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

by

Robert Byron Ratner

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requirements for the degree of

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Committee in charge:

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Spring 1997

The thesis of Robert Byron Ratner is approved:

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Chair   Date

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University of California, Berkeley
Spring 1997

"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), <u>Animal Dreams</u>

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 and to encourage students to get involved with "changing things."

Acknowledgments

I would not have been able to write this thesis without the tremendous support I've received from my family, friends, teachers, and co-workers. I'd especially like to thank the members of my thesis committee - Meredith Minkler, Joyce Lashof, and John Hurst - for providing me with value feedback, support, and patience in waiting for my drafts. Alan Steinbach has been an ideal mentor for me as an instructor, clinician, community activist, and strong supporter of the Suitcase Clinic. Thanks Alan. My housemates James, Ori, and Alex have helped make this year one of the best of my life, especially in terms of FOOD. They've helped push me along with my thesis with gentle prodding - "so how's the thesis going Rob?" Thanks guys! Thanks to members of the " independent thinking" thesis group for your feedback and support, especially the group's founders - Soma, Bimla, and Neva. I'd like to thank my classmates for being some of my best instructors during my three years at UC Berkeley. Sharon, thanks for providing me with the encouragement and support I needed to work on this thesis. You've given me a lift I sorely needed at this stage in my life.

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 an 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

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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 (Congressional Research Service, 1988). Poor and uninsured individuals are also more likely to have undiagnosed and untreated conditions that lead to premature morbidity and mortality (Congressional Research Service, 1988). 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 detracting from social change? How and what should students learn from their experiences in these clinics? Should such clinics exist at all?

In this thesis, I take 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. The first tier is a "corporate system" that provides regular, ongoing care for the insured, and the second tier or "charity system" 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 incorporates service provision AND work 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 as "the process of enabling (empowering) people to increase control over, and improve, their health,' the prerequisites to which are no less than peace, shelter, education, food, income, a stable ecosystem, social justice and equity (WHO, 1986)." 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"; the distinction I make between the two will be discussed later. It is hoped that this praxis will prove useful for existing clinics and 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

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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 during a time of economic prosperity, 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; O'Connor, 1976). 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, and to allow nonprofessional workers to upgrade their training roles and responsibilities to the limits of their abilities (Schacter, 1977)."

Organizers within the free clinic movement discovered that at a certain point in the development of their programs paid staff members became essential. As their organizations grew, so did managerial and administrative responsibilities. Demands for their programs and services grew in the context of declining funds for human services in the 1970s and 1980s. During the 1970s, a period of economic recession, Richard Nixon called for cutbacks in funds for NHCs and community clinics; community clinics were less dependent on government funds than NHCs. He asked these clinics to become more self-sufficient. In the 1980s, government health policy moved away from an emphasis on universal health care coverage to an emphasis on cost containment and reduced health care spending (Freeman, 1982).

Declining funds and a new emphasis on cost containment forced both NHCs and free community clinics to cut back on their programs and to increase their patient volume. Faced with funding shortages, clinics often decided to cut back on community development efforts, paraprofessional staff positions, and other "progressive" programs in favor of the continued provision of medical services.

The challenges of sustaining an increasingly large volunteer organization became overwhelming for some clinics. At this juncture, the early free clinics founded during the late 1960s and early 1970s, had several options. Some accepted government funding and recognition as community health centers. Others limited their use of government funds by seeking multiple alternative funding sources such as fundraisers, foundation grants, and private donors. Others maintained a volunteer-only philosophy and limited the work of their programs to the constraints of volunteerism; this last philosophy typified that of student-run clinics that continued as student-run.

The following comments, from 1970, come from a leader of a free clinic in Berkeley, California regarding their clinics movement away from maintaining a completely volunteer organization:

> "The implementation of the Clinic's objectives has been a significant example of what can be done on a voluntary, community basis to reach an otherwise inaccessible population. But, the experimental phase is over and the voluntarism upon which the Clinic has had to depend will, in part, become self-defeating. Professional workers and members of the community will continue to give of their time, but the clinic must be able to maintain a paid, core staff and operate on a more stable budget. A history of community clinics has shown that they cannot continue to be effective if they must depend entirely on voluntary services (Schwartz, 1971)."

One of the founders of a student and community-run free clinic in a St. Louis housing project espoused a similar viewpoint that same year:

> "Continuing operation both as a medical-care facility and as a unit of potential teaching value requires more than a volunteer effort. Adequate community support, stable funding and permanent staff, all strengths still being developed, are vital to such a program (Freidin, 1970)."

Student-run clinics that remained student-run were able to do so because of support from academic medical centers (AMCs). The school affiliation provided clinics with liability coverage, a stable volunteer pool to recruit from, and the administrative and financial support necessary to keep the clinics operational. AMC sponsorship of student-run clinics reflected their historical commitments to providing care for the poor and uninsured and their desire to find innovative and cost-effective methods for providing this care.

After the closure of dispensaries, academic medical centers (AMCs) and non-profit hospitals shouldered much of the burden of providing care to uninsured populations (Moy, 1996). This burden has become increasingly difficult for AMCs to carry in the 1990s health marketplace characterized by increasing price competition from health maintenance organizations and shifting government policies, such as cuts in Medicare

and Medicaid expenditures (Moy, 1996). Eliminating this burden has been difficult for AMCs, because they are being asked to take more responsibility for the health of the communities in which they are located at the same time that funds for such care are being reduced (Barry et al, 1994). In addition to these new challenges, underserved patients have always required additional services such as social services, outreach, health education and promotion, transportation, translations, and after care services; these services increase the cost of providing care incurred by AMCs. To pay for the care of underserved patients, today's AMCs rely on cost-shifting to patients with private health insurance, cut backs on programs, and the creation of alternative service sites.

Student-run clinics have historically offered AMCs a cost-effective, alternative location for the provision of care to uninsured and poor individuals. Student-run clinics also offer AMCs an opportunity to enhance student learning in a community-based, ambulatory-care setting; AMCs have been under additional pressure from government, policy experts, and students to create such learning opportunities for students.

An increased emphasis on primary care training and the national movement to create "service learning" programs have both contributed to the increasing pressure on AMCs to support student-run clinics. These factors partially explain the rise in student-run clinics during the past decade. The service learning movement, which began in the late 1980s, "refers to a method under which students learn and develop through active participation in...thoughtfully organized service experiences that meet actual community needs, that [are] integrated into the students' academic curriculum or provide structured time for [reflection, and] that enhance what is taught in school by extending student learning beyond the classroom and into the community...(Corporation for National and Community Service, 1990)." Within an ideal service learning program, service and learning goals are of equal weight and each goal enhances the other for all participants (Sigmon, 1994). Government funding for service learning programs has increased over the past decade offering AMCs some additional funds for providing care to the poor and

uninsured. The value of medical education in such a setting received public recognition in 1992, when then Secretary of Health and Human Services, Louis Sullivan, MD, visited Hahnemann University's Homeless Clinics Project. He proclaimed it a model that should be emulated, whenever possible, by *every medical school* in the country (Hahnemann University, 1992). Service learning programs are also viewed as programs that help students maintain their original motivations for entering medicine:

> "Medical students often deteriorate through their professional education from enthusiastic, humanitarian first-year students to tired and disillusioned fourth-year students viewing their profession far removed from the caring vocation they once imagined...By fostering students' innate altruism [through community service projects and mentoring], medical schools may succeed in cultivating caring and humanism in their student physicians (Reuler, 1994)."

Fewer student-run clinics from the 1980s and 1990s, have gone on to become fully operational community clinics when compared to student-initiated clinics from the 1960s and 1970s. Student-run clinics generally lack the funding and staffing resources to become fully operational community clinics unless the leadership decides to make a bold move at expansion. Such moves have been less likely this decade, which may reflect AMCs growing desire to maintain student-run clinic service learning programs as part of their educational system. Other potential reasons for a decline in clinic conversions include decreased access to funding, changes in the economics and practice of medicine, changes in perceptions of community involvement and social change, and changing visions of student leaders.

Student-Run Clinic Histories: Scope and Student Motivations

Student-run clinics begin with the efforts of students working with community members and school faculty and administration. An ongoing American Medical Student Association (AMSA) survey of medical school community health projects has found that **over forty U.S. medical schools support student-run clinics** (some information from this survey is included in Appendix One: Notes on Student-Run Clinics). Some schools

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operate three or more student-run clinics. There are probably **over sixty student-run clinics nationwide**. Although each clinic has its own unique history, their histories share some common features.

Almost all of the student-run clinics started with a small number of students, usually no more than five, with a strong desire to open a free community clinic. One of the founders of a student-run clinic summarized the power of a few when he wrote: "The most important ingredient for starting a student-run clinic is motivated students willing to work hard, adapt to a variety of situations, and energize others to participate with heart-felt vigor and teamwork (Cohen, 1995)." Student motivations for starting clinics vary, but they stem from an altruistic desire to provide for underserved communities while they develop knowledge, skills, and attitudes in their future profession. In some cases, students became motivated to start clinics after learning about clinics at other schools.

Medical student organizations and literature have promoted student-run clinics at conferences and in journals, newsletters, and other media. One of the founders of the Homeless Health Project at Hahnemann University in Philadelphia wrote an article for the Journal of the American Medical Association entitled "Eight Steps for Starting a Student-Run Clinic (Cohen, 1995)." Other schools have been involved with circulating "How To Start Up A Clinic" manuals. In an article on student-run clinics, Eric Poulsen (1995) encourages others to participate: "We hope students and faculty members will be encouraged to get involved with their school's clinics or to create them where none exists."

Among some clinic founders and coordinators, there is a belief that the most good can be accomplished by finding those most in need. The desire to "do something good" and to give to the "underserved" and the "less fortunate" is a powerful driving force behind student-run clinics. One of the students involved with a Yale University student-run clinic wrote about the benefits of "helping a ...vulnerable (and sometimes forgotten) population" in response to a survey question on the benefits of student-run clinics

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(AMSA, 1997). Although not universally true, many students feel they benefit from working with "the other", that is, members of a community outside their traditional realm of experience. Students often describe these communties as "needy", "dependent", "underserved", "vulnerable", and "less fortunate". It is rare to find student leaders referring to the communities they work with in terms of their assets and strengths.

Students also start and participate in clinics to make practical use of their "book learning." Working in clinics brings textbook learning alive for students. They benefit from early clinical exposure and observation of role models. The desire to "practice practicing medicine" is another driving force for student involvement. Some clinic founders hoped that by creating student-run clinics and involving their colleagues in these clinics, they could instill a commitment to public service and community involvement among their fellow students. Students involved with volunteer free clinics openly acknowledge that they grow personally and professionally from their experiences. Many students believe they "give" less than they "receive" from their work at free clinics.

Some of the earliest student-run clinics were founded as "models" of a new type of health care that incorporated community participation and multidisciplinary teamwork into their operation. The earliest student-run clinics wrote more than later generations about their program's commitment to broader social change. The following excerpts come from members of the Student Health Organization, a national organization founded by health science students from around the country:

> "We see health in the broadest possible perspective entailing all aspects of the growth and development of the individual in his society. As students our thoughts are on the future. Yet we know that this future is being created today in the vision and the actions of the contemporary world. This knowledge compels us to be engaged in and critical of the direction of our society today. It is essential that we speak our minds on the crisis in the American health care system...As students in the health sciences we strongly support the concept of health as a right; we endorse all efforts to write bigotry out of medical practice and provide standardized quality care for all; we call for the development of alternative service for medical personnel and fulfillment of their national obligation; and we present

ourselves in an interdisciplinary manner in demonstration of our approach to health issues (McGarvey, 1969) [Student Health Organization statement agreed upon by nine regions of SHOs]."

"The essence of our *radicalism* will be found in our sustained efforts to change ourselves, our schools, and our professions. We have the tremendous advantage of youth... Health care is ours to capture and the strength we have is the strength we have in each other (McGarvey, 1969) [Key note speaker at third national assembly]."

Student-run clinics founded in the 1980s and 1990s are less likely to promote "radicalism", but there is a tremendous interest among students in volunteerism, and in particular work in student-run clinics. In an AMSA New Physician article published in November of 1995 more than fifty-five percent of respondents to a magazine survey stated they currently volunteer or have volunteered at a free clinic. An additional thirty-four percent plan to volunteer at a free clinic sometime during their medical training. Sixty two percent of females and forty-five percent of males currently volunteer or have volunteered at a free clinic. High interest levels in student-run clinics can be seen at schools across the country.

Students at the UCSF medical school are limited in the amount of times they can volunteer at their homeless clinics each year. At the Student Health Action Committee Clinic at UNC-Chapel Hill "so many medical students sign up [to volunteer] that they're allowed to work only one night each year, and even so, many students are turned away." At UC Davis, students estimate that over 90% of all graduating medical students have spent time volunteering at one or more of their five student-run clinics during their tenure as medical students. According to Dr. Paul Dallas, director of the ambulatory care residency program at Roanoke Memorial Hospital in central Virginia, residents from their program, "will volunteer in the free clinic [Bradley Free Clinic of Roanoke] after spending hours and hours at work in the hospital because they get a feeling of contributing to the community." Dr. Dallas feels that student and resident interest in free

clinic work is high because, "a lot of us went into medicine for that reason - to give something back to people."

Most of the literature published by student-run clinics indicates that their founders were from outside the communities they sought to serve. The term "outside" refers to the fact that involved students rarely come from the same geographic or identity communities (people of color, homeless individuals, migrant workers, etc.) of those they choose to serve. In deciding which communities to serve, students often rely on information from service providers and clinical faculty as opposed to hearing input from the community in question. Selected communities tend to be the "visible poor", such as homeless people or migrant workers, or ethnically-defined communities such as those served by the Asian Health Concern or the Clinica Tepati clinics at UC Davis. These communities, as defined by the students, do not always view themselves as communities, but this label is given to them by others. For example, many homeless individuals do not want to be considered part of a "homeless community." In spite of this, many student-run clinics target *the* "homeless community" as if it is a discrete entity. Community definition often hinges on students' desire to find those most in need.

After defining their communities, student-run clinic organizers typically go through a short process of community assessment. Most commonly, this involves reviewing literature on the community, speaking with service providers, and soliciting the advice of outside experts. Few, if any, student-run clinics involve community members in the assessment process. Students filled with enthusiasm for starting a clinic and with little free time to spare often devote minimal time and energy to community assessment.

Following the process of community assessment, clinic organizers move on to establishing mission statements, goals, and objectives. These elements vary widely among clinics in terms of their scope, depth, and ease of evaluation. Most of the student energy invested in clinics goes toward establishing and maintaining regular operations. Manuals on student-run clinics highlight emphasize set up and maintenance of a clinic.

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These manuals rarely address issues of vision, defining community, community assessment, establishing missions and goals, and evaluation activities. Although sorely needed, both to improve operations and to corroborate their utility, student-run clinics do not generally establish and maintain methods for evaluating their organizations. For evaluation to be possible, clinics must have established measurable goals and objectives. The next section contains a compilation of student-run health clinic goals, in various stages of measurability, from around the country. These goals will be revisited in Part III of this thesis.

Compilation of Clinic Goals: Service, Learning, Social Change

The following section contains a summary of goals from over 40 student-run clinics from around the country. The goals have been placed under categories of service, learning, or social change. The term "service" refers to the provision of an action or good to meet the need of another. "Learning" refers to a process or action geared toward developing student's knowledge, skills, or attitudes. "Social change" refers to a non-service oriented process for altering the structural and collective (economic, political, social, and cultural) influences on an individual's health and well-being as opposed to providing medical *services* or advocating changes in *individual* behavioral.

The placement of these goals into the categories of service, learning, and social change was somewhat arbitrary and there is significant overlap among the categories. The list does not represent the goals of a single clinic. Rather, it is intended to create a national picture of student-run clinic goals. The sources for the appendix material include personal communications with clinic leaders, journal articles on student-run clinics, conference materials, clinic brochures, and an AMSA Community Health Task Force survey of medical-school affiliated community health projects (AMSA, 1997).

Compilation of Clinic Goals: Service, Learning, Social Change

Service Goals

1. To identify and meet the unmet community needs of underserved populations (homeless individuals, migrant field workers, recent immigrants, the urban poor, etc.)
2. To increase access to primary health care and other medical services among underserved populations.

    Methods for accomplishing this goal include:
    a) Selecting an accessible location.
    b) Operating at accessible times.
    c) Conducting outreach programs and services.
    d) Creating "one-stop shopping" multi-service centers where an individual can address multiple needs.
    e) Offering walk-in appointments.
    f) Providing free medical services and free dispensed (not prescribed) medications.
    g) Serving as an entrance point into the medical care system and ongoing health care access; which entails maintaining a strong referral network
    h) Maintaining an informal, non-judgmental atmosphere.
    i) Reducing waits and increasing time available to spend with providers.
3. To create programs that promote health on multiple levels, i.e., medical services, social support, employment opportunities, preventive health education, etc.
4. To facilitate collaboration and networking among organizations and individuals in order to promote the health of underserved communities.

Learning Goals

1. To "sensitize" students to the medical and social needs of underserved populations.
2. To push students to confront stereotypes and to reflect on their values and attitudes toward underserved communities.
3. To breakdown knowledge and power barriers between health professionals, health professional students, and underserved community members by encouraging mutual learning and discussion among these groups.
4. To develop students' abilities to work with people from different cultural backgrounds.
5. To prepare students for collaborative work in a multi-disciplinary service provider team and to give them the tools they need to utilize a wide array of community and other resources.
6. To expose students to primary care practice early in their education.
7. To expose students to multiple role models providing them with an opportunity to develop their own identity through selective emulation.
8. To help students develop their clinical skills by exposing them to clinical work early in their education in a lower pressure environment than that of the clerkship years.
9. To help students develop population-specific clinical skills, e.g., elderly, children, recent, immigrants, etc.
10. To develop students' communication and health education skills.
11. To provide students with an opportunity to become involved with and develop skills in clinical administration and operation.
12. To teach students how to create and maintain a medical record system.
13. To involve students in planning and creating cost-effective services with limited resources.
14. To encourage students to think about the determinants of health in broad terms.
15. To introduce students to a cyclical educational process of service and learning, action and reflection.
16. To foster social responsibility, active citizenship, and lifelong volunteer work among health professionals and future health professionals.

Social Change Goals

1. To work toward bringing an end to poverty ("A War on Poverty").
2. To increase the number of primary care physicians working in underserved communities.
3. To promote volunteerism as a solution to providing medical care to underserved populations.
4. To develop a "pure" model of medical practice that includes the following elements: a) low-cost/cost effective care; b) informal, non-intimidating environments; c) long-term relationships with patients; d) long appointment times with patients; e) Multi-disciplinary health care teams
5. Reduce health professional disenchantment with medicine.

As the previous pages indicate the service goals of student-run clinics fall into four major categories: 1) meeting unmet community needs of underserved populations; 2) increasing access to primary care and other medical services; 3) creating multi-disciplinary health promotion efforts; and 4) facilitating collaboration and networking among organizations and individuals in order to promote the health of underserved communities. Although health care is not always a top priority among underserved communities, students involved with student-run clinics often build their programs around the goal of increasing access to primary care and other health services. This allows students to become involved with community work within their future career field. Leaders of student-run clinics have developed various methods for trying to increase access to health services.

One method involves locating clinic services in close proximity to the target community. For example, several of the clinics serving homeless individuals operate out of shelters, soup kitchens, or drop-in centers for the homeless. One of the first student-run clinics provided care to housing project residents of a St. Louis housing project by operating a clinic on the premises. By bringing services to the community, student-run clinics become more accessible. In addition to location selection, clinic operation hours also influence accessibility. The majority of clinics operate weekday evenings and weekend mornings; these are convenient times for student volunteers and community members that have other obligations during weekday working hours.

A minority of student-run clinics conduct outreach programs as part of their operation. The Homeless and Indigent Population Health Outreach Project (HIPHOP) of the University of Medicine and Dentistry of New Jersey - Robert Wood Johnson Medical

School conducts home visits of patients seen at its free clinic. These visits are conducted by a community nurse and a first-year medical student. The Camillus Health Concern, a former student-run clinic at the University of Miami School of Medicine, is located near a shelter and regular street outreach is an integral part of the clinic's work. A team consisting of a volunteer nurse, physician, and medical student walks the streets of Miami, with limited medical supplies, talking to people on the streets about their health concerns. The Yale University Internal Medicine Residency Program operates a mobile health van outreach team for homeless individuals. These outreach efforts seek to bring care to community members rather than requiring them to initiate the contact.

Student-run clinics try to increase access to services and promote health on multiple levels by offering a wide-variety of health and social services at one site. The Suitcase Clinic in Berkeley, California operates a wide variety of services and programs each week. These include acute care medical services, optometry care with free prescription glasses, legal counsel, social service assistance and referrals, chiropractic care, facilitated group discussions, and a variety of periodic special services include assistance with tax returns, reapplication for welfare benefits, and influenza shots. The Camillus Health Concern, mentioned previously, offers podiatry services, social services, mental health counseling, referrals to community agencies, legal services, primary care, and a variety of preventive and health maintenance services such as immunizations, HIV screening and counseling, and disability examinations. "Recognizing that health is not strictly biological phenomenon, the [University of Pennsylvania University City Hospitality Coalition] medical clinic seeks to address a broad spectrum of health related issues such as housing, employment, financial stability, social services, community

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support, education, and hygiene." Other clinics offer free dental services or referrals for free or reduced cost dental care. Clinics also often coordinate preventive health programs and education. By offering multiple programs at one site and through teamwork among providers from multiple disciplines, student-run clinics try to meet a variety of needs at one time in one location. A diversity of services allows clients to choose among a variety of health and related services.

Most student-run clinics operate on a walk-in, first-come, first-served basis. This allows individuals to seek services on the same day, and it removes the burden of needing to set an appointment and keep it. Individuals from underserved communities often find it difficult to keep appointments because of the uncertainty of each day, limited access to transportation, and of other more pressing demands on their time. Without an appointment system, clinics cannot guarantee that everyone needing services will be seen during a given clinic session. Clinics have tried various methods for addressing this problem including setting appointments for those who don't get seen during a given session, referring people to other programs, and providing individuals with alternative services and education rather than a full appointment.

Nearly all student-run clinics offer free services and free dispensed, rather than prescribed medications. As a result, clinics have minimal financial paperwork and no billing of individual patients. The free-service nature of the clinics allows individuals to seek care without fear of getting billed for services they cannot afford or receiving a prescription for medications they cannot purchase. Since most clinics do not charge for their services, their funds are limited which in turn limits the services they can provide.

Due to these limitations, most student-run clinics maintain ties with other community clinics and health care centers that can provide a higher level of medical care or other services. These links help student-run clinics serve as "stepping stones" into the health care system. It is hoped that individuals seeking care at a student-run clinic can be supported and encouraged to receive care from other providers if necessary. Rather than playing the role of a primary care gatekeeper that limits access to services, student-run clinics serve as primary care guides that encourage individuals to seek services from a system they may have avoided in the past. Maintaining strong referral networks requires that student-run clinic leaders make an extra effort to foster collaboration and networking among organizations and individuals concerned about the health of the clinic's target community. Some clinics maintain advisory boards composed of faculty, students, and community representatives in order to strengthen the connection between volunteers and community members.

As evidenced by the list of clinic learning goals at the beginning of this section, student-run clinics tend to articulate learning goals more frequently and more specifically than service or social change goals. This reflects a tendency for student-run clinics, as well as other service-learning programs, to emphasize student learning over other aspects of their programs. The learning goals also reflect what students are expected to get out of their volunteer time. Clinic learning goals encompass a wide range of issues including skill development, attitude change, and exposure to underserved communities. The following quote from the Camillus Health Concern in Miami, which requires students to work there during their training, illustrates how important this clinic has become to the educational experience of students at the University of Miami Medical School (UMSM):

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"The UMSM students were asked to evaluate their clinical training sites. Camillus Health Concern was rated as the place students would most like to spend more time. It was rated the best setting to learn clinical knowledge of common problems, social responsibility, ambulatory medicine, cost consciousness, meaningful interaction with faculty, student responsibility, and adequacy of supervision....ranked second only to the major teaching hospital as a place to learn clinical knowledge of unusual problems and to private physicians' offices as a place to learn positive patient interactions (Fournier, 1993)."

One of the main goals of student-clinic founders is to sensitize themselves and their colleagues to the medical and social needs of underserved communities. It is hoped that through their volunteer work students will begin to appreciate the multiple social, environmental, behavioral, and biological influences on an individual's health such as their financial and housing status, their social support system, their diets, and other factors. Through exposure, it is hoped that students will become more emotionally and intellectually aware of the extent of poverty and inadequate access to health care.

"Fears and prejudices are confronted and stereotypes are shattered" according to the Camillus Health Concern Clinic (Fournier, 1993). Many students from this clinic comment on the "sense of shared humanity" they experience with patients which leads to compassion and empathy rather than pity and sympathy. "This is a powerful antidote to the unspoken but prevalent attitude at medical centers that poor patients are legitimate subjects 'on which to practice'" states Fournier (1993). At the Stout Street Clinic at the University of Colorado, "...[students] get exposure to the homeless population and discover they're not just drunks and drug addicts (AMSA, 1997)." Organizers of the Redding Homeless Shelter Clinic, sponsored by the Nevada School of Medicine, believe that one of the major impediments to recruiting physicians to work in underserved health care settings is physician prejudice and fear. It is assumed that exposing residents to positive experiences in a homeless shelter will alleviate some of these fears and biases, which in turn will increase resident interest in caring for underserved communities (Fiore, 1995).

Redding Homeless Shelter Clinic organizers and organizers at other clinics often assume that exposure to members of an underserved community, in and of itself, will force students to confront stereotypes and reflect on their values and attitudes toward underserved communities. Anecdotal evidence supports this assumption, although few studies have been done to systematically examine attitude change. There have been some studies that suggest an association (not causation) between exposing students, and residents, to underserved populations such as the homeless and increased awareness of professional values such as altruism and equality (Fiore, 1995).

During medical school, students become acculturated to new norms of behavior and attitudes. Some commentators on medical education describe how the medical education process inculcates students with a heightened sense of knowledge and power that hampers the quality of their interactions with patients and others. Student-run clinics attempt to break down the power barriers between health professionals, health professional students, and underserved community members by engaging in mutual learning.

The informal environments present at student-run clinics are believed to be more conducive to this type of mutual learning. Patients may feel more in control when working with a student; they are asked to take on a role as a patient teacher-learner. Not every patient wants to take on this role, nor are all staff members prepared to facilitate such a process. The creation of a mutual learning environment often hinges on physician supervisors who typically make the ultimate decisions about treatment and the educational process. Volunteer physicians may choose to exclude patients from the learning experience thereby maintaining control of knowledge, or they can include patients and other team members in a mutual learning dialogue. Most student-clinic leaders strive to cultivate the latter process.

Through volunteer work at student-run clinics, students face challenging cross-cultural interactions. These interactions offer students an opportunity to develop cross-

cultural competencies. Students also work in environments with service providers and organizations from different disciplines; this creates an opportunity for cross-disciplinary teamwork building which, it is hoped, will ultimately benefit service users. Within their disciplines, students are exposed to the different practice styles of rotating professional volunteers. Students can selectively emulate professional role models based on their cumulative observations of a variety of professionals in action.

Early exposure of students to outpatient care medicine is believed to serve several purposes. As stated earlier, it allows students to "see why they came to school in the first place (AMSA, 1997)." Textbook knowledge can be put in context with actual clinical work. The early clinical exposure allows students to develop their clinical and interpersonal capabilities in a relaxed, non-threatening environment without grading or formal evaluations. Skills they develop include interviewing, physical examination skills, clinical problem-solving, and patient management. Skill development of this nature can be gained in settings other than at free clinics. However, the informal atmosphere and the opportunity to "do good" while learning are believed to make student-run clinics a better learning environment for these clinical skills. According to students involved with the Davis Community Clinic, free clinic volunteers are much better prepared for the wards during their third and fourth years (AMSA, 1997). Student volunteers also have the opportunity to develop population-specific clinical skills in some clinics by working with specific populations such as children, the elderly, recent immigrants, homeless individuals, and others. In addition to developing traditional clinical skills, student-run clinics try to foster the development of communication and health education skills.

Some students involved with student-run clinics have the opportunity to take on leadership positions as clinic administrators. These leaders develop additional skills as clinic managers. They learn about medical record management, financial planning, staff

scheduling and recruitment, and other skills necessary for the planning and operation of a community clinic.

At some schools, student-run clinics are affiliated with classes or seminars conducted by guest lecturers. Course titles include "Community Health", "Health Care for the Poor and Homeless", "Health Care Organization and Administration Elective", "Health Care to Underserved Populations", and others. Student volunteers concomitantly enrolled in relevant classes have the opportunity to develop a cyclical learning process of service and learning, action and reflection. This means that students learn to ask questions based on their service experiences; they then learn how to answer these questions. Alternatively, students develop questions in the classroom that they answer through their community service experiences. This cyclical learning process strives to foster the development of socially responsible, active citizens. Poulsen (1995) suggests that this goal is probably more important than any of the clinical skills students develop as part of their volunteer experience.

As stated in the previous section, student-run clinics from the 1980s and 1990s do not generally share the same lofty social change goals as their counterparts from the 1960s and 1970s. However, today's clinics do still maintain some social change goals. One student-run clinic leader wrote about her desire to contribute to a renewed "War on Poverty (AMSA, 1997)." A more common goal among today's student-run clinics is to increase the number of primary care physicians working in underserved communities.

There have been some studies that indicate an association between students exposed to work in an underserved community and their likelihood to practice primary care and to continue some type of work with underserved communities. Student surveys at Darthmouth show those that participate in community service are more likely to go into primary care (AMSA, 1995). Rush Medical College found that 65% of medical school graduates from 1990-92 who volunteered at a free clinic entered primary care. More impressively, 78% of the most active student leaders in community service projects

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entered primary care residencies (Zuckerman, 1997). In a study by Madison (1994), there was a correlation between community service experience and eventual choice of generalist specialties. It is unclear from these studies whether students career choices were made before or after their exposure to community service in underserved communities. Students may not be moved to devote their whole careers to work with underserved communities, but it is hoped that their student-run clinic experiences will at least motivate them to continue volunteering upon completion of their training.

In contrast to non-student run free clinics and neighborhood health centers, only a handful of student-run clinics have mission statements and goals that view health care as a right and call for universal health coverage. The absence of these statements is indicative of a tendency to accept local volunteerism as a solution to the problems of underserved communities. Such a solution is promoted by more conservative thinkers, who believe the next step in the free-care movement might be physicians, in essence, operating their own free clinics within their private practices. These experts cite studies[1] that demonstrate the extent of physician volunteerism and argue that if physicians devoted enough volunteer time the problems of the uninsured would disappear. Unwittingly, student-run clinics may contribute to health policy arguments that support "volunteerism" as a solution to the problems of the underserved by not promoting an alternative vision.

