which worked as multidisciplinary teams in community settings to provide direct services and stimulate social change; SHOs established some of the first modern student-run health clinics.

The leaders of the free clinic movement, including student-run clinics, shared many of the values espoused by the founders of NHCs. However, free clinics were not established within the context of a federal program, and they relied heavily on volunteer staff. Many free clinic founders avoided government support in an effort to create an alternative health care movement not constrained by government regulations and funding restrictions. As with the NHCs, health activists, including young health professionals and students, played an integral role in the establishment of free clinics. Free clinics generally started in areas with a lack of medical care. According to a national free clinic survey, about 70 free clinics were established between 1967 and 1969 (Smith, 1971). "Free" meant that these clinics offered free services, tried to reduce and avoid interruptions in patient care, strove to maintain a casual, respectful, and nonjudgmental clinic environment, and emphasized the comfort of patients (Caldwell, 1986). One of the founders of a free clinic wrote the following about the "free clinic tradition":

"In the free clinic tradition, [clinics] had a mandate to provide health care in an atmosphere free of the usual stereotyped roles for nurses, physicians, aides, and patients. An attempt was made to demystify the physician's role, to provide patient education, to bring non-physician health workers into the decision-making process,