Student-run clinic leaders see the clinics they coordinate as models of a "purer" form of medical practice that includes several key elements, some of which have already been mentioned. These elements include: low-cost care for acute medical problems often treated at a greater expense elsewhere; informal, non-intimidating environments; ongoing relationships with patients; longer appointments with patients, and practice in a multi-disciplinary setting. Although often unaware of it, many of these elements reflect

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[1]For example, an AMA survey found that 67.7% of U.S. physicians provided some type of charity care in 1994.

the historical ties student-run clinics have with NHCs and the ties of NHCs with community-oriented primary care (COPC) theory. Both NHCs and COPC theory emphasize the aforementioned elements.

Student-run clinics do provide low-cost medical services. For comparison purposes, free clinics, including student-run clinics, spent $1-4 per patient visit in 1972. NHC clinics spent $85-$170 per patient per visit in 1967 (Gordon, 1969). On average, today's free clinics provide five to six dollars of care for every one dollar in donations, and they pride themselves on this fiscal efficiency (Tschida,1995). Some of these differences in expenditures reflect the lack of laboratory facilities at free and community clinics. Student-run clinics have demonstrated the potential to reduce emergency room visits and hospitalizations among underserved populations, thus reducing AMC costs. The Homeless Outreach Project at Hahnemann University estimates that its programs saved the local emergency department $40,000 during a one year period (AMSA, 1996).

Student-run clinics receive funding from a variety of sources including school support, foundation grants, government grants, in-kind donations, and other private donations. Most student-run clinics have budgets of less than $30,000 per year. The fiscal efficiency of these clinics stems from their use of in-kind donations and volunteer time rather than reductions in patient visit time or other restrictions on practice. However, student-run clinics have restricted practices because of limited supplies, equipment, and facilities.

Health professionals involved with student-run clinics appreciate the freedom to practice medicine without excessive financial paperwork and the opportunity to spend more time with patients. Free clinics pride themselves on how much time they spend with each patient. At one free clinic in San Francisco, each appointment lasts about an hour, as opposed to the 15 minutes of attention people get in managed care practice (Tschida, 1995).

One of the faculty sponsors of the Camillus Health Concern in Miami claims that students learn cost-consciousness by volunteering at the clinic. He argues that practitioners learn to consider the financial and other constraints on the clinic and its patients before making clinical decisions. As a result, practitioners request fewer additional off-site tests or care because of their expense and because such referrals place an additional burden on patients. In this context, students and practitioners learn to rely more on clinical histories and physicals to make diagnoses and less on laboratory work-ups. Some educators believe that the reduced availability of laboratory testing forces students and practitioners to develop their skills at history-taking and physical examination. Others view reduced laboratory testing availability as indicative of substandard care at student-run clinics.

Students and health professionals derive personal and professional satisfaction from working in student-run clinic environments. By working with "people most in need" volunteers derive more satisfaction than from working with those "less in need". Having multiple resources available at one site at one time is also appreciated by health professionals. By practicing in an environment antithetical to the stereotypical managed care clinic, characterized by a loss of autonomy and a focus on profit, practitioners feel they are returning to a "purer" form of medical practice that coincides more closely with their original perceptions of themselves as health professionals.

The "pure" form of medicine practiced at student-run clinics has limits. Services are limited in scope. Patient time with health professionals and students may be longer than in managed care organizations, but not all of this time is used as patients would wish. Patients are often interviewed multiple times by students and professionals before receiving a diagnosis and treatment. Since most student-run clinics operate on a first-come, first-served basis, many clients have to wait several hours to be seen. There are many other problems, questions, challenges, and criticisms associated with student-run

clinics. Some of these have already been mentioned. The next section reviews some of these issues.

Key Problems, Questions, Challenges, and Criticisms

Student-run clinics face multiple operational challenges and have been subject to criticism about their purposes and effectiveness as well as the quality and meaning of the learning that takes place at these clinics. One criticism of student-run clinics is that individuals involved with these clinics often do not have a vision of how their local efforts relate to national social concerns around poverty, discrimination, and heath care insurance and access. The demands of providing services and maintaining an organization on a regular basis make it difficult for organizers to address issues beyond the immediate concerns of their patients. By devoting so much time and energy to service provision, individuals may be diverting attention away from broader questions of social justice. Rather than addressing the root causes of some of the problems faced by student-run clinic users, organizers may be contributing to a growing "service industry" that perpetuates a charity-based system of care for some and an insurance-driven system for others (McKnight & Kretzmann, 1992). Students assume they are accomplishing "the most good" by providing services to those "most in need" when they may have a greater social impact through other avenues such as policy work or education. Unwittingly, student-run health clinics buttress the arguments of conservative thinkers who believe the problems of the uninsured and underserved can be solved through voluntary efforts. The demands of "drowning babies in a river" should not prevent all those on the banks of the river from investigating who is throwing the babies into the river or hastening their fall.

The dual purposes of student-run health clinics as service providers and educational experiences represents an ethical dilemma. Is it ethical for students to

"practice" on poor people in order to become physicians? When student-run health clinics focus more attention on student learning than on community health promotion the ethics of their work becomes questionable. In addition, programs that emphasize student learning and minimize opportunities for mutual learning and teaching among professionals, students, and service users contribute to further schisms in power between service providers and service users. If students learn from their experiences that charity-based services and the use of the poor for learning are acceptable situations, then student-run health clinics contribute to rather than alter an oppressive system.

Student-run health clinics often assume that student exposure to underserved populations results in attitude changes and an increased likelihood that students will enter careers as primary care physicians in underserved communities. Some studies have demonstrated associations between these factors, but no studies to date have established a causal link. It could be that students who volunteer at free clinics are more likely to possess certain attitudes and to have an interest in primary care medicine with underserved communities *before* they begin volunteering rather than *as a result of* their volunteering.

Founders of student-run clinics are often community outsiders unfamiliar with the nuances of the "outsider-defined" communities they target. When outsiders create programs for communities that are not involved with the organizational planning process, they create programs based on their own perceptions of a community's deficiencies and needs. The strengths and resources of the community are not usually considered. Such a process results in services that the agency *can* provide rather than services and programs the community *wants* (McKnight & Kretzmann, 1992). Community resources may be

diverted away from issues of greater importance in the student-run health clinics efforts to come into existence. Community outsiders also face multiple cultural barriers when they work with individuals from different classes, races, genders, and other non-mutual identities. Student-run health clinics often fail to confront the barriers created by their positions as community outsiders. This failure is more common when students get caught in a hurried attempt to establish a student-run health clinic to keep up with students at other schools.

The services provided at student-run health clinics are often limited. These clinics lack the resources to provide certain diagnostic tests and treatments. Volunteers rotate through the clinics on a weekly basis making continuity of care virtually impossible. Some student leaders choose to involve as many students as possible in the clinics which leads to a situation where students volunteer only a few times per year. As a result, service users never establish relationships with student volunteers. Quantity of students is favored over having a smaller number of committed volunteers at the clinics on a regular basis. With rapid turnover of professional and student volunteers, there is little time for on-the-job training which is the most common method in which volunteers are trained. Completely volunteer-run student clinics must struggle like the early free clinics to maintain their organizations without paid staff members.

Student-run health clinics face multiple operational issues such as legal and liability concerns, recruiting volunteers, maintaining adequate funding, and others. Logistical issues can become all-consuming for volunteer-only organizations. These logistical issues pull energy and time away from other issues and programs such as

planning and evaluation and working on community-wide issues rather than just providing for individual service needs.

In spite of their best efforts, few student-run clinics have been successful in regularly providing patients with entrance into the health care system and continuity of care. Finding places to refer patients who have no health insurance and who are poor presents a major challenge to clinic organizers. Many patients come to student-run clinics, because they eschew the mainstream medical care system. However, since these clinics have service limitations some patient problems can only be adequately addressed within the traditional care system. Establishing referral networks requires that student organizers create an alternative system within a system.

Even if clinics are equipped to provide referrals, some clinic users may eschew traditional care in favor of student-run health clinics. This would not be as much of a problem if student-run clinics could provide comprehensive primary care. As they are currently constituted, student-run clinics do not and cannot provide such care. One student volunteer commented on how this situation could lead to the provision of "band-aids" for people who have serious, untreated medical problems:

> "Although I am pleased that the clinic has become an accepted by a large number of people at the meal, I am concerned about the message our presence may be sending. During the summer, I attended a meeting (along with other students who organize homeless health clinics) where speakers from Philadelphia Health Management Corporation talked about health care delivery to the homeless. They warned us of the danger that these small clinics may become substitutes for using a primary care physician, and thus serve only as a band-aid station providing immediate care but concealing larger health problems. I became acutely aware that we may actually be doing the clients we serve a disservice. The clinic is not equipped to provide comprehensive care and should serve only as a stepping stone (Presser, 1995)."

Many questions about student-run clinics remain unanswered. Few studies have been done on these clinics, and the clinics themselves rarely conduct evaluations. This lack of information makes it difficult for student-run health clinics to address their critics and to improve their work. This additional information will be crucial to the future of student-run health clinics.

Developing a Vision

The litany of criticisms and challenges faced by student-run clinics make it appear that these clinics have a limited role in our health care system and society, perhaps even a destructive role. The actual impact of these programs remains unclear because of a lack of research and evaluation data. Even without this information, there are some steps that student-run clinics can take to remedy some of their problems, challenges, and criticisms. The rest of this thesis is devoted to developing an outline of such steps.

Health professions students have and can play a critical role in promoting community health and healthy public policy (McGarvey, 1969). Student-run clinics provide students with one avenue for involvement. As isolated entities, it is unlikely that student-run clinics will have an impact at the national level. With greater networking and sharing of ideas and resources, student-run health clinics have the potential to make such an impact.

The next section contains an analysis of student-run clinics that utilizes literature from the fields of community oriented primary care (COPC), community organizing, and popular education. The section ends with a praxis proposal for student-run clinics.

Part III: Student-Run Clinic Praxis

Introduction

Literature from the fields of COPC, community organizing, and popular education provides valuable insights for student-run clinics. This literature addresses some of the key goals, questions, concerns, and challenges faced by student-run clinics, as well as raising additional issues. All three fields address, directly or indirectly, issues of community health promotion, social change, and organizational development and operation. However, the field of COPC is most germane to student-run clinics since it lays out the elements of a primary care-public health practice within the confines of a clinic. Community organizing and popular education are activities that can take place within a COPC clinic, and these fields will be discussed within this context. The Codman Square Health Center in Boston is an example of a community health center that has successfully combined the use of these three fields in its operations (Schlaff, 1991); student-run clinics could benefit from a similar use of these fields.

COPC provides an excellent framework for analyzing and guiding the practice of student-run clinics for several reasons. Today's student-run clinics evolved out of efforts to apply COPC principles during the 1960s, and several of today's clinics strive to apply COPC principles. The COPC model incorporates many of the goals espoused by student-run clinics and provides principles for service, learning, and social change goals. Student-run clinics attempt to merge medical care and public health practice; this is a chief aim of COPC. Unlike community organizing and popular education theory, COPC theory represents a model of practice for individuals trained in the health professions. Health professionals may certainly utilize and benefit from an understanding of community organizing and popular education theory, but academically-trained practitioners in these fields typically receive training in social welfare, public health, or education rather than medicine.

The Third Report of the Pew Health Professions Commission entitled <u>Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century</u> endorses COPC as an integral approach to medical care for the next century. During the Clinton administration's efforts to reform the health care system, several authors wrote about the benefits of incorporating a COPC approach into any reforms (Wright, 1993; Cashman, et al., 1994). COPC has proven effective in enhancing community health and there is evidence that COPC models may enhance the cost-effectiveness of health care programs (Kark, 1993). More than 30 studies have shown that community health centers, which utilize at least some principles of COPC, have reduced the rate of hospital admissions and the mean length of hospital stays thus reducing costs (Geiger, 1983). A study of data from neighborhood COPC practices in South Africa, Israel, the United States, Canada and Wales provides evidence for the effectiveness of the COPC approach (Abramson, 1988). Community health centers, which have historically utilized at least some COPC principles, have shown their effectiveness in numerous studies by lowering infant mortality rates and hospital emergency room utilization by their clients when compared to similar populations who are nonusers, and all for lower per capita medical costs. (Chabot, 1971; Gold & Rosenberg, 1977). Several managed care organizations currently apply or are considering applying some of the principles of COPC as a cost-effective means of promoting the health of their enrollees (Boumbulian, 1991; Gjeltema, 1997). In the United States, family practice residents are now required to have some training in COPC. One of the factors preventing more widespread utilization of COPC is the lack of training programs available for health professionals in training. The use of COPC principles within the context of student-run clinics can partially fill this void. These are a few of the reasons for utilizing COPC as a framework for student-run clinics. Before developing a COPC-based model for student-run clinics it is important to have a minimum understanding of the history and key elements of COPC, community organizing, and popular education. The next three sections cover these topics.

Community Oriented Primary Care (COPC)

The year was 1940 and the setting was Pholela, a rural town in South Africa. Sidney and Emily Kark, both recent, white, Western-trained, medical school graduates, helped establish the first health center in South Africa that was the responsibility of the health department of the central government. Pholela Health Center was established as a pilot project in a rural community among a black, Zulu population (Kark, 1981). The early services of the clinic were curative in nature. Individual patients came to the clinic seeking care for a variety of ailments. Clinic staff did there best to cure and relieve individual pain and suffering. It soon became apparent to the Karks' and others involved with the clinic that the individual ailments they saw on a daily basis were often a reflection of community-wide health problems. To transform the clinic into an organization that promoted health and quality of life in addition to providing "sick care", the Karks' began to develop a series of ideas about community-based medicine. These ideas evolved into a conceptual model that linked public health and primary care medical practice. This model calls for an integration of personal curative and preventive medical services, demographic study, epidemiologic investigation, community organization, and health education (Geiger, 1982). In this model, multidisciplinary family health teams consisting of a family physician, family nurse, and community health educator, serve defined populations and provide treatments to patients and community in light of the biological and the epidemiological, social, and psychological sciences (Susser, 1993). Home visits with families was seen as integral to understanding the multi-factorial influences on a family and community's health. Another central tenet of this model is that primary care should "be rooted *in* communities, *for* communities, and *with* communities (Geiger, 1993)." Work in a community starts with a "community diagnosis" or community assessment of social, cultural, and environmental determinants of health. The success of community interventions is monitored by trained health recorders. Primary care epidemiology, the measurement of health status in populations,

was seen as a foundation for community action. Epidemiologic information is used to identify what Kark calls, "community syndromes," that is, conditions that impact the health of the entire community. The Kark's called their model Community-Oriented Primary Health Care; the model is referred to as Community-Oriented Primary Care (COPC) in the United States.

The Karks spent time in the United States and at the World Health Organization (WHO) in Geneva, and settled in Israel where they continued further development of the COPC model. This model had a profound impact on the NHC movement in the United States and in the WHO's primary health care initiatives. Interest in COPC has resurfaced in the United States after about a 20 year hiatus. In 1982, at an Institute of Medicine (IOM) Conference, two primary obstacles were cited that prevented the widespread use of COPC in the United States. These obstacles were the widespread perception that COPC was a way of designing services for the disadvantaged and not an option for society as a whole. The other obstacle was the predominance of the fee-for-service reimbursement model. Other obstacles to widespread implementation include limited federal and state support for preventive health services, the individualism of medical education, the momentum generated by technological advances, and the sheer size and instability of American communities (Tollman, 1991). Large community size and instability make it difficult to define a community for intervention that goes beyond the numerator population, that is, the group of individuals that seek care at the clinic. The IOM recommended development and testing of methods for performing COPC functions, the implementation of a fully developed COPC model in several practice settings, and an assessment of the impact and cost effectiveness of COPC principles.

Over a decade after the IOM report, there has yet to be a fully developed COPC model. As stated earlier, health maintenance organizations (HMOs) interested in reducing costs and promoting the health of their members are exploring innovative practice models including COPC, but none of these organizations have fully implemented

the model. Several medical schools now provide students with experiences in COPC as a way of preparing future physicians for community-based primary care practices. At some health professions' schools, there are student-run clinics that attempt to integrate COPC principles into their learning and service provision.

Sidney and Emily Kark, considered the founders of the COPC concept, view COPC as a combination of *community medicine* and *primary care* services applied to a specific population group. Medvin (1986) defines *primary care* as "health care delivered on first contact with the health care delivery system and which ideally includes the following attributes: accessibility of services to the user, a comprehensive array of services, coordination and continuity of care over time, and accountability by the practitioner for quality, benefits, and risks of such services." Tapp and Deuschle (1969) define *community medicine* as "the academic discipline that deals with the identification and solution of the health problems of communities or human population groups." The objectives of community medicine are to prevent disease by modifying the environment and the distribution of health care services. Examples of community medicine include maternal and child health, communicable disease and sanitary control, and nutrition programs. The focus of community medicine is on population groups and not individuals. Consequently, epidemiologic methods are used to perform community diagnosis, surveillance, and evaluation.

The following table illustrates how the Karks conceived of primary care and community medicine:

Summary of the Complementary Functions of Clinical and Epidemiologic Skills in Development of Community Oriented Primary Health Care (Kark, 1981)

Clinical/Primary Care (Individual)	Epidemiologic/Community Medicine (Population Group)
Examination of a patient. Interview and examination of individuals by history-taking, physical and psychologic examinations, laboratory, x-ray, and other special techniques.	Survey. State of health of communities and families, using questionnaires, physical and psychological testing, and special facilities for such investigations.
Diagnosis. 1. Usually of a patient. Differential diagnosis to determine main cause of patient's complaint. 2. Appraisal of health status of a "well" person, such as a pregnant woman, well children, periodic health examinations of adults.	Community Diagnosis. 1. Health status of the community as a whole or of defined segments of it, e.g., health of expectant mothers, growth and development of children, birth and death rates. 2. Usually problem oriented. Differential distribution of a particular condition in the community and the cause of this distribution.
Treatment 1. According to diagnosis and depending on resources of patient and medical institutions. 2. Intervention usually follows the patient seeking care for illness or advice about health.	Treatment 1. According to the community diagnosis and depending on resources of the health service system. 2. Intervention on basis of survey findings often before any illness notified or recognized.
Continuing Observation. Evaluation of patient's progress and sometimes for further diagnostic work-up.	Continuing Surveillance Surveillance of health state of community and ensuring continuing action. Evaluation of intervention programs.

Tollman (1991) synthesized the writings of Kark and others into a list of essential and highly desirable features of COPC. Many of the features on this list match the goals espoused by student-run clinics. Tollman's list is as follows:

Essential features:
1. Complementary use of epidemiologic and clinical skills;
2. A defined population for which the service is responsible;
3. Defined programs to address community health problems;
4. Community involvement in promoting its health;
5. Health service accessibility: geographic, fiscal, social and cultural.

Highly desirable features:
1. Integration, or at least coordination, of curative, rehabilitive, preventative and promotive care;
2. A comprehensive approach extending to behavioral, social, and environmental determinants;
3. A multidisciplinary team;
4. Mobility, including "outreach" capability, of the health team;
5. Extension of community health program into broader programs of community development.

Early work in community-oriented primary care focused on community action and saw information gathering and research as a means to help set priorities and to practice effective action. The COPC approach devotes attention to factors beyond the health sector that affect health status including such things as poverty, inadequate housing, and discrimination. A unique feature of the COPC model is its emphasis on working within a defined community, understanding its members, and maintaining continuing, stable, community-wide involvement in the health center's operation.

A major difference between U.S. COPC models and those used abroad is the emphasis placed on community involvement in the health center. The IOM did not report on the issue of community involvement in its 1982 commissioned report on COPC. Abramson, one of Kark's colleagues regarded community involvement as an "essential feature" of COPC. The COPC approach in the United States tends to be predominantly service oriented and minimizes community involvement and community development

projects (Tollman, 1991). In the United States, COPC epidemiology is viewed primarily as a tool for health services research as opposed to a tool to be used in developing community action. There is a significant difference in approach that is "community oriented" and one that is "community participatory." "Purer" or "community participatory" models of COPC, as developed by Kark and colleagues, involve the community in the identification of its problems and in creating programs to tackle these problems. The COPC literature in the United States provides little insight into how to integrate such community participation into COPC practice. The popular education and community organizing literature helps fill this void.

Another difference between the U.S. approach to COPC and the "purer" approach advocated by Kark is in the method of implementaton of a COPC practice. Within the United States, the IOM and others advocate a gradual, stage-based approach to integrating COPC into medicine. Kark and others outside the United States feel that a COPC practice does not exist without all of the essential elements plus as many of the highly desirable elements as possible, as defined previously. The IOM recommended this approach because it was felt that a fully-operational COPC model was unrealistic in the complex and competitive American medical system. The IOM reasoned that it would be better if medical providers integrated at least some of the COPC principles; asking providers to integrate all the principles at once was deemed unrealistic. Since student-run clinics do not usually meet the criteria for primary care services (see definition above), the stage-based approach of implementing COPC seems most appropriate for these clinics. However, the ideal should remain the full implementation of the principles. The table on the following page outlines the stage approach advocated by the IOM. Stage I represents the least developed stage of a COPC function, whereas stage IV represents the most developed.

IOM Stages of COPC Function (Nutting and Conner, 1986)

COPC Function	Stage I	Stage II	Stage III	Stage IV
Defining and characterizing the community	Based on subjective impressions of the practitioners and/or consumer	Characterized by extrapolation from secondary data sources	Enumerated and charaterized by ad hoc data base specific to the community	Enumerated and characterized from a current and complete data base of the community
Identifying community health problems	Based on subjective impressions	Extrapolation from secondary data	Use of data sets specific to the community	Routine mechanisms identify and set priorities among a range of problems
Modifying the health care program	Based on national or organization-wide initiatives	In response to special resources that become available	Tailored to identified needs of the community	Targeted on specific high-risk individuals and groups
Monitoring the effectiveness of program modifications	Based on subjective impressions	Extrapolation from secondary data	Use of data sets specific to the community	Specific to program objectives and differential impact among risk groups

The COPC model applies a cyclical approach to ongoing program monitoring of interventions and health status (Cashman, et al., 1994). First, a primary-care or public-health program defines and characterizes the community for which it assumes responsibility. Second, the program organizes and involves the community to establish the foundation of a community-professional partnership. Third, a community diagnosis/needs assessment and a resources inventory are conducted. This assessment is used to develop appropriate priortization of health interventions. Fourth, community-based interventions are developed and implemented. Lastly, ongoing monitoring and evaluation procedures are incorporated into the organization's practice. After a specified time, community-based interventions are evaluated with preestablished criteria. Depending on the success of the intervention, the process may return to reunderstanding the problem and consulting the community or the intervention will continue because of its success. These steps are carried out in a cyclical fashion with constant refining of the aforementioned steps. This process requires a lengthy time period before the success of an intervention can be measured; it also requires that the health center maintain continuity and stability in the health teams' relationships with the community.

Community Organizing

Minkler (In Press) defines community organizing as a "process through which communities are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching the goals they collectively have set." Several historical milestones contributed to the development of community organizing practice and theory in the United States.

The term community organizing was coined by American social workers in the late 1800s in reference to their efforts to coordinate services for newly arrived immigrants and the poor during the settlement house movement (Garvin and Cox, 1995). Within the field of social work, early approaches to community organizing emphasized collaboration, consensus, and cooperation as communities were helped to self-identify

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and to increase their problem-solving abilities (Ross, 1955). Other milestones outside the field of social work also contributed to the historical development of community organizing practice and theory. These include: 1) the post- reconstructionist period organizing by African Americans to try to salvage newly won rights that were rapidly slipping away; 2) the populist movement which began as an agrarian movement and become a multi-sectional coalition and a major political force; 3) the labor movement of the 1930s and 1940s which taught the value of forming coalitions around issues, the importance of full time professional organizers, and the use of conflict as a means of bringing about change.

By the 1950s, a new brand of community organizing had gained popularity. This new brand stressed confrontation and conflict strategies for social change and built on older, union-based models of social action. This style of organizing was most closely identified with Saul Alinsky (1969, 1972) and became known as social action organizing. This form of organizing stressed redressing power imbalances by creating dissatisfaction with the status quo among the disenfranchised, building community wide identification, and helping members devise winnable goals and non-violent conflict strategies and other means to bring about change. The targets of social action organizing are the site of production (supporting labor demands) and the public sector. Alinsky promoted an "urban populism" based in neighborhood "people's organizations" oriented to building community power, discovering indigenous leaders, providing training in democratic participation, and proving that ordinary people could challenge and beat City Hall.

The strategies and tactics developed by Alinsky and others in the 1950s were used to achieve broader social change objectives, through the civil rights movement, followed by the women's movement, gay rights movement, anti-Vietnam war organizing, the disability rights movement, and increased organizing among people of color worldwide.

The late 1950s and early 1960s marked the beginning of the liberation struggles of people of color. Groups focused on self-determination and fought for sharing of political

liberties and material affluence. Organizing among people of color focused on building community capacity and targeting the state; balancing the two goals was a challenge.

In the 1960s, the federal government supported efforts at urban decentralization and citizen participation as part of the Office of Economic Opportunity. Community Action Programs of the OEO sought "maximum feasible participation" of community in their programs. Community Action Programs were typically started by professionals and were more institutionalized and formalized. In these programs the state was not the target of democratic insurgency but the employer and supporter of citizen initiatives.

The 1960s was also characterized by a new left movement of students, for example, Students for a Democratic Society (SDS), the Student Health Organizations (SHOs) and the Student Nonviolent Coordinating Committee (SNCC). The focus of these groups was on "participatory democracy" and "letting the people decide" which in turn lead to pressure for policy changes and the formation of alternative social groups. After 1965, these groups adopted more Marxist and nationalist perspectives. These groups experimented with participatory democracy, nonhierarchical decision making, prefigurative cultural politics, linking the personal with the political, direct-action tactics, and constituency-based organizing (students, the poor, etc.) They emphasized the formation of coalitions or political parties tied to national revolutionary and emancipatory struggles.

New social movements of the 1970s and 1980s were characterized by highly diversified, single-issue or identity-oriented, community-based efforts. These movements were based on the principle that ordinary and previously oppressed people should have a voice and can make history. Efforts focused on citizen and community participation which gives "voice" to those previously silent in public discourse. Such participation was deemed essential for improving decision making, addressing a wide range of problems, and democratizing society. The phrase "by any means necessary" typifies the gamut of strategies and tactics, from revolutionary to interest-group politics, used by these groups.

These groups believed that culture must be blended with the quest for "empowerment" into an identity or a constituency-oriented politics. The feminist principle that "the personal is political", that is, that individuals should organize around aspects of daily life most central to them, became prominent during this time period.

Within the health field, beginning in the 1970s, the World Health Organization placed a major new emphasis on community participation in health programs. In 1986, the WHO adopted a new approach to health promotion that stressed increasing people's control over determinants of their health, high level public participation, and intersectoral cooperation (World Health Organization, 1986). This approach evolved into what is now known as the Healthy Cities movement. There are now over 3,600 healthy cities and communities worldwide (Duhl, 1993). "Healthy Cities" aim to create sustainable environments and processes through which governmental and non-governmental sectors collaborate to create healthy public policies, to achieve high-level participation in community-driven projects, and ultimately, to reduce inequities and disparities between groups (Duhl, 1993; Tsouros, 1995). These examples illustrate the attempts of a major force in international health to incorporate some principles of community organizing.

All of the aforementioned efforts and movements have been considered to fall under the rubric of community organizing, at least by some writers. There is no universal classification system of community organizing efforts, but the best known typology is Rothman's (Rothman and Tropman, 1987). He originally proposed that most community organizing efforts fell into one of three categories - locality development, social planning, or the social action model. Rothman now acknowledges that organizing efforts might involve "mixing" and "phasing" of two or more models. Newer conceptualization of organizing from the 1980s and 1990s include models of feminist organizing, multicultural organizing, and community building.

Rothman's models of locality development, social planning, and social action organizing, have varying elements. Locality (or community) development is a heavily

process-oriented model, stressing consensus, cooperation, and the development of group identity and a sense of community. Social planning is heavily task oriented and stresses rational-empirical problem solving, usually by an outside expert, as a means of addressing selected problems. Social planning is concerned "with establishing, arranging and delivering goods to people who need them". Building community capacity or fostering radical or fundamental social change does not play a central part. (Rothman and Tropman, 1987). Social action is both task and process oriented. It is concerned with increasing the problem-solving ability of the community and with achieving concrete changes to redress imbalances between the privileged and the oppressed or disadvantaged. The table on the following page from Rothman and Tropman (1987) highlights distinguishing features of these three models:

Three Models of Community Organization Practice According to Selected Practice Variables (Rothman & Tropman, 1987).

	Model A (Locality/Community Development)	Model B (Social Planning)	Model C (Social Action)
1. Goal categories of community action	Self-help; community capacity and integration (process goals)	Problem solving with regard to substantive community problems (task goals)	Shifting of power relationships and resources; basic institutional change (task or process goals)
2. Assumptions concerning community structure and problem conditions	Community eclipsed, anomie; lack of relationships and democratic problem-solving capacities; static traditional community	Substantive social problems; mental and physical health, housing, recreation	Disadvantaged populations, social injustice, deprivation, inequity
3. Basic change strategy	Broad cross section of people involved in determining and solving their own problems	Fact gathering about problems and decisions on the most rational course of action	Crystallization of issues and organization of people to take action against enemy targets
4. Characteristic change tactics	Consensus: communication among community groups and interests; group discussion	Consensus or conflict	Conflict or contest; confrontation, direct action, negotiation
5. Salient practitioner roles	Enabler-catalyst, coordinator; teacher of problem-solving skills and ethical values	Fact gatherer and analyst, program implementer, facilitator	Activist advocate: agitator, broker, negotiator, partisan
6. Medium of change	Manipulation of small task-oriented groups	Manipulation of formal organizations and data	Manipulation of mass organizations and political processes
7. Orientation toward power structure (s)	Members of power structure as collaborators in a common venture	Power structure as employers and sponsors	Power structure as external target of action: oppressors to be coerced or overturned
8. Boundary definition of the community client system or constituency	Toal geographic community	Total community or community segmnet (including "functional" community)	Community segment
9. Assumptions regarding interests of community subparts	Common interests or reconciable differences	Interests reconciable or in conflict	Conflicting interests which are not easily reconcilable: scarce resources
10. Conception of the client population or constituency	Citizens	Consumers	Victims
11. Conception of client role	Participants in an interactional problem-solving process	Consumers or recipients	Employers, constituents, members

According to Minkler (In Press) the key elements of community organizing theory are: 1) a broad definition of health and its influences; 2) the definition and conceptualization of community; 3) a community analysis; 4) the principles of power, empowerment, and critical consciousness; 5) increasing "community competence" or problem solving ability; 6) the principles of participation or "starting where the people are"; 7) the principles of issue selection; 8) organizing strategies and tactics; 9) the measurement and evaluation of success. Many of these elements are similar to those in COPC theory, so a more detailed discussion of these elements will be left until the section entitled "Theory Synthesis for a Student-Run Clinic Praxis."

Popular Education

The historical roots of popular education extend back to the French Revolution (Jeria, 1990). Since this time, popular education has evolved into an alternative educational movement characterized by "the empowerment of adults through democratically structured cooperative study and action, directed toward achieving more just and peaceful societies within a life sustaining global environment. Popular education's priority is the poor, oppressed, and disenfranchised people of the world-ordinary people (Hurst, 1996)." Popular education has had different histories in different continents.

In Europe, Bishop Grundtvig initiated the Scandinavian Folk School Movement. "Cultural Circles" in Paris and the "Worker's Education Movement" in Britain contributed to the spread of popular education in Europe. In North America, there were contributions from the 19th century populist movement in the United States, the Chautaugua movement in the U.S., the Antigonish movement in Nova Scotia, labor colleges and worker education in the U.S. and Canada, the Highlander Folk School in Tennessee, and others. In Latin America, the work of Paulo Freire, Francisco Vio Grossi, Orlando Fals Borda, and others contributed to the spread of popular education in that

continent. The work of Yusuf Kassam, Paul Mhaiki, and Julius Nyerere in Tanzania contributed to the popular education movement in Africa. In Asia, popular education spread via the work of Rajesh Tandon and the Society for Participatory Research (Hurst, 1996).

Contemporary popular education draws heavily from the work of Paulo Freire. As an educator in Brazil during the 1950s, Freire developed a highly successful literacy program for slum dwellers and peasants. The traditional colonial-based educational system taught a select group of Brazilians to accept the world view of a small elite. Using Freire's educational methodology students learned to read and write through discussion of personal problems, such as limited access to agricultural lands. As the causes of their collective problems became clear, the students reflected upon these problems and developed plans that could be taken to change their situations. Freire described this process of action-reflection-action as "conscientization." This process helped participants acquire new literacy skills while simultaneously helping them to understand and change their own realities. Brazil's military coup in 1964, temporarily ended Freire's work in Brazil, but he and his educational methodologies were spread throughout the world.

Most of the essential elements of popular education discussed in this review come from the work of Paulo Freire, in particular, his work Pedagogy of the Oppressed (Freire, 1970) which has had a major impact on community organizing and popular education in the United States. Central to Freire's notion of popular education is his emphasis on the condition of oppressed people, that is, the urban and rural poor who form the vast majority of people in most Third World countries. Freire believes that both the oppressor, those that perpetuate a system of social inequality, and the oppressed, those in the targeted group, are dehumanized by their state. The oppressor tends to objectify the world into haves and have nots. They act on and believe in a right of possession. To counteract their own dehumanization, the oppressor conducts periodic acts of "love"

which also serve to placate the oppressed. An example of this may be seen in the Rebuild Los Angeles efforts that took place after the Los Angeles uprising. The concept of "white guilt" and action based on this guilt may serve as another example of this phenomenon. According to Freire, those suffering from the process of losing humanity (the oppressed) eventually turn against those denying it (the oppressor). In seeking humanity, the oppressed must not become oppressors themselves. They must become restorers of humanity to both.

Oppressors subjugate the oppressed through a variety of conscious and unconscious means. They maintain a system of false generosity that protects the social order by preventing the oppressed from critically analyzing and changing their state. Welfare and social service programs in the United States may be considered to be part of a program of false generosity.

Initially the oppressed identify with the oppressor and see social reality in the context of the oppressor. To avoid oppression the oppressed believe they must become like the oppressors. For example, a homeless man may come to believe that he must own a home with a white picket fence to become more human.

Self-deprecation and self-hate are characteristics of the oppressed. "They call themselves ignorant and say the 'professor' is the one who has knowledge and to whom they should listen (Freire, 1970)."

> "The colonized man will first manifest this aggressiveness which has been deposited in his bones against his own people. This is the period when the niggers beat each other up, and the police and magistrates do not know which way to turn when faced with the astonishing waves of crime in North Africa...While the settler or the policeman has the right the livelong day to strike the native, to insult him and to make him crawl to them, you will see the native reaching for his knife at the slightest hostile or aggressive glance cast on him by another native; for the last resort of the native is to defend his personality vis-a-vis his brother."
> ----Frantz Fanon, The Wretched of the Earth (1991)

During an interview on the McNeil/Lehrer News Hour in 1994, an organizer in the black community made the following observations, similar to those of Frantz Fanon

in the quote above, regarding high rates of black on black killing. "When a black man sees another black man, he sees himself. And since he has no respect for himself, he has no respect for any other black man. He can kill himself without a second thought, so he can easily kill another black man without caring."

Freire believed that "the oppressed must see examples of the vulnerability of the oppressor so that a contrary conviction can begin to grow within them." Without this the oppressed will continue disheartened, fearful, and beaten.

> "The peasant is a dependent. He can't say what he wants. Before he discovers his dependence, he suffers. He lets off steam at home, where he shouts at his children, beats them, and despairs. He complains about his wife and thinks everything is dreadful. He doesn't let off steam with the boss because he thinks the boss is a superior being. Lots of times, the peasant gives vent to his sorrows by drinking."
>
> ---Interview with a peasant.

Freire believes that the oppressed cannot transform their reality without awareness of it and without mutual support from other members of the oppressed class. A liberating educational pedagogy of the oppressed must be with not for the oppressed. The pedagogy must allow oppressed people to perceive the nature of their oppression, and this perception must stimulate people into action to liberate themselves. Both action and reflection are necessary in this process.

To Freire education is a political process far from the "neutral" process described by the perpetuators of the system. Freire believes education serves two major purposes-sectarianism or radicalization. According to Freire, sectarianism is fanaticism, castrating, mythicizing, irrational, and turns reality into a false reality. A radicalizing education is critical, creative, and contributes to increases in one's commitment to an individual position and greater engagement in transforming objective, concrete reality.

A radicalizing or liberation education practice differs from traditional sectarian or "banking" education. In liberating education people are subjects of their own learning, not empty vessels filled by teachers' knowledge. Traditional education methodologies

have a narrative character. The teacher becomes the subject and the student the object.

The teacher presents a static, mechanical reality, outside of the student's (object's) reality.

The student has information from the teacher deposited into their mind. The knowledge

they receive is a gift they are to receive, memorize, and repeat.

Banking education, the antithesis of liberation education, includes the following (Freire, 1970):

> (1) Teacher teaches and the students are taught.
> (2) Teacher knows everything and the students know nothing.
> (3) Teacher thinks and students are thought about.
> (4) Teacher talks and the students listen meekly.
> (5) Teacher disciplines and the students are disciplined.
> (6) Teacher acts and the students have the illusion of acting through the action of the teacher.
> (7) Teacher chooses the program content, and the students (who were not consulted) adapt to it.
> (8) Teacher confuses the authority of knowledge with his or her own professional authority, which she and he sets in opposition to the freedom of his students.
> (9) Teacher is the Subject of the learning process, while the pupils are mere objects.

In this type of educational environment the students become passive and adapt to

the world. The process annuls their creative power. True revolutionary leaders must

reject the banking educational approach for a "problem-posing" education, that is, the

posing of problems of human beings in relation to the world. Acts of cognition and

critical thinking, not transfer of information characterize revolutionary education. A

liberation education is always "cognitive" never "narrative." A liberation education

"classroom" is filled with teacher-students and student-teachers. Liberation education

overcomes authoritarianism and an alienating intellectualism.

Liberating education provides people with a critical consciousness of political,

economic, and social forces influencing their lives. This ultimately leads to an

understanding and motivation to respond to their situation. Freire calls this

understanding "conscientizcao" or "conscientization" or "critical consciousness."

According to Freire, the attainment of conscientization requires praxis, that is, a cycle of listening-dialogue-action-reflection or the naming and transformation of the world. Sacrificing action in the cycle leads to "verbalism" and sacrificing reflection leads to uninformed "activism."

Liberation education includes dialogue about people's objective situation and their awareness of that situation. According to Freire dialogue requires humility, faith in people and their power to create and recreate, hope, critical thinking and belief in change. According to Freire (1972) education, "is a live and creative dialogue in which everyone knows some things and does not know others, in which all seek together to know more. This is why you, as the coordinator of a cultural circle, must be humble, so that you can grow with the group instead of losing your humility and claiming to direct the group, once it is animated."

The program content of education or political action must be the present, existential, concrete situation, reflecting the aspirations of the people, what Dorothy Nyswander (1956) calls "starting where the people are." The liberation educator poses the lives of people back to them and ask them to critically analyze their own reality.

Before embarking on a popular education program, liberation educators must investigate or assess aspects of the community they will be working with. The investigation should involve program participants in the information gathering process. Liberation educators must establish trust within communities before embarking on an educational program. Various means can be used in the investigation including secondary sources such as newspaper articles or informal discussions with community members at different times and places. Appendix Three contains guidelines for community assessment methods from community organizing literature that can also be used as tools for a popular education community investigation.

The ongoing process of investigation should be directed at identifying contradictions, controversies, and other stimulating issues within a community. These

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issues are used as codes for discussion. Codes are emotionally and socially charged representations of students' problems, such as words, pictures, films, interviews, role-plays, personal learner stories, artwork, collages, photographs, or other elements. A code re-presents the participants reality back to them and allows them to project their emotional and social responses in a focused fashion.

Freire suggests that codes be familiar, not overly explicit or enigmatic, and must trigger different themes. Codes should help participants connect the feeling of needs with an understanding of the causes of the needs. For codes to be effective, they must be coupled with a problem-probing questioning strategy that motivates people to think about actions they can take to solve a problem. A good code is a creation from the listening process that captures the emotional meaning of key problematic issues, and the social context of these issues in participants' lives, yet does not present solutions. According to Wallerstein (1988) effective "codes":

1) Embody a familiar, deeply felt and easily recognized problem situation, presented in people's own language.
2) Should be presented as a problem with many sides to avoid conveying a good or bad point of view.
3) Should focus on one concern at a time, but allow for historical, cultural, and social connections.
4) Should be open-ended without solutions; any resolution or strategy should emerge from the group.
5) Problem should not be overwhelming, but should offer possibilities for group affirmation and small actions for change.

An example of an investigation and code could involve a liberation educator finding that among homeless people participating in a discussion group there is a strong belief in the distinction between deserving and undeserving homeless individuals. The educator could pose the group with a problem or "code" whereby they are asked to play the role of a shelter worker screening "deserving" from "undeserving" homeless people. Using a problem-posing questioning strategy, the group can go on to analyze the source

of this distinction, its validity, and its use. Ideally, the awareness raised from the discussion will lead to a collective group action.

Several problem-posing or inductive questioning guides have been developed for use with Freirian pedagogy. An inductive questioning strategy is used that grounds people in discussing their personal experience and affective world, helps integrate their experiences into a broader social context, and leads to further seeking of alternatives to problems. Inductive questions include: What are the problems here? Have you experienced anything similar before? What are the immediate and underlying causes? What can be done to solve this situation or prevent a future occurrence? The facilitator plays a key role as a questioner and should promote empathy, reinforce active listening skills, and encourage participatory discussion. Shaffer (1983) developed a mnemonic for an inductive questioning strategy based on the acronym "S-H-O-W-E-D". The questioning strategy is as follows:

- What do we **See** or how do we name the problem?
- What's really **Happening** to this individual in his/her life?
- How does this story relate to **Our** lives? How do we feel about it?
- **Why** has this person experienced these problems at an individual and family level? What are the root societal causes?
- How might we become **Empowered** now that we better understand the problem?
- What can we **Do** about these problems?
- The questions are repeated with each new code and theme.

Wallerstein (1988) summarized the key elements of a popular education program as discussed in this section. These elements include listening or investigating the felt issues or themes of the community, participatory dialogue about the investigated issues using a problem-posing questioning strategy, and action or positive changes people can envision followed by reflection.

Popular education programs can be developed within student-run health clinics in conjunction with community organizing efforts. The principles of popular education can also be applied to mutual learning processes during service provision and in classroom

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service-learning experiences. The next section outlines a praxis for utilizing popular education and community organizing theory within the context of a COPC-based student-run health clinic.

Theory Synthesis for a Student-Run Health Clinic Praxis

The task of this section is to synthesize the literature reviewed in the previous sections in a fashion that is usable by student-run clinics. COPC theory is used as a guiding paradigm for this proposed praxis. The term "praxis" is preferable to "model" because praxis refers to a process that varies with context and utilizes ongoing critical analysis whereas model generally refers to a stagnant, prefabricated set of steps to follow without the analytical piece. First, an organizational framework for student-run clinics is proposed based on Kark's distinction between primary care services and community medicine. Second, a spiraling process of program planning referred to in COPC, community organizing, and popular education literature is described. This process, which will be referred to as the health program cycle, should be repeated throughout an organization's existence and serves as a guiding framework for program planning. "Spiraling" refers to the fact that the process repeats itself and grows in scope and depth as the process continues.

Organizational Framework

The chart on the following pages represents a possible organizational framework for student-run clinics. The framework is designed with the aforementioned spiraling process in mind. Represented in the chart are the two major divisions of a COPC practice - primary care services and community medicine. In addition, there is an administrative division which serves a vital function in student-run clinics.

Primary Care Services	Administration	Community Medicine
Major roles: Provision of individual services by volunteer professionals, students, and trained community members.	**Major roles:** Training and management of volunteers and other staff; organizational maintenance; historicity.	**Major roles:** Operation of community-specific, community-based, and community-wide programs.
Guiding Principles: 1) Provision of community-desired curative, rehabilitative, preventive, and promotive services by a multi-disciplinary health services team at one stie simultaneously. 2) Collaboration and communication with other clinic groups is key. 3) Personal issues can be political issues; personal care issues should be connected with efforts of community medicine wing of clinic. 4) Follow a mutual learning practice among professional volunteers, student volunteers, and service users.	**Guiding Principles:** 1) Managerial wing of entire clinic. Serves as communication link among different clinic teams. 2) Maintains clinic historicity - transmission of clinic history, visions/values, goals, objectives, and evaluation strategies from generation to generation via training, written materials, etc. 3) Coordinates "service-learning" class for student volunteers. 4) Organizational maintenance issues: staff management and recruitment, funding, budgeting, meetings, supplies, social functions, policies and protocols, legal and liability issues. 5) Clinic should strive to have at least some paid administrative staff.	**Guiding Principles:** 1) Works closely with primary care services wing to develop projects from community-wide "personal issues". 2) Utilizes public health, community organizing, and popular education principles. 3) Works for broader social change and represents the "political" wing of the clinic. 4) Monitors clinic success & failure through ongoing community assessment and evaluation processes.

Primary Care Services (cont.)	Administration (cont.)	Community Medicine (cont.)
Teams (types of services should be based on community requests, possibilities are listed): Medical services (strive for primary care alone or in collaboration with other organizations), legal, dental, social services, mental health counseling, optometry, chiropractic, child care, etc. + service outreach programs.	**Teams (possibilities):** Clinic coordinators, development directors, treasurer, volunteer recruiters, and others.	**Teams (possibilities):** 1) Coalition Building Team- team devoted to establishing collaborative networks among individuals and groups sharing similar goals. 2) Advisory Board - community members, current and past staff members, representatives from other organizations provide advice on clinic operations and contribute to ongoing spiraling process outlined in the next section. 3) Epidemiology/Evaluation Team- helps evaluate health programs and conducts ongoing community assessments using epidemiology and other tools. 4) Popular Education/ Community Organizing Group - group that meets regularly at the clinic. Uses principles from popular education and organizing to raise awareness among community members and volunteer staff in order to mobilize them into action around community issues. 5) "Community" Staff - role for volunteers from target community to participate within the clinic in any appropriate division.

The primary care services division is the entity responsible for providing community-desired services at the clinic. "Community-desired" refers to the notion that services and programs at the clinic should be created in consultation with members from the clinic's target population. Service provision is performed by a multi-disciplinary health team, and the clinic operates multiple services at one site simultaneously. The service team must work closely with the administrative division for funding, supplies, training, and guidance. In addition the service team working in conjunction with the community medicine teams, can facilitate a process whereby personal problems are transformed into community issues for groups to address. Service providers must strive to create an informal environment that encourages mutual learning among clinic professionals, students, and service users. A variety of services can be developed at student-run clinics depending on community desires. A list of possible services is given in the table. Ideally, the service team would have a subgroup devoted to service outreach which could provide services and information outside of the clinic setting.

In this proposed framework, the administration division serves as the glue, the major communication and managerial link, that holds the clinic together. The major roles of the administrative team include training and management of volunteers and other staff, organizational maintenance issues, and maintaining transmission of clinic history from one generation of volunteers to the next. Maintenance of clinic history is a problem faced by many student-run clinics that rotate student and professional volunteers on a regular basis. Assigning this task as part of an administrative function may increase the likelihood that clinic history, visions and values, goals and objectives, and evaluation strategies will be passed on to the next generation of clinic staff. Clinic history can be

maintained through story telling, written documents, training programs, and other methods. The administrative division would also be responsible for coordinating any "service-learning" classes affiliated with the student-run clinic. The classes would include training as well as the use of popular education methods to engage students in their own process of listening-dialogue-action-reflection. Various positions could make up the administrative team such as a treasurer, clinic coordinator, fundraiser, and others. Many of the original non-student-run free clinics abandoned completely volunteer-run organizations to hire administrative staff members. Student-run clinics should consider this option. Advantages of paying some staff members include a stable pool of staff that have been with the organization over the long-term. These members can help transmit clinic history to short-term volunteers. Paid staff also can perform administrative work that provides students and volunteers with little learning and personal growth thereby relieving students of additional work that prevents them from participating in community medicine or primary care services activities.

The third proposed division of this framework is community medicine. Few student-run clinics today maintain a cohesive community medicine entity. This division would perform the population-based tasks of the student-run clinic. Public health, community organizing, and popular education theories can be used by this division. This entity also makes efforts to engage in broader social change and conducts ongoing community assessments as part of an evaluation process.

Possible teams within this division include a coalition building team, an advisory board, an epidemiology and evaluation team, a popular education and community organizing discussion group, and a team of "community" volunteers. The coalition

building team would be devoted to establishing collaborative networks among individuals and groups sharing goals similar to that of the student-run clinic. This team would strive to build networks with both social change and service-oriented organizations. Coalition building is crucial to developing a productive referral process for student-run clinic users. An advisory board would help clinic members make decisions about programming and other issues. This advisory board should include some members from the clinic's defined community as well as current and past volunteers, and representatives from other supportive organizations. The epidemiology and evaluation team would be responsible for conducting ongoing community assessments and designing studies or methods to evalute the efforts of student-run clinics. This team would utilize principles of epidemiology and empowerment evaluation (to be discussed later) as well as community health assessment tools from the COPC, community organizing, and popular education literature. A popular education/community organizing group can be held at student-run clinics during its hours of operation. This group can serve as a vehicle for raising consciousness about group problems and developing actions to address them. Such a group could be co-facilitated by student volunteers and community members. Principles from community organizing and popular education literature can serve as guides for this group. Finally, although not necessarily responsible for their supervision, the community medicine division could help develop and support a team of volunteers and staff from the clinic's target community. Such volunteers could take on a variety of tasks depending on their skills and interests. Ideally, these individuals would be given decision-making power within the organization.

Health Program Cycle

The diagram below represents the components of the proposed health program cycle:

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┌──────────────────────────────────────────────────┐
│           Health Program Cycle:                    │
│   Guided by Organizational Vision and Values       │
│                                                    │
│       (Mission Statement & Philosophy)             │
└──────────────────────────────────────────────────┘

┌───────────┐        ┌──────────────┐
│  Define   │───────▶│  Community   │
│ Community │◀───────│ Assessment/  │
└───────────┘        │ Consultation │
                     └──────────────┘

    ┌──────────────────────┐          ┌────────────────────┐
    │ Renew Cycle of Health│          │ Develop Health Progra│
    │       Programs       │          │        with          │
    └──────────────────────┘          │ Goals and Objectives │
                                       └────────────────────┘
┌──────────────────────────┐
│  Reflect on Successes &   │
│ Failures of Health Program│
└──────────────────────────┘

   ┌──────────────────────┐      ┌────────────────────────┐
   │ Evaluate Health Program│◀────│    Take Actions/        │
   │         and           │      │ Implement Health Program│
   │        Actions        │      └────────────────────────┘
   └──────────────────────┘
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The cycle represents a process for developing a new health program or goal for student-run clinics. These new efforts should flow from the clinic's vision and values and input from its defined community. These two elements - vision and values and defining community - should be performed before the cycle is begun since they serve as the foundation for clinic action. These two elements may undergo revisions during the cyclical process. Following the cycle sequentially may work for some clinics, but it is not essential. Certain components follow others more readily, but clinics will have multiple projects occurring simultaneously making it difficult to follow the cycle in an orderly fashion.

The points for this proposed process or praxis, in written form, are:

1) Create or revisit an organizational vision and values. [Vision and Values]
2) Define or redefine the target community. [Define Community]
3) Conduct a community assessment. [Community Assessment]
4) Establish an organizational mission with project and learning goals and objectives based on steps 1-3. [Mission, Goals, and Objectives]
5) Implement projects and actions and sustain organizational operations. [Actions]
6) Monitor process of previous steps & conduct an outcomes evaluation. [Evaluation]
7) Promote adaptation and renewal of unsuccessful efforts and institutionalization of successful efforts. [Reflection and Renewal]

Each of these points will be reviewed in detail using the aforementioned theoretical literature and information from student-run clinics. The rest of this part of the thesis contains detailed discussions on each of the seven elements outlined above.

<u>One: Vision and Values</u>

Before embarking on a community project, potential project leaders should consider their vision and values. This step should take place before defining a target community and before undergoing a community assessment. Vision and values guide an organization and make leaders more aware of their motivations and aspirations. It is common for student-leaders to neglect this step and to jump right into defining a target community. Miller (1993) states that "[community organizing] action rooted in deeply held values is more likely to be sustained that that which relies solely on addressing a specific injustice." He suggests that a values and ideology discussion become part of the organizing process. Miller's statement applies equally well to student-run clinics. The following is a list of questions and values to consider before establishing a student-run clinic or to consider as a part of reinventing an already existing clinic. A discussion of each of these points follows the list. These points should be revisited on a regular basis since they are values and questions to guide practice rather than steps in a cookbook approach.

1) Conduct a motivational analysis - when and why to start a student-run clinic? [Motivation]
    a) Meeting unmet needs of underserved populations.
    b) Alternative health care movement.
    c) Service-learning experience.
2) Reflect on the role of students in society. [Student Roles]
3) Consider the feasibility of student-run clinic involvement in social change. [Social Change Feasibility]
4) Consider the limits of services for promoting health. [Limits of Services]
5) Develop a broad conceptualization of health and its influences. [Broad View of Health]
6) Build an understanding of ideology, power, oppression, and empowerment. [Ideology, Power, Oppression, and Empowerment]
7) Support a social justice rather than a market justice orientation. [Social Justice vs. Market Justice]
8) Promote community participation and "starting where the people are". [Participation and Relevance]
9) Remember that the personal is often political. [Personal as Political]
10) Develop perspectives on multiculturalism and identity politics. [Multiculturalism and Identity]
11) Focus on increasing community competence and envisioning the results of social change. [Results and Community Competence]

1) Motivation

The three main motivations driving the formation of student-run clinics are a desire to meet the unmet needs of underserved communities, to create an alternative health care movement, and to create an opportunity for students to participate in a service-learning experience. Underserved communities are defined by their lack of access to medical services and student-run clinics strive to meet this need. In addition to increasing access to medical services, student-run clinics try to meet the other needs of their target populations by offering additional population-specific services and referral advocacy.

Many founders of student-run clinics appear to be motivated to meet needs out of an altruistic desire to help the less fortunate. As stated earlier, leaders do not typically consider themselves part of the communities they decide to serve. There is a belief that students can accomplish the "most good" by serving those "most in need of services."

Among students that volunteer at clinics, there are a wide array of potential reasons for their participation including altruism and compassion, giving back to one's own community, a desire to learn and practice in their future field, and "resumé filler." It is worthwhile for students to examine their individual motivations for initiating and operating student-run clinics.

Students that see themselves as community outsiders serving "needy" people may find it difficult to engage with clinic service users as equals. This perspective may lull students into social problem "passivity." They may come to feel they are "doing enough" about "the problem," so why should they become involved politically around the issue. Maintaining distance from oppressed communities allows one to lose some of the urgency experienced by those living in the community. Some distance is necessary, but too much is stultifying. With a "needy" orientation, it is difficult to see people as more than service consumers. When student involvement stems mostly from a desire to learn, rather than a desire to promote community health, clinic service users become objectified lessons for future clinicians. Those only seeking resumé material will have little to offer service users and will probably gain little from their learning experience.

The literature reviewed for this thesis offers some alternative motivational perspectives for student-run clinics to consider. By focusing on meeting the needs of *under-served* populations, student-run clinics restrict their programs to increasing available services and access to services. An argument has been made, and will be discussed later, that a need-focused, service-oriented organization can accomplish little in reducing needs and may in fact increase them by the creation of a service industry around human needs. For example, throughout the 1980s and 1990s there has been a proliferation of soup kitchens, free clinics, short-term shelters, and other programs for homeless individuals that meet urgent needs but rarely address the long-term social and individual problems that contribute to homelessness such as a poverty, a lack of affordable housing, an inadequate mental health care system, and others. An alternative

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to a need-based, service-oriented perspective is one that views community health promotion as a central guiding principle.

The health, in a broad sense, of both volunteers and service users should be enriched through participation in student-run clinics. Programs should not limit themselves to services and should consider the limitations of such a focus. Services are necessary to meet immediate needs, but some community medicine efforts should be made to address broader concerns through collective group effort.

Engaging in collective effort with community members, requires that volunteers reconceptualize their relationship to service users. Rather than viewing them as the "most needy" and the volunteers as "doing the most good", it is important that volunteers, program users, and their communities engage in mutual processes that benefit all. Lily Walker, an Australian aboriginal woman, succinctly articulated the distinction between "do gooder" and mutuality conceptualizations of community involvement when she said:

> "If you are here to help me, then you are wasting your time. But if you come because your liberation is bound up in mine, then let us begin (Valvarde, 1991)."

The emphasis on mutuality is equally as important for understanding the educational processes that take place at student-run clinics. Physician, patient, and student can choose to engage in a mutual process to understand the patient's "health deterrents" and to address them together through a sharing of knowledge, skills, and experience, or the physician and student can assume positions of authority and utilize the patient as a "case" for learning medicine. An example, may help to clarify this distinction.

Suppose, a homeless man comes to a student-run clinic with a progressively worsening, productive cough over the past three days. The student interviewing the man finds out that he lives on the streets and has been smoking 2-3 packs of cigarettes per day for the past twenty years. In a mutual learning experience, the physician, student, and

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patient would meet together. The physician would hear the patient's story, perform a physical examination with the student, and would vocalize her or his understanding of the patient's problem in a way that both student and patient could understand. The student and patient could ask questions to clarify the physician's explanation and recommended treatment. Included in this discussion would be an acknowledgment that living on the streets makes it difficult for people to stay healthy. This statement could serve as a code for further discussion among the patient, student, and physician on how and if the patient wants to address their living situation. Patients can be given options to choose from such as a list of shelters in the area, a chance to participate in a group discussion with other people living on the street, or others.

In an interaction based on authority, the physician would complete a history and physical explaining things only to the student using medical jargon. The patient would be referred to as if was absent: "sometimes people who smoke a lot develop a chronic cough." The patient would be told what to do and how to do it without consulting the patient about the viability of the recommendations. The patient would be used by the physician to explain a particular disease process to the student, and the patient would be excluded from this education. The fact that the patient was homeless would not be considered in the diagnosis and treatment, and the issue would not be raised in the clinical interaction.

A mutuality orientation borrows from popular education in that it encourages collective discussion and understanding of a problem. It offers the physician, student, and patient the opportunity to discuss social factors influencing an individual's health. A mutuality orientation is not appropriate for all patients in all situations. Someone with a painful, acute illness may prefer an immediate, authoritative treatment without a period of consultation and education. Others may prefer such an approach because of their personalities or an acculturation to the norm of doctor as authority and patient as passive follower of advice, a "banking education" norm. Physicians and students must work to

create an environment appropriate for each given patient. Without an emphasis on mutuality, authoritarianism dominates because of the strength of its tradition.

Student-run clinics often see themselves as part of an alternative health movement helping to fill gaps in the health care system. The fact that certain communities have inadequate access to health care services reflects a lack of health insurance and a dearth of health practitioners willing to provide services to these communities. It is hoped that student-run clinic experiences will increase the number of health professionals willing to work in underserved communities, although there has been no study that confirms student-run clinic involvement "converts" individuals to such a commitment. Rather than addressing the systemic lack of health insurance issue, student-run clinics often view their voluntary efforts as one method for meeting the service needs of uninsured populations. From this perspective, volunteerism becomes the solution to a lack of health insurance.

This conservative viewpoint is one that student-run clinics should advocate against. Promotion of universal health insurance and access to care should be a motivation behind the formation of student-run clinics. It is beyond the scope of this thesis to construct an argument that favors universal coverage over a two-tiered system of care for Americans: one based on insurance and the other based on charity. Suffice it to say, a two-tiered system violates principles of human rights and social justice and ignores the fact that almost all other industrialized countries in the world guarantee some form of health care to their citizens. It is up to student-run clinic leaders to decide which approach they want to promote. At the very least, they need to reflect on the role their clinics play in buttressing the cause of those who promote "volunteerism" as a solution.

Students should consider opening a student-run clinic when the community they identify supports one. Students should avoid the temptation to "keep up with the Jones'" by imitating student-run clinics at other schools simply because they have them. Competition with other schools should not be a motivation for starting student-run clinics. A student-run clinic in one community may be inappropriate in another. Prior to

embarking on the development of a clinic, students should continue working through their vision and values. They should define a community to work with and should consult with them to assess the community's priorities and interests. Students with a commitment to community health promotion will be willing to offer their skills, knowledge, and time in a way desired by the community even if it does not involve the establishment of another clinic. The process of defining and engaging community is extremely challenging and not as simple as this paragraph would indicate. Further discussion of these steps is forthcoming. First, there are several other components to values and vision that student-run clinics should consider.

2) Student Roles

Students should consider the strengths, resources, and limitations that their involvement contributes to community health and social change efforts. What do students contribute to society that others do not and why should clinic be student-run? Multiple authors (Fiore, 1995; Fournier, 1993; Konen, 1992) have commented on the idealism and energy of medical students prior to entering medical school. These authors see student-run clinics as vehicles for channeling this energy and for maintaining student altruism and compassion that often gets dampened through the medical education process. Students bring a fresh perspective to old situations that can help bring groups together and solve formerly intractable problems. Students represent "the future" in the eyes of their elders, so channeling their energies into "positive activities" is deemed a social good. Community and academia are often at odds with each other; students can help bridge the gap between these entities. As outsiders, students can often help find common ground among quarreling organizations which can in turn be used to help foster coalition building. Students bring a high level of energy, enthusiasm, idealism, and ingenuity to their work, however their efforts are limited by several factors.

Students must fulfill their responsibilities as learners in an educational system, so they have limited time to give to volunteer efforts, especially if they must work to

financially support their education. It is difficult for many students to make leadership or long-term commitments to organizations. Many community organizations remain wary of working with students whose first priority is rarely community work. Students come and go with ideas and their efforts are often viewed as non-sustainable. A lack of knowledge, skills, and experience limits the work of students and, at times, idealism bordering on hubris can prevent them from hearing the advice of their instructors, elders, and superiors. Idealism that falls short of its target may lead to burnout and apathy. Students often lack historical knowledge of the work of students before them, making it difficult to maintain project continuity. New leaders bring new ideas and often change organization policies and practices that have been built over several years. Some student-run clinic volunteer positions are in such high demand that students volunteer at clinics only once per year. In such a setting, each clinic session has a new set of people making continuity difficult if not impossible to achieve. Not all students bring idealism and energy to their work. As stated earlier, some students participate in community projects for self-serving reasons such as their personal edification and résumé building. Desires to learn and to develop one's marketability are legitimate and important, however, they become destructive if they dominate individual and organizational ethos.

Historically, students have played integral roles in many social movements in the United States including the civil rights, environmental, anti-Vietnam War, feminist, and gay rights movements. Health professional students have also been active in creating new models of service provision, health promotion, and social change; the Student Health Organization discussed in the first chapter of the thesis is an example of this activism. Students can contribute to social change within the health sector and student-run health clinics can be part of this effort. An understanding of the history of student activism and the strengths and limitations of studenthood are important elements for leaders to consider in establishing or maintaining student-run clinics.

3) Social Change Feasibility

Historically students have demonstrated an ability to play significant roles in social change movements, as illustrated by the examples listed above. However, the examples of movements given relied more on direct organizing tactics and consciousness raising than on service provision. Within these movements, service programs were secondary to direct action and were seen as a byproduct of an increasing desire to create new models of service provision, such as women's health clinics and their connection with feminism. Modern student-run clinics emphasize service over organizing and education. With this structure, student-run clinics may not be appropriate venues for social change.

Some of the early neighborhood health centers and free community clinics hoped to generate social change while simultaneously providing needed services. Clinics were seen as central locations that could help build coalitions around promoting community health. These clinics were founded on a COPC vision which linked knowledge gained from service provision to larger public health and social change interventions. The few clinics that successfully fostered community development projects and social change were those that utilized organizing and education principles within the context of their program's services. These clinics also gradually turned over control of the clinics from community "outsiders" to community "insiders." Clinics that failed to incorporate social change into their activities in spite of good intentions often felt constrained by fiscal and service provision demands as well as a lack of community involvement.

Taylor (1979) stated that, "the most obvious way in which free clinics can act against the political mobilization of a neighborhood is in directing the energy of the people they attract as patients and workers into the all-consuming work of service delivery. Patients receive treatment and some relief and their attention is diverted from the systemic problems that caused their physical ailments. Radical organizers may get caught up with the daily trials of keeping the clinic open that they have no time to devote

to combating the agencies which set priorities and policies in the health care sector...Free clinics, then, may inadvertently facilitate the co-optation of leaders of political movements."

Clinics typically receive little to no funding for organizing and consciousness-raising projects in today's health care environment. Funds are slotted for restricted types of service provision and are often accompanied by additional regulations. In order to survive, many community health centers and free clinics have been forced to cut back on programs other than service provision. Those clinics that operate organizing and consciousness-raising programs must solicit funding from alternative sources such as private donors, foundations, and fundraisers. Waitzkin (1983) argued that community clinics can be an appropriate focus for community organizing activities. However, he warned that social change could not take place if clinics remained isolated and vulnerable to frequent shifts in funding streams. For clinics to be effective as social change vehicles, Waitzkin felt they needed to be a part of a unified health care system or develop strong coalitions.

The same forces limiting community health center and free clinic social change efforts limit the activities of student-run clinics. In addition, student-run clinics are limited by the previously discussed, inherent limitations associated with being a student. Student leaders focused on maintaining service programs are likely to pour funds into service provision rather than social change efforts connected with the clinic. Student-run clinics should strive to avoid the all-consuming demands of service provision and devote at least some of their resources to population-based interventions and social change efforts. By establishing a national network of student-run clinics with a stable funding source, these clinics may begin to buffer themselves from financial constraints that limit their population-based interventions.

4) Limits of Services

John McKnight has been a vocal critic of American society's tendency to focus on services as solutions to community problems. He believes in the creation of neighborhood associations to tackle community issues through the use of their already existing capacities, skills, and assets of a community. McKnight and Kretzmann (In Press) believe that problem and need focused assessments lead to more services and the creation of clients. Special needs are found that can only be met by outsiders. Community members become consumers without incentives to become producers. The creativity and intelligence of individuals gets devoted to the "survival-motivated challenge of outwitting the 'system' or on finding ways -- in the informal or even illegal economy -- to bypass the system entirely." With a community capacity perspective, community building rather than service provision becomes the goal. Rather than needing service providers, community's utilize enablers and facilitators that help to bring out their resources in a productive fashion.

The promotion of health- mental, physical, psychological, and social- and overall well-being requires more than the provision of medical services. In fact, medical services have historically played a small role in improving the health of populations. Public health interventions, educational programs, and economic change have contributed much more to overall improvements in health status than medical services. Student-run clinics devoted to promoting health must focus on more than individual needs by conceiving of health in broad terms and facilitating population-based change efforts.

5) Broad View of Health

Mark Twain once said that, "if your only tool is a hammer, all problems look like nails." So is the case with a biomedical view of health. Similarly, if your only tool is medical care, than all unhealthy people look like patients (McKnight, 1994). However, there is abundant evidence that medical care plays a minor role in promoting the health of people. Prevention efforts that are population-based and focused on social conditions are

generally more effective at promoting health than efforts aimed primarily at treating individuals (Wallack, In Press). Broad definitions of health and its influences are an important aspect of vision and values that student-run clinics should consider.

Factors that contribute to the development of physical disease include germ agents, behavioral and lifestyle factors, genetics, inadequate medical care, and environmental affronts. Powerlessness and a lack of control are hypothesized to increase general susceptibility to disease. Environmental affronts that contribute to disease include toxins or unsanitary conditions. Social factors influencing susceptibility to disease include social supports, life changes, and the social consequences of poverty. The top five causes of death in the United States among those between the ages of 0 and 44 are behaviorally related (Jan. 1992): accidents, cancer, heart disease, homicide, and suicide. The US Healthy People Report posits that 50% of disease is due to lifestyle factors, 20% from environmental factors, 20% from genetics, and 10% from inadequate medical care. Due to these trends, there has been a historical shift in health interventions in the United States away from attacking germ agents to attacking unhealthy behaviors.

Discussions of disease-risks are political and value-laden. With the majority of deaths in the United States resulting from behaviorally-related disease, interventionists can choose to emphasize self-reliance and personal change or government interventions and structural changes. The question becomes where does blame lie--with the individual or with societal forces?

In the 1960s, the United Kingdom decided to lay some blame on societal forces. The U.K. heavily taxed alcohol advertising and consequently saw a reduction in cirrhosis to half U.S. levels (Wallack, In Press). Business may benefit from emphasis on personal habits. For example, insurers can charge higher rates for smokers. An orientation based on the fields reviewed for this thesis emphasizes community and structural changes in addition to personal changes. This orientation affirms that personal change is a byproduct

of community and structural change, but personal change is inadequate to address some of the more glaring reasons for differences in health status among groups.

Poverty is recognized as a, if not the major risk factor for disability and premature death (Alder et al., 1994 & House et al., 1988). Recent work suggests that the most important influence on health status among social class variables may be an individual's level of education (Winkleby, et al., 1992). In cross-cultural comparisons, it appears a society's health status is not linked solely to per capita income, but to income variability and therefore the extent of relative deprivation and discrepancy within a society (Wilkinson, R., 1992). This fact is particularly significant in the United States where 20% of the U.S. population controls 85% of the nation's wealth (Feenberg & Poterba, 1992). Gaps in health status across social class are due to more than inadequate access to medical care as evidenced by health differentials in countries with universal coverage and guaranteed access to health care, such as England and Scandinavian countries. According to Stoller and Gibson (1994) people who are disadvantaged by "systems of inequality" have more acute and more chronic health problems than those who are not. Why is there a link between socioeconomic status and health?

One possibility is that less healthy people become lower class citizens because of their poor health. Another possibility is that factors associated with poverty lead to increased morbidity and mortality. Common explanations for class differentials in health status under the second possibility given above, include: unsanitary living conditions, malnutrition, unemployment, hazardous jobs, poor educational opportunities, less healthy lifestyles, and discrimination. The link between poverty and health seems to be due to increased susceptibility to disease more than specific risk factors or exposure events.

Internalized lack of control, from living in a poverty area, may contribute more to ill health than specific agents or risk (Haan, et al, 1989). Class seems to influence health status more than minority status. However, both poverty and racism lead to ill health. People in higher positions with more job control have less illness and disease. Decision-

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making power and skill discretion at work improve health; work demands or stressors such as physical exertion or monotony decrease health. Social support is a mitigating factor in decreasing the psychological toll of stressful work situations. Living in poverty, being low in the hierarchy, or being without control are broad risk factors that increase susceptibility to disease. "Control" refers to control of outcomes (locus of control), over specific behaviors (self-efficacy), and control over one's destiny, or having the resources and competencies to cope with life demands. Control means having a sense of coherence in life, that is, situations are in control around a person. People without control do not have adequate resources or power to deal with psychological and objective demands. Resources include personal, interpersonal, financial, and systemic. Policy and the health establishment tend to ignore the influence of socioeconomic status on health.

"Alienation and lack of a sense of connection to others have long been associated with heart disease, depression, risky health behaviors, and a variety of other adverse health outcomes." (Minkler, In Press, p. 3). Several researchers (Cohen & Syme, 1985; Eng and Cunningham, 1990) have shown that social involvement and participation themselves can be significant psychosocial factors in improving perceived control, individual coping capacity, health behaviors, and health status. Social support reduces morbidity and mortality and may also play a critical role in one's perception of control. Support may act as a "buffer" during stressful events and has a "direct effect" on the development of inner strength. Groups and social support are also valuable for achieving change in people through peer pressure, changing group norms, or acting as a group for external change.

In the United States, the dominant ideology of individual responsibility for improving oneself and one's health reinforces powerlessness. Many health promotion and disease prevention programs target individual risk factors, rather than organizational practices or socio-economic risks. These programs emphasize individual behavior change rather than participation to affect community changes that address both individual

and societal risks. To counter these trends and to address the discrepancies discussed above, an orientation based on COPC, community organizing, and popular education, adopts a position on health promotion closer to that of the World Health Organization (WHO) than the US Department of Health and Human Services. The WHO states that "health promotion is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. Such a process requires the direct involvement of individuals and communities in the achievement of change, combined with political action directed towards the creation of an environment conducive to health (World Health Organization, 1986)." Student-run clinics can benefit from understanding these multiple influences on health and utilizing the proven health benefits of social support, participation, and an enhanced sense of control in one's life.

6) Ideology, Power, Oppression, and Empowerment

The terms ideology, power, oppression, and empowerment are part of the lexicon of community change terminology. These terms provide a framework from which community interventionist view the world and their role in it. An understanding of these terms may provide student-run clinics with insights into their work with underserved populations.

Wallerstein (1988) defines ideology as a manner of thinking characteristic of a class or individual. Ideology is a set of ideas at the basis of some economic or political theory or system. Some characteristics of American ideology, according to Wallerstein, include beliefs in individual autonomy and freedom, in self-interest as a motivating force, in equality of opportunity, in social mobility, in the reward of hard work, and in consensus of common interests. American culture and ideology view power as power over others, as in a competition. Democratic pluralism posits that groups or people who prevail are the most powerful. Those who don't prevail are considered apathetic, rather than being seen as not having resources of power. The powerful can create political

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values and biases that limit discussion. According to Wallerstein, the social system shapes conceptions and wants in a manner contrary to the interests of the powerless or oppressed, so there are no conflicts. The absence of conflict would be expected in an environment where glaring inequalities exist and the powerless have no expectations of different social conditions. Quiescence is maintained through false wants -- "false consciousness", "internalized oppression", or "alienation." Popular education methodology strives to raise awareness of the dichotomy between ideology and social reality and how it affects people's lives.

According to Mondros and Wilson, a community organizer's perspective on power has roots in political economy theory (Mondros and Wilson, 1994). Organizers typically accept Max Weber's (1978) classic definition of power as the probability that an individual or group will have their will win out despite the resistance of others. Within this framework, resources are allocated on the basis of power, rather than merit or efficiency. Unequal distributions of wealth, health, and life chances are heavily determined by political, economic, and socio-cultural factors. Issues that get defined, undefined/treated or untreated as health problems reflect power struggles (Minkler, In Press). This view, based on political economic theory, rejects the dominant ideology that individuals and groups attain power solely on the basis of merit and "deservingness" (Katz, 1995).

Lukes' (1974) conceptualized power on several levels, and Minkler (In Press) uses his conceptualization within the context of community organizing. *Situational power* is at the level of the individual. It manifests itself as the ability to make decisions within the existing rules of the game, for example, voting. *Organizational level power* refers to the ability to define the rules of the game, as when elites and powerful organizations determine what issues become "hot topics." Examples include the "new right" and abortion and the tobacco industry fighting laws prohibiting smoking. *Systemic level or structural power* refers to the ways in which the structure of the economic and political

system favors certain interests without any conscious decision making, agenda setting, or manipulation of public policy. An example of structural power is that actions to improve the environment or public health are not taken if they would restrict corporate profits. One of the reasons structural power is able to reproduce itself is through Gramsci's notion of hegemony (Simon, 1991). Hegemony involves people actively accepting values that are against their best interests; this concept of hegemony is similar to Wallerstein's notion of quiescence maintained through false wants, discussed above.

Feminist ideology has adopted a "counter-conceptualization" to the dominant notion of power in the United States. Feminism emphasizes *power with* and *power to* rather than more hierarchical notions of *power over* (French, 1986). Rather than viewing power in terms of competitive struggles for limited resources, a feminist perspective views power as limitless and sees a lack of power as a failure to develop one's own innate power as opposed to "stealing" power from another.

"Empowerment" is a loosely used term that has been co-opted by business and conservatives. In spite of this, empowerment remains an integral part of community health promotion efforts. Wallerstein (1992) defines empowerment as "a social-action process that promotes participation of people, organizations and communities toward the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice." Businesses and conservatives often speak of empowerment in terms of self-esteem or self-efficacy. Empowerment is much broader than self-esteeem, self-efficacy or other behavioral interventions that exist independently from participation in environmental or community change. Empowerment processes target individual, group, and structural change.

Katz (1983-1984) defines empowerment at a community level in terms of achieving equity. Braithwaite (1989) and Cottrell (1983) view empowerment as a community's capacity to identify problems and solutions. Florin & Wandersman (1990) and Kieffer (1983-84) view empowerment as participatory self-competence in the

political life of the community. Syme (1988) defines empowerment as increased control of destiny. The key components of all these definitions are increased *participation* in community life, increased personal and community *control*, enhanced *problem-solving abilities* and the *capacity to fight for social justice* at a personal and community level.

Empowering processes and the raising of critical consciousness are important elements to consider incorporating in a student-run clinic praxis. The introduction of these elements requires a conceptualization of power and ideology and tools to raise critical consciousness and foster empowerment. Such tools, some of which are discussed in this thesis, are available in the literature on popular education and community organizing.. This section provided a brief review of these concepts. Utilization of these concepts hinges upon the utilization of a social justice rather than a market justice orientation.

7) Social Justice vs. Market Justice

According to Jacqueline B. Mondros and Scott M. Wilson (1994) the world view of social welfare community organizing practitioners is characterized by concerns with justice, fairness, the application of democratic principles, and a sense of collective responsibility. Organizers tend to favor social justice over market justice; student-run clinic leaders should also consider adopting such an orientation. Market justice refers to a system in which people are entitled only to those valued ends such as status, income happiness, etc. that they have acquired by their own individual efforts, actions or abilities (Beauchamp, 1976). A market justice system places emphasis on individual responsibility, minimal collective action, and freedom from collective responsibility, except to respect other persons' fundamental rights. Health problems and their solutions are seen in individual terms. People choose their own lifestyles. A social justice orientation sees health as also tied to social and environmental conditions. A social justice orientation supports the concept of inalienable human rights. This perspective

does not deny the need for individual responsibility nor does it minimize collective responsibility for the good of all. From this perspective, individual lives are influenced by the world around them and are not simply reflections of individual choice and will.

8) Participation and Relevance

Adherence to the principles of community participation and relevance are key concepts throughout the stages of the student-run clinic praxis proposed in this thesis. Dorothy Nyswander (1956) a health education leader articulated the principle of relevance or "starting where the people are", and Minkler (In Press) views this as perhaps the most fundamental tenet of health education practice. Nyswander's principle means that organizations should start with the community's needs and concerns not with a personal or agency-dictated agenda. This is a challenging task since it is easy for an agency or a professional to project their own values on a community or to be constrained by funding sources.

"Starting where the people are" is a challenging principle to follow since community outsiders may lack access to "hidden community discourse", or they may misinterpret apparent community apathy because of their own lack of cultural competence, a lack of access to key stakeholders or cultural translators, or a lack of self-reflection on the problematic nature of power dynamics between themselves and community members (Scott, 1990). Outsiders may have access to community discourse, yet find that a community's identification of goals and selection of strategies and actions challenge their own level of comfort, or reflect values such as racism, sexism, or homophobia. In these situations, the principle of relevance must be tempered with the paramount principle of social justice in the larger community.

Social psychology theories of learning and adult education emphasize that teacher-learners should develop their own understandings and make and act on their own decisions. This requires high-level participation in the learning process. The same level

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of participation is essential in all levels of a community organization founded on community involvement. Effective participation means sharing power and responsibility not tokenism and limited decision-making. Alinsky (1969) articulated his views on the importance of participation when he said, "To give people help, while denying them a significant part in the action, contributes nothing to the development of the individual. In the deepest sense it is not giving but taking- taking their dignity. Denial of the opportunity for participation is the denial of human dignity and democracy. It will not work."

Gillian Kaye (In Press) identified six reasons why people participate in groups, organizations, or associations. Keeping these reasons in mind can help student-run clinics maintain community and volunteer participation. Her reasons are known as the six "R's" of participation and they are included in Appendix Two.

9) Personal as Political

One of the fundamental tenets of feminism is that personal issues are often political. This same principle can be applied at student-run clinics. The individual health concerns and medical problems that patients bring to clinics frequently reflect broader political, social, and economic forces. Clinic leaders aware of the principle that the personal is often political can bring individuals together around common personal struggles, which can then become community struggles.

For example, service users receiving welfare benefits may have had reductions or cuts in these benefits. Bringing service users together who have been adversely affected by these cuts and raising their collective consciousness of this as a political issue may serve as a vehicle for mobilizing this group. They can go on to participate in efforts to reverse, slow, or propose alternatives to further cuts in benefits.

10) Multiculturalism and Identity

Contemporary social change efforts frequently revolve around issues of identity and culture. The work of feminists, gay rights activists, and people of color fighting for their groups typifies these efforts. Student-run clinic volunteers often are outsiders in the communities in which they work. These volunteers face issues of identity and cultural dissonance in their interactions with service users. Student-run clinics should thoughtfully consider the cultural competence of their organization. It is useful for student-run clinics to maintain a world view that sees diversity and multiculturalism as a rich resource and opportunity rather than a problem or obstacle to address. Inclusion should be valued over exclusion.

Rivera & Erlich (1995b) feel that a community organizer should share a similar cultural and racial identification with the community they work with. According to these authors, most successful organizers are activists who can identify with their communities culturally, racially, and linguistically; they have an intimate knowledge of language and subgroup slang. Since most student-run clinic volunteers do not share these characteristics of "succesful organizers," clinic leaders should make extra efforts to recruit volunteers of similar backgrounds and to involve community members themselves in the operation of the clinic. Clinic leaders should also look for commonalities of community identification between volunteers and service users; these commonalities can be used as building blocks. For example, a white, upper-middle class, male volunteer of European descent working with a homeless African-American female faces multiple cultural and identification barriers. However, these individuals may share a common

community identification based on the city in which they live or the religious community in which they identify.

Carmen Rita-Nevarez (1997) using several resources compiled a list of characteristics of culturally competent systems of care and a list of critical aspects of cultural competence. The lists, which follow, may help student-run clinics in designing culturally competent organizations:

A Culturally Competent System of Care...
1) Values diversity - sees and respects diverse cultures.
2) Undergoes continuous cultural self-assessment - has a system(s) for performing self-assessments and has a sense of its own culture.
3) Appreciates the dynamics of difference - that is, the dynamics of cross-cultural interactions.
4) Institutionalizes cultural knowledge - the system sanctions and in some cases mandates the incorporation of cultural knowledge into its delivery framework.
5) Adapts to diversity - the system adapts to create a better fit between the needs of minority groups and services available.

Critical Aspects (Principles) of Cultural Competence
1) Everyone is ethnocentric.
2) You cannot learn everything about all cultures, it is most important to accept one's own ethnicity and another's without judgement (nonjudgmental tolerance based on the recognition that everyone operates from an ethnocentric perspective).
3) It is important to recognize the importance and acceptability of culture as a viable concept for ethnic groups.
4) There is no single road to cultural competence.
5) Cultural competence is a long-term, dynamic, developmental process, not a state to achieve.
6) Cultural competence challenges the dominant paradigm.
7) The process of achieving cultural competence must be a separate activity but it also must be integrated throughout the organization.
8) Cultural competence requires an understanding of the dynamic nature of the socio-political environment.

11) Results and Community Competence

As discussed above, increased "community competence" or problem solving ability is an integral part of community empowerment and is a goal and outcome of any successful community organizing project. Without "community competence" communities become dependent on outside providers. Murray Ross, widely regarded as the father of community organizing practice, argued that community organization could not be said to have taken place unless community problem solving ability had been increased in the process (Ross, 1955).

A "competent community" as defined by Cotrell (1983) is "one in which the various component parts of the community are able to collaborate effectively on identifying the problems and needs of the community; can achieve a working consensus on goals and priorities; can agree on ways and means to implement the agreed upon goals; can collaborate effectively in the required actions." In other words, "competent communities" function autonomously by utilizing their own internal resources.

One key in developing "community competence" is the identification and development of leaders within the community (Hope & Timel, 1984). Hope & Timel (1984) identified two types of leaders integral to community competence. The first type of leader is a consciousness raiser that helps stimulate people to think critically and to identify problems and new solutions. The second type of leader facilitates by acting as a process monitor so the group can discuss its own content in the most productive way possible. Both types of leaders are needed to insure the successful functioning of a community in achieving social change.

Community organizers can utilize social network techniques to help identify natural helpers or leaders within a community. These techniques include tools to map personal and/or community networks and assets. The techniques can be used to help natural helpers identify their own networks and involve network members in their own community assessment and actions necessary to strengthen community networks

(McCallister & Fisher, 1978; McKnight & Kretzmann, 1992); these are some of the first steps that can be taken in developing community competence. Leadership development and training should follow leadership identification.

Increasing community competence is part of the vision that student-run clinics should strive to incorporate into their work. The components of the values and visions outlined above should be revisited by student-run clinics on a regular basis. A review of the values and visions behind an organization will help it sustain itself during difficult times and will help the organization maintain its course. The next step in this proposed student-run clinic praxis is defining community informed by the values and visions given above.

Step 2: Define Community

One of the key distinguishing features of a community-oriented primary care practice is that the practice works with a defined community that extends beyond the clinic's service users. Within the COPC literature the service user population is known as the numerator population and the target community is known as the denominator population. The goal of a COPC program is to promote the health of the denominator population.

Student-run clinics typically define their target populations based on who lacks health insurance or access to health services. Thus, all individuals that fall under one or both of these categories become a "community" as defined by an outside organization, the student-run clinic. Student-run clinics also have a tendency to define their denominator population based on the visibility of the group. For example, since homeless individuals are visible on the streets they are often the target population. This may not be the best approach for defining community. Student-run clinic definitions and conceptualizations of community provide direction for the rest of the steps in this proposed praxis, so student

leaders should consider the implications of their definitions. The theoretical literature provides some insights into the definition process.

Ronald Labonte (In Press) is critical of the loose use of the term "community" by helping professionals who rarely operate with a definition or conceptualization of community in mind. Helping professionals often use the term "community" as a loose reference to anything outside of their institutions of operation. How one defines community affects how one interacts with community members. It determines whether or not one conceives of oneself as a community insider or outsider, the information one gathers about a community, the programs that develop, and the evaluation of success or failure of efforts in a community. When helping professionals define community it is usually in the static vocabulary of data accessible units such as poor women, geographic regions, or hospital service users.

The Toronto Department of Public Health (1994a) offers the following alternative definition, focused on shared identity: "A community is a group of individuals with a common interest, and an identity of themselves as a group. We all belong to multiple communities at any given time. The essence of being a community is that there is something that is "shared." We cannot really say that a community exists until a group with a shared identity exists."

Hunter (1975) defined several types of communities. One type of community is a *geographic or functional* spatial unit that meets basic needs for sustenance. Another type of community involves units of *patterned social interaction* as seen in a work or school environment. A third type of community involves *symbolic units of collective identity* such as religious, racial, or cultural. Eng and Parker suggested the addition of a fourth type of community to Hunter's list (1994). They called this community a social unit of *people coming together to act politically for changes.*

Community definition options for student-run clinics include: data accessible units, groups with shared collective identities, geographic units, groups with patterned

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social interactions, and groups coming together to act politically for change. One or more of these definitions may be used in the defining process.

Once student-run clinics develop a working definition of a community, they can move on to the next step of community analysis. As the community analysis continues, student-run clinics can refine their community definition. One of the key aspects of this definition and analysis process is involvement of identified "community members" to determine the usefulness of the community definition and to involve potential service users in defining their own communities. Early involvement in organizational development also increases the likelihood that community members will feel ownership of the program that develops from the analysis.

Three: Community Assessment

Community assessment refers to the process of learning about a community and its needs, strengths, resources, hopes, and desires. It is the next stage of a COPC process after "community" has been defined and conceptualized. The purpose of the assessment and values and assumptions underlying the process influence technique choice, interventions proposed, the utilization of data obtained, and the perceptions of who owns the data in the first place. Problems associated with community analysis include failure to involve the community, a focus on needs only and the exclusion of strengths, and a failure to empower community members through the process.

As a first step, it is crucial that the defined community participate in the community analysis. Early involvement of the community in understanding itself and its aspirations is crucial to maintaining community participation in a COPC effort. It is much more difficult to encourage involvement if a plan has been developed without first

consulting community members. A truly empowering community analysis is "of, by, and for" the community. Data collected as part of the analysis will be used to establish program goals and to measure the success of interventions based on ongoing monitoring of community data.

Marti-Costa and Serrano-Garcia (1983) argue that needs assessment is an ideological process which can serve political purposes ranging from system maintenance and control to promotion of social change and consciousness raising. An example of how a needs assessment can maintain the status quo is to plan a health fair and then consult the community about the hours for the fair rather than consulting them about the appropirateness of the fair. Marti-Costa and Serrano-Garcia believe that community asessment should measure, describe, and understand community lifestyles. It should assess community resources to lessen external dependency. Assessment data should be returned to community members to facilitate residents' decision-making. Community members should be provided with skills trainings in leadership and organizational skills, so they can participate in the ongoing assessment process. The process should facilitate collective activities, group mobilization, and consciousness raising.

According to Hancock and Miller (In Press) the information collected through a community assessment should provide a stimulus for change, a means for monitoring change, and a guide as to how to assess the impact of change. Information that will stimulate change has "social and political punch", like a popular education "code." Such information includes hard data and stories that point up differences and inequalities in health and its prerequisites among different groups in the community. The inequalities raised by the analysis must be sensitive to short-term change. In other words, the data

must help groups create tangible actions to bring about change. Information about processes of change or of actions is much more accessible in the form of stories and observations. Information should be gathered to encourage empowerment. For example, community members can be asked to define and describe the elements of a good or healthy community. Information collected must also be accessible to the community. It should be kept in mind that 21-25% of the US population is either functionally illiterate or operating at the lowest level of literacy (US Dept. of Education, 1993). Consequently, audio and visual not just written information, should be utilized.

Marti-Costa and Serrano-Garcia (1983) differentiate among community assessment techniques based on the degree of contact with the community when using a given technique. A *no contact technique* relies on statistics and document reviews as representative of community problems. Epidemiologic studies of a community, a cornerstone of COPC practice, represent such a technique. Although the authors identify this as a "no contact" technique, it is possible to contact community members and involve them in collecting this type of information through training in relevant areas such as computers, library usage, and others. Community members can also be involved in interpreting the information as part of their ongoing involvement. Such a process could incorporate principles of popular education in analyzing the data collected. *Minimal contact methods* include "windshield" or walking tours through an area at different days and times. Houses, autos, degree of activity and social interaction can all be observed. Community members can be trained to look at community with a "stranger's eyes," that is, to be critical observers of their own community (Kent, 1970). *Interactive contact*

methods include key informant interviews, door-to-door surveys, and small group methods such as popular education, nominal group process, and focus groups.

John McKnight (1994) believes that "institutions learn from studies" and "communities learn from stories," so he recommends collecting stories in formal (newsletters, videos, workshops, collections of stories, etc.) and informal (discussions, focus groups, etc.) ways. McKnight also advocates the use of community strength questions during the assessment process. Examples (Eng, 1990-91) of these include: What are the things you like best about your community? What makes this a good or healthy community in which to live? Who do people go to, to get things done? How have people here come together in the past to make a decision or solve a problem?

Another important element of the "how to of assessment" is triangulation, i.e., the use of multiple methods for gathering information. Multiple authors have written about the components of a community asessment. Appendix Three contains sample assessment methodologies from various authors. These methods can be mixed and matched to "triangulate" the process.

<u>Four: Mission, Goals, and Objectives</u>

This step involves the brainstorming, refining, and recording of achievement markers. The mission statement should serve as a guiding statement of the clinic's vision and values. Goals represent an articulation of the program's targets. Goals should evolve out of the process of defining and assessing the community. Objectives are generally considered to be detailed, stepwise statements of how a program plans to achieve a goal. Objective statements should be measurable, that is, statements should contain timelines for completion and objectively measurable task(s) to complete.

Too often student-run clinics develop mission statements, goals, and objectives without consultation and involvement of members from the targeted community. With such an omission, student-run clinics become programs that primarily benefit students and other volunteers. Clinic goals become projections of the stereotypes, assumptions, and outside observer bias of clinic leaders. Although community participation levels within an organization will vary in time, space, and manner, it is important to maintain at least a modicum of such involvement for student-run clinics to stay true to a COPC, community organizing, and popular education orientation.

Many of the goals outlined in the section on student-run clinics are appropriate for a clinic with a COPC orientation provided these goals develop in concert with community input. The following section contains a revision of the compilation of clinic goals outlined previously. This revision tries to incorporate some of the principles articulated in health program cycle elements one through four. Strikethrough text is used to illustrate old goals that should be removed, e.g., ~~removal~~. *Italics* represent additions to the original

goals list, and **Arial text** represents commentary on the goals. A sample objective is given for each goal when appropriate.

Revision of the Compilation of Clinic Goals:
Service, Learning, Social Change

Service Goals

1. To identify and meet the unmet community needs of underserved populations (homeless individuals, migrant field workers, recent immigrants, the urban poor, etc.) *by facilitating a process to involve them in identifying their needs and utilizing their already existing strengths, skills, and resources to meet these needs.*

   Sample Objective: By February 2, 1998 clinic organizers should complete step one of the action-oriented community diagnosis procedure given in Appendix Three.

2. To increase access to primary health care and other medical services among underserved populations *in the short-term*:

   Methods for accomplishing this goal include:

   a) Selecting an accessible location.

   Sample Objective: Through the community assessment process work to identify a list of accessible locations based on community input.

   b) Operating at accessible times.

   Sample Objective: Determine through consultation with community members and volunteers the most ideal times for operation.

   c) Conducting outreach programs and services.

   Sample Objective: Develop an outreach effort that is implemented at least once per week.

   d) Creating "one-stop shopping" multi-service centers where an individual can address multiple needs.

   Sample Objective: Provide services requested by community members whenever possible.

   e) Offering walk-in appointments.

   Sample Objective: Offer walk-in appointments each week and develop an alternative appointment-making procedure for those who cannot get an appointment on a walk-in basis.

   f) Provide free medical services and free dispensed (not prescribed) medications.

   Consideration must be given to whether or not the clinic wants to screen service users regarding their true need. Some clinics fear that people capable of paying for services may utilize clinic services because they are free; this would limit spots for the "truly needy." This viewpoint is similar to one espoused by critics of nineteenth century dispensaries. A sliding fee scale can be developed to charge patients based on their means.

   Studies on free clinics have shown that typically no more than 10% of free clinic users have health insurance or other means of payment. Screening for the "truly needy" may not be justified with such a small

percentage of service users that can afford care. Screening programs can be time consuming and alienating for staff and clinic users. Sliding fee scales go against the principle of free services, although some clinics may need to consider this option to pay for their operations.

    g) Serve as an entrance point into the medical care system and ongoing health care access; which entails maintaining a strong referral network.

        Sample Objective: Within the next year, find at least one ophthalmologist willing to provide free medical services to ten clients per year.

    h) Maintain an informal, non-judgmental atmosphere.

        Sample Objective: Include discussion of clinic atmosphere and what it means during the volunteer training sessions.

    i) Reduce waits and increase time available to spend with providers.

        Sample Objective: Maintain a log of time patient's wait and time they have with the physician provider. Try to improve these numbers.

    j) Try to develop a "culturally competent" organizational process.

        Sample Objective: Within the year, involve at least one member from the targeted community(ies) in volunteering at the clinic.

    k) To provide free child care at the clinic each week.

        Sample Objective: Child care would include programs for children desired by community members.

    l) Work toward establishing elements of primary care at student-run clinics with continuity of care being one of the major areas of emphasis.

        Sample Objective: Try to establish a regular volunteer pool that will work regularly at the clinic. Conduct follow-up outreach with service users at the clinic.

3. To create programs that promote health on multiple levels, i.e., medical services, social support, employment opportunities, preventive health education, etc.

    Sample Objective: To initiate at least one health promotion program in conjunction with community members, involving them in a process of planning and establishing a timeline for implementation of the program.

4. To facilitate collaboration and networking among organizations and individuals in order to promote the health of underserved communities.

    Sample Objective: To have at least one meeting per year among groups and individuals sharing goals similar to our program.

5. To establish regular means for community participation in student-run clinic planning and operations such as regular community meetings, an advisory board, ongoing community assessments, volunteer staff positions for clinic users, etc.

    Sample Objective: To establish a regular popular education/community organizing discussion group at the clinic site.

6. *To create programs that build community strengths, skills, and resources*
   Sample Objective: Utilize a community skills inventory to assess the types of skills and talents present in the targeted community; utilize this information in concert with community members to develop community building programs, e.g., small business development.
7. *To apply the principle that personal issues that arise during service provision are often political issues.*
   Sample Objective: To establish a process for connecting individual concerns with group attempts to address these concerns at a community level.
8. *To utilize the principles of COPC, community organizing, and popular education as guides to the creation of new programs or the reform of existing programs.*
   Sample Objective: Use the literature review information and stepwise process outlined in this thesis as a guide to incorporating these principles.

Learning Goals

1. *To incorporate the cyclical process of popular education into the service and learning, action and reflection of volunteers and service users.*
   Sample Objective: At the end of each clinic night conduct a reflection and action session among volunteers that incorporates popular education principles including a problem-posing methodology.
   Sample Objective 2: Provide training for volunteers, including professional volunteers, on how to incorporate service-users into a mutual learning process rather than a manipulative one, i.e., all parties involved become teachers-learners.
2. To "sensitize" students to the medical and social needs of underserved populations.
   Sample Objective: Develop a popular education process of action and reflection for students that increases their awareness of the needs of underserved populations.
   REMINDER: Exposure in and of itself does not lead to attitude change or action. A cycle of listening-dialogue-action-reflection is needed. This reminder applies to nearly all of the learning goals.
3. To push students to confront stereotypes and to reflect on their values and attitudes toward underserved communities.
   Specific Objective: To measure students beliefs about underserved communities before and after their involvement as volunteers in the student-run clinic.
4. To breakdown knowledge and power barriers between health professionals, health professional students, and underserved community members by encouraging mutual learning and discussion among these groups.
   Specific Objective: To conduct role plays demonstrating the effects of knowledge and power barriers in a clinical interaction. Use this role play as a code in the context of a popular education session.

5. To develop students' abilities to work with people from different cultural backgrounds.

> *Sample Objective: To incorporate a cultural barrier code into a popular education session for volunteers sometime during their training and at regular intervals throughout their volunteering.*

6. To prepare students for collaborative work in a multi-disciplinary service provider team and to give them the tools they need to utilize a wide array of community and other resources.

7. To expose students to primary care practice early in their education.

> *Sample Objective: To recruit students as volunteers during their first year of attendance and introduce them to the theoretical concepts of primary care and COPC. Have them compare the student-run clinic with primary care and COPC theory and develop actions to move the clinic closer to primary care and COPC.*

8. To expose students to multiple role models providing them with an opportunity to develop their own identity through selective emulation.

> *Sample Objective: Encourage/require students to maintain a journal with reflections on the elements of practice that they want to incorporate into their own work.*

9. To help students develop their clinical skills by exposing them to clinical work early in their education in a lower pressure environment than that of the clerkship years.

> *Sample Objective: To include clinical skills training as part of new volunteer training and offer regular opportunities for students to ask questions and practice their clinical skills during their volunteering.*

10. To help students develop population-specific clinical skills, e.g., elderly, children, recent, immigrants, etc.

> *Sample Objective: To introduce students to the concept of population-specific medicine within the context of one-on-one clinical interactions during their training sessions.*

11. To develop students' communication and health education skills.

> *Sample Objective: Include communication and health education training for volunteers and provide them with opportunities to reflect and act around these skills during their volunteering.*

12. To provide students with an opportunity to become involved with and develop skills in clinical administration and operation.

> *Sample Objective: To establish leadership positions with job descriptions and skills needed/developed within the context of these positions.*

13. To teach students how to create and maintain a medical record system.

> *Sample Objective: To incorporate medical record use into volunteer training and to have regular popular education sessions around medical record keeping. (A sample discussion code would be the problem of recording HIV/AIDS diagnoses in medical records or the computerization of medical records).*

14. To involve students in planning and creating cost-effective services with limited resources.

Sample Objective: To involve community members and volunteers in the process of allocating limited resources for programs. Conduct regular budgetary planning meetings.

15. To encourage students to think about the determinants of health in broad terms.

Sample Objective: To include discussion about determinants of health in post-clinic popular education debriefing sessions.

~~16. To introduce students to a cyclical educational process of service and learning, action and reflection.~~

16. To foster social responsibility, active citizenship, and lifelong volunteer work among health professionals and future health professionals.

Sample Objective: To conduct a study of student-run clinic volunteer alumni to gauge their level of citizenship activity after their volunteer stint; assess how they think their student-run clinic volunteer work influenced their decision(s) on how to use their time.

Definitions of social responsibility and active citizenship need to be developed.

17. *To balance the service, learning, and social change goals of student-run clinics.*

Sample Objective: To conduct regular discussions among volunteers and clinic users about the balance of these goals; develop actions to maintain a proper balance when appropriate.

18. *To foster the development of knowledge, skills, and attitudes of a community-based health professional.*

Sample Objective: To conduct a pre- and post-test self assessment survey to determine how volunteers feel about their level of competency in certain skills.

Some of the competencies have been addressed in other objectives, e.g, cross-cultural competency. The following sample list of attributes of community-based professionals come from several sources (Walter, 1995; Pilisuk, In Press; Rivera & Erlich, 1995b; Alinsky, 1972; Mondros & Wilson,1994):

1) Managing interconnectedness - systems thinking, direction, coordination, facilitation, appreciation, and affirmation, relationship building, bringing people together to identify common grievances, developing ideological congruence with other oppositional efforts.

2) Communication - through medium of speech, writing, music, art, film or movement, willingness and ability to listen and see, to understand.

3) Process awareness and management - awareness about how what is happening is happening, enabling people to run effective meetings. Knowledge of organizational behavior and decision-making. Skills in program planning, development, administration, and management.

4) Process commentary - involves ability to articulate process and to bring the discussion of process into the present.

5) Creative planning - reconciling and unifying multiple visions/conflicting agendas, where possible, toward the design of programs and the use of resources.

6) Personhood - clarity, strength, commitment, vision, integrity, flexibility, willingness to take leadership, capacity to earn trust and respect of community members, responsibility, follow through, self-critical, reflective, awareness of how their personal values shape their world view, respecting of

diverse communities, the ability to exchange positive energy, the willingness to change, awareness of self and one's personal strengths and limitations (knowing when to ask for help and when to share responsibilities), curiosity, irreverence, imagination, a sense of humor, an organized personality, a free and open mind with political relativity.

7) Risk-taking - willingness and ability to suspend the power, privilege, prestige, and protection offered by one's own background and be willing to be less safe.

8) Skill-builder with capacity to delegate and extricate -should be able to transfer their skills to others, for example, setting up meetings, accessing public authorities, etc. Capable of training new leaders. Great community organizers help others receive the praise and accolades. Empower people to select issues and strategies.

9) "Conscious contrarians" (Mondros & Wilson, 1994) - challenge people's thinking and shake them up. Challenging accepted vision of things. Community organizers live "backwards", opposite of convention. Rather than looking for pathogens, they look how to achieve and maintain health. Have an analytical framework for understanding power, authority, politics, and economics. "A well-integrated political schizoid...a bit of a blurred vision of a better world (Alinsky, 1972)."

10) Community connectedness - similar cultural, racial, or other community identification. Most successful organizers are activists who can identify with their communities culturally, racially, and linguistically. Familiarity with community customs and traditions, social networks, and values. They have an intimate knowledge of language and subgroup slang.

11) Historical knowledge - a historical knowledge of past organizing strategies, their strengths, and limitations

12) Community health praxis skills- Skills in conscientization and empowerment and assessing community psychology. Skills in empowerment evaluation also help.

Social Change Goals

1. To work toward bringing an end to poverty ("A War on Poverty")
    Sample Objective: To conduct at least one project per year in conjunction with community members to promote ideas and action around eliminating poverty.

2. To increase the number of primary care physicians working in underserved communities

3. To promote volunteerism as a solution to providing medical care to underserved populations

2. *To increase access to primary health care and other medical services among underserved populations in the long-term by addressing root causes of these problems.*
    a) *To increase the number of primary care physicians working in underserved communities.*
        Sample Objective: To participate in studies to determine the effect of volunteer work in student-run clinics on future practice locations.

b) *To promote universal health coverage for all citizens and health care as a right.*
>   *Sample Objective: To network with other organizations promoting universal coverage and to co-sponsor at least one event per year with such organization(s).*

4. ~~To develop a "pure" model of medical practice that includes the following elements: a) low-cost/cost effective care; b) informal, non-intimidating environments; c) long-term relationships with patients; d) long appointment times with patients; e) Multi-disciplinary health care teams~~

3. To promote the use of a health care model based on the principles of COPC, community organizing, and popular education.
>   *Sample Objective: To educate student-run clinic volunteers about the theory behind some of the programs established at student-run clinics.*

4. Reduce health professional disenchantment with medicine.
>   *Sample Objective: To incorporate periodic popular education discussions on the motivations of health professionals and how the health care system contributes to preventing them from practicing their trade as they had envisioned.*

The next step involves implementation and action around the mission, goals, and objectives. Selecting issues and projects as well as learning how to implement projects is a crucial step in the operation of any organization. It is at this point that theory translates into reality. Suggestions rather than a cookbook approach are outlined in the next section.

Five: Actions

Student-run health clinics may conduct a variety of different actions and programs depending on the results of the previous four elements of the health program cycle and the organization's resources. This section contains brief discussions on some of the possible actions clinics can take within the organizational framework proposed in this thesis. These discussions contain references to additional readings on a particular subject that may help clinic organizers with a given action or program. Appendix Four contains more detailed information on these references. The actions and programs that will be discussed include:

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1) Service Provision
2) Coalition Building Team
3) Advisory Board
4) Epidemiology/Evaluation Team
5) Popular Education/Community Organizing Group
6) "Community" Staff
7) Education/Learning

Service provision at student-run clinics involves multiple disciplines at one location. Clinic organizers should strive to develop service programs based on expressed needs of community members. Outreach programs to provide services and to inform community members about available services is an important component of service provision. Many of the "How to Manuals" written by student-run clinic leaders address issues of service provision including supply list, sample forms, and how to operate a multi-disciplinary environment. Literature on service provision to underserved populations is also available. The American Medical Student Association (AMSA) has published a collection of materials on providing community-based medical care entitled National Health Service Corps Educational Program for Clinical and Community Issues in Primary Care. AMSA also publishes other useful materials regarding service provision; they should be contacted for their most current materials (See Appendix Four). The COPC literature also provides valuable information on service provision within the framework developed in this thesis. There are also multiple books and articles on the subject of service provision to underserved communities. Appendix Four contains some references to literature on health care for homeless people.

Coalition building is a key component of a student-run clinic practice. Work with other organizations and individuals provides student-run clinics with referral networks and increased resources for more effective collective action. An inevitable feature of coalitions is unspoken agendas making it essential that coalitions understand conflict and learn how to negotiate differences. Labonte (In Press) states that coalitions develop out of a belief in a "superordinate goal" that is compelling for all parties but not attainable for

each separate group. Many articles and books have been written on the subject of coalition building; some of these are referenced in Appendix Four.

Advisory boards serve as links between current clinic leadership, clinic alumni, community members, and other community organizations. Advisory boards differ from coalitions in that the "superordinate goal" of these boards is the improvement of student-run health clinics. Genuine service user participation in advisory boards is a crucial aspect of maintaining community participation in student-run clinics. Readings on community participation and advisory boards are contained in Appendix Four.

The epidemiology and evaluation team is responsible for ongoing community assessments using no contact and other assessment methods. This team also helps to evaluate the effectiveness of the clinic in achieving its goals. Numerator, patient population, computer databases are being used by community clinics around the country to examine their practices and to determine if they are truly reaching their target or denominator population. An upcoming section on empowerment evaluation provides additional information on a useful evaluation strategy for student-run clinics. Appropriate references are included in this section.

Popular education and community organizing groups within student-run clinics apply the principles of these fields as part of their efforts. Aspects of this literature has already been discussed. Literature on social action organizing contains useful information on how to select issues for groups to tackle and how to prepare and implement strategies for addressing these issues; references on this subject are contained in Appendix Four.

"Community" staff refers to the involvement of service users in the planning and operation of student-run clinic health programs. Such involvement requires the identification of community leaders or natural helpers, training of these leaders, and the establishment of organizational space in which these leaders operate. Social network techniques, referenced earlier, can be used to help identify natural helpers or leaders

within a community (McCallister & Fisher, 1978; McKnight & Kretzmann, 1992). There are additional resources on leadership development and changing organizations to utilize community leaders.

The education and learning that takes place at clinics incorporates service provision education, the raising of critical consciousness, learning about health and its influences, and development as community leaders. Popular education literature and the service-learning literature provide useful information regarding learning at student-run health clinics. A common principle in this literature is that learning and education are a two-way process where individuals alternate between teaching and learning.

The use of the media and the world wide web are two techniques that can be utilized by student-run clinics to help meet their objectives. Both techniques have multiple uses including public policy advocacy, networking, educating large numbers of people around an issue, and addressing specific community issues. Lawrence Wallack (In Press) has written extensively about media advocacy and its uses to influence public health. His work is a good place to start when student-run clinics are considering the use of the media to promote an agenda. Several authors have written about the use of the World Wide Web by community organizations; these materials are listed in Appendix Four.

Six: Evaluation

Measuring and evaluating the success of student-run clinic efforts is essential for perfecting and promoting these clinics as well as for developing an understanding of their limitations. Evaluation has been a weakness of most student-run clinics. Consequently, little has been written on the subject. In its simplest form, evaluation involves determining whether or not specific goals and objectives were accomplished within a given time frame. The method of evaluation will depend on the particular goal or objective. COPC interventions based on epidemiologic information might best be

evaluated by comparing the epidemiology data before and after an intervention. Community organizing and popular education interventions can be evaluated within an empowerment evaluation framework which will be discussed subsequently.

Student-run clinic evaluation efforts, like those of community organizing efforts, have historically been fraught with difficulties for several reasons (Coombe, In Press). When funds are short, evaluation is one of the first project components to be cut. Student-run clinic organizers often lack knowledge about evaluative processes and methods. Student-run clinics are difficult to evaluate because of their continually evolving nature and staff pool, the complex contextual issues they address, and the fact that projects often seek change on multiple levels. Many standard evaluation tools focus on long-term change in health and social indicators and miss shorter-term, system-level impacts which student-run clinics are also concerned with, for example, improvements in organizational collaboration, community involvement and action, and promotion of healthier public policies or environmental conditions. Ideally, evaluation methods utilized by student-run clinics will enhance community participation and will contribute in the short-term to improving clinic programs. Traditional evaluation methods are not well-suited for many of the goals of student-run clinics.

Traditional evaluation methods lend more credibility to quantitative than qualitative methods. Evaluations are often conducted by outside professionals who determine what to study, what methods to use, and what conclusions to draw from findings. Traditional evaluation methods are based on a dichotomy between the evaluator and the subject which promotes a myth of researcher objectivity and places evaluation in the control of an elite group. Such a process oversimplifies social reality and reduces the likelihood that the evaluative information will be utilized in subsequent actions to solve problems. The knowledge produced from the evaluation may be irrelevant or invalid, and may even be used in a destructive fashion. Methods used may reinforce the

powerlessness of community members and the power imbalance between professional experts and "the people."

Macguire (1987) argues that knowledge has become the single most important basis of power and control in our society and is increasingly concentrated in the hands of "experts" and the elite. Knowledge of the people is deemed "not valid" because it is not technological or scientific. Evaluation approaches that foster dependence and powerlessness mitigate against empowerment as an outcome. Community organizations want to maintain "distance & neutrality" in their evaluations to be credible to policymakers, funders, and other audiences. On the other hand, they want to ensure that evaluation at least improves organizational and program effectiveness and leads to action that transforms social structures and conditions which oppress communities. Macguire (1987) proposes that, "objectivity is not gained through detachment from the setting, but rather through deep involvement in and reflection about the setting."

A new method of evaluation, known as empowerment evaluation, has been proposed to address some of the shortcomings of traditional evaluation described above. Fetterman (1996) defines empowerment evaluation as the "use of evaluation concepts, techniques, and findings to foster improvement and self-determination. This method uses both quantitative and qualitative methods in a democratic and collaborative effort to help people help themselves." Fawcett (1996) describes the methodology of empowerment evaluation as "an interactive and iterative process by which the community, in collaboration with the support [evaluation] team, identifies its own health issues, decides how to address them, monitors progress toward its goals, and uses the information to adapt and sustain the initiative." Empowerment evaluation is designed to increase community capacity and to become an ongoing, sustainable part of the community's planning and action. The community is empowered through involvement in the evaluation process and community members gain personal skills, insights, investment in the organization, and a better understanding of community resources and needs.

Coombe (In Press) describes three guiding principles essential to empowerment evaluation: 1) Authority over and execution of research is a democratic, highly collaborative process between the community participants and professional evaluators as resources and allies; 2) The process of evaluation is sustainably incorporated into the ongoing planning, action, and reflection of the organization and community; 3) The ultimate goal is to help communities use self-evaluation and research to become stronger, more effective, and more self-determined.

Fawcett, et al. (1996) developed a six-element process for empowerment evaluation. This process resembles the seven-step health program cycle outlined in this thesis and should work well within this framework. The process follows:

Note: "Support team" refers to professional evaluators and related staff. In the case of student-run clinics the "support team" would refer to volunteer staff.

Step 1) Assessing Community Concerns and Resources
- Where are we now?
- Take inventory of community assets and needs, program strengths and weaknesses.
- Methods include community meetings, focus groups, interviews, surveys, community mapping, or participant rating systems.

Step 2) Setting a mission and objectives
- Where do we want to go? Revisit and rewrite mission and objectives to meet current status.
- What results would we like to see? How would we know if we achieved them?
- What level of improvement is desirable? Acceptable? How will we know if we're making progress? What changes (intermediate outcomes) could serve as benchmarks or early markers of movement toward our goals?
- How will we assess our process and our performance?
- Methods for establishing a mission and objectives include facilitated group meetings with creative brainstorming, sorting and categorizing ideas, critical discussion and prioritizing based on agreed-upon criteria, and reaching consensus.

Step 3) Developing Strategies and Action Plans
- How will we get there? See "Five: Actions" and process for #2 above.
- Develop specific steps for achieving results - who does what by when. The more specific the better for monitoring and evaluation.

Step 4) Monitoring process and outcomes
- How do we know we're on track?
- Define measures, collect process and outcome data, and interpret findings.
- Conduct regular collection, feedback, and interpretation.
- Documentation methods: periodic written activity logs or reports, journals, tracking of key events, portfolios, interviews, surveys, observations, and reviews of community-level data for changes (e.g., rates of injury or disease).

Step 5) Communicating Information to Relevant Audiences
- Who needs to be notified along the way?
- Conduct reflection, interpretation of meaning, and problem solving based on evaluation.
- Methods: written reports, community meetings, newsletter articles, media coverage, journal articles, presentations at meetings and conferences of professional associations, labor or business groups, coalitions, and other forums.

Step 6) Promoting Adaption, Renewal, and Institutionalization
- How can we use what we've learned to prepare for the next journey?
- Repeat steps 1-5.

Empowerment evaluation is a useful tool because it can help build consensus, set priorities, and validate choices of goals (Coombe, In Press). This type of evaluation provides valuable input on the feasibility and the importance of an organization's action plan. Scarce resources can be directed or redirected to strategies that work best. Evaluation helps people get the knowledge and skills they need to build healthier communities. Additional benefits of empowerment evaluation include (Coombe, In Press): 1) Overcoming resistance to evaluation, demystifying the process, and institutionalizing evaluation methods within communities; 2) Enhancing integration of quantitative and qualitative methods; 3) Adapting, evolving, and inventing evaluation methods, indicators, and instruments; 4) Enhancing the ability of communities to do systematic data collection; 5) Creatively linking community participants and evaluators in a mutual learning partnership.

Conducting empowerment evaluation requires overcoming several challenges. This form of evaluation conflicts with traditional assumptions about objectivity and distance; empowerment evaluation assumes evaluation is never "neutral". Evaluators and participants need to develop new skills and understanding in order for empowerment to occur. Roe, et al., (In Press) outlined several skills needed by someone interested in conducting empowerment evaluation. These include excellent traditional evaluation skills, the capacity to work well in a team environment, and professional skills such as flexibility, quick-thinking, self-critical thought, optimism, and a genuine interest in the groups they work with. Empowerment evaluation takes a great deal of time, effort, and personal commitment that participants and evaluators may find difficult to make. It requires a commitment to be responsive to rapid and unexpected shifts in program design and operation; this is both a strength and a challenge of this form of evaluation. The notions of empowerment, community competence, and capacity building are still vague concepts requiring context specific definitions; thus, they are difficult to evaluate. Empowerment evaluation models provide a framework for student-run clinics to begin developing their traditionally weak evaluation programs. Implementation of evaluation at student-run clinics will require a group of volunteers dedicated to this process. This is why an epidemiology/evaluation team was proposed in the organizational framework section. With evaluation data, student-run clinics can progress to the last step of the seven step process, that is, the process of reflecting back on the first six steps and their success.

Seven: Reflection and Renewal

The last point of the seven-point process involves reflecting on the success of the previous six points in achieving their aims. Impressions and information from the program's work should be discussed in conjunction with community members at regular intervals throughout the year.   Popular education methodologies can be used to analyze the information and impressions as codes to generate further action. Unsuccessful efforts should be adapted and renewed while successful efforts should be institutionalized when appropriate.

One dilemma facing student-run clinics, as discussed in Part I of the thesis, is when to become a fully-operational, institutionalized, community clinic. There is no simple answer to this question. Such a conversion should be considered within the framework of the previous six points. With community support and need for such a conversion, the opportunity for sizable and stable funding, the organizational capacity and leadership to make such a change, and demonstrated effectiveness at achieving its goals, student-run clinics should consider the conversion option. Clinics that become fully operational do not necessarily need to lose their affiliation with training programs; student volunteers can continue to play important roles in fully operational clinics.

Leaders should be wary of ego issues around "their projects." An attitude that promotes their project over others is a trap that often leads to interorganizational competition and the proliferation of services at the expense of collaborative community efforts. Sometimes coalition building rather than developing a new community project can have a greater impact on community health. These are only some of the factors to

consider when exploring the option of developing a fully operational community clinic. Other issues will arise within the specific communities in which the clinics are located.

The proposed seven point student-run clinic praxis is not a cookbook approach that leads to a final product. Rather, it represents a repetitive, not necessarily sequential, process for helping an organization grow, renew, and achieve its goals. Part IV of this thesis details the efforts of one student-run clinic to utilize some of the points proposed in the praxis.

Part IV: Experiments at the Suitcase Clinic

Introduction

Several elements from COPC, community organizing, and popular education theory and from the praxis in Part II were utilized at a student-run clinic in Berkeley, California. This part of the thesis discusses these experiments at the Suitcase Clinic.

Students from the University of California, Berkeley (UCB)-University of California, San Francisco (UCSF) Joint Medical Program (JMP) and the UCB School of Public Health founded the Suitcase Clinic in September of 1989 out of a desire to address the unmet needs of Berkeley's homeless population. Students conducted a community assessment by speaking with service providers in the area including the Alameda County Health Care for the Homeless Program and the Berkeley Free Clinic, both health care providers to Berkeley's homeless population. From their assessment, the students concluded their was a need for additional services and for an opportunity for students to learn about community medicine. The students recruited volunteer physicians, gathered supplies, and received a donated van to begin their project.

Initially, the clinic was mobile; students and volunteer physicians rode around in the donated van carrying supplies in suitcases. When the van broke down, the students developed an alternative plan. They established an alliance with a church-based social service drop-in center for the homeless and planned to operate the clinic out of the church.

The Clinic now operates a weekly drop-in center for homeless and low-income residents in Berkeley and Oakland, California, although services are not restricted to individuals residing in these cities. Every Tuesday night, UC Berkeley students and

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community volunteers gather at the First Presbyterian Church in Berkeley to offer a variety of services and programs. These include acute care medical services and referrals, legal advice, social service referral and advocacy, optometry care and eyeglasses, chiropractic services, hair styling, facilitated group discussions, free clothing/food/hygiene supplies, and drop-in programs operated by the Berkeley Emergency Food and Housing Project.

The clinic was founded by public health and medical students and is currently administered by a planning committee of undergraduate students. Undergraduate volunteers must be enrolled in a "Suitcase Clinic" elective course before volunteering at the clinic. The course provides students with volunteer training and an opportunity to learn about issues affecting homeless individuals. Approximately 100 undergraduate students, 10 medical students, 30 optometry students, and 10 chiropractic students work at the clinic each year.

Financial, liability, and classroom support for the clinic is provided by Cal Corps, the university's community service support organization, and the Health and Medical Sciences Department within the School of Public Health. The Clinic's budget is over $8,000 per year with funds coming from a variety of sources including foundations, the university, and private donations. The clinic makes abundant use of in-kind donations, especially for its pharmaceutical supply. Volunteers from the community and the university contribute to the ongoing operation of the clinic. The Suitcase Clinic shares many of the clinic goals outlined for clinics in Part I of the thesis. Community participation in the clinic, especially among service users, has been limited throughout the clinic's history. The clinic has an advisory board comprised of professional and

student volunteers, "alumni volunteers", and one service user who has been involved with the clinic since its inception.

The author of this thesis has been a volunteer at the clinic for over three years. Working collaboratively with other clinic members, the author attempted to integrate some of the principles outlined in Part II of the thesis. The application of the principles involved changing some aspects of established organizational culture and recruiting allies to advocate for these intraorganizational changes. There was no systematic strategy used by the author for encouraging changes, largely because the author was learning the theory while trying to implement it. The sustainability of the changes that have taken place at the clinic remains to be seen; there are several "resisting forces" to sustainability which will be discussed later.

The implementation of principles was envisioned as an effort to move the Suitcase Clinic in the direction of a community oriented primary care (COPC) practice that utilized principles of community organizing and popular education. Since the Suitcase Clinic is a longstanding organization based on a collective, rotating leadership, changes to the Clinic were not implemented without first receiving the support of the undergraduate planning committee and the clinic's advisory board. Changes that have taken place at the clinic as a result of efforts to integrate social change theory include the following:

1) Rewriting of the clinic's mission statement and goals and the development of a clinic policy book. [Policy Book]
2) Ongoing projects aimed at community assessment. [Community Assessment]
3) Conversion of a didactic health education discussion group into a popular education/community organizing forum. [S.H.A.R.E.]
4) Involvement of clinic service users in clinic operations, clinic training, and clinic evaluation. [Service User Involvement]
5) The development of a computerized database to monitor the numerator population, i.e., those individuals that utilize services at the clinic. [COPC Epidemiology]
6) The introduction and exposure of medical and undergraduate student volunteers to community-oriented primary care, popular education, and community organizing. [Exposure to Theory]
7) Efforts to improve collaboration among other community organizations that address similar issues. [Coalition Building]
8) An assessment of the organization's "cultural competence." [Cultural Competence]

Policy Book

The Suitcase Clinic's values, vision, mission, goals, and other organizational information were never articulated in a single written document until last year. Writing such a document served several useful purposes. It allowed clinic leaders to compile a rarely used, random collection of historical documents into a single policy book. It also forced some of the clinic leadership to go through some of the points developed in Part II of this thesis. These points included identifying clinic vision and values, defining the target community, and establishing a mission with goals, objectives, and some evaluation strategies.

The process of writing a policy book took well over a year and the number of student volunteers involved with the process declined over time. The idea of a policy book was proposed by a new group of undergraduate administrative coordinators at a clinic retreat. The new coordinators found it difficult to sift through the boxes of documents passed on to them by their predecessors.

Few of the students at the retreat were interested in working on the development of the policy book. A small group of approximately ten students, nine undergraduates

and the author of this thesis, formed a subcommittee to work on the compilation and creation of a policy book. At no stage in the development of the book was there input from volunteer professionals, community service providers, or individuals from the clinic's targeted population. Although it is hoped that feedback from these groups will be solicited in the future. By the time the policy book was completed, there were only two students involved with the process. As support for the process dwindled so did buy-in to the assertions made in the final document.

The first task tackled by the group was the creation of an outline of material to cover in the document. After several months of discussion and circulating drafts, the group had an outline for the policy book. The outline contained the following headings:

1) Abstract
2) Mission and Clinic Philosophy
3) Current Goals, Objectives, and Evaluation Strategies
4) Clinic Divisions - Class, Clinic, Administration
5) Clinic Positions
6) Clinic Meetings
7) Clinic Relationships with Community Organizations
8) Clinic Protocols
9) Legal/Liability Issues
10) Appendix

The creation of the policy book proved to be much more challenging than anticipated. During the process, student leaders struggled with several of the points from the student-run praxis. One of the more contentious issues was defining the clinic's target community. The step of defining community is a first step in all three theoretical fields discussed in this thesis. Up until the creation of the policy book, the Clinic had been operating without a clear definition of its target community.

The Clinic was founded out of a desire to help homeless individuals in Berkeley, and the majority of the student leadership felt it was appropriate to provide services to whoever came to the clinic without defining a "target" community. Over the years since its inception, the clinic has provided services to Berkeley's homeless population as well

as others in need of services. The most common characteristics among service users are low-income status and lack of health insurance or access to health care services; the majority, but not all of the service users, are homeless.

There was a reluctance among clinic leaders to define the Suitcase Clinic's target population as homeless individuals residing in Berkeley, because this would exclude the many other people who utilize the services at the clinic. Leaders also hesitated to limit the Clinic's community in terms of geography to Berkeley since many service users came from other surrounding cities such as Richmond, Oakland, and San Francisco. The author of this thesis was the staunchest proponent of clearly defining the clinic's target community.

Arguments were presented in support of defining a community rather than just providing to those who came to the clinic. The COPC approach to medical practice was discussed and the distinction between the numerator (patient population) and denominator population (targeted community) was highlighted. The reluctance to define a community was in part a reflection of the leadership's unwillingness to see the clinic as a public health or community organizing entity. Most students viewed the clinic in terms of a limited array of services to whoever wanted or needed them. Eventually, the student leadership accepted the view of the clinic as both a service provider and public health promoter. After agreement was reached on this point another problem was raised.

The students struggled with the issue of identifying a community based on class and housing status. Recognizing themselves as community outsiders, the students wondered if it was appropriate to define a target community as homeless or low-income individuals. The students were mindful of Labonte's (In Press) admonition that, "we cannot really say that a community exists until a group with a shared identity exists." The group identity of "low-income" and "homeless" is an identity that most individuals don't want to become associated with on a permanent basis. In addition, these terms are not well-defined.

Low-income could refer to anyone below a certain income threshold or someone unable to meet basic needs because of limited funds. Homeless individuals have been defined in a variety of ways to include those on the streets, in shelters, in vans and cars, temporarily housed in single room occupancy hotels, and other shelter situations. Would individuals who are homeless or low-income identify themselves along these lines or along some other lines such as gender, place of birth, racial or culturally identity, or others? Community was also difficult to define because of the mobility of the clinic's target population. Is it useful to distinguish between Berkeley and Oakland's homeless, when homeless individuals often move from one city to another? Another weakness of the community definition process was that none of the "community members" discussed were involved in defining their own community. This fact was remedied somewhat by the involvement of homeless and low-income people in an ongoing process of community assessment, to be discussed later.

Ultimately, a compromise was reached that defined the Suitcase Clinic's main target population as homeless individuals residing in Berkeley. However, all clinic documents were to define the clinic's target community as "homeless and low-income residents from Berkeley and Oakland, California, although services are not restricted to individuals residing in these cities." Such a compromise was designed, so that clinic leaders would focus their community-wide interventions on Berkeley's homeless population while not restricting services to this group. The limitations of the terms " homeless" and "low-income" were acknowledged during the development of the policy book, but these limitations were not discussed in the book itself.

The mission and clinic philosophy included in the clinic policy book address some of the points raised regarding student-run clinic vision and values. Although the Suitcase Clinic's vision and values have been recorded there is not widespread knowledge or acceptance of these perspectives among clinic volunteers for two reasons. There was not widespread volunteer involvement or any community involvement in the

process of writing the policy book. Individuals have difficulty understanding, relating to, and accepting values statements that they did not participate in developing. In addition, the rotating nature of the clinic's volunteers has made it difficult to transmit the written vision and values to successive generations.

The following table illustrates vision and values statements included in the policy book and how they correspond to principles articulated in Part II of the thesis. Within the table, the term "participant" refers to individuals from the clinic's target community that participate in the clinic as service users or in some other capacity. Most of the policy book statements contained in the table are preceded by the phrase, "We believe…" within the actual policy book.

Vision or Value	Suitcase Clinic Statement in Policy Book
Motivational analysis; role of students in society.	• "The mission of the Suitcase Clinic is to promote the health and overall well-being of homeless and low-income individuals through service provision, cooperative learning, and collective action among community and professional volunteers, students, and participants."
Balancing Service and Learning	• "That the Clinic plays an important role in raising awareness about the concerns of homeless and low-income persons, through education of participants, volunteers, and the community-at-large. Through cooperative learning participants and volunteers develop knowledge, skills, and attitudes necessary to take collective action to promote the health and well-being of homeless and low-income people." • "That the learning experience of volunteers should not take precedence over their role in offering services and programs for participants. Any tensions that arise between the two should err in favor of participant interests, and not those of the volunteers."

Limits of services for promoting health; developing a broad conceptualization of health	• "That health is a state of complete physical, mental, and social well being, not merely the absence of disease and infirmity. Health promotion requires more than medical care and should include programs that address behavioral, social, and environmental issues that affect people's quality of life." • "*Health promotion* has become 'the process of enabling (empowering) people to increase control over, and improve, their health,' the prerequisites to which are no less than peace, shelter, education, food, income, a stable ecosystem, social justice and equity." --World Health Organization (WHO) Charter for Health Promotion, Ottawa, 1986.
Build an understanding of ideology, power, oppression, and empowerment	• "If you are here to help me, then you are wasting your time. But if you come because your liberation is bound up in mine then let us begin." --Lily Walker • "That empowerment involves cooperative learning which encourages personal reflection and a clinic environment that fosters personal growth through the sharing of ideas, resources, and support." • Criteria for empowerment (footnote): 1) Improved status, self-esteem, cultural identity; 2) The ability to reflect critically and solve problems; 3) The ability to make choices; 4) Increased access to resources; 5) Increased collective bargaining power; 6) Legitimation of people's demands by officials; 7) Self-discipline and the ability to work with others. From (Labonte, 1990)
Social justice over market justice	• "In the dignity of all human beings, and hold that health care is a right of all persons, regardless of ability to pay."
Community Participation/"Starting where the people are"	• "That clinic projects should stem from the participants' expressed needs and hopes rather than from providers' beliefs about participants' needs. Thus, ongoing participant evaluations of the Clinic will guide program evolution and development." • "That clinic projects should strive to be proactive rather than reactive by: 1) Responding to the concerns of all homeless and low-income persons and not just those that come to Clinic; 2) Utilizing individuals' strengths and resources rather than simply focusing on needs; and 3) Advocating for public policies that address long-term concerns in addition to immediate needs."

Perspectives on Multiculturalism and Identity Politics	• "That Clinic projects and services should be accessible in terms of time, place, and manner. Accessibility requires sensitivity to social, economic, and cultural differences between volunteers and participants. Efforts at increasing accessibility should include involvement of participants as volunteers and the recruitment of volunteers that reflect participant diversity."

Following the development of a mission statement and clinic philosophy, a few of the student leaders developed a set of goals, objectives, and evaluation strategies for the upcoming year. The goals were lumped into categories of particular divisions or programs of the clinic. These included the undergraduate class, the intake process, recordkeeping, referrals, the medical division, S.H.A.R.E., the legal division, funding and donations, administration, evaluations, and new projects. The goals and objectives were clearly written, easy to follow, and easy to evaluate. One year after the recording of the goals, very few of them have been realized. The goals were not revisited on a regular basis throughout the year. The clinic as a whole did not sustain a program of goals and objectives that a small number of its members developed. Short-term emergencies and needs of the clinic took precedence over achieving the goals, and the few students involved with writing the goals did a poor job of distributing and describing them to other clinic members. One of the goals that was partially achieved was the beginning of an ongoing community assessment process.

Community Assessment

Once a community was defined, an informal process of ongoing community assessment was initiated. This process included the development of a map of social services for the homeless in Berkeley, a review of data on homelessness in Alameda

County and Berkeley, a review of literature on homelessness and health care for the homeless from around the country, and discussions with service providers and policy makers in the county and city. Importantly, discussions with homeless and low-income people from the Berkeley and Oakland area were also part of the assessment. When possible, homeless and low-income member participants in the popular education/community organizing discussion group (S.H.A.R.E.), to be discussed later, were encouraged to collect feedback from friends and acquaintances living in similar situations. In this way, information was gathered from a variety of sources.

The data is still being collected and compiled and has yet to be fully re-presented back to volunteers and clinic participants. A copy of the community assessment to date coupled with computer data about the numerator population at Suitcase Clinic and insights from service users is included in Appendix Four for reference.

The community assessment information has the potential to be used in a cyclical process of listening-dialogue-reflection-action as described by Freire. The data collected has been introduced to the most recent Suitcase Clinic class of undergraduate volunteers, and they were asked to take on the role of COPC planners using the data collected. In this fashion, students were introduced to COPC and were involved in interpreting information about the community served by the clinic. Evaluations of this class session have not yet been compiled.

The S.H.A.R.E. group discussed in the next section has played an integral role in providing the clinic with ongoing community assessment information.

S.H.A.R.E.

Beginning in 1994, the Suitcase Clinic started to hold discussions at the clinic every Tuesday evening. Initially, these discussions focused on traditional health education issues such as sexually transmitted diseases, nutrition, hygiene, and other topics. For several years, these discussions were attended by a small group of three to five service users who came more for the socialization than for health education. As the students that founded the original health education group graduated from UC Berkeley and left the area, new students came in to continue the group meetings.

This new group of students was interested in theories of popular education and community organizing and wanted to try to transform the group in a way that incorporated some of the theoretical principles from these fields. One of the first steps taken by this new group of student facilitators was to encourage the regular participants to develop a group name and identity. The group developed a name, and it has received increasing recognition over the year the group has been in existence. The name the group arrived at was S.H.A.R.E. (Searching How to Achieve Respect and Empowerment). In addition to creating a name and identity, the group's facilitators, including myself, encouraged the group to develop ground rules for their discussions. A copy of these ground rules is included in Appendix Five. S.H.A.R.E.'s student facilitators approached each meeting with the goal of trying to getting the group to focus on a collective problem that they could realistically do something about. Time was also devoted to trying to understand the roots of collective problems.

Participants in the S.H.A.R.E. group were recruited from the Berkeley Emergency Food and Housing Project's Quarter Meal free dinner and from the service users at the Suitcase Clinic. Word of mouth also brought new members into the discussion group. The student facilitators of the group are all working toward careers in medicine, public health, and/or biological research. Currently, there are four student facilitators that rotate duties within the group. There is one male and three female student facilitators. Their

ethnic backgrounds are Southeast Asian, Chinese, Japanese/Mexican, and European American. Non-student participants in the group include homeless and non-homeless individuals. There is a core group of four to five non-student participants, and a group of other participants that come on a sporadic basis. Roughly eighty percent of the group members are male. Group members are of mixed ethnic backgrounds including African American, Native American, European American, Puerto Rican, Mexican, and others.

Members of the group face multiple challenges including recovering from addiction, coping with severe mental illnesses, coping with physical disabilities, and surviving without a stable source of income. Group members sleep in a variety of places including their own apartments, vans, the streets, shelters, or at the homes of friends. Non-student members have brought a variety of talents, skills, and resources to the group.

Many of the group's members possess gardening skills and some work as gardeners. One group member has an incredible memory for dates and events. The group has also been blessed with non-student members who have taken on leadership positions around particular organizing projects. Since its inception, the group has taken on several projects. The most successful project was in response to the closure of a local shower program for homeless individuals.

One of the S.H.A.R.E. members discovered that a weekend and evening shower program for the homeless was being eliminated. He brought this to the attention of the group and the group decided to research why the *only* weekend shower program for the homeless was being closed. Several weeks went by as group members talked to City staff members and other individuals familiar with the shower program. As the research process continued, S.H.A.R.E. members found that almost everyone in the city claimed ignorance about the closure of the shower program. Even the people who ran the shower program knew little about why it was being closed. During this research process, it became clear that one man held all of the information about the program closure. This man, the City of Berkeley's homeless services coordinator (HSC), became the target of

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the group's efforts. Multiple phone calls were made to his office which he did not return. After one month of multiple phone calls, the group decided it was time to change tactics since this person seemed to be in control of the shower program's fate. A petition drive was proposed, and one of the group members drafted a letter to be signed by as many people as possible. A copy of this letter is included in Appendix Six.

Several hundred signatures were collected, and three of the non-student S.H.A.R.E. members took active roles in pushing the process forward. The letter and signatures were sent to the HSC. The S.H.A.R.E. group planned to utilize the media to draw attention to the issue if we did not hear from the HSC within two weeks. After the letter and signatures were sent, one of the students involved with the group took it upon herself to track down the city's HSC. She went to his office and spoke to his supervisor. A week later the HSC contacted the S.H.A.R.E. student facilitators and agreed to arrange a meeting with the S.H.A.R.E. group. A date was set and flyers advertising the meeting were posted around the city (a sample flyer is included in Appendix Seven). Approximately twenty-five people attended the initial meeting with the HSC. The purpose of the meeting was to get information about why the shower program was being closed and what alternatives could be developed. This meeting was facilitated by one of the non-student S.H.A.R.E. members.

At this meeting, it was discovered that the shower program was being cut because usage of the program was dropping, the costs of operating it were increasing, the neighborhood did not like having homeless people using their local pool facilities, and the city was cutting the budget for homeless services. S.H.A.R.E. members provided the HSC with several researched alternatives to closure of the shower program these included finding another site, conducting a fundraiser, and recruiting volunteers to run the program. The homeless services coordinator legitimized the demands of the S.H.A.R.E. group at this first meeting and expressed a willingness to work with the group to develop an alternative program.

Several more meetings were held with the HSC who proposed deadlines for action that he did not follow. The HSC and S.H.A.R.E. negotiated an agreement to work on establishing a free weekend shower program at an alternative site; the goal of finding alternative evening showers was postponed, since this goal was not deemed as important. S.H.A.R.E. began to work with the staff from a local drop-in center to expand their existing shower program to weekends. The City of Berkeley was willing to pay for this expansion on a trial basis. About six months after initiation of the organizing effort, an alternative weekend shower program was opened for a total of six hours each weekend. The program was established as a three month pilot project pending continued support from the local neighborhood and the city council. The pilot project period has ended and the program continues to receive support. After the program was established, the S.H.A.R.E. group continued to provide support to the drop-in center sponsoring the showers. S.H.A.R.E. worked to get 50 towels donated from the university recreational sports facility and alerted the drop-in staff to the fact that some of their towels were being stolen. In conjunction with the university residence halls, S.H.A.R.E. conducted a toiletry drive that resulted in the collection of over 3,500 toiletry items to be used by the shower program.

In achieving the results that it did, the group went through the multiple steps involved with an issue organizing process: selecting an issue important to the group, researching the issue, finding a target to challenge, using various tactics to pressure the target, negotiating for an alternative program, and seeing that the new program develops. The issue was sufficiently large enough to inspire action, but small enough to lead to a successful organizing effort. As a result of the group's work, an alternative weekend shower program now provides free showers to over 60 individuals per week. Another result of the successful effort was the empowerment of the S.H.A.R.E. group as a whole and the empowerment of individual members. This single success provided the group with confidence and skills to tackle other community issues.

The three non-student leaders that played a major role in the organizing process subjectively accomplished Labonte's (1990) criteria for empowerment: 1) Improved status, self-esteem, cultural identity; 2) The ability to reflect critically and solve problems; 3) The ability to make choices; 4) Increased access to resources; 5) Increased collective bargaining power; 6) Legitimation of people's demands by officials; 7) Self-discipline and the ability to work with others. These elements of empowerment were not specific goals of the organizing process. Rather, they resulted from working on an issue defined by a community member, involving community members in addressing the issue, and drawing from their skills as leaders.

After this success, the S.H.A.R.E. facilitators decided it was important to celebrate the victory. The S.H.A.R.E. group received free theater tickets to attend the musical "Working" by Studs Terkel and donations to cover a restaurant-dinner for all the group members. Turnout for this event was better than for any previous S.H.A.R.E. meeting or activity. All student and non-student S.H.A.R.E. members that heard about the event came for the show. After the show, some of the non-student members commented on how the musical didn't reflect the perspectives of the homeless and poor. I, as one of the student facilitators, picked up on these comments and decided to discuss this potential "Freirian code" at the next meeting.

At the next meeting, I asked for feedback on the musical and the night out. Everyone appreciated the dinner and most enjoyed the musical. There was a unanimous request to organize similar events in the future. Several of the non-student members reiterated their concern that the musical did not adequately represent the lives of poor and homeless people. I asked the group what could be done about this lack of representation. One member suggested that people pay more attention to the world around them and actually talk to people on the street rather than ignoring them. No one suggested the idea of having the S.H.A.R.E. group create a play to represent the stories of poor and homeless people.

I, being the source of this idea, suggested it to the group and became the idea's advocate. There was a lukewarm acceptance of the proposal. Some non-student members seemed interested in the idea, others did not. All of the other student facilitators were behind the proposal. None of the non-student members were willing to take the lead on the idea, but some of the members expressed that they had experience developing plays.

I took on a leadership role around this idea and pushed the skit at S.H.A.R.E. meetings for the next few months. Several non-student members became advocates of the skit, but these individuals were disliked by the majority of S.H.A.R.E. participants. The skit became associated with these disliked members and as the skit came closer to completion, S.H.A.R.E. members became increasingly reluctant to "come out" as homeless in front of a large group of people. Although the skit was never completed, it contributed significantly to the evolution of the S.H.A.R.E. group. It also demonstrated the importance of having group members identify their own issue and getting early commitments from members to taken on leadership roles in a project. Without these elements, projects are less likely to be successful.

The play was developed through the impromptu generation of skits with a student playing the role of a homeless protagonist traveling through the world of homelessness. This process allowed the non-student participants to guide the student facilitator through the life of a street person. Participants enjoyed redirecting their experiences of oppression on someone connected with oppressive communities - a white, male, upper-middle class medical student. The skits engaged participants in a discussion of the problems faced by homeless individuals. It also enabled them to examine their own lives with a critical, outsiders, eye. Audio tapes and minutes from the skit sessions were recorded and several of the group's non-student members have sought to distribute the idea of the skit to homeless filmmakers and others who expressed an interest in finishing

the skit. Appendix Eight contains minutes from the skit that developed during the course of S.H.A.R.E. meetings.

The other student facilitators and I decided to discontinue the skit as support and enthusiasm for the project declined. After closure of the skit project, the S.H.A.R.E. group went through a transitional period characterized by low attendance and dispassionate meetings. Only one of the three leaders of the shower organizing effort continued to attend the S.H.A.R.E. meetings. One of the three leaders that stopped attending became overwhelmed with the number of activities in her life, including the demands she felt the S.H.A.R.E. group was placing on her. She "decompensated" and was hospitalized for a mental illness she previously had controlled with treatment. She nearly lost the apartment she had worked years to pay for and was seen back on the streets smoking multiple packs of cigarettes per day, a habit she did not used to have. The other former leader, who had the ability to speak with a spiritual passion that resonated with group members, dropped out of a substance abuse recovery program that he was involved with and moved into his own apartment. He returned to the S.H.A.R.E. group only once after leaving the recovery program, and could not be reached at his work or home phone numbers after that point. The loss of these two individuals had a profound effect on S.H.A.R.E. These leaders helped guide the group in decisions on appropriate projects and helped facilitate successful meetings.

The student facilitators struggled to get the group to identify its next project. For about a month, student facilitators tried to engage the group in grappling with welfare reform by bringing in "codes" regarding changes to AFDC, SSI, Food Stamps, and other welfare programs. Discussions took place and information was shared but there was little action the group felt motivated to take. The group discussed the root causes of poverty and the dynamics of a global economy characterized by unregulated multinational corporations. A month passed with reflection but no action. The group was informed

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about a anti-welfare reform rally, but none of the members thought participation in the rally was worthwhile. This period was not devoid of any successes.

During this time period, the man who broached the idea of organizing around the closure of the shower program gave an interview to National Public Radio on welfare reform. His interview was recorded on tape and replayed for the other S.H.A.R.E. members. During the interview, this member articulated a position discussed in the S.H.A.R.E. group that pushing people into jobs that don't pay enough and don't exist will result in more people living on the streets. The S.H.A.R.E. group strongly supported his statement and applauded his efforts.

Discussions on welfare continued without a clear understanding of the scope of welfare and the reform proposals. Reflection without action began to wear on the group. Attendance and enthusiasm dropped. The group discussed an idea, advocated by a student facilitator, of microenterprise lending and providing loans to individuals interested in establishing small businesses. There was some interest in assessing the skills of group members to determine what type of small business the group could create. Interest was lukewarm largely because group members thought such an effort was unrealistic. None of the members directly expressed that they thought the idea was unrealistic, but their lack of interest indicated something was wrong. Members became wary of talking about welfare reform. At this point, the student facilitators conducted an evaluation meeting among the group's participants.

At this meeting, attended by a relatively new member who had begun to take on a leadership role, the student facilitators discovered that group members felt welfare reform was too big of an issue for such a small group to address. This led to a discussion of the role of the S.H.A.R.E. group. From this discussion evolved the current vision of the S.H.A.R.E. group. Participants said they came to meetings for the support, friends, information, and the chance to talk about their lives. They also appreciated the opportunity to make a difference in their community with projects like the establishment

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of a weekend shower program. One member stated that the S.H.A.R.E. group was "real education", because it was about people sharing their lives with each other. The most popular S.H.A.R.E. events were social events- two musicals that the group attended. Members stated they were interested in talking about the root causes of problems and bigger issues, but didn't feel such a small group should take on such issues alone. They suggested that S.H.A.R.E. build coalitions with other organizations around bigger issues. Group members were motivated by the opportunity to help others one-on-one or through community efforts, and they felt the relationships formed within S.H.A.R.E. gave them some power to be active as community helpers. As a result of this feedback, the S.H.A.R.E. group adopted a new meeting structure:

- Introductions and Announcements
- Recruitment of New Members
- Local Community Project(s)
    *Application of community organizing principles to local
        community projects
- Information Sharing/Coalition Building
    *Discussion of root causes and networking with other
        organizations to tackle bigger issues
    *Popular Education format
- Social Event Planning
- Develop Agenda for Next Meeting
- Cross-Talk (non-facilitated) Time

The key elements of this new structure were information sharing and coalition building, local community action projects, regular social events outside of Tuesday evening meetings, and scheduled time for non-facilitated conversation. Group members also expressed the value of having refreshments at the meeting. This new meeting structure has worked well. The limiting factor in the development of the group continues to be the amount of time that student facilitators invest in the various elements of the meeting. S.H.A.R.E. has been largely unsuccessful in training non-student leaders to take on weekly responsibilities for the group. Non-students take on leadership positions under

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certain circumstances, but none feel capable of making weekly commitments. One of the major reasons for this is the lack of stability in the lives of many of the non-student members. They cannot predict where they will be each week, and it is difficult for them to take on responsibilities outside of their survival responsibilities. Student facilitators have made periodic efforts to involve non-students as leaders. However, the student facilitators have become more reluctant to "push" participants since one of the group's non-student leaders went through the aforementioned personal crisis which she partially attributed to increasing demands from her various volunteer projects. Alternatives to this reluctance such as creating leadership teams, rather than relying on individual leaders, need to be developed and tried.

Another challenge faced by the group has been the difficulty in defining boundaries between student and non-student participants. The students advocate increasing involvement from non-student members, but are reluctant to treat their relationships with non-student members as equal to their relationship with other students. Student members have been willing to invite other student members to their homes, to give them their home phone numbers, to loan them money or other goods, to provide them with car rides to their homes, and to treat them as colleagues. Some of the students in the S.H.A.R.E. group have offered these things to some of the non-student members. In some cases where students have opened their personal lives to non-student members, non-students have called students at home at odd hours or have made unreasonable demands on students. The boundary between students and non-students has been a crucial issue for S.H.A.R.E., because the group's leaders strive to breakdown these boundaries. One non-student member clearly articulated the effect such boundaries have within the group when he said, that he sometimes feels that the S.H.A.R.E. students provide him with "charity" on Tuesdays but do not want to associate with him outside of the meetings. The S.H.A.R.E. student facilitators continue to be challenged by this issue and have decided to continue pushing to breakdown barriers while being mindful of the

risks involved with prematurely trusting people. The student facilitators have reflected on and discussed how it is easier for them to trust other students as opposed to poor and homeless people. This process has served as a valuable tool for students to reflect on the sources of their reluctance to become closer to non-students. As in other aspects of their lives, the student facilitators have tried to cultivate relationships before entrusting acquaintances with personal information and favors. Relationship building within the S.H.A.R.E. group, according to one non-student member, is limited since students generally spend one year or less as clinic volunteers. Such building requires a long-term, weekly commitment from students. Several of the S.H.A.R.E. groups founders have made such a commitment; it remains to be seen whether another generation of students can be found to make the same commitment.

S.H.A.R.E. has the potential to grow into a strong suborganization within the Suitcase Clinic. Other divisions of the clinic have become increasingly supportive of S.H.A.R.E.'s efforts and the clinic's student leaders are turning toward S.H.A.R.E. participants for advice on how to improve the Clinic. Programs similar to S.H.A.R.E. could be duplicated at other student-run clinics. The original student facilitators of the S.H.A.R.E. group will all be graduating within the year and leaving the area. It remains to be seen whether a new group of students can be recruited and adequately prepared to take on the role of facilitators.

Service User Involvement

Some of the non-student S.H.A.R.E. members have taken on formal and informal roles as clinic leaders and advisors. Participants have helped to train new undergraduate volunteers to work as caseworkers at the clinic. Members have contributed advice about clinic programs and have provided students with ongoing community assessment feedback. S.H.A.R.E. participants often help setup the clinic each Tuesday night. They

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also have provided information to new service users and have prevented altercations on some nights.

The increasing involvement of S.H.A.R.E. participants in clinic planning and operations has led to an organizational challenge. As participants have grown to know professional and student volunteers, they have begun to utilize services without signing up for them. Participants often directly request advice from professional volunteers without following the normal sequence of steps involved with utilizing services. Some of the participants may feel entitled to services because of their contributions to the clinic. They may also feel it is appropriate to ask service-oriented questions of professional volunteers who are now more like colleagues. The clinic members have yet to address this issue. A collective solution to this problem will need to be discussed among student, professional, and service user volunteers.

The Suitcase Clinic has an advisory board that meets every two months. One of the members on the advisory board is a clinic service user. He has been involved with the clinic since its inception and provides stability to a clinic that is staffed by temporary student leaders. His involvement with the advisory board is somewhat marred by the fact that his suggestions and opinions are often ignored. Undergraduates student volunteers involved with the advisory board have more respect for physician input than service user input. This respect probably stems from the aspirations of many of the undergraduates to become physicians and their lack of faith in the input from the service user. Professionals involved with the group also have a difficult time accepting input from the service user. Professional training, which promotes a sense of power, may contribute to this difficulty. These factors limit genuine community participation in the advisory board. The attitudes of advisory board members to its one service user need to be challenged. In addition, greater service user involvement in the advisory board is needed.

Suitcase Clinic has not yet established official roles for community members. Many of the clinic's service users would like to contribute to the clinic in some way, but

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no specific roles have been developed for these individuals. Liability concerns, no formal training, issues around conflict of interest, and a lack of student leadership, have prevented student leaders from integrating service users into the regular operation of the clinic. Conflict of interest issues include whether or not service users should have access to the files of other service users, should they be given the opportunity to sign up for a service without having to wait in line, and others. Continued service user participation in the clinic will depend on the continued existence of the S.H.A.R.E. group and a commitment among student leaders to make such participation a priority.

COPC Epidemiology

In an effort to characterize the numerator population, that is, the individuals utilizing services at the Suitcase Clinic, new recordkeeping forms and a computerized database were created. A small sample of about 90 medical records were entered in the database to produce the data found in the appendix. The information collected from the use of the database has proven useful for examining how well the Suitcase Clinic is meeting its mission and goals.

Comparing clinic data with city and county data highlights discrepancies between the clinic's numerator population and its denominator (target) population. These discrepancies can serve as codes for student leaders and clinic service users that could lead to action. For example, the data collected illustrates that medical student volunteers rarely record information about mental illness and substance use in their medical histories. Through discussions with medical students, it was discovered that many felt uncomfortable asking or recording information on these issues. Students were unaware of why and how these issues should be addressed within the context of the Suitcase Clinic. In data from Alameda county and the City of Berkeley, it is clear that mental illness and substance use are important issues among homeless individuals. Meetings with other community agencies revealed that major concerns among service providers

include mental health and substance use issues. This area is filled with opportunities for informed action and further reflection.

The data collected revealed discrepancies in the gender and racial makeup of service users when compared with clinic volunteers. The data also revealed that fewer African Americans, women, teenagers, and children use Suitcase Clinic services than use other homeless services in Alameda county. This could be due to a variety of reasons, one of which could be the demographic makeup of student volunteers. One action the clinic might take is to recruit a more diverse group of volunteers and to become more aware of the impact of culture in this type of community organization. This issue is discussed further in the next section.

The data collected has proven useful as an analytical tool, but the next step of action has not taken place. Reflection without action does not contribute to improving the organization or to social change. Data entry is a time consuming process and the clinic has yet to establish a mechanism for entering information on the thirty or more people that seek services each Tuesday night. The time student leaders can commit to the clinic has been the limiting factor in entering and utilizing the COPC data.

Cultural Competence

A group of medical students involved with the Suitcase Clinic and some public health students not involved with the Clinic completed a cultural competence assessment of the clinic. One of the motivations for this project was the racial discrepancy data mentioned in the previous section. The assessment involved a review of clinic documents and data, interviews with service users at the clinic, and observation of clinic activities. The findings and suggestions that resulted from this process are given below:

I) Cultural discrepancies between volunteers and service users.
    A) Gender - recommend recruitment of more male volunteers + additional training/education.
        1) Volunteer male to female ratio is about 2:8.
        2) Service user male to female ratio is about 6:4.

3) Female volunteers have experienced sexual harassment from male service users. This issue needs to be addressed during training and in terms of organizational policy.
4) Several of the S.H.A.R.E. participants stated that some male service users come to the clinic because of the attention available from "young, good-looking women."

B) Race - recommend recruitment of more African American and Latina/o volunteers and increased attention to racial and cultural issues at the clinic.
1) About 80% of volunteers are of Asian descent, and most of the remaining 20% are white.
2) 50% of service users are white and 40% are African American.
3) Many of the drop-in center users are of African American descent and fewer of them sign-up for services from the Suitcase Clinic. Racial segregation is evident at the clinic with African Americans predominating on the basketball court and television area, and whites and Asians predominating in the clinic service areas.
4) The percentage of African Americans seeking services at the Suitcase Clinic is less than the percentage seeking services from other agencies in Alameda County.

II) Missed subgroups/services within the Clinic's targeted community based on comparing clinic data with county and city data.
A) Homeless Youth.
1) Gay and lesbian issues important for this subpopulation; evidence of lack of sensitivity and training around these issues from survey of undergraduate students enrolled in the Suitcase Clinic class.
2) Lack of outreach and programs for this group.
B) Homeless families with children; homeless women.
1) Lack of child care.
2) No relationships with programs for homeless families with children.
3) Inaccessible environment for these groups - timing, cultural sensitivity, safety, church/religious materials, etc. Issues that need investigating if the clinic wants to work with this group.
C) People with drug and alcohol addictions, mental illness, physical disabilities, veterans status, who are victims of violent relationships, HIV/AIDS.
1) Lack of practical volunteer training around these issues
2) Lack of established referral networks
3) Lack of programs for these groups or links with programs for these groups
4) Inaccessible environment for these groups - church environment may turn people off.

III) Cultural Blindness Assumptions.
    A) The majority of service users and volunteers interviewed during this assessment process subscribed to the belief that race and culture should not be important issues at the clinic. Volunteers and service users wanted to create an environment where race and culture did not matter and where everyone was treated equally. Some service users identified this as a strength of the Suitcase Clinic. The "organizational culture" supported by staff may lead to a selection of service users that don't have strong identifications with racial or cultural groups. This may partially explain the lower proportion of African-American service users and the segregation present at the clinic.

    B) In spite of this cultural blindness position, volunteers acknowledged the importance of understanding "class" cultural differences as well as the culture of "homelessness." Volunteers also said it was valuable to have language interpretation services available at the clinic.

    C) Volunteers tended to avoid identifying themselves as part of a particular racial or cultural group.

    D) Volunteers wanted to know how they could become more aware of other cultures without stereotyping individuals.

    E) Recommendations including incorporating cultural awareness into volunteer training, developing organizational positions about the importance of race and culture, listing services and languages available each night at the intake area, and conducting popular education-type processes around the assumptions associated with a "cultural blindness" position.

IV) Cultural Competency Strengths at the Suitcase Clinic.
    A) Volunteers received positive reviews for spending time with service users. Positive words used to describe volunteers by service users were "good listeners," "caring", "patient", and "nonjudgmental".

    B) S.H.A.R.E. received positive feedback from the assessment team for its emphasis on empowerment and collective action.

    C) The Suitcase Clinic class received positive feedback for accepting homelessness as a culture and preparing students to work with homeless individuals.

    D) Free services that meet community needs were identified as a culturally competent organizational trait.

    E) The medical divisions debriefing session at the end of each clinic night was highlighted as an excellent environment for reflection about cultural and other issues that arise at each clinic session.

The clinic volunteers have not yet taken action on any of the issues identified through the assessment process. A lack of volunteer time, poor dissemination of the assessment findings, more urgent service and programmatic needs, and a lack of

commitment from clinic leadership have contributed to the lack of action around the findings.

Coalition Building

The Suitcase Clinic has begun a process to work more closely with other organizations and individuals that share similar goals. The policy book contains a list of organizations that the clinic works with and hopes to work with. The Suitcase Clinic has worked with Life Long Medical Care to establish a volunteer program at their community clinics. These clinics provide primary care medical services to individuals from the Suitcase Clinic's target community, as well as other populations. Former Suitcase Clinic undergraduate volunteers have been trained to work as medical assistants at these clinics. Medical assistant help with patient intake, vital sign assessment, recordkeeping, and other functions. The volunteer program was established to provide the clinics with free staff support during a period of financial cutbacks. Volunteers were expected to gain additional skills and knowledge in community medicine through their experience, and they were expected to share expertise gained from their experiences as volunteer social workers at the Suitcase Clinic. The collaborative project was also established to strengthen communication and joint projects among the various community clinics serving homeless and low-income people in the East Bay geographic community. Several Suitcase Clinic volunteers have also made efforts to establish joint programs with the Berkeley Free Clinic.

Suitcase Clinic has been involved with an effort to establish a South Berkeley coalition devoted to addressing the problems of homeless people. S.H.A.R.E. members have participated in county efforts to organize homeless and low-income people.

Working alone, the Suitcase Clinic cannot function as a COPC clinic. However, in conjunction with other community organizations and individuals it can play a vital role in stimulating collaboration and fostering a community-wide COPC effort. As with the

other aforementioned interventions, coalition building has been limited by the energy students and participants can commit to building such relationships.

Ideally, paid staff members from other organizations would take a more active role in establishing community networks. This has not occurred. Volunteers from the Suitcase Clinic have demonstrated that students can play a role in initiating this process. However, it remains to be seen whether students, who come and go, can sustain a coalition of organizations and individuals. Utilization of the literature on coalition building may provide a stronger foundation for student action in this arena. In addition, the establishment of an organizational team solely focused on coalition building, as outlined in the proposed organizational framework, may provide the organizational backbone needed for sustaining such efforts.

Exposure to Theory

Students involved with the S.H.A.R.E. group have been exposed to social change theories and have attempted to utilize them in the context of their discussion group. Undergraduate volunteers involved with the clinic were recently exposed to COPC during one of their class sessions. Otherwise, volunteers and participants have had limited exposure to the theories discussed in this thesis.

The limited exposure to social change theories given to student volunteers has made widespread changes in Suitcase Clinic impractical. The interventions discussed have been carried out by small groups of students without widespread support from the entire clinic organization. Without the institutionalized education of the clinic community about social change theories and the reasons behind the recent interventions discussed in this thesis, the changes at the clinic over the past few years may not continue. The high turnover of volunteers and the tendency of student leaders to "recreate the clinic" in their mold make sustained organizational change unlikely. To maintain a student-run clinic praxis similar to that outlined in Part II of this thesis

requires documentation, training that incorporates the principles from Part II , stable leadership to maintain historical continuity within the clinic, and an interest on the part of students to work on more than service provision. Stable leadership can come from long-term paid staff members or a strong advisory board composed of service users and long-term volunteers and clinic supporters. As with other student organizations, the transition from one student leadership core to the next is crucial. With a poor transition, the organization loses some of its history and effectiveness.

Evaluating the Experiment

The interventions discussed above were all part of an effort to implement social change theories into the operation of a student-run clinic. These interventions were of varying success and are at various stages in their development. The S.H.A.R.E. group has demonstrated the utility of conducting a popular education/community organizing group within the context of a student-run clinic. Student volunteers involved with S.H.A.R.E. have developed communication and facilitation skills, as well as knowledge of community organizing and popular education practice. Students also built alliances with low-income and homeless people to tackle community problems. All members of the S.H.A.R.E. group went through various stages of Labonte's (1990) criteria for empowerment. Tangible projects accomplished by the group included the development of an alternative weekend shower program for homeless individuals, the beginnings of a play on homelessness, the involvement of the group in People's Park reform proposals, involvement in local and state elections, participation in welfare reform meetings and debates, and the beginning of involvement in a homeless drop-in center gardening project and refurbishment. Among non-student participants in the S.H.A.R.E. group there was evidence of significant changes.

Individuals developed communication and leadership skills, as well as the confidence to speak up on community issues. Some members developed friendships and their loneliness dissipated. Several members went from being homeless to finding

housing. One member went from being a regular patient in the medical division to a regular participant in the S.H.A.R.E. group who had less of a need for medical care. A few of the members found employment. Some became active in other community organizations. S.H.A.R.E. members contributed to training student volunteers and contributed their ideas regarding clinic improvements.

The policy book has provided the clinic with a historical document detailing clinic vision, the clinic's goals and objectives, and the clinic's target population. For this document to have an impact in the organization, it must be suppported and widely distributed among the clinic's volunteers and community advisors. A great deal of information and commentary was collected as part of a community assessment process and cultural competency review. Some reflection on this information has taken place, but action around identified issues has not occurred. Reflection without action leads to verbalism.

As a result of the interventions discussed in this thesis, a noticeable change has taken place in the attitude and knowledge of some clinic volunteers. There is a markedly greater appreciation of the importance of community participation in the operation of the clinic. Students who used to describe S.H.A.R.E. as a place "where they discuss things", now speak of the group in terms of empowerment and community action. Volunteers have gained some familiarity with the concepts of COPC and the potential uses of a patient database. How volunteers will be affected by their experiences at the Suitcase Clinic requires longitudinal follow-up.

A more rigorous empowerment evaluation process and more time are needed to determine the long-term usefulness of the praxis proposed in this thesis. In the short-term, the interventions have proven useful for enhancing community participation, engaging in community organizing efforts, and collecting data useful for clinic planning. Volunteers have gained some additional perspectives on health care provision including exposure to COPC and an alternative values system of health care provision. The major

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forces resisting the sustainability of the interventions are student time and interest in administrative and community medicine interventions. Most student volunteers involved with the Suitcase Clinic are interested in practicing and developing their clinical skills rather than creating evaluation teams or facilitated community organizing processes. For the Suitcase Clinic to incorporate these changes, volunteers and paid staff with an interest in these interventions will need to be found. It is hoped that the experiments at the Suitcase Clinic will continue and that other student-run clinics will glean useful concepts from these experiments.

Part V: Conclusion

Student-run clinics have played an important role in providing free medical services to underserved populations. The clinics serve as educational experiences for students and multi-service centers for community members. However, student-run clinics that lack a broad vision of their social role may actually contribute to what Freire called a "system of false generosity" and what McKnight calls a "service industry." Calls for a second-tier system of charity-based medical services for the poor is an inappropriate goal for society to strive for and for student-run clinics to contribute to. Nor is it appropriate for student-run clinics to ignore the broader social forces contributing to the ill health of the patients they see at their clinics.

Student-run clinics, with the proper balance of student-learning, community service, and social change programs can play a vital role in shaping the future of health care and citizenship in the United States. The literature on community-oriented primary care (COPC), community organizing, and popular education provides valuable insights to student-run clinic leaders hoping to stimulate rather than stagnate social change efforts.

Experiments with these social change theories at the Suitcase Clinic demonstrate their potential, but also their limits. Application of these theories requires an increased time and resource commitment from student leaders and other volunteers at student-run clinics. It also requires agreement about the organization's vision, values, mission and goals. Students and professional have traditionally been reluctant to have faith in the communities they serve. This lack of faith makes genuine community participation impossible. Student-run clinics are characterized by rapid turnover of volunteers and leaders making it difficult to sustain any efforts that go beyond a traditional service model of medical care delivery. Students are often reluctant to devote time to volunteering in areas outside of their field of interest. Consequently, student-run clinics have difficulty finding leaders to tackle administrative and community medicine tasks.

Maintenance of service programs dominates the attention of volunteers since the need for service provision appears endless and the number of organizational "crises" never abates. For students to integrate social change principles, they will need to hire some support staff or find a mechanism for maintaining strong organizational historicity, such as through an active advisory board. The application of the social change principles pose additional challenges within the context of student-run clinics.

Organizing efforts at the Suitcase Clinic demonstrated the risk of demanding too much involvement from community members. In addition, student volunteers struggled to clarify personal boundaries between themselves and community members. Coalition building efforts require greater planning and organizational commitment than the Suitcase Clinic has been able to provide.

If student-run clinics are to make a difference at the national level, leaders will need to continue building national networks using the world wide web and other tools available to them. The mass media should also be involved in such efforts.

As one S.H.A.R.E. participant said, "If students aren't going to change things then who is?" Students are in the process of learning and shaping the way they think and act during their education. These formative years can have a tremendous impact on the future practices of individuals. Student-run clinics provide students with an opportunity to develop a professional practice that emphasizes community involvement, critical reflection, a desire to fight injustice, and a commitment to active citizenship.

Whether or not student-run clinics can accomplish the things discussed in this thesis remains to be seen. There is a lack of formal evaluations of student-run clinics that assess the impact these clinics have on students and on their communities; such evaluations are sorely needed. I hope that existing student-run clinics and those individuals and groups contemplating the creation of a student-run clinic will experiment with the application of the vision articulated in this thesis. Students can help

reconceptualize "service-learning" as "social change-learning", and they can be part of

creating and assessing the impact of these clinics on our society.

Part VI: Bibliography

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Part VII: Appendices

One: Notes on Student-Run Clinics

Fall, 1967: University of Medicine and Dentistry of New Jersey/New Jersey Medical
   School. Newark, New Jersey. Ten students from Student American Medical
   Association, Student Health Organization, and Newman Club organized the Family
   Health Care Center after the Newark summer riots. State health department funding
   for $20,000 approved July 1968. As of 1972 -112 medical students on 28 teams with
   a budget of $30,000. One evening per week for four hours within one of the
   university hospital clinics. Community Relations Committee of five Newark
   residents, three students, and one faculty member acts as an advisory board. Still in
   existence as of 1996.
June, 1968: University of Washington, St. Louis. Medical students and housing project
   residents (Pruitt-Igoe Men's Progressive Club). Pruitt-Igoe Medical Action Program
   at the Pruitt-Igoe Housing Project. (Freidin, 1970). Original goals to provide
   preventive care or to develop new methods of health-care delivery failed because of
   large investment of time necessary to organize such changes, the conventional
   attitudes of the students toward health care, and the need to educate the community to
   the value of new programs. Problems with community representation: rushed
   community involvement, territorial issues within communities.
July, 1968: Student Health Organization of Chicago. Health professions students and
   residents of the Robert Taylor Housing Project. Robert Taylor Clinic.
Late, 1968: Duke University. Durham, NC. Edgemont Community Clinic.
Late, 1968: University of North Carolina-Chapel Hill. Chapel Hill, North Carolina.
   Chapel Hill-Carboro Family Health Clinic. Formed by the Student Health Action
   Committee (SHAC), UNC-Chapel Hill. Free medical clinic to serve low-income
   residents of the Chapel Hill-Durham area. Still operates each Wednesday after hours.
Spring, 1969: University of Louisville. Greater Louisville Organization for Health
   (GLOH). Annual budget of $37,000. Initially, GLOH was composed of a group of
   idealists motivated by desires to remedy some of the problems of our society. "Too
   much was expected too quickly" (Levy, 1972) "Transient groups, such as students,
   do not have the time necessary to develop lasting relationships of trust with a poverty
   community." Difficult for students to take time and energy to work with the
   community and solicit their involvement. Recommend consumers should be
   responsible for non-medical matters after the clinic is created.
1971: University of California, Berkeley, other schools. Oakland, California. La Clinica
   de la Raza (LCDLR). Founded by university students at the height of the Chicano
   movement in 1971 (Merideth, 1994). Initially LCDLR provided free medical care to
   low-income and no-income Latinos out of an abandoned barber shop. The clinic went
   on to become a fully operational health center. LCDLR sought to provide primary
   health care to thousands of Latino, primarily Mexican immigrants living in East
   Oakland. At that time, there was an almost complete lack of medical and mental
   health services in Spanish available in the area. Consequently, a strong emphasis was

placed on providing culturally and linguistically appropriate services to Oakland's Latino residents.

1971: UC Davis. Asian Health Concern. Started in 1971 by 3 students. Clinica Tepati also started in 1971.

1975: Northeastern University, Boston University. Neighborhood activists and students from the Codman Square neighborhood of Dorchester, Massachusetts. Formed volunteer-run Codman Square Health Center that became a fully operational community clinic in 1979. Codman Square's mission is "to serve as a resource for the physical, social and mental health of the Codman Square community."

1984: University of Miami School of Medicine. Camillus Health Concern - intern in internal medicine started treating people in room of a shelter on a voluntary basis. Others - nurses, social workers, private practitioners, and students and faculty from University of Miami School of Medicine soon contributed time and energy. Federal Health Care for the Homeless award and private donations of equipment and supplies allowed clinic to expand and hire full-time staff. Volunteer specialists. Voluntary legal services.

1987: Mercer University School of Medicine. Georgia. "Expanded Teen Clinic" - health screening clinic for teenagers (AMSA, 1995).

Fall 1988: University of Colorado . Health Care for the Poor and Homeless. Stout Street Clinic Saturday mornings (9 am - 12 pm) in downtown Denver. Clinic run by regular staff during week. No community input but input from clinic staff. Student driven and department sponsored. Elective course associated with volunteer work.

1989: Hahnemann University and Medical College of Pennsylvania. Homeless Clinics Project. Clinics (Five weekly clinic sites). Founded by two medical students after they read an article in the New Physician (AMSA) about student-run clinics for the homeless at other schools. One motivation to give medical student early contact with patients. "The clinic exposes students to a side of medicine that you may not see until you do your clerkship years in the third and fourth year." According to the AAMC, effort is one of the largest student-run clinics in the nation. Four evenings/week serving more than 2,200 patients/year. Located at four area shelters and a street outreach site. Named a Point of Light for June 23, 1992 - the 809th such commendation. Undergraduates and other graduate students involved with social service component and children's activities.

January, 1990 (van outreach); opened doors Sept. 25, 1990: University of California, Berkeley. Suitcase Clinic. Health policy class. Desire to meet unmet needs of homeless population. Medical students in collaboration with other students.

1990: University of Wisconsin, Madison. MEDIC. Provides free health services to indigent communities in Madison.

1990: Stanford University. 1989 study of health care access in the mid-peninsula area between SF and San Jose, found severe problems in access for homeless and low-income individuals and families. First-year medical student with help of other students. More than 40 physicians and 130 medical students have contributed to the clinic.

1990: University of Arizona. Refugee Clinic.

1991: University of Pennsylvania. West Philadelphia. University City Hospitality Coalition Medical Clinic. Community Health Summer Internship project of University of Pennsylvania medical student David Kregenow. Help from interns from the Empty the Shelters summer program, the staff of UCHC, and selected faculty. Interschool Homeless Health Initiative (a collection of area medical school students involved with homeless health clinics and interested in issues of homelessness - Thomas Jefferson, Hahnemann & Medical College of Pennsylvania, Penn and Albert Einstein Medical Center.

1991: University of Kansas. Children's Primary Care Clinic. Predominantly indigent and minority patients. M, Tu, Th, F 6-9:30 pm.

January, 1992: Yale University Internal Medicine Residency Program homeless health care outreach.

1992: University of Medicine and Dentistry of New Jersey - Robert Wood Johnson Medical School. Homeless and Indigent Population Health Outreach Project (HIPHOP). One hundred twenty medical, public health, and physician assistant students, faculty and staff members and community representatives. Students present to physicians - family, internal, and peds clinics. Junior high student health ed classes, high school AIDS education, participation in community health fairs, clothing drives, and food drives.

1993: University of Massachusetts Medical School. Mondays 6-9 pm, free clinic. Basement of church.

1994: Yale University School of Medicine. Project Hope. Clinic for homeless.

1995: Wright State University School of Medicine. Dayton, Ohio. Project Reach Out. Provides free health-care services to homeless and working-poor populations in and around the Dayton Metropolitan area.

March, 1996: University of Colorado School of Medicine. Warren Village Pediatric Clinic. Single individual that did volunteer work @ transitional housing program for single parent families. What got the program started: "An excellent mentor and advocate. Support of the University administration. Strong interest by MANY medical students. Interest by community physicians. Need -- a population with limited access to health care."

1996: Albert Einstein College of Medicine of Yeshiva University. Physical exams/health screenings, health education.

1996: UC Irvine Medical School. UCI MedReach: Student Physicians in Community Outreach and Clinical Training. Operate evening pediatrics clinic. 60% Hispanic, Middle Eastern, and Laotian. Student-run clinic at site of regular clinic. Operates M-Th from 5-8 pm and Saturday.

1996: UCSD Medical School. Free Clinic.

Unknown Start Date: Dartmouth. "A student-run, free pregnancy clinic that is operated by female medical students in conjunction with Planned Parenthood" Regarding community service - "The students believe that they are part of a movement to produce a different kind of physician, one who espouses a higher purpose than the self-interest that medical education can evoke."

Unknown Start Date: UC Davis. Three more clincs in addition to Asian Health Concern and Clinica Tepati. Credit for participation in clinics. University malpractice coverage. University funding. 5 student-run clinics; one run by undergraduates. Recommend slow growth (Pi, 1995). Founded by students who performed a community-needs assessment and selected a location within the community where students could provide easy access to residents. "estimated 35,000 patient visits in the past 20 years."

Unknown Start Date: University of California, San Francisco. Student Homeless Health Care Project: Wed. 5-9 pm, Sat. 10 am - noon; foot care clinic every other Saturday. Tuesdays and Thursdays 6 pm at other site (foot care on Wed. evenings at this site)

Unknown Start Date: University of Florida. Equal Access Clinic.

Unknown Start Date: University of Kentucky. Salvation Army Clinic.

Unknown Start Date: University of Louisville. Hope Clinic (Ped. Clinic for Homeless) & Blitz Clinic (for women).

Unknown Start Date: University of Utah. 4th Street Clinic for the Homeless. Traveler's Aid Shelter (Rio Grande Clinic?)

Unknown Start Date: University of Pittsburgh - lack of primary care clinics for indigent. Goal to establish clinic that fulfilled a community need while providing medical education. Program for Health Care to Underserved Populations.

Unknown Start Date: Medical College of Wisconsin. Student-run clinic in Milwaukee. So many students want to volunteer they have to choose by lottery who gets to volunteer.

Unknown Start Date: Loma Linda University. Two migrant farm worker clinics.

Unknown Start Date: Rush Medical College. Community Health Free Clinic in Chicago. Staff the clinic one night a week.

Two: The Six "R's" of Participation by Gillian Kaye

1) Recognition

People want to be recognized for their leadership to serve the members of their communities and organizations. We all want to be recognized, initially by the members of our own group and then by members of other groups, for our personal contribution to efforts to build a better quality of life.

TIP: Recognition can be given through awards and dinners, highlighting contributions and praising and naming at public events.

2) Respect

Everyone wants respect. By joining in community activities, we seek the respect of our peers. People often find their values, culture or traditions are not respected in the work place or community. People seek recognition and respect for themselves and their values by joining community organizations and coalitions.

TIP: Don't schedule all of your planning meetings during regular working hours-this may exclude many grassroots leaders who hold other jobs. Meet in the evenings and provide dinner and childcare or at least meet late enough so that those attending can take the time to provide dinner and childcare for their families.
Translate materials and meeting agenda into languages other than English if it's necessary and provide translators at meetings.

3) Role

We all need to feel neeeded. It is a cliché; but it's true. We want to belong to a group which gives us a prominent role, and where our unique contribution can be appreciated. Not everyone searches for the same role. But groups must find a role for everyone if they expect to maintain a membership.

TIP: Grassroots leaders and members have had the experience of being "tokens" on coalitions. Create roles with real power and substance.

4) Relationship

Organizations are organized networks of relationships. It is often a personal invitation which convinces us to join an organization. People join organizations for personal reasons to make new friends, and for the public reason to broaden a base of support and/or influence. Organizations draw us into a wider context of community relationships which encourage accountability, mutual support, and responsibility.

TIP: Provide real opportunities for networking with other institutions and leaders.

5) Reward

Organizations and coalitions attract new members and maintain old members when the rewards of membership outweigh the costs. Of course, not everyone is looking for the same kind of rewards. Identify the public and private rewards which respond to the self interests of members in order to sustain their role in the coalition.

TIP: Schedule social time and interaction into the agenda of the coalition where families can participate. Make sure there is an ongoing way to share resources and information including funding opportunities and access to people in power.

6) Results

Nothing works like results! An organization which cannot "deliver the goods" will not continue to attract people and resources.

TIP: To many grassroots leaders and residents, visible projects and activities that directly impact conditions and issues in their communities are the results they are looking for in return for their participation.

Three: Community Assessment Methods

<u>Components of a Healthy Cities Community Assessment (Hancock & Duhl, 1986)</u>

1) People's perceptions of the strengths and resources of their communities, as well as their individual and collective health and well being;
2) Stories about the formal and informal processes of developing healthy cities and healthy communities;
3) Data and stories about the community's physical and social environment;
4) Data and stories about inequities in health, and about the prerequisites necessary to address these inequities;
5) Health status data at the neighborhood or small area level, incorporating mortality and morbidity data and both subjective and objective assessments of physical, mental and social well being

<u>Mapping Community Capacity (McKnight & Kretzmann, In Press)</u>

*Focus on community capacities, skills, and assets.

1) *Primary Building Blocks - Assets and Capacities Located Inside the Neighborhood, Largely Under Neighborhood Control*
   Individual Capacities
   - Identify individual skills, talents, knowledge, and experience (individuals can complete a personal capacity inventory)
   - Personal Income - income, savings, and expenditure patterns
   Gifts of Labelled People
   Individual Local Businesses
   Home-Based Enterprises
   Associational and Organizational Capacities
   Citizens Associations
   Associations of Businesses
   Financial Institutions, esp., Community Development Banks
   - Exs. Grameen Bank in Bangladesh, South Shore Bank in Chicago
   Cultural Organizations
   Communications Organizations - bulletin boards, local radio, TV
   Religious Organizations
2) *Secondary Building Blocks - Assets located within the community but largely controlled by Outsiders*
   Private and Non-Profit Organizations
   - Institutes of Higher Education
   - Hospitals
   - Social Service Agencies
   Public Institutions and Services
   - Public Schools
   - Police
   - Fire Departments
   - Libraries
   - Parks
   Physical Resources
   - Vacant land, vacant commercial and industrial structures, vacant housing

- Energy and waste resources (excess use in low-income communities)

3) *Potential Building Blocks - resources originating outside the neighborhood, controlled by outsiders*

Welfare Expenditures
- Cook County, IL - over $6,000 annually spent by government for low-income programs for every man, woman, and child whose income falls below the official poverty line. On a per capita basis poor people receive only 37% in cash and 63% in services. (Kallenback and Lyons, 1989)

Public capital improvement expenditures
- "Infrastructure"

Public Information

3 key questions for using map:
1) Which organizations can most effectively function as "Asset Development Organizations" in our neighborhood (Alinsky-type, multi-issue people's organizations, community development corporations)?
2) What kind of community-wide research, planning, and decision-making processes can most democratically and effectively advance this rebuilding process in our neighborhood?
3) How can our neighborhood build useful bridges to resources located outside the community?

Community Assessment from Hagland, et al. (1990)

Components of Community Assessment
  Quantitative or Descriptive
1) A demographic, social, and economic profile compiled from census or local economic development data resources. Population by age, sex, and racial or ethnic heritage. Family structure, marital status, housing conditions, education levels, immigration, divorce rates, voting participation, crime rates, and available quality-of-life measures. Employment, labor force characteristics, poverty and related welfare and social security beneficiary rates, general business conditions, & major economic developments.
2) A health risk profile (including behavioral, social, and environmental risks).

a) Behavioral risk - dietary habits, use of drugs, alcohol, and tobacco, patterns of physical activity. Medical care utilization by individuals or groups, self-care activities, perceived health needs. Utilization of alternative health care programs.

b) Social indicators of risk: stress of long-term unemployment, isolation, and/or poor education has been associated w/ poor health status. Positive health outcomes related to social support mechanisms.

c) Environmental Factors - water, soil, air, climate, housing characteristics.

3) A health/wellness outcomes profile (morbidity/mortality data): age-specific death rates, proportional mortality ratios, unnecessary deaths, potential years of life lost, and morbidity and mortality rates.
4) A survey of current health promotion programs. Consult w/ key informants. What areas of health have the most activity.
5) Special studies of target groups, awareness levels, perceived needs, organizational capacity, and so on. Churches, sports and recreation groups.

Qualitative Data
1) Community Leadership Interviews.
2) Assessing Readiness and Opportunity for Change
   a) Attitudes, expected level of participation, and commitment to change among leaders
   b) History of common community vision and success with previous projects
   c) Resources, conflicting agendas, past leadership conflicts
3) Media
   a) Newspapers (publisher/editor, feature editors, and so on; non-daily papers, including shoppers' guides; circulation data and geographic area covered)
   b) Radio stations (market area served and target audiences)
   c) TV stations (market area served and target audiences)
   d) Billboard or other major advertisers (any "public service" space available?)
   e) Note key contact persons - health beat, news or public service director.
4) Health Care Providers/Facilities
   a) Types and numbers of health personnel.
   b) Public and private health agencies, insurers, HMOs. Full range of health care programs and populations served including alternative health care programs.
   c) Associations and societies for professional providers, including physicians, dentists, chiropractors, nurses, nutritionists/dietitians, pharmacists, social workers, and others.
   d) ID officers, regular meetings, newsletters.
   e) List hospital and clinic administrators, directors of various departments and hospital board members.
   f) List public health board members.
5) Educational Institutions
   a) School districts in area
   b) Schools for each district. Key school board members and principals.
   c) For each school, # of students/grade and # of classrooms per school.
   d) Same information for private or parochial schools in area

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6) Government Agencies
   a) Key agencies: county executive, mayor's office, city manager, judicial, congressional representatives, safety and planning offices.
   b) Describe above agencies: size, staff, key programs.
   c) Copies of smoking control and other health related ordinances (city and county) and review legislative hx of attempts to change ordinaces over last 5 yrs.
   d) Location and size of city and county employment; any health projects by government.
   e) Describe general political climate.
7) Economic/Commercial Organizations
   a) Worksites and businesses from Chamber of Commerce reports, public documents. List key CEOs, company presidents.
   b) Estimate proportion of employees at large businesses who live in target community.
   c) Data on unemployment rates.
   d) Enumerate cigarette and food vendors, wholesalers, and distributors.
   e) Enumerate key businesses, with health concerns or programs.
8) Labor Organizations
   a) List major trade unions.
   b) Describe local union coverage, history of business-labor relations.
   c) Describe health program benefits.
9) Religious Groups
   a) ID existence of any interfaith council or council of churches and synagogues.
   b) Describe general characteristics of church attendnace and primary affiliation.
10) Voluntary and Private Organizations
   a) List relevant voluntary organizations (health and social services).
   b) Collect annual reports.
   c) For each organization, note numbers of commitees, volunteers, and so on.
   d) List self-help and mutual assistance groups.
11) Other Organizations
   a) List significant coalitions, associations, groups, service clubs, and so on.
   b) List community meeting places (e.g., community center, recreational facilities, and parks).
   c) List special community wide events, sponsors, key activists in organizing.

12) Summary of Leadership Contacts
      a) Summarize key leaders in each sector/organization above.

Eng & Branchard's (1990-91) Action-Oriented Community Diagnosis Procedure

I. Specify the target population and determine its component parts using social and demographic characteristics that may identify commonalities among groups of people.
    A. Race or ethnicity
    B. Religion
    C. Income level
    D. Occupation
    E. Age

II. Review secondary data sources and identify possible subpopulations of interest and geographic locations
    A. County and townships
    B. Church, school, and fire districts
    C. Towns
    D. Agency service delivery areas
    E. Industries and other major employers
    F. Transportation arteries and services
    G. Health and other vital statistics

III. Conduct windshield tours of targeted areas and note daily living conditions, resources, and evidence of problems
    A. Housing types and conditions
    B. Recreational and commercial facilities
    C. Private and public sector services
    D. Social and civic activities
    E. Identifiable neighborhoods or residential clusters
    F. Conditions of roads and distances people must travel
    G. Maintenance of buildings, grounds, and yards

IV. Contact and interview local agency providers serving targeted areas
    A. What are the communities most in need and why?
    B. Which communities have histories of meeting their own needs, and how?
    C. What services are being provided by agencies or other organized groups? Which are utilized and which are under-utilized?
    D. What, in their opinion, are the major problems still facing communities they serve?
    E. Where do they recommend finding additional information to document needs:
        • Referrals to other service providers
        • Referrals to leaders of community organizations
        • Referrals to informed members of communities

V. Select a community and contact and interview community informants most frequently cited inm provider interviews

A. What is the name their community is most commonly known as?
B. Describe a time when there was a problem in their community that they tried to resolve:
  - How was the need determined?
  - How did the community organize themselves?
  - Who were the influential people involved?
C. In their opinion, what are the present needs in their community?
D. Who would have to be involved to get things done in their community
E. What outside services or resources do people in their community known and use to meet their needs?
F. What other people like themselves, who know about their community do they recommend being contacted?
G. Would they be interested in attending a meeting "to find out the results from these interviews? And what do they suggest as times and places to hold such a meeting

VI. Tabulate the results from the secondary data, the provider interviews, and the community informant interviews and analyze the degree of convergence among the needs identified
A. Determine the extent of agreement/disagreement across the three lists of needs and how each identified need is defined
B. Determine the extent of agreement/disagreement across the three lists of needs and the priority accorded to each identified need

VII. Present the findings in meetings with community informants interviewed and other influential community members frequently cited by the providers and community informants
A. Assess the validity of the definitions for each need and redefine them, if necessary, according to how they are manifested in this community
B. Determine a priority listing of needs according to interest in undertaking a solution
C. Select a need with high priority and determine questions that need to be answered, such as:
  -Who suffers from this problem?
  -When is this problem most prevalent?
  -How severe are the short- and long-term consequences from this problem?
  -What are the possible causes of this problem?
  -What is the range of solutions for reducing or controlling this problem?
  -What are the available resources and additional resources required for each possible solution?
D. Plan the next steps for finding answers to the questions

Four: Action References

1) Service Provision
    A) How To Manuals
        Suitcase Clinic Policy Book
        300 Eschleman Hall
        Berkeley, CA 94720
        (510) 642-5476

        Salvation Army-Globeville Clinic Manual
        University of Colorado Health Sciences Center
        4200 East Ninth Avenue, Box B166
        Denver, CO 80262
        (303) 315-6758 or 315-6567

        The Homeless Outreach Project of
        The Medical College of Pennsylvania and Hahnemann University
        MS 962 Broad & Vine
        Philadelphia, PA 19102
        (215) 762-4888

    B) American Medical Student Association
        1902 Association Drive
        Reston, VA 20191
        (703) 620-6600
    C) COPC Literature - Please see the bibliography.
    D) Health Care for Homeless People
        Brickner, et al. Health Care of Homeless People
        Rogers & Ginzberg, Eds. Medical Care and the Health of the Poor.
        Wood, D. Delivering Health Care to Homeless Persons: The Diagnosis and Management of Medical and Mental Health Conditions.

2) Coalition Building
    Butterfoss, F., Goodman, R., & Wandersman, A. (1993). Community Coalitions for Prevention and Health Promotion. Health Education Research.

    Edelstein, M. (1992, April). Building coalitions for sustainability: An examination of emergent partnerships addressing environmental and community issues. Paper presented at the annual meeting of the Environmental Design Research Association, Boulder, CO.

    Mizrahi, T. & Rosenthal, B. (1992). Managing dynamic tension in social change coalitions. In Community Organization and Social Administration: Advances, Trends, and Emerging Principles. New York: Haworth Press.

Wandersman, A., Goodman, R.M., & Butterfoss, F.D. (In Press). Understanding Coalitions and How they Operate: An "Open Systems" Organizational Framework. In M. Minkler (Ed.), <u>Community Organizing and Community Building for Health</u>.

3) Community Participation and Advisory Boards

Arnstein, Sherry. (1969). A ladder of citizen participation. <u>Journal of American Institute of Planners</u>, (July), 216-224.

Florin, P. & Wandersman, A. (1990). An introduction to citizen participation, voluntary organizations, and community development: Insights for empowerment through research. <u>American Journal of Community Psychology</u>, <u>18</u> (1), 41-54.

Gutierrez, L. and Lewis, E. (In Press). Education, Participation, and Capacity Building in Community Organizing with Women of Color. In M. Minkler (Ed.), <u>Community Organizing and Community Building for Health</u>.

Prestby, J, et al. (1990). Benefits, costs, incentive management and participation in voluntary organizations: A means to understanding and promoting empowerment. <u>American Journal of Community Psychology</u>, <u>18</u> (1), 117-149.

Woelk, G.B. (1992). Cultural and Structural Influences in the Creation of and participation in Community Health Programmes. <u>Social Sciences and Medicine</u>, <u>35</u> (4), 419-424.

4) Social Action Organizing

Alinsky, Saul. (1969). <u>Reveille for Radicals.</u> Chicago, IL: University of Chicago Press.
Alinsky, Saul. (1972). <u>Rules for Radicals.</u> New York: Random House.

Staples, L. (In Press). Selecting and "Cutting the Issue". In M. Minkler (Ed.), <u>Community Organizing and Community Building for Health</u>.

Shaw, Randy. <u>The Activist's Handbook.</u>

5) World Wide Web

Uhler, C. (In Press). Online Computer Networks: Potential and Challenges for Community Organizing and Community Building Now and in the Future. In M. Minkler (Ed.), <u>Community Organizing and Community Building for Health</u>.

Nancy Milio's (1996) <u>The Engines of Empowerment: Using Information Technology to Create Healthy Communities and Challenge Public Policy.</u>

Schuler's (1996) <u>New Community Networks: Wired for Change.</u>
Yates' <u>The Internet: What it Can and Can't Do for Activists.</u>

Community Oriented Primary Care (COPC): Suitcase Clinic Community Assessment

Definition of Primary Care

Health care delivered on first contact with the health care delivery system and which ideally includes the following attributes: accessibility of services to the user, comprehensive array of services, coordination and continuity of care over time, and accountability by the practitioner for quality, benefits, and risks of such services.

Essential and Highly Desirable Features of COPC

Essential features:
1. Complementary use of epidemiologic and clinical skills;
2. A defined population for which the service is responsible;
3. Defined programs to address community health problems;
4. Community involvement in promoting its health;
5. Health service accessibility: geographic, fiscal, social and cultural.

Highly desirable features:
1. Integration, or at least coordination, of curative, rehabilitive, preventative and promotive care;
2. A comprehensive approach extending to behavioral, social, and environmental determinants;
3. A multidisciplinary team;
4. Mobility, including "outreach" capability, of the health team;
5. Extension of community health program into broader programs of community development.

Introduction to Community Context

The Suitcase Clinic is a free medical and social service clinic open to anyone in need of services. The Clinic's mission states that the clinic serves homeless and low-income residents from Berkeley and Oakland although services are not restricted to individuals from these cities. The primary target community of the clinic is homeless individuals residing in Berkeley.

This paper describes some of the characteristics of the homeless population in Alameda County with more specific information about homeless individuals in Berkeley. The geographic community of the Suitcase Clinic is discussed. A review of programs for homeless individuals and a demographic description of the clients receiving medical services at Suitcase Clinic is also included. Data used in this review comes from several research projects conducted between 1991 and 1996. The methodologies used in these research projects vary from reviews of service provider reports to randomized interviews

with homeless individuals. Although far from perfect, the data used in this paper provides a rough picture of the homeless population in Alameda County and the City of Berkeley.

Geographic Community

The Suitcase Clinic operates at the First Presbyterian Church Activities Building located on Dana between Channing and Haste in Berkeley. Telegraph Avenue and its restaurants and businesses, street vendors, panhandlers, students, and others, is one block east of the church. People's Park is less than three blocks away. University Cooperative Housing is across from the church on the Haste side of the building, and a residence hall is located adjacent to the church parking lot on Channing. The surrounding neighborhood consists mostly of student apartments, university buildings, churches, and local businesses.

In addition to the Suitcase Clinic, there are several other programs for homeless individuals in this neighborhood. Nearly all of the services in the area are affiliated with or located in a church. The Berkeley Emergency Food and Housing Project (BEFHP) operates a daily free meal program known as the Quarter Meal, a women's shelter, and a drop-in center within the neighborhood. Catholic Worker and Food Not Bombs provide regular breakfasts and lunch, respectively, within the "South of Campus" neighborhood. The Berkeley Ecumenical Chaplaincy for the Homeless operates a free clothing program as well as other activities and services for homeless individuals; they are located on Durant at Trinity United Methodist Church. Within the same building, the Berkeley Free Clinic (Berkeley Community Health Project) offers health care and referral services throughout the week. Homeless Outreach Workers and Mental Health Outreach Workers from the City of Berkeley conduct street outreach and work at some of the churches in the area. Alameda County Health Care for the Homeless brings their mobile health care van to the area once per month.

A fold out map of homeless services programs in Berkeley is available.

Background Information on Homelessness in Berkeley & Alameda County

(Alameda County Housing and Community Development Program, 1995) & (City Manger's Office, 1993)

Location	Homeless on any Given Night	Total Homeless at some point in a year	Available Shelter Beds
Alameda County	9,000-15,000	27,000-60,000	2,200
City of Berkeley	800-1,000	---	220

Berkeley's homeless population is largely divided into two subgroups based on the length of time people have been homeless. One group, about 40% according to one study, have been homeless for five years or longer. The other group are homeless for the first time

and have been homeless for less than one year. Those unable to "exit" homelessness tend to be those of male gender, the mentally ill, and those homeless for more than one year.

Individuals sleep in various places such as the streets and parks, shelters, transitional housing facilities, shared living arrangements, their own residences, jail, and residential drug treatment facilities.

Suitcase Clinic Data

The Suitcase Clinic serves about 116 clients/month = 1,392 clients/year (Note: Not an
    unduplicated count).
Average # of visits to Suitcase Clinic Medical Division per person (N=105) = 2.0
    a) 65% of the patients only came to the Suitcase Clinic once.
Housing Status of Medical Patients (N=23)
        Shelter = 30%
        Streets = 26%
        Apartment (Rent or Share) = 22%
        Not Recorded = 17%
        Car = 4%
        "Homeless" (Shelter + Street + Car) = 60%

Age of Homeless Individuals

The average age among adults in Alameda County and Berkeley is between 36 and 37.
Homeless women tend to be somewhat younger than men (average age 35), and homeless
women with children tend to be youger still (average age 31) [Robertson, et al., Course...,
1994].

According to the Emergency Services Network data (Emergency Services Network,
...January-March, 1994, 1994) on homless individuals seeking services, individuals fell
into the following age groups:

Age Range of Those Seeking Services without a Guardian	Percentage Within Given Age Range (Alameda Cty.)	Percentage Within Given Age Range (Suitcase Clinic) [N=105]
Under 18	.4%	4%
18-29	23%	24%
30-39	41%	27%
40-54	30%	41%
55 and older	5%	5%
Mean	36.5 years	38 years

Robertson's study (Robertson, et al., Course..., 1994), found that the mean and median
age at which homeless individuals first became homeless as an adult was 33.

Homless youth and elderly individuals may be underrepresented in studies for a variety of
reasons including the dearth of services available for these groups. National and Alameda
County data estimate that about 4% of the homeless population is unaccompanied youth
(less than 18 years old without accompanying guardian). The City of Berkeley estimates
that homeless youth may make up as much as 15% of its homeless population (City
Manager's Office, 1993).

On any given day, 700 children and youth are in emergency foster care or in Juvenile Hall in Alameda County. More than 4,000 youth are in foster placements, juvenile camps, the California Youth Authority, mental health facilities, group homes or other institutions. When discharged or "age out"often have nowhere to go (Alameda County Housing and Community Development Program, 1995).

Race/Ethnicity

(Alameda County Housing and Community Development Program, 1995)

Race/Ethnicity	In Service Programs	Oakland Population (1990 Census)	Suitcase Clinic (N=70 out of 105)
African-American	64%	43%	39%
Caucasian	26%	28%	51%
Hispanic	6%	14%	4%
Asian/Pacific Islander	2%	14%	3%
Native American	1%	.5%	3%
Other	1%	.3%	4%

Gender and Family Composition

(Alameda County Housing and Community Development Program, 1995)

Gender	In Service Programs	At Food Sites	Suitcase Clinic Medical (N=105)
Male	54%	80%	58%
Female	46%	20%	42%

Table below made by calculating data from (Alameda County Housing and Community Development Program, 1995)

Household Composition and Adult/Child Proprotions	Percent of Total Homeless Population in Alameda County	Absolute Number among Homeless in Alameda County (Using 27,000 estimate)	Suitcase Clinic Medical (N=85)
Adults (over 18)	78%	21,000	96%
Adults without accompanying children	56%	15,000	96%
Adults with accompanying children	22%	6,000	---
Unaccompanied Youth (under 18)	4% (15% in Berkeley)*	1,000	1%
Children (under 18) with guardian	18%	5,000	2%
Homeless Families (Adult w/ child)	41%	11,000	---

*Data for Berkeley not available in other categories. The 15% is a City of Berkeley estimate.

Three percent of those seeking services were pregnant women. According to several studies, homeless families are the fastest growing segment of the homeless population. The vast majority of homeless families with children are headed by a single mother.

Homeless men are more likely to be older, to be veterans, and to report longer histories of homelessness. Homeless men are more prevalent in Oakland and non-shelter sites, whereas women are more likely to be found at shelter sites and outside Oakland.

Drug and Alcohol Use

(Robertson, <u>Drug Disorders...</u>, 1993)

Key: Lifetime Disorder Percentage (Current Disorder Percentage)

Drug Disorder	Total (N=564)	Men (N=385)	Women (N=179)
Any Substance Use Disorder	69.1 (52.4)	71.0 (54.0)	62.5 (46.5)
Alcohol Use Disorder	52.6 (38.8)	56.0 (40.8)	40.3 (31.6)
Drug Use Disorder	52.2 (31.3)	52.5 (31.2)	51.2 (31.8)
Cocaine	37.3 (24.5)	36.5 (24.3)	40.1 (25.5)
Crack	27.1 (19.3)	26.2 (18.7)	30.4 (21.1)
Other Cocaine	24.8 (15.2)	24.7 (15.8)	25.1 (13.1)
Cannabis	25.9 (14.2)	29.6 (15.9)	12.9 (8.1)
Stimulants	17.0 (11.7)	18.3 (13.4)	12.5 (5.6)
Opiates	14.7 (9.5)	16.0 (10.8)	10.2 (4.9)
Heroin	11.0 (7.1)	12.4 (8.3)	6.1 (2.9)
Other Opiates	8.7 (5.9)	9.2 (6.8)	6.6 (2.9)
Sedatives	10.7 (6.8)	10.7 (7.6)	10.7 (3.9)
Hallucinogens	8.7 (4.4)	10.0 (5.7)	3.9 (0.0)
PCP	2.2 (0.8)	2.5 (1.1)	1.2 (0.0)
Multiple Drug Disorders			
Including cannabis	48.3 (31.3)	49.7 (31.2)	43.5 (31.8)
Excluding cannabis	41.0 (29.0)	41.4 (29.2)	39.4 (28.0)

County self-report of dual/triple diagnosis = 10%
City of Berkeley estimate of dual/triple diagnosis among Berkeley's homeless population = 40%

Suitcase Clinic Data
Recreational Drug Use

       A) Current Drug Use (N=85)
              Yes = 5%
              No = 18%
              Not Asked/Recorded = 77%
       B) Past Drug Use (N = 85)
              Yes = 6%
              No = 4%
              Not Asked/Recorded = 90%

Alcohol Use

Drinks/Weekday	% of patients w/ recorded information (N=85)
None	15%
0-2	18%
3-5	2%
6-10	2%
>10	0%
Not Asked/Recorded	63%

Special Subgroups Among the Homeless

Group	Alameda County Homeless Population	General Population
Mentally Ill	35-42%	---
Veterans	15-34%	11%
HIV/AIDS	15-25%	.4%
Physically Disabled	15%	---
Victims of Domestic Violence	30-60% of women	11-54% lifetime prevalence among those visiting ERs

Medical Problems

51% of those surveyed in a Berkeley study on homelessness (City Manager's Office, 1993) said they had some type of chronic medical problem(s). The most frequently mentioned were asthma, diabetes, epilepsy, alcoholism, and migraine headaches. Opinions of medical services almost always positive. Suggestions for improving the medical system in Berkeley included streamlining the clinic system to reduce waits, and providing more than one medical opinion.

Health Insurance Status	Suitcase Clinic Medical Patients (N=105)	Alameda County Homeless Population	State of California General Population (Under 65), 1992
None	55%	73%	23%
Not Asked/Recorded in Chart	30%	---	---
MediCal	12%	16%	13%
Medicare	3%	4%	2%
Veterans/Military Insurance	0%	17%*	3% (active-duty)
Private	0%	10%	59%

*Only 1% of those with VA insurance reported use of any VA facility for medical care during the past year.

Suitcase Clinic Data
Health Insurance (N=105)
> No Health Insurance = 55%
> Not Asked/Recorded in Chart = 30%
> MediCal = 12%
> Medicare = 3%
> Private = 0%

The following is a list of potential barriers to accessing health care among the homeless (Watkins-Tartt, 1994):

- Health Care Not a Priority
- Denial
- Shame
- Fear
- Distrust
- Address Requirements and Lengthy Processing
- Transportation
- Crowded Waiting Rooms
- Long Waits for Appointments
- Language Barriers
- Illiteracy
- Limited Access to Telephones, Showers, and Laundry Facilities
- Unfamiliarity with Available Services
- Lack of Skills to Manage Red Tape
- Lack of Follow Through

Most Common Diagnoses (# of visits with given assessment or reason for visit) [N=85]

A) **Specific (Suitcase Clinic)**	**ACHCH* (1995-96 Data)**
1) Otitis Media	1) Dental ♣
2) Hypertension	2) Substance Use (Alcohol & Drug) ♣
3) Bronchitis	3) Visual/Eye Problems
3) Upper Respiratory Infection	4) Other
5) Asthma	5) Hypertension
6) Eye Infections	6) Musculoskeletal Pain/Trauma
6) Injuries from Fights	7) Skin Problems
6) Pharyngitis	8) Gynecological Problems ♣
6) Plantar Fascitis	9) Mental Health Problems ♣
6) Cough	10) Asthma
11) Skin- Fungal Infection	11) Bronchitis
12) Scabies	12) Tuberculosis-screening, Dx, Tx...♣
12) Skin- Minor Bacterial Infection	13) Otitis Media
12) Arthritis	14) Upper Respiratory Infection
12) Lower Back Pain	15) Sexually Transmitted Diseases
♣	
12) Allergic Rhinitis	16) Urinary Tract Infection
12) Injuries from Accidents	17) Pharyngitis
18) Dyspepsia	18) Viral Syndrome
18) Insect Bites	19) Allergies, Allergic Reactions
18) Cellulitis	20) Physical Exams ♣

*ACHCH = Alameda County Health Care for the Homeless Data

♣ = To denote ACHCH Top 20 Encounter not included in Suitcase Clinic Top 20. These discrepancies are worth evaluating in making plans for the Suitcase Clinic Medical Division.

B) Categories (% of visits at Suitcase Clinic)
Pulmonary (20%)
Ear, Nose, and Throat (16%)
Dermatologic (16%)
Musculoskeletal (13%)
Cardiovascular (9%)
Accidents and Injuries (8%)
Gastrointestinal (5%)
Eye (4%)
Other, each <2% of visits (11%)

Some Data on Services in Alameda County

(Alameda County Housing and Community Development Program, 1995).

Emergency Shelter Beds
North County	501
Mid County	158
South County	105
East County	61
Total	**825**

Targeted Beds
Families	79
Domestic Violence	80
Single Men	48
Mentally Disabled	71
HIV/AIDS	13
Total	**291**

Transitional Housing Beds
Beds	288
Transitions	
Project (subsidies)	150
Total	**438**

County Supported Alcohol/Drug Treatment Facilities
Total Service Spots	**364**

Permanent Housing for Homeless (not complete count of all units available)
Shelter Plus Care	519
Homeless Mentally Ill	29
HIV/AIDS	60

Total   **608**

Berkeley spends more than $1 million in local tax funds per year on shelters, outreach, social services, food and counseling. This money leverages more than $20 million of additional funds from state, federal, and private grants. (Note: $800 per month for 1,000 people = $800,000/month or $9.6 million/year).

S.H.A.R.E. Members List of Important Issues (from meeting minutes; not in any particular order)

1) Lack of long-term, affordable housing.
2) Draconian cuts in welfare programs without concomitant increases in living-wage employment opportunities.
3) People's Park - loss of activism, drug-dealers and abusers that congregate around the clothing Free Box, lack of positive community activities in the park.
4) Drugs and alcohol and a lack of programs for people.
5) Lack of mental health services.
6) Lack of compassion, respect, and love for poor and homeless people leads to loneliness and a loss of community spirit. Loss of spiritual faith.
7) Abusive, manipulative people on the streets - including the police, homeless, and non-homeless people.
8) A global economy run by unaccountable multinational corporations.
9) International examples of continued oppression.

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Watkins-Tartt, Kimi. <u>Barriers to Care</u>. Alameda County Health Care for the Homeless, 1994.

S.H.A.R.E.
Groundrules

1. **Confidentiality**

   Personal items discussed during the meeting should be kept confidential, unless the person or group involved gives approval to discuss the topic outside the meeting.

2. **Respect**

   Respecting other group members means not interrupting, insulting, ignoring, or treating another group member in any fashion that they consider disrespectful.

3. **No "Put Downs"**

   Avoid putting down others when making comments.

4. **Use "I" Statements**

   When discussing your opinions or ideas, take ownership of what you say, e.g., "I think ....."; "I was hurt by what you said...", etc.

5. **Risk-taking**

   The group should strive to value risk-takers. Don't be afraid to bring up controversial or emotional topics.

6. **Right to Pass**

   Any one in the group has the right to pass even if they are called upon to speak.

7. **Acknowledge your own emotions**

   Rather than projecting your emotions on others, state how you are feeling using "I" statements.

8. **No intoxication**

9. **No group or racial slurs**

10. **Honesty**

11. **Think before talking**

12. **No loud cross talk** (15 minute cross talk time at end of meeting)

    Cross talk refers to "side conversations" that may take place during meetings. Avoid these and keep attention focused on the current speaker. Save time for cross talk at the end of each meeting.

2422 McKinley Str. Apt. C
Berkeley, California 94703
Telephone: (510)643-6786
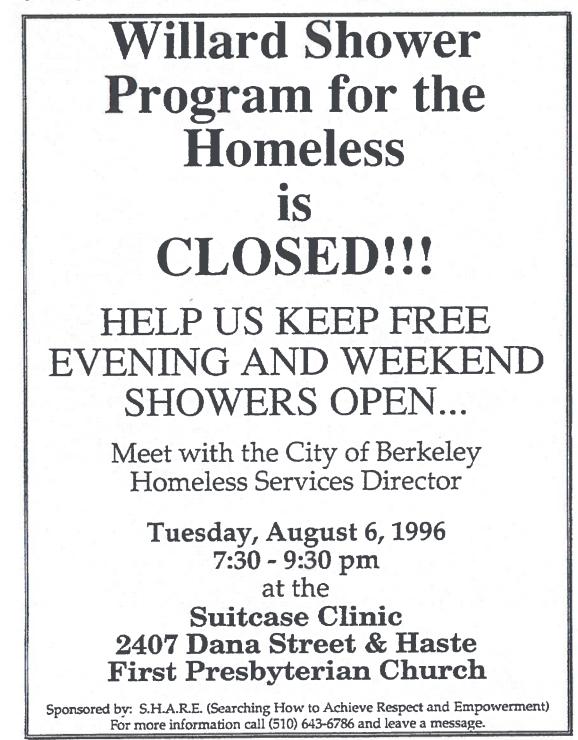Fax: (510)643-6786

July 23, 1996

Mr. _____

Dear _____

We have been devastated by the recent closure of Willard Showers for the Homeless. It served as a vital resource for many of us in the homeless community. For sixteen years Willard has provided showers on the weekends and evenings. For many of us who work on the weekends Willard allowed us to clean ourselves of the smell and look that accompanies stereotypes of homeless people and to function more efficiently at the work place. It has allowed us to maintain our jobs and better our quality of life. With high unemployment coupled with reductions in services such as shelters, GA, and the recent changes in the SSI policy; it is becoming more difficult for those of us who are struggling to continue along the path out of homelessness.

Berkeley has been at the forefront in respect to public participation in its decision making process. However, the public has been unable to express its opinion on the closure of Willard due to the lack of public notification. This greatly concerns us.

We have been attempting to understand why Willard was closed. Unfortunately, we have been unable to make much headway from our visits to Berkeley City Hall. We understand that as a public figure you may have a busy schedule; however, we would much appreciate it if you could inform us on the reason behind the dismantling of Willard Showers for the Homeless, a resource that has been an integral part of our lives.

Sincerely,

Willard Shower Program for the Homeless is

CLOSED!!!

HELP US KEEP FREE EVENING AND WEEKEND SHOWERS OPEN...

Meet with the City of Berkeley
Homeless Services Director

Tuesday, August 6, 1996
7:30 - 9:30 pm
at the
Suitcase Clinic
2407 Dana Street & Haste
First Presbyterian Church

Sponsored by: S.H.A.R.E. (Searching How to Achieve Respect and Empowerment)
For more information call (510) 643-6786 and leave a message.

Nine: S.H.A.R.E. Play

S.H.A.R.E. Play

Ideas

Target Audience = Telegraph crowd, students, professionals (lawyers, doctors, chiropractors), middle-class people

Where will it be? Medical Division room of Clinic.

Props: Blankets, Hats, (?)

Topic Ideas:
- Hearing disability verification from doctors
- Hotel room of my own; place to call my own
- Waiting for a place to move into
- Lack of respect to homeless people
- Police interrogation
- Access to health care
- How are needs being met and how do homeless people handle themselves after being turned away from a resource?
- Skin color doesn't matter
- Working together is a good thing
- Waiting in line to get GA/Food Stamps
- Church worker serving food to homeless
- Demonstration on welfare rights, homes not jails, food not bombs, etc.
- Crime, attacks
- Politics (i.e., welfare bill)
- Shelter and how homeless people are turned away
- Drug addiction and its destructive role in society
- The importance of volunteers (including doctors) and the effect their work has on society

The Skits:
1) Cop harrassing homeless person asleep in the park
   a) Homeless person just in town from New York City
   b) Sleeping in park with open bottle, blanket, lying on bench
   c) Officer approaches and wakes person; tries to give citation for open bottle
   d) Person throws bottle; conversation about not having money; no place to sleep
   e) Officer walks away tells person to watch himself
2) Another homeless person watches what just happened and offers advice about detox
   a) JJ and Robert converse about detox and why important to go into detox
   b) Tells about detox, GA and food stamps
3) Person on bicycle gets arrested on a federal warrant
   a) Person riding bike arrested

    b) Local officer sees Robert in store doorwell; tries to give ticket/move him along
4) Going through process of applying for GA and food stamps
    a) In line for GA and food stamps; act out process
    b) Told about Food Project as place to pick up mail; decides to find out about it
5) Going to Quarter Meal and ending up at the mailbox
    a) Told by another person in line for food, but actually in line for mail
    b) Ike, John, and Robert in line - Ike says not in line for food
6) One homeless person goes to Ike for advice on resources (computer classes, bus system)
7) Computer training

---Nov. 5, 1996
7) Computer training
8) Free Box @ People's Park
9) Quarter Meal
10) Jail/Court - 100 hours of community service
11) Computer class
12) Shelter/Robbery
13) Jail/Court - Aoi 90 hours of community service
14) Suitcase Clinic Intake
15) Suitcase Clinic - Caseworker, medical student, doctor
16) Highland ER

--- Nov. 12, 1996
17) @ Highland Hospital: Robert waits for hours; doctor diagnoses Robert w/ internal bleeding and operates on him
18) In Ward 3: Nurse serves breakfast, tells him he needs to check out in 2 hours. Robert had bad kidneys and liver. Doctor tells him to stay for five days. Doctor tells nurse he needs to stay.
19) 5 days later, Rob feels a little better. Gives him 2 more weeks because he's homeless and has no place to rest.
20) John (social worker) talks to him about alcohol problem. Rob is going through withdrawal. Doctor gives him morphine. Security guard straps him down. Social worker talks to him about detox. Security guard removes straps.
21) Robert gets checked out of hospital, talks to social worker. Robert gets list of detox programs from John.
22) Scene 3: Robert goes to an AA meeting. Introductions; everyone tells why they are alcoholics.

12/10/96

23) 2nd AA Meeting
24) Quarter Meal
25) Shelter: lottery, showers, morning wake up
26) Herrick Hospital: Accupressure, new program, 30 to 60 days